Discussion

The key findings of this survey conducted by the ABN are:

1. For consultant neurologists involved in patient care (DCC and SPA PAs), the number of FTEs is 1 per 91,175 (1.1 per 100,000) and not 1 per 75,292 as calculated by the Royal College of Physicians. This is much less than expected for similar high income European countries[5] (eg. France and Germany both have 1 per less than 25,000). This inevitably has an impact on quality of care provided for patients with a neurological condition especially with regards to equitable and timely access to a consultant neurology opinion throughout the UK.
2. As per the RCP data, there is significant geographical variation in the number of consultants throughout the UK.
3. There is a gradual shift when comparing the trainee and consultant data towards better gender and ethnic representation in the former.
4. There is concern for future workforce planning in that the number of female trainees is increasing but of the 27% of consultants that work part time 47% are female and work part time mainly due to family commitments. In contrast the 42% of male consultants that work part time generally do so at the latter stage of their careers due to partial retirement. If the increasing number of female trainees continue to work part time at the same rate as the current female consultants do then this will have an impact on consultant neurologist numbers in the immediate future.
5. The type and number of sub-specialist clinics offered by consultant neurologists is appropriately centred around the three most prevalent neurological conditions (epilepsy, multiple sclerosis and Parkinsons disease) with the exception of stroke which may be explained by stroke care being traditionally shared by multiple medical specialities.

The ABN survey has provided valuable and accurate data on the number of consultant neurologists involved in patient care, the gender and ethnic breakdown of the consultant body and for the first time the breakdown of general neurology and sub speciality practise. Similar data is provided for neurology trainees.

The key limitation of this survey is the assumption that the respondents to the survey are representative of the consultant neurologist / trainee population.

Whilst it is reassuring to see the shift among neurology trainees towards a more representative gender and ethnic mix, there are worrying findings highlighted by this survey. The fact that the number of neurologists involved in patient care is much less than comparative to European countries[5] is particularly worrying at a time when there is a marked and welcome increase in therapies for neurological conditions which often need specialist administration and monitoring (eg. immunotherapies for multiple sclerosis, thrombectomy for stroke and the advent of novel genetic therapies for inherited neurological diseases). Although there is geographical variation in the number of neurologists in the UK with particular recruitment difficulties in certain parts of the UK that need addressing, the total number of consultant neurologists in the UK is too low and workforce planning needs to focus on increasing this number. This is particularly important as neurologists are increasingly and appropriately involved in stroke care, and the plan for neurology training in the new Shape of training curriculum is for all future neurologists to be dually trained in neurology and stroke medicine for the benefit of the patients.

Another urgent concern is the dual impact of LTFT working doubling as trainees move to consultant posts and the 6% of neurologists who have retired and returned. We appreciate there are too few doctors across all specialities in the UK[4] and that various long term solutions are being discussed to address this. There is an urgent need to immediately address the needs of young parents to make it easier to work more if they choose to do so. Making it more attractive for consultants not to either retire early or retire and return but to stay full time longer could also be made feasible immediately by removing the financial penalties of continuing to work full time. This is an issue which affects all specialities and is under active discussion which hopefully will lead to a speedy resolution.

We would like to thank all who contributed to this survey. Having accurate information is the first step towards recognising problems and working towards solutions.

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Working less than full time – trainee experience, and top tips

By Amy Ross Russell and Rhian Raftopoulos
Full author details on page 34

Data from the RCP 2017/2018 census demonstrates that the number of physicians training flexibly at both consultant and trainee levels is increasing. Approximately 27% of neurology consultants, and 12% of neurology trainees work Less Than Full Time (LTFT), according to the ABN workforce survey 2018, and 18% of responses to the recent ABNT census 2020 were LTFT trainees.

This perhaps reflects a changing culture within medicine and more broadly within society itself recognising the need for a better work-life balance with greater autonomy over how and when we work. There are many reasons a doctor may choose to work LTFT as well as many different ways of working flexibly and the concept and accessibility of flexible working within the NHS is still evolving.

We are two neurology trainees at different stages in our career who have chosen to work LTFT and we hope to give you the benefit of our experience so far.

We both started LTFT working on our return to work after our first maternity leave. We hoped that working flexibly would give us the best of both worlds, allowing us to spend important time at home with our children, whilst continuing to progress and thrive in our careers.

The reality is not always as simple and there are times when the two worlds compete and spill over into each other, and it can sometimes feel like we are performing neither role well. Juggling our two identities effectively without feeling a sense of disloyalty to either or both is a challenge.

However, overall LTFT working has been a positive experience for both of us and has given us the flexibility to enjoy the demands of neurology training, whilst also enjoying quality time with our family.

Eligibility (and being organised)

Recent changes to guidance mean that all junior doctors with "well founded individual reasons" should have the option of LTFT working and all applications should be viewed positively. In practice LTFT requests are mainly prioritised based on two categories. Category 1 includes disability or ill health (this can include undergoing IVF), caring for an ill or disabled partner, relative or

dependent, or caring for children. Category 2 includes unique opportunities for personal professional development as well as non-medical professional development including management courses. It is encouraging that The RCP is supportive of broadening category 3 training whereby a trainee can work LTFT without a specified reason.

