BRITISH SOCIETY OF GASTROENTEROLOGY

Consultant gastroenterologist job planning guidance

Bernard Brett and Jeremy Shearman

On behalf of the BSG Job Planning Advisory Group* and the Clinical Services and Standards Committee.

***The BSG Job Planning Advisory Group comprises:**
Dr Bernard Brett, Consultant gastroenterologist, Norfolk and Norwich University Hospitals NHS Trust
Dr Jeremy Shearman, Consultant gastroenterologist, South Warwickshire NHS Foundation Trust
Dr Tony Tham, Consultant gastroenterologist, The Ulster Hospital, Immediate past chair of BSG Clinical Services and Standards Committee (CSSC)
Dr Alistair McKinlay, Consultant gastroenterologist, Aberdeen Royal Infirmary, BSG President
Dr Andrew Douds, Consultant gastroenterologist, Norfolk and Norwich University Hospital, BSG CSSC Chair
Dr Rupert Ransford, Consultant gastroenterologist, Wye Valley Trust. BSG CSSC Deputy Chair
Dr Melanie Lockett, Consultant gastroenterologist, North Bristol NHS Trust, Previous BSG Workforce Lead
Dr Helen Fidler, Consultant gastroenterologist, Lewisham and Greenwich NHS Trust, BMA Council Deputy Chair

Contents

Glossary of terms
Recommendations
Introduction
- Key Elements in a Job Plan

The New Consultant
Varied Patterns of work
Later Careers
Definitions and Contractual Considerations
- Direct Clinical Care
- Supporting Professional Activities (SpA)

Direct Clinical Care
- Outpatients clinics
- Multidisciplinary Meetings
- Clinical Administration
- Endoscopy
  - **Training Lists**
  - **7-day working and planned care including endoscopy**

In-patient work
- Ward-based Cover
- Board Rounds
- Medical Admissions Unit (MAU) and General Internal Medicine (GIM) Cover
- A worked Example of inpatient care

Emergency, On-call and Unplanned Clinical Work
- Scheduled Emergency Work
- Consultant of the Day/Week/Month
- 7-day working and the ten clinical standards
- Calculations
- Unscheduled emergency work (on-call)
- Out-of-hours endoscopy
- Worked Examples
- Compensatory Rest
- Public (Bank) Holidays in-patient work
- Prospective cover

Nutrition Service
Supporting Professional Activities (SPAs)
- Personal SPAs
- Quality Improvement Activity
- Organisational Duties including clinical management
- Consultant Mentoring
- Supervision of Doctors in Training
- Undergraduate and locality teaching
- Research
- SPAs for Research
- Professional roles and responsibilities
- Additional Responsibilities

Additional Considerations
- Departmental Job Planning
- Less than Full time (LTFT) consultant posts
- Annualised Job Plans
- Work Diaries
- Electronic Job planning
- Objectives

The impact of pandemics such as COVID-19
Private Professional Services
Fee Paying Services
Travel Time
Annual Leave, Study Leave and Professional Leave
Supporting Resources
Example Job Plan for a Newly appointed consultant
Job Planning Check List
References/ Source Documents

Glossary of Terms

BMA: British Medical Association
BSG: British Society of Gastroenterology
CEA: Clinical Excellence Awards
CMG: Clinical Management Groups
CQC: Care Quality Commission
DCC: Direct Clinical Care
e-Job planning: Electronic job planning – referring to software to support and record job planning
GI: Gastrointestinal
GMC: General Medical Council
GOD: Gastroenterologist of the Day
GOM: Gastroenterologist of the Month
GOW: Gastroenterologist of the Week
GP: General Practitioner
HPB: Hepato-panreatico-biliary
IBD: Inflammatory Bowel Disease
IT: Information Technology
LNC: Local Negotiating Committee
LTFT: Less than full time
MDT: Multi-disciplinary team
MJPCC: Medical Job Planning Consistency Group
NHS: National health service
PA: Programmed Activity
RCP: Royal College of Physicians
SPA: Supporting Professional Activities

Recommendations

General

Good job planning should be undertaken in a positive and constructive manner by both the gastroenterologist and their employer. The aim should always be to benefit patients, staff and the wider NHS. It should be negotiated and fully agreed by both parties. It should not be imposed.

The BSG believes that patients should be at the centre of the job planning process. A key aim should be to improve patient safety, experience and outcomes. Staff must also be a key focus, the job planning process should help motivate, develop and retain staff to ensure sustainable high-quality services.

Consultant job planning must be aligned with the terms and conditions of the national consultant contract.

It should be emphasised that this guidance will continue to evolve over time particularly given the rapid changes in healthcare provision necessitated by the COVID-19 pandemic.

Out-patient work

An out-patient clinic taking four hours (3.75 hours in Wales) in total is equivalent to 1 Programmed Activity (PA) of Direct Clinical Care (DCC) and should include time for all necessary administrative tasks such as making notes, dictating and ordering investigations. New patient appointments should be allocated at least 30 minutes, and follow-up appointments 20 minutes. These times should reflect the needs of the patient rather than the experience of the gastroenterologist. The time involved in undertaking a virtual clinic is unlikely to be any less than that taken reviewing patients face to face (even though there is no physical examination).

