	Mon	Tue	Wed	Thurs	Fri
8.30am	Admin	Cons meeting	Stroke meeting	xxxxxxxx	Neuro Xray
					MR (3/6mths)
9.00am	OPD			xxxxxxxx	
lunchtime		directorate teaching			department teaching
2.00pm		xxxxxxxxxx	Crediton	xxxxxxxx	
4.00pm					admin

Hi Mark

I know you've been waiting for this for ages, I apologise for being so tardy. Apologies too if this reads as a whine – it is not meant to be, it is just observation of what is done and where I (we) feel there are problems. It is complicated as we have a 6 monthly rolling rota that Martin, Anthony and I share that dovetails with our own (different) fixed commitments. My timetable of fixed commitments is as above – the part I object to in this is the Morning Report that was added in and coincides with the neuro X-ray meeting. Initially we all did MR on Thursday and Friday of the 2 months we were on Kenn, I now do 3 months of Fridays instead. Morning Report when on Kenn would seem sensible but we still do acute ward rounds and stroke clinic on those months and the x-ray meeting is important. Lately the MR timetable has been set by one of the secretaries and is even more erratic, this is something we as a department will discuss but in reality there isn't a straightforward answer as none of us have space.

The rest of the sessions are divided as follows:

1) Acute Ward Round (9.00-10.00) on Clyst (if closed a peripatetic ward round of outliers) followed by Daily Stroke Clinic

2) Acute Ward Round (9.00-10.00) on Clyst and teaching Right Sided Weakness pathway week (Tuesdays only)

3) Daily Stroke clinic (10.00 start may be brought forward) Tuesdays only

4) Clyst rehab MDM, this takes most of the afternoons troubleshoot only afterwards

5) Ward round on Kenn ward. I am timetabled to do MDM also but this is at a different time from Martin and Anthony and the therapists are usually unavailable so often reg led on the Tuesday afternoon

6) SPA! So far has been used as admin time

Part sessions and other fixed commitments we have as a team are:

Weekly discharge summary meeting (takes 1-2 hours)

RSW feedback

Acute stroke MDM

Meetings such as the Stroke Providers Meeting, Clyst Business meeting and Clinical Issues Forum take place at regular intervals

The Safeguarding work that I do has no protected time, likewise any service development, research etc that M and A do have little in the way of protected time.

For the last 6 months on average I have been timetabled to have:

Month1. Direct clinical care: 5.5 sessions, Admin 0.5 session, SPA 1 session

Month2. Direct clinical care: 5, SPA 1, teaching 1

Month 3. Direct clinical care:5.5, teaching 0.5, SPA 1

Month 4. Direct clinical care: 5.75, SPA 1, Admin 0.25

Month 5. Direct clinical care: 4.5, teaching 1, spa1, admin 0.5

Month 6. Direct clinical care 5, teaching 1, SPA 1

At least once per month, usually more, the SPA is consumed into timetabled activity to cross cover, at all other times this becomes dealing with letters, phoning GPs etc. Likewise any activity that I do (annual leave, conference etc) that coincides with the acute round, teaching or stroke clinic is covered by my colleagues.

As a team we would like:

1) to have enough admin and SPA time - for me that would allow more time to develop the Safeguarding role including dementia service etc. For Anthony and Martin this includes dedicated research time

2) 3 episodes of Consultant presence on the ward/week – 2 full WR 1 MDM & troubleshoot. In light of the situation with junior doctors we feel that this is the minimum we should do on the rehab side/Kenn

3) Dedicated time for a relative's clinic – this would also free up junior doctors as well as reduce complaints and hopefully could have an impact on length of stay

4)Consistency in the person doing the acute ward round, at the moment this cannot happen and patients may be admitted under your name but be seen by everyone other than you or a different person each day.

5) We are also thinking about how we solve the dilemma of acute stroke/TIA at weekends

The only way we can see to develop the service for stroke and Kenn ward is to appoint another physician. Will is taking the business case to the executive.