If you are considering working LTFT then it is important to talk to the right people as early as possible. Getting the support of your educational supervisor and training programme director is key. There is an application form to fill in that can be obtained via your deanery LTFT administrator. Again ensure you fill in this form early to allow your deanery as much time as possible to accommodate your request.

Once your application has been approved and you have decided your percentage working hours, it is a good idea to get in contact with the department that you will be working in and identify key clinical and educational activities during the week to guide which days of the week to work. Where there is some flexibility, think carefully about which days you want to work. We prefer to work three consecutive days so as to provide some continuity of care and mindset, whereas others prefer to break the week up to avoid having all the work and time away from home in one chunk (and vice versa!)

If relevant, get your childcare organised early. Our jobs are not always predictable so take into consideration opening hours of the nursery/childminder. For example, is there any flexibility if you need to stay late? Do you have a back-up plan in case of sickness etc.?

Time (and being organised)

Most LTFT posts are slot shares where the responsibilities of one full time post are split between the two (or more) trainees, but you're employed and paid as individuals. Get in touch with your slot share partner as soon as possible. Negotiating working days and ensuring both of your needs are being met can be tricky but it is much better if you can achieve this between yourselves. A good working relationship is key as you will need to ensure good handover (especially if there are a lot of inpatient responsibilities) and trust that your job share will follow up on urgent issues that have arisen during your working days. If this relationship works well it will make both your lives easier as well as being a source of moral support.

Get a copy of your rota as soon as it is available and remember that each LTFT doctor must be given a personalised work schedule. Ensure that you know your rights and responsibilities with regards to out of hours work as some rota coordinators may not have a good understanding of this for LTFT trainees. We would recommend reading the BMA good rostering guide prior to contacting your rota coordinator. Some key recommendations we have found useful to know include:

1. You will be required to work the pro rata percentage of each type of shift on the full time rota (in a slot share out of hours work should be split 50% and any additional hours required to meet the LTFT percentage should be made up with educationally beneficial normal working hours)
2. Unless otherwise agreed a normal, long day or twilight shift should not be rostered on a non-working day
3. Night shifts should only encroach on a maximum of one non-working day in a fixed working pattern
4. Adequate notice should be given if fixed working days need to be changed
5. Annual leave and study leave is calculated on a pro rata basis
6. Where a doctor's working hours fall below their LTFT percentage and they are required to 'make up shifts', any additional shifts should be on normal working days unless otherwise agreed

It is likely at some point that issues will arise with your rota. Be as proactive and as flexible as you can in finding a solution. Remember that you are not alone and if you are struggling to resolve rota issues get in touch with the Champion of Flexible Working (it is now mandatory for each trust to have one). Make sure you involve your educational supervisor in your discussions.

Money

Although LTFT allows greater flexibility it does have financial implications and means that your pay takes a hit. It is important to have thought carefully through your financial commitments (including childcare costs or additional costs incurred by travelling to work or being at work) before deciding on your percentage hours. When you get your first pay cheque ensure you check your pay slip is correct, as in our experience mistakes are common. This is a good resource for taking you through your payslip step by step. https://www.bma.org.uk/features/lessthanfulltimetrainees/

In addition remember that pension contributions for LTFT doctors are based on their full time equivalents.

If you do need to supplement your income LTFT trainees are now allowed to undertake locum work – see here for guidance. https://www.copmed.org.uk/publications/guidance-on-undertaking-additional-work

Some colleges and memberships, eg GMC/BMA offer reduced rates if your income is below a certain threshold.

Career progression

Remember also that working LTFT will extend your training and delay your CCT date. The JRCPTB provides this tool to help you work out your CCT date https://www.jrcptb.org.uk/training-certification/less-full-time-training

You will still be required to have an annual ARCP and you will be required to complete a pro rata number of assessments. There will of course be less time within a week to complete these, but the extension to your training should mean there is overall as much, if not more opportunity to identify suitable cases. You still need admin time and time for personal development, so be careful not to let this be taken over with clinical duties to "make up for not being there other days". Again, if there are difficulties with this, involve your Champion of Flexible Working.

Training opportunities may be limited to particular times of the day or week, for example sub-specialty clinics or MDTs. It is helpful to think about these early to allow you to plan how to achieve this experience/training, and your educational supervisor should be able to help you with this. Sometimes it is possible to rearrange your working days for a couple of weeks, or to arrange to attend a different clinic/MDT as an alternative, or find a suitable course to replace this experience. Close attention to your e-portfolio, careful design of your Personal Development Plan (PDP), and close liaison with your educational supervisor will be important in ensuring smooth progression and avoiding falling behind. We would encourage you to be proactive in this, as it is easy to let it slip, and hard to find time to catch up.