Clinical administration

Clinical or patient-related administration (DCC) can be considered as “predictable” (directly linked to fixed clinical care commitments such as clinic letters, review of results etc.) or “unpredictable” (calls/emails from patients, GPs, colleagues, asynchronous consultations- defined as a consultation where the patient and clinician interaction occurs at different times eg enhanced specialist triage, advice and guidance etc). Each needs to be considered separately in calculations of total clinical activity. Work diaries will be particularly useful in the calculation of “unpredictable” clinical administration.

The BSG recommends that patient related administration is allocated a minimum of 1.5 PA (DCC) for a 10PA job plan for a full-time Gastroenterologist or Hepatologist. Considering the increasing number of patients each Consultant is responsible for, despite not physically meeting many of them, it is quite possible for 2.5 PAs (DCC) or more to be required to appropriately manage the workload.

Endoscopy

One session of endoscopy should equate to 1PA (DCC, 4 hours) and this should allow adequate time for changing in and out of scrubs (and personal protective equipment), team brief, WHO check lists, associated administration including report writing and booking investigations, patient reviews and communication. The content of lists should be adjusted according to the experience of the endoscopist <u>and</u> the anticipated clinical workload (including training, therapeutic and complex procedures, surveillance etc.)

In-patient work

Models of in-patient care have become increasingly complex with many organisations adopting extended shifts (e.g. consultant of the week and its variants). This important work must be appropriately reflected in any job plan with careful consideration to protect consultants from clinical conflicts (e.g. being expected to deliver emergency and planned care simultaneously).

Emergency work (including on-call)

Emergency work encompasses both predictable (weekend ward rounds) and unpredictable (on-call and emergency endoscopy) activity. Each needs to be calculated separately. The BSG recommends that every Trust/Health board aims for an on-call/weekend frequency of no more than 1:8.

Scheduled and emergency weekend working must incorporate an appropriate amount of compensatory rest (in line with the European working time directive).

Supporting professional activities

The BSG supports the RCP recommendation of an absolute minimum of 1.5PAs (SpA) for each consultant to sustain their professional standing (i.e. revalidation and appraisal). Less than full time (LTFT) posts require equivalent time for revalidation, appraisal, study and professional leave. This requires case by case consideration.

The BSG believes that Supporting Professional Activity (SpA) should incorporate the increasingly import role of mentoring. Appropriate time needs to be acknowledged for both senior clinicians (as mentors) and newly appointed consultants (as mentees).

Support of regional and national work

The BSG believes that every consultant should be encouraged to contribute to the wider needs of gastroenterology and the NHS through involvement in recognised regional, national and international associations and collaborations.

Introduction

Consultant job planning remains a fundamental contractual requirement for consultants and associate specialist doctors. This is becoming an increasingly complex process with the more varied and flexible roles of senior clinicians and the implementation of a plethora of both clinical and non-clinical IT systems (including e-job planning applications). More recently doctors work patterns have had to undergo significant change at pace in response to the Coronavirus 19 (COVID- 19) pandemic caused by the infectious disease that results from severe acute respiratory syndrome coronavirus 2 (SARS -CoV-2) (this will be referred to COVID-19 in this document). This has accelerated changes to clinical practice such as the use of telephone clinics or virtual clinics (where IT systems provide video images as well as sound to enable clinics to be carried out at a distance).

No single guidance document could encompass all possible scenarios and calculations to cover all potential job-planning issues, but this guidance should provide the basis for discussion in the vast majority of situations.

Over recent years there has been an increase in Trust mergers, often with pre-existing, and at times very different approaches to job planning, the use of this guide should help to provide consistency.

The BSG believes that patients should be at the centre of the job planning process. A key aim should be to improve patient safety, experience and outcomes. Staff must also be a key focus, the job planning process should help motivate, develop and retain staff to ensure sustainable high-quality services.

Key elements in a job plan are (1, 2, 3 & 4):

- objectives
- direct clinical care
- on-call and emergency work
- supporting professional activities such as clinical audit participation, case note review and other activities relevant to the individual's revalidation
- additional responsibilities and duties
- external duties
- private professional services
- fee-paying services
- travel time
- annual leave and study leave
- supporting resources.

This guide is aimed both at individual consultants and at clinical directors/job planners with patient care and high-quality service provision at its centre. It is applicable to all four Nations in the United Kingdom and where appropriate specific inclusions or exclusions are mentioned to reflect differences in approach. It outlines recommendations to support both the establishment of an initial job plan, such as that which would be adopted by a newly appointed consultant gastroenterologist and recommendations that support more complex job planning processes for those consultants who have taken on a range of roles. It aims to provide information on a range of current potential issues such as short to medium term changes in response to a pandemic, out-of-hours cover for GI bleeding, seven-day services, team job planning, patient related administration, electronic job planning and less than full

time working. It includes some definitions and some worked examples that are aimed to both help understanding and also to assist with individual job planning situations.

