

The consultant's caseload: a working framework

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Consultants psychiatrists have a limited time to offer their services. Current contracts, based on population norms, do not establish limits to consultants' workload. Reorganisation of service provision, rising demands and marked social differences in different localities have brought these population norms into question. What is the desirable workload for a consultant to ensure a decent level of care to patients? A model is proposed that specifically applies to whole-time consultants within a catchment area, and those working in adult general psychiatry. It will need to be adapted for other specialities. The figures given are estimates, which will need to be audited appropriately for refinement. It is hoped that such an analysis will facilitate the process of purchasing care for specific patient groups, and be a clearer way of identifying gaps in clinical service.

Model and basic assumptions

Consultants, as any person in a working environment, have a limited time to offer their services. Current contracts, based on population norms, do not establish limits to consultants' workload, who are expected to respond to all referrals arising out of the catchment area. Reorganisations of service provision, rising demands and marked social differences in various localities, especially in London boroughs, have brought these population norms into question. A more appropriate model, which circumvents any imperfections in weighted capitation formulae, should take into account the specific workload undertaken by each consultant, the particular patient characteristics of that workload, and the supportive infrastructure in each area. Similar views have been expressed in the USA (Goldman *et al.* 1994) and in this country (Watson, 1985, 1986; Creed, 1995). In times when consultants are asked to prioritise care, it is particularly relevant to assess the differential workload imposed by patients with varying diagnoses, so that this information can be passed on to purchasers

when they are deciding what to purchase and for whom.

The following exercise specifically applies to whole-time consultants within a catchment area, and those working in adult general psychiatry. The model will need to be adapted for other specialities. The following figures are estimates, and are intended as illustrative examples, and therefore will need to be audited appropriately for refinement, but they have been produced after extensive consultation with colleagues in the North Thames Region. This paper is intended to help those involved in negotiating the provision of local services to specified quality levels. It is hoped that such an analysis will facilitate the process of purchasing care for specific patient groups, and be a clearer way of identifying gaps in clinical service. Within trusts, and applied to different specialisms, this model can generate discussion on apportionment of responsibilities and manpower requirements.

Work hours

Assuming an eleven session per week whole-time appointment (excluding time on duty), a typical consultant should spend the following time in non-clinically related activities per week. We accept that by breaking down the components of the job into separate areas we are not taking into account some degree of overlap and interdigitation of tasks but we have tried to bear this in mind by allocating time to each one of these activities and reducing them by 15%. They are therefore conservative estimates. It should be pointed out that we do not believe that at the moment consultants spend the desired amount of time in research-related activities, mostly because of pressures of clinical work. It is also suggested that committee work is voluntary(!) and should be considered outside professional time, although we contend that with extra

managerial responsibilities consultants should include this time as part of their core activities. Likewise, travelling has not been traditionally included within contracts, but it should be argued that with increasing dispersal of venues for psychiatric services, consultants and other professionals will be spending a substantial proportion of their working day getting from the acute unit to the locality mental health centre, from the community residential home to primary care settings, and so forth. Finally, we also are advised that contractually lunch breaks do not exist!

Taking into account that:

1 session=3.5 hours
and a full-time contract=11 sessions/week
Working hours per week=3.5 × 11=38.5 hours per week.

If we divide non-clinical working hours into three broad categories, administration, research and teaching we estimate that the consultant will spend on average every week:

Administration (to include committee work, telephone calls, reading, corresponding, information meetings with management)	7 hours
Research (to include academic meetings and audit)	3.5 hours
Teaching (to include supervision of juniors, other disciplines, formal/informal staff meetings, journal clubs, etc.)	6 hours
Travelling (between bases) (at the moment non-contractual)	4 hours
Total	20.5 hours

This would leave a total of 38.5–20.5=18 hours/week to dedicate to clinical activities.

After discounting holidays and study leave (8 weeks) the clinical time available over a period of one year would therefore come to:

$$18 \times 44 = 792 \text{ hours.}$$

Patient workload

The analysis assumes that the consultant has the support of a full-time junior doctor clerking and looking after his/her in-patients, as well as doing a limited amount of out-patient work, a full complement of nurses in-patient and community settings, and is closely working within a multidisciplinary team of social workers, psychologists, occupational therapists and other disciplines. It is worth bearing in mind that although some clinical work can be delegated, there are specific responsibilities, especially those duties under the Mental Health Act, which only the consultant can undertake. Time spent

with particular groups of chronically ill patients will also depend on residential facilities and staff available in the locality. We have considered two scenarios: one where the consultant is always available and time is included to see the patient and relatives personally throughout the clinical intervention (the ideal), and a second one where the consultant delegates many of the tasks to his junior colleagues and other staff in the multiprofessional team (the alternative).