Challenges

We would be lying if we said there had not been challenges along the way. Not all colleagues find it easy working with job-share trainees, and conflicting schedules make certain clinical roles or responsibilities harder. Ensuring continuity of clinical care is more challenging, and there is less time to get to know complex patients or situations. You need to rely on handover information from your colleagues, and sometimes will not be able to have the benefit of a face to face handover but need to rely on written information. This is difficult. It requires energy and enthusiasm for what you are doing, and means you sometimes feel you under-perform compared to your colleagues (or former self). Try not to think this way, but appreciate that developing the ability to become rapidly acquainted with a case is a key skill in becoming a senior trainee, and when necessary, explain that you need a little more time to get to grips with a complex case.

It can be more difficult to establish yourself within the team, especially if you start training LTFT before you are well known in a team, or around a time you change places of work. LTFT trainees often describe feeling they are not taken as seriously as their full-time counterparts and you can miss out on opportunities simply because you are not around as much. Comments such as "what are you doing on your day off?", or "don't worry – you don't have time for this" can be frustrating and reflect a misperception of LTFT working.

Arranging out of programme (OOP) opportunities, and funding for OOP may be more challenging. Again, this is mainly tackled by knowing your rights, and being organised. Trainees should not be prevented from taking time OOP (for good reasons) on the basis of working LTFT, in exactly the same way that any other trainee should not be prevented because

there are staffing issues. But, as with the latter, it is always best to plan ahead, communicate clearly with your training programme director and educational supervisor, and be as flexible as possible. This not only gets people on your side, but also means that the process will be smoother, as the necessary organisation for filling your space, and arranging funding can be sorted, and it avoids last minute disappointments. Remember that time OOP may also be LTFT and there will be implications from this on experience, opportunity, and duration of time OOP.

Benefits

Despite all the challenges mentioned, in our experience, the benefits far outweigh the challenges and it has definitely been the right decision for us. LTFT has provided us with a better work life balance – allowing us to spend more time with our young children, easing some of the pressure on family life, and avoiding this feeling "squeezed" into a weekend.

The reduced burden of on calls is significantly appreciated, especially when the reasons for LTFT working include responsibilities at home, and when sleep is at a premium!

At work, we find we have a greater appreciation and enthusiasm for our work. The 'extreme end of week fatigue' is much less of a problem when working a three-day week, and having less time spent at work during the week, particularly if you have previous experience of full time working, can feel liberating!

The slower pace of training can also be a real benefit, as new opportunities open up, and you may end up taking a very different route to that which you originally planned. You have more time to 'enjoy the ride' and reflect on what you want to get out of your training, before you are committed to a substantive consultant post.

Top Tips for LTFT working success
Be organised
Contact the right people at the right time
Know your rights and responsibilities
Know who to contact for help if problems occur
Communicate any problems early on
Be proactive and flexible in finding solutions
Seek out other LTFT for advice/support-find a mentor
Set realistic and achievable training goals
Prioritise goals/objectives in order of importance/time sensitivity
Handover is everything!
Show initiative and seek out opportunities
Be kind to yourself – accept that you cannot be all things to all people all of the time!
Always have a back-up plan in case of emergencies
Other useful resources
BMA LTFT guidance https://www.bma.org.uk/advice/career/applying-for-training/flexible-training-and-ltft
The BMA good rostering guide https://www.bma.org.uk/advice/employment/contracts/junior-doctor-contract/rostering-guidance/roster-design-for-ltft-doctors
NHS Employers Doctors in Flexible training. Equitable pay for flexible trainees
Other sources of support
BMA LTFT forum
LTFT Trainees Facebook page
The Medical Women's Federation
ABN LTFT representative

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Tuberous Sclerosis Complex

By Philippa Ward

It's nearly nine years since I first heard the words Tuberous Sclerosis Complex. I remember the date very clearly – Friday 24th February 2012 – but most other memories from that time are cloudy and vague, to say the least. You see, I was physically and emotionally drained. I had a five-month-old baby who had spent the previous ten days behaving oddly, making strange jerky movements and crying incessantly. I had an energetic two-year-old in the mix too. You can imagine what my life was like. So, my first reaction on hearing those words was "tubular what?" I thought immediately of the Mike Oldfield classic, Tubular Bells. That was about as much as my already-full brain could manage.

I was the kind of exhausted that every parent with a small baby and a toddler experiences at some point. But, I was also exhausted from the double-whammy of rejections I had received from two different GPs who had dismissed my concerns about my baby, Thomas, as "colic" and "teething". One of them even said "you can't think he's having seizures". Oh, how ironic those words seem today.

You see, on Valentine's Day, I had been getting Thomas ready for bed when I noticed he was making very subtle jerky movements with his arms. He was five months old, so I thought he should have grown out of the startle reflex, but that was the only thing I could think of that made any sense. However, it didn't really make any sense and something just didn't seem right. Over the course of the next few days, things got worse. Thomas was doing this strange movement, which I could only describe as an exaggerated version of the startle reflex, more and more. He was also crying more than usual. I guess, looking back, I was pretty certain, deep down, that there was something terribly wrong with him. I knew from my experiences with my older son that