Good job planning should be undertaken in a positive and constructive manner by both the gastroenterologist and their employer. The aim should always be to benefit patients, staff and the wider NHS. It should be negotiated and fully agreed by both parties. It should not be imposed.

A job plan is a prospective agreement between the individual doctor and their employing organisation. It should usually take place on an annual basis with timely interim job planning meetings when and if significant within-year changes to commitments or timetabled activity have been introduced, or need to be considered. The BSG supports a more flexible and dynamic approach at times of crisis such as in response to a global pandemic (e.g. COVID-19) but all good job planning principles should still underpin the process.

Doctors are strongly advised to determine PA/timetabling issues and implications with their employer prior to commencing additional work via an interim job plan review. In many cases the process within organisations may not be as prompt or timely as one would ideally hope or expect and so retrospective job planning is required relatively frequently (this is appropriate if overall workload and other commitments have changed above and beyond what was anticipated since the last job planning meeting and an interim job planning meeting could not be arranged).

There are several ways that a doctor's work might change between job planning meetings not least in response to a global pandemic where widespread and significant changes might be required. A doctor may choose to undertake a new activity without prior job planning or line management agreement, they may be asked to undertake a new activity and there are times when a doctor may feel they must take on an additional activity in order to maintain patient safety and high-quality care. In rare and specific situations, a consultant may be requested to "act down" for short periods, usually single shifts to cover absence of training grade doctors. This issue is beyond the scope of this document. Consultants faced with such requests should access the BMA 'acting down' policy and local policies which will assist with emergency clinical work arrangements.

If a Gastroenterologist chooses to take on a new role or activity without prior agreement through personal interest or because they believe it is in the wider interests of patients or the NHS then the Trust can legitimately decline to pay for this activity retrospectively - agreement should be sought at the next job-planning meeting regarding continuing with the activity in question – where possible we recommend that the Gastroenterologist requests an early job plan review. For external duties, such as work for GMC, CQC, BSG, RCP or BMA prior agreement should be obtained. The BSG strongly recommends that employers consider the important role of consultants in the wider NHS as recognized by the association of Royal Medical Colleges (10). The BSG encourages employers to recognise through appropriate PA allocation in job planning all formal roles within their Hospital or Trust (such as education roles, Clinical Lead and Governance leads) -such roles should not be remunerated through other mechanisms such as CEA awards in England or Discretionary points in Scotland.

The BSG supports the establishment of Medical job plan consistency committees (see - Consultant Job Planning: A Best Practice Guide. NHS improvement revised 2017) 3. NHS Improvement recommends Trusts/Health Boards consider setting up a medical job plan

consistency committee (MJPCC) with core membership including Medical Director (or their representative), human resources representative, two LNC representatives and relevant clinical directors. Their purpose is to ensure consistency and an even-handed approach across the trust, as well as compliance with the framework, the contract and all national guidance.

As has been demonstrated by the clinical response to the recent COVID-19 pandemic, clinicians of all grades have to remain constantly flexible and be prepared to change their working practice to sustain their support to patients in ever-changing circumstances. For their part, Trusts need to constantly provide support for consultants and mutually respectful job planning will remain the cornerstone of this crucial relationship.

The new consultant

Newly appointed consultants should usually be initially employed on a 10PA contract if full-time. Trusts should advertise all posts as potential job shares and also offer flexibility to accommodate those who wish to work less than full-time (there is no absolute right to an offer of less than full-time (LTFT) employment but for both equality reasons and in order to both attract and retain the workforce of the future the BSG strongly encourages this option to be offered). A typical 10PA job plan will include 7.5 DCC and 2.5 SpA sessions. In many cases the new consultant will find that the work commitment required is more than 10PAs worth of work. Common components that are under-estimated at the time of appointment are patient-related administration and in-patient workload along with *ad hoc* additional emergency cases in endoscopy or clinic. A job plan diary should be kept (12), and an interim job plan review requested once this is complete. New consultants, and ideally all consultants particularly at times of significant change, should be offered a mentor who should be able to support them in the job planning process as well as with the wider aspects of their role and career.

Varied patterns of work

For many, if not most consultants working in the NHS, the weekly timetable is not the same for each week of the year. For some the main difference occurs during on-call days. Many have periods on and off the wards. In addition, many undertake periods as the Gastroenterologist of the day, week or month (GOD, GOW or GOM). In most of these situations it is best to consider the weekly PA allocation for each weekly timetable (i.e. week one on the wards, week two GOW, week three to week six elective work). The overall allocation should then be based on the average time for each activity, bearing in mind that for weekends, bank holidays and out of hours (7pm – 7am) in England one PA is 3 hours of activity, not 4 hours as for the daytime PA. This is one of the reasons why those recording job-planning diaries should be encouraged to complete a full rota cycle in order that they capture the impact of both on-call and on the ward periods. Electronic job planning (discussed below) will calculate the allocation automatically.

Later Careers

The BSG supports the later careers work undertaken by the Royal College of Physicians. The NHS needs to retain the expertise and experience senior consultants and this should include utilising their skills in leadership, teaching and training, mentoring and coaching of more junior consultant colleagues and other NHS staff. For example, it is becoming increasingly the case that newly appointed consultants will require additional training and support to develop skills in ERCP, therapeutic endoscopy, hepatology and nutrition. As more experienced consultants

are increasingly needed in these varied supporting roles consideration needs to be given to increasing their SpA allocation to allow adequate time for this type of work.

Trusts and Health boards need to recognise that out of hours cover becomes increasingly challenging as staff age and consideration should be given to adjusting commitments from the age of 55 (earlier if there are significant or relevant health issues). The BSG believes that retaining consultants on overnight on-call rotas beyond the age of 60 should only be by mutual consent. For more information please see – 'Later Careers: Stemming the drain of expertise and skills form the profession. RCP 2019' (6)

Definitions and Contractual Factors

Consultant job planning must be aligned with the terms and conditions of the national consultant contract (1)

Seven day working (particularly emergency work) must adhere to the recommendations of the European Working Time Directive. This is especially important with respect to periods of compensatory rest.

- One **Programmed Activity** (PA) is 4 hours in England, Scotland and Northern Island in normal working hours (7am to 7pm, Monday to Friday in England and 8am to 8pm in Scotland) or 3 hours of activity at other times, In Wales 1PA is 3.75 hours in duration. If a consultant undertakes a single activity of 4 hours duration (e.g. an out-patient clinic, an endoscopy list or a teaching session) that takes place every week whilst they are not on leave then this would constitute 1 PA in their job plan.

It should be noted that sessions that are less than four hours in duration would usually be allocated less than 1PA. – Exceptions could for example include: a clinic that lasts for just over 3 hours but where it is agreed in the job planning meeting that the administration associated with the clinic will be included to take the total time up to four hours giving a 1 PA allocation (this should not be double counted elsewhere in the job plan i.e. if the one PA for clinic includes administration time then the clinic cannot contribute to administration time allocated elsewhere within the job plan – see patient related administration); another exception discussed below could include an endoscopy list that last three and half hours but the time taken for changing into scrubs and for reviewing patients and completing notes, requests and patient's reviews is included to bring the total to the full 4 hours (the requirement for special circumstances such as the need for full PPE will add further time outside the list itself).

Direct Clinical Care (DCC) relates to work that directly relates to patient care and directly benefits patients. In the case of most DCC activities such as clinics, endoscopy lists and multidisciplinary meetings there is usually a considerable amount of patient administration required outside of the actual time commitment of the session (as well as a lot of administrative tasks that take place during the sessions). Checking histology, reviewing results, liaising with GPs and other colleagues, dealing with patient queries, seeing referrals and handling complaints are all important DCC activities and must be timetabled and/or have time allocated to be undertaken flexibly.

Many employers and many employees are choosing to annualise job plans, and calculate the annual number of each type of DCC session. This is not contractual, and consultants can decline an annualised job plan although in-effect e-job planning tools are usually set up to work on an annualised basis. Many consultants prefer this approach as it can allow more flexibility around working patterns. A common estimate is for the working year to be considered as 42 weeks (allowing for study/professional leave and annual leave, and 'stat days'), and if a consultant is working 2 clinics per week the employer may expect up to 84 clinics per year. In the case of consultants who have taken on additional internal or external roles (such as work for the BSG, RCP, GMC, CQC, or BMA) consultants may need negotiate a smaller number of annualised sessions to accommodate their other demands, and inclusion of these in their job plan is essential. Many Trust/Health Boards cancel activities on a number of half days per year to accommodate departmental governance meetings – this would lead

to a reduction in the number of sessions of a particular affected activity that are deliverable in that year and therefore the expected number of sessions per year in the job plan should accordingly be reduced.

The number of fixed sessions delivered on a Monday will usually be slightly less than forty-two (as more bank holidays occur on a Monday) on the other hand fixed sessions delivered on Tuesdays through to Thursdays would usually amount to just over forty-two (as fewer bank holidays fall on these days).

As discussed above most consultants have weekly timetables that are not the same each week with for example on-call days and time on the wards and time off the wards. It is important to consider the PA time for each week when that the session is worked (when there is some week to week variation in a timetable) and then for the final job plan agreement to determine the average weekly impact of that session. For example, if for 1 out of 4 weeks a consultant undertakes a sub-specialist clinic that lasts 4 hours that will equate to 1PA for that week but only 0.25PA when annualised in the final job plan. Electronic job planning software (discussed below) will automatically calculate the PA allocation.

Supporting Professional Activities (SPAs) relate to professional, educational, administrative and academic responsibilities. These are essential components of a consultant's work. They include activities that help maintain an individual's professional knowledge and skills and also include activities that are essential to maintain a high quality and safe clinical services. SpAs also enable consultants build a portfolio of evidence for their annual appraisals to ensure they can be revalidated. Many Trusts allocate a number of 'personal SpAs' that are focussed on activities such as the individual doctors CPD, Governance work, appraisal preparation and appraisal itself in order to prepare for revalidation. Other SpA work such as Educational supervision, and being an appraiser are captured separately.