Not all patients take the same amount of clinical time and input from a consultant. The following are broad nosological categories we have used for this analysis, with some illustrative vignettes.

(a) Psychosis

(i) *Young adult schizophrenic*. Patient is likely to be still living with parents. His symptoms have brought him into trouble with the police. He abuses drugs. Parents are unable to handle situation any longer, and are asking statutory services to take over. Patient seen at home, admitted on a section. Over a period of a year has been admitted twice to hospital after non-compliance with medication.

(ii) *Chronic schizophrenic*. Patient has been known to services for many years and lives in a group home. She occasionally relapses when she discontinues her depot injection, and community psychiatric nurses provide most of the clinical input.

(iii) *Manic depressive*. Has regular hypomanic swings despite being on lithium salts. Occasionally these swings become extreme and require admission to hospital.

(b) Neurotic

An agoraphobic middle-aged housebound woman, with occasional bouts of depression and marital difficulties. We are assuming that she will not require admission to hospital.

(c) Personality disorder

An inadequate man in his late 20s finding himself regularly getting into fights as a result of drunken behaviour. Occasionally experiences brief psychotic-type experiences. Has been in prison for violent offences.

Patient clinical times

In this part of the exercise, we are including the time it is predicted that the consultant will

be involved in the management of the patient over a period of a year.

(a) (i) **Young schizophrenic patient**

	Ideal (hours)	Alternative (hours)
Domiciliary visits and home assessments (× 3)	6	3
Letters	2.5	2.5
Phone calls	4	2
Case presentation × 2	1	1
Ward round time		
1st admission 8 weeks	2	2
2nd admission 4 weeks	1	1
Patient and family meetings	6	2
Managers/MHRT+reports	4	4
Section 3 assessment	1	1
Section 117 pre-discharge meeting × 2	2	2
Consent to treatment	0.5	0.5
Out-patient appointments (inc. section 117 meetings)	6	1
Total	36	22

Note. We estimate that most of these patients with this diagnosis are likely to require admissions under the Mental Health Act. A third are likely to require attendances at either or both mental health review tribunals (MHRTs) and managers' meetings.

If a patient does not apply to the MHRTs, or is informal and compliant with treatment over period of a year this figure can be reduced to 29 hours (14.5 hours in the alternative model).

A small percentage of patients, say 5–10%, are likely to have dealings with the law, creating further forensic work, some requiring prison visits. Should they need to be placed on registers, they would require another hour long meeting.

(a) (ii) **Well-known chronic schizophrenic** (Same for ideal and alternative models)

	hours
Out-patient appointments/reviews	2
Letters	0.5
Home assessments/Non hosp. setting	2
Letters	0.5
Phone calls	2
Total	7

Note. We estimate that 10% of these patients over a year are likely to experience acute schizophrenic breakdowns requiring admission, in which case these would demand approximately half as much time as acutely ill schizophrenic patients, i.e. 18 hours (9 hours); 20% are likely to become subacutely ill, without the need for admission, but concerted attempts to keep them in the community are likely to impose extra burdens on consultant staff, and

we therefore estimate the same time, approximately 18 hours per patient per year. This would add approximately 4 hours to the 'average' patient in this category.

(a) (iii) **Manic depressive psychosis**

	Ideal (hours)	Alternative (hours)
Out-patient appointments	4	2
Domiciliary visit	2	2
Phone calls/planning		
Travel/coordination	2	2
Letters	3	1
Case presentation	0.5	0.5
Ward round time (admission 10 weeks/year)	2.5	2.5
Patient and family meetings	3.5	1
Pre-discharge meeting	1	0.5
Section 3 assessment	0.5	0.5
Consent to treatment	0.5	0.5
Section 117 &/or pre-discharge meeting/s	2	1
MHRT/managers	3	3
Total	24.5	16.5

Note. We estimate that 50% of patients will present for admission with hypomanic/manic presentations where it is likely they will be on a section and appeal against their sections. For those who do not require sectioning, we estimate a reduction in time by 4.5 hours in the ideal model and 4 hours in the alternative model. A proportion will convert to depressive illnesses. The literature indicates that mixed affective disorders spend additional time in hospital.