Direct Clinical Care (DCC)

Direct clinical care is any session that is involved in providing clinical care. This may be "patient-facing" (e.g. clinics, ward rounds or endoscopy lists) or "non-patient-facing" clinical activity (e.g. patient-related administration or MDTs) – virtual clinics whether by telephone or video software are considered patient-facing. When first agreed in 2003 the Department of Health and the BMA published a list of work codes (also referred to job codes in the latest BMA documentation) and updated versions of these codes can be used in the job planning diary available for free from the BMA (Microsoft Excel Spreadsheet document) example C1 for Emergency Attendance, C2 for Outpatient Clinic, C3 for operating session, C4 for Ward round and C11 for Patient related administration. It should be noted that C10 is included which is for travelling between sites for clinical work.

Out-patient clinics

Out-patient services are often provided by the consultant, supported by a variety of other staff including doctors in training plus specialist nurses and/or other allied health care professionals. The reduction of junior doctors' hours and their involvement in the commitment to significantly contribute to the emergency medical service in many hospitals usually means that the junior medical staff cannot attend outpatient clinics as regularly as their supervising consultants.

An out-patient event (e.g. clinic visit) will comprise:

- Preparing to invite the patient into the clinic room including reviewing referral letters, last clinic letter (if applicable) and any relevant results.
- The consultation with the patient including often a clinical examination
- The ordering of on-going tests and management (including prescribing) and
- The recording of the visit (including the generation of a letter usually through dictation)

Increasingly the format/conduct of "out-patient" exchanges with patients is transforming with the adoption of telephone consultations and "virtual" with video consultation clinics which can be supported by several software products. This process has accelerated in response to the COVID-19 pandemic and guidance is given in the BSG document 'Rebooting gastroenterology and hepatology outpatients in the wake of COVID-19' https://www.bsg.org.uk/covid-19-advice/bsg-guidance-rebooting-gastroenterology-and-hepatology-outpatients-in-the-wake-of-covid-19/. Although such approaches might not involve a physical examination of the patient it should not be assumed that the time taken to conduct such work is necessarily any less than a traditional clinic visit, particularly for follow-up visits - clearly a conventional examination cannot be undertaken. Consultants undertaking virtual consultations are advised to keep up to date with all current and evolving guidance on such activity from the appropriate professional bodies (General Medical Council, British Medical Association, Royal College of Physicians etc).

The COVID-19 has also helped some organisations in the move towards group clinics or group sessions largely replacing information giving consultations. The GMC and the BMA provide some guidance in relation to these new ways of working (15 & 16)

Consultants have different approaches with for example some dictating all clinic letters at the end of the whole clinic with many dictating after seeing each patient.

The speed with which patients can be safely seen by one consultant and his/her team will be dependent upon the consultants' level of experience, junior doctor and specialist nurse support,

outpatient clinic nursing support, the quality and efficiency of IT, sub-specialty, case mix and new to follow-up ratio. The important use of chaperones also needs to be considered – for clinics that do not have an outpatient assistant in each room, additional time will be required for each consultation when a chaperone is requested. Most new patients require at least 30 minutes each, and this assumes reasonably efficient IT systems and full outpatient nursing support. Clearly with experience and efficient systems some clinicians will be able to safely see patients in a slightly shorter time period.

Patients reviewed after an initial straight to test investigation (or 'new follow-up' patients) often take as long as new patients and would require 30 minutes per patient. Follow-up patients should be allocated 20 minutes each.

It has to be noted that as more routine follow-up work is either provided by primary care, or delivered by Specialist Nurses and simpler cases are often discharged, the case mix is gradually becoming more complex and follow-up appointments are becoming more challenging to manage appropriately in a short period of time – this is even more the case with those that are selected for face to face consultations as these patients are more likely to require an examination or are more likely to require complex discussions including the breaking of bad news. Consultants will also require time to supervise trainees and Specialist Nurses and other non-Medical staff such as Physicians Associates. These factors should be considered and scheduling 'catch-up' breaks and debriefing time at the end of clinic should be timetabled.

For trainees the time allocated should be significantly longer, especially for those in the early years of training and particularly in their early years debriefing time is recommended.

An out-patient clinic taking four hours in total (3.75 in Wales) is equivalent to 1 Programmed Activity (PA) of Direct Clinical Care (DCC) and should include time for all necessary administrative tasks such as making notes, dictating and ordering investigations. New patient appointments should be allocated at least 30 minutes, and follow-up appointments 20 minutes. These times should reflect the needs of the patient rather than the experience of the gastroenterologist.

Team job planning (see below) can be useful to plan service delivery reflecting on the anticipated demand for any element of the service including outpatients. If there is a short-fall between the number of clinical sessions that can be reasonably and realistically delivered and the anticipated demand this should be used as an opportunity for the employee and employer to discuss ways of achieving a full workforce and or exploring innovative solutions. The BSG encourages a collaborative approach to developing and delivering solutions.

Multidisciplinary Meetings (MDTs)

Gastroenterology is a specialty that has a large number of associated MDTs (including upper GI cancer, lower GI cancer, HPB cancer and IBD). For most of these MDTs one or more consultants will be core members and one will often be the chair (although the chair for many will be from a different specialty such as a relevant surgical specialty) – in these circumstances the full session should be recorded as DCC (code C7). For others who may be intermittent attendees who occasionally present patients and on other occasions attend for the educational value then their attendance could be recorded in part as DCC and part as SPA. The PA commitment for each consultant will vary but for most one would expect 0.5PAs or more (one or two, one to two-hour MDTs per week) but for some the allocation should be significantly more, especially if there is a significant amount of preparation work - if for example someone is chairing a session and needs to review notes, histology results, endoscopic and radiological findings beforehand.

Clinical administration

The volume of patient related administration varies from sub-specialty to sub-specialty and post to post. Clinical administration can be divided into that ***related to fixed direct clinical care sessions (and therefore more predictable)*** and administration that is ***un-related to fixed direct clinical care sessions (and therefore less predictable)***. For example, for direct clinical care sessions such as outpatient clinics there will be a predictable amount of associated administration (such as letters to write and validate and results to review). This should also include review and oversight of work/results undertaken by doctors in training and nurse specialists. ***Clinical administration unrelated to fixed direct clinical care sessions*** relates to clinical work unconnected to existing direct contact clinical activity. This might include review of referral letters, email, advice and guidance and telephone advice. Asynchronous consultations (defined as a consultation where the patient and clinician interaction occur at different times) are likely to become increasingly common during and after the COVID-19 pandemic and the administrative work generated needs to be included in overall clinical administration time.

There is no absolute formula for calculating the expected volume of administration work that is directly related and unrelated to direct clinical care sessions but in general for a Gastroenterologist one would expect this to be somewhere between 25% and 33% of time spent on direct patient-facing activities but can be significantly more.

With pooled endoscopy lists, an increasing number of non-medical endoscopists, straight-to-test pathways and other providers delivering additional sessions to reduce waiting times and meet demand the volume of clinical administration is not directly proportional to an individual doctor's scheduled patient facing activity. There is usually the need to deal with investigation and treatment results from all these other sources. The clinical administration workload that is not related to direct patient facing activities does not stop when the consultant is on annual leave.

The BSG recommends that patient related administration is allocated a minimum of 1.5 PA (DCC) for a 10PA job plan for a full-time Gastroenterologist or Hepatologist. Considering the increasing number of patients each Consultant is responsible for, despite not physically meeting many of them, it is quite possible for 2.5 PAs (DCC) or more to be required to appropriately manage the workload.

Clinical administration does not cease entirely when consultants are away on leave. Depending on the nature of a consultant's work and specific local arrangements of cover consideration might need to be given to additional clinical administration time following a period of prolonged leave (i.e. more than one week).

Consultants involved in specific clinical administration sessions such as Clinical Assessment Services or Senior Clinical Triage to manage referrals should usually have this type of activity separately recorded and often as fixed timetabled sessions. This role has become increasingly important as services re-focus their clinical activity in the aftermath of the Covid-19 pandemic. Job-planning diaries (see Job Planning Diary section) can be used to help identify the true volume of this type of workload.

Clinical or patient-related administration (DCC) can be considered as "predictable" (directly linked to fixed clinical care commitments such as clinic letters, review of results etc.) or "unpredictable" (calls/emails from patients, GPs, colleagues etc.). Each needs to be considered separately in calculations of total clinical activity. Work diaries will be particularly useful in the calculation of "unpredictable" clinical administration.

Endoscopy

Gastroenterologists usually provide a range of endoscopy services. Each fixed list and any annualised lists should be recorded within the job plan including the type of endoscopy provided (such as: upper, lower, mixed, ERCP, bowel cancer screening, training lists and therapeutic lists). In addition to outpatient endoscopy services, which form the vast majority of most departments' workload, gastroenterologists usually provide the bulk of the inpatient service especially for GI bleeding and complex therapeutic cases. It is common practice for emergency cases to be added to lists provided by consultant gastroenterologists resulting in these lists often taking longer than those provided by other endoscopists – if the time taken on average is significantly longer then this should be reflected in job plans with a higher PA allocation per session than for those undertaking pure outpatient diagnostic lists.

As with all work 1 PA is 4 hours of work, specifically for endoscopy this should include approximately 30 minutes for starting and finishing, including changing into scrubs (including the use of appropriate personal protective equipment or PPE), team brief, WHO check lists etc – this

is supported by JAG (11). There is no reason why the length of sessions should not be the same for morning or afternoon lists although many units run slightly shorter afternoon lists.

The amount of work conducted within any one session (1PA) of clinical activity will now depend on a number of key factors. Traditionally, for job plans it should be expected that 1 PA of endoscopy comprises 10 "points" of endoscopy activity (see below) but this will be less if 'turnaround' time is delayed. If lists regularly over run, an interim job plan should be requested. In the aftermath of the COVID-19 pandemic procedure durations and turnaround time between cases will be considerably longer than most departments have historically experienced. These timings will be influenced by whether or not the procedure is accepted to be an aerosol generating procedure (AGP) and hence the level of PPE required for the attending staff. An additional consideration in many departments will be the deep cleaning/decontamination of the endoscopy procedure room between patients. This in turn may be influenced significantly by the availability of negative pressure ventilation.