(b) **Neurotic patient**

	Ideal (hours)	Alternative (hours)
Assessment	1.5	(same but seen by registrar)
Letters	2	
Out-patient appointments (seen once a month)	5.5	
Liaison with GP and other services	1	
Total	10	

(c) **Personality disorder**

	Ideal (hours)	Alternative (hours)
Assessment in prison	3	3
Court reports/attendances	3	3
Phone calls (solicitors, etc)	2	2
Case presentation	0.5	0.5
Ward round (admission 4 weeks)	1	1
Patient/family meetings	3.5	1
Pre-discharge meeting	1	0.5
Court attendance	4	4
Out-patient appointments	3	1
Letters	2	1
Total	23	17

Case mix

In summary, estimated times dedicated to patients over a period of a year with these diagnostic descriptions come to:

	Ideal (hours)	Alternative (hours)
(a) (i) Young schizophrenic patient (adult)	36 (29)*	22 (14.5)*
(a) (ii) Chronic schizophrenic patient	7	7
(a) (iii) Manic-depressive patient	24.5 (20)**	16.5 (12.5)**
(b) Neurotic patient	10	10
(c) Personality disorder	23	17

*Patients who do not apply to the MHRTs or are informal and compliant to treatment over a period of one year.

**Patients who do not require sectioning.

Most adult psychiatrists have a mix of cases under their care. Under current health reforms, purchasers, whether they be health authorities of GP fundholders, will have a greater say on the level and composition of this case mix.

In this exercise we have not addressed the added complications of co-morbidity, especially as far as abuse of alcohol and other drugs when associated with psychiatric illness. We expect that when co-morbidity is present, an addition of 20% should be estimated for consultant time.

Example

We must bear in mind that we are here referring to patients who are actively being looked after by the consultant at any one time. Many patients are likely to be on the 'books' but not demand consultant time, except for occasional reviews.

In the ideal model, assuming a consultant with a catchment area of 50 000 in a deprived London borough admits at least 15 acute young schizophrenic patients over a period of one year, that these patients are admitted under a section of the Mental Health Act, and that four apply to MHRTs(*), fail to comply and are readmitted, the demand on time will be:

(*) $4 \times 36 = 144$ hours
 $11 \times 29 = 319$ hours
 Partial total = 463 hours

In the alternative model, and keeping roughly to the same amount of hours, the consultant and his team will be able to look after 27 patients, seven of whom we estimate will require Mental Health Act work:

(*) $7 \times 22 = 154$ hours
 $20 \times 14.5 = 290$ hours
 Partial total = 444 hours

This scenario only allows the rest of the consultant's 372 hours of clinical time to be spent on patients with other conditions. Say:

	Ideal	Alternative
Acute schizophrenia	15 patients (453 hours)	27 patients (434 hours)
Manic depression	3 patients ($3 \times 24.5 =$ 73.5 hours)	5 patients ($5 \times 16.5 =$ 82.5 hours)
Chronic schizophrenia	29 patients ($29 \times 7 =$ 203 hours)	29 patients ($29 \times 7 =$ 203 hours)
Neurosis	4 patients ($4 \times 10 =$ 40 hours)	4 patients ($4 \times 10 =$ 40 hours)
Personality disorder	1 patient ($1 \times 23 =$ 23 hours)	2 patients ($2 \times 17 =$ 34 hours)
	Ideal	Alternative
Total clinical time (hours)	792.5	793.5
Total caseload	52 patients on active clinical list	67 patients plus those seen by multidisciplinary team.

Locally, audit committees could test the validity of these estimates as they will clearly vary in different population-based practices, and will be influenced by the skill mix of multi-disciplinary teams and the degree of development of specialist tertiary services in each district. Added to this, the advent of the care programme approach, supervision orders and registers will obviously impact on consultant's time.

Acknowledgements

We would like to thank all members of the Psychiatric Advisory Committee of the ex-North East Thames Region as well as Alastair Scotland, Regional Medical Advisor, for their help in the preparation of this paper.

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