It must be recognised that endoscopy lists do also generate additional administration both during the list (e.g. the ordering of additional tests/investigations) and also displaced from the list (e.g. reviewing, communicating and acting on histology results).

A very basic calculation of endoscopy points could be based on the following (from JAG) (11):

Upper GI endoscopy (OGD)	= 1 point
Colonoscopy	= 2 points
Bowel Cancer Screening Colonoscopy	= 2.5 points
Complex Therapeutic endoscopy such as EMRS	= 2.5 points or more
Flexible sigmoidoscopy	= 1 point
ERCP	= 3 points

For most consultant gastroenterologists their endoscopy lists will include a diverse range of patients requiring a number of additional endoscopic interventions. Individual Trusts/Health Boards must determine how they manage such demand/complexity but many may decide to establish some pragmatic consensus such as:

PEG	= 2 points
Oesophageal stent	= 2 points
Varices surveillance	= 1.5 points – to accommodate the need for banding
Barrett's surveillance	= 1.5/2 points – sedation and multiple biopsies
IBD surveillance colonoscopy	= 2.5 -3 points
Planned EMR/large polyp	= 2.5 -6 points (size, morphology, site, access, & number) *
Bowel Cancer Screening colonoscopy	= 2.5 - 3.0**

* The most complex polyps can require 90 minutes or more per case and the allocated time should be determine by the advanced colonoscopist or the complex polyp MDT

** The bowel cancer screening programme recommends 4 cases per list and the change to FIT testing along with changes to surveillance protocols means that the number of polyps including larger polyps per list is likely to increase

JAG provides further information regarding the content and duration of lists (11). It is likely that this will require revision in light of current and future requirements for infection prevention and control.

Training Lists

If a consultant gastroenterologist is performing a training list for any of the endoscopic procedures then the number of procedures undertaken should be reduced proportional to the composition of the list and the experience of the trainee (e.g. 6 points for early trainees and 8 points for more advanced trainees). Training lists by nature will always have more administration per patient than service lists (i.e. patient-related administration and recording of the training episode).

7-day working and planned care including endoscopy

Increasingly Trusts/Health Boards are resorting to planned/scheduled work at weekends. Whether this work is undertaken in an *ad hoc* fashion or as part of an agreed (and possibly annualised) job plan it is imperative that this does not conflict with other commitments such as emergency work/on-call (see general section on 7-day working below).

In-patient work

There are various models currently used in hospitals and NHS Trusts. The PA implications will be dependent upon a variety of factors including: workforce numbers; workload; whether there is a General (Internal) Medical component; whether or not there is an on-the-ward and off-the-ward model; the availability of junior doctors especially middle-grades doctors, physicians associate and specialist nurse support; whether or not a gastroenterologist of the day/week or month is in place; and the expected frequency of patient review. The number of patients that can be safely cared by a single consultant will be dependent upon the availability and experience of the other team members as well as the time allocated for this time of direct clinical care.

Models of in-patient care have become increasingly complex with many organisations adopting extended shifts (e.g. consultant of the week and its variants). This important work must be appropriately reflected in any job plan with careful consideration to protect consultants from clinical conflicts (e.g. being expected to deliver emergency and planned care simultaneously).

A patient interaction on a ward round includes a clinical assessment of the patient, the formulation of a management plan, including further investigations and documentation of the outcomes. The BSG supports the RCP recommendation of 10 to 15 minutes per patient interaction meaning that during a ward round (1 PA, DCC) an individual consultant should look after no more than 16 to 25 patients depending on case mix. Longer ward rounds are mentally and physically challenging and are not in the best interests of optimal clinical care and should not be the routine.

The traditional model, which is still in place in many hospitals, would expect a consultant to undertake two full ward rounds per week with at least some additional time on one or two days to review new admissions, patients with a higher acuity of illness, review results and to see relatives. Depending the factors mentioned above this is likely to translate into two and a half to three PAs per week whilst on the wards (not including on-call commitments) in addition to timetabled clinics and lists.

Ward based cover

There are several variants of this model in which the responsibility for inpatient ward-based care rotates between members of the team and those on the wards undertaken fewer clinics and/or lists than those off the wards. In some instances, the ward cover provided is still relatively traditional with for example two main ward rounds per week, but many Trusts are moving away from this approach. In many cases the on-ward consultant provides 5-days a week or more cover, in some cases with five full ward rounds each day. With this pattern of working all other morning activities would need to be cancelled and if there is a further expectation for afternoon board rounds or meeting relatives etc. then most other afternoon clinical sessions may also need to be cancelled.

In some hospitals there is some cross over with the Gastroenterologist of the Week (GOW) model and the ward-based doctor is also responsible for some if not all elements of the GOW service including inpatient and sometimes outpatient referrals and in some cases day-time emergency endoscopy.

The PA allocation for such models needs to be locally determined and agreed. A given day of such work might amount to more than 2 PAs (DCC) to allow for extended hours and on-call commitments. For a full 7-day ward cover service including weekend on-call, other scheduled commitments must be appropriately cleared and predictable on-call time calculated (remembering a PA is 3 hours out of hours) – such models would usually equate to a minimum of 12PAs (DCC) per week (10 PAs Monday to Friday and 2 PAs over the weekend). If consultants work a continuous week and weekend an appropriate period of compensatory rest should be allocated in line with the recommendations of the European Working Time Directive (EWTD). Regardless of EWTD compliance, the BSG supports Trusts and consultants to move away from 12-day periods of continuous working wherever possible.

It must be recognised that Trusts/Health Boards would expect such cover to be provided 52 weeks of the year. Given that an individual consultant will work no more than 42 weeks per year, an appropriate adjustment in scheduled work during non-ward weeks would be necessary to keep the overall workload within 10 PAs. Depending on the workload and frequency of ward weeks any individual consultant may have to restrict their non-ward week to 8 PAs or less (i.e. have a day off per week). For this reason (amongst others) the BSG recommends that such work be shared amongst consultants (i.e. 1 in 8 rota). In some Trusts/Health Boards, if the workload is relatively light, it might be possible to deliver such a model with fewer than 8 consultants but the workload and work balance requires careful consideration.

Depending on the extent of junior doctor support it may be possible for consultants operating consultant of week or similar models to be responsible for a larger number of inpatients but this should not exceed 30 patients.

Board Rounds

Board rounds are short discussion rounds where each patient is discussed in turn focusing on their treatment and care needs and the key steps required to facilitate safe and timely discharge. They are usually led by the on-the-ward consultant jointly with the senior ward nurse. They may occur once or even twice daily and should usually be approximately 30 minutes in duration. They are often included in the allocation of on-the-ward time but if not are likely to require approximately an additional 1PA of DCC for the weeks when they are undertaken.

Medical admission Unit (MAU) and General Internal Medicine (GIM) cover

In addition to the Gastroenterology service many consultants also provide clinical input to the GIM service either through a contribution to the on-call service or through Medical Admission Unit (MAU) or short stay unit sessions. These should be recorded separately.

A worked example of inpatient care

An example of inpatient cover using a system utilised in some hospitals is as follows: - the inpatient service is shared between all or most consultants in the specialty team with team members rotating between different roles. This system enables more frequent consultant input per patient with improved continuity of care. It may be agreed that older consultants are able to 'opt out' of the on-call rota and this might also include ward cover if they choose to do so. The Academy of the Royal Colleges supports the option to opt out of on-call work at the age of 60 (6).

The workload could involve for example:

board rounds 1-2 times per day (1.25 PAs);
3-5 consultant ward rounds per week of 16-25 inpatients (3-5 PAs);
Medical Admissions Unit (MAU) in-reach 1-2 times per day (2.5 PAs);
seeing referrals from other specialties (2.5 PAs);
attending formal MDT meetings to discuss complex inpatients (0.5 PAs) and
ad-hoc meetings with patients and relatives plus ward related admin (1 PA).

This would give a total of 10.0 to 12.75 Direct Clinical Care PAs per week when covering all the duties described. Often a team will split this work with for example one consultant covering the wards and one covering the GOW service.

There would therefore need to be a minimum of 520 PAs per year to cover this element of service (given leave etc. the Trust would need to agree approximately 12.5PA divided between the covering consultants). If there were 8 consultants in the team there would need to be 1.5 PAs per consultant per week delivered across 52 weeks per year (internal cover). When considering the associated SpAs and clinical administration this would mean that for ward-cover alone (not including on-call or General Medical duties such as MAU or shore stay cover) almost two whole time equivalents would be required.

This approach would be difficult to deliver with fewer than 6 consultants to make up the rota.

Emergency, On-Call and Unplanned Clinical Work

Emergency work encompasses both predictable (weekend ward rounds) and unpredictable (on-call and emergency endoscopy) activity. Each needs to be calculated separately. The BSG recommends that every Trust/Health board aims for an on-call/weekend frequency of no more than 1:8.

Scheduled emergency work

Scheduled emergency work is delivered in sessions or shifts such as weekend sessional work providing ward cover. For example, consultants asked to undertake a session of in-patient/ward work on a weekend should record that as 1 PA (DCC). This should recognise that 1 PA equates to 3 hours of premium time (weekends and evenings). In-patient ward work including the review of new admissions etc. will be variable but usually most teams will be able to determine a realistic average duration required for such activity, accepting that there will be some week-to-week variation. Scheduled emergency work should not overlap with planned work (such as an out-patient clinic or elective endoscopy list).

Consultant-of-the-Week/Day/Month

Many Trusts use some variant of this model (see above) where an allocated consultant sees all new inpatient referrals, is available to provide an opinion to other specialties and may also review all outpatient referrals and emergency Gastroenterology admissions. This is in effect a shift albeit in a larger envelope of time. The demand during such periods will vary within and across Trusts. Again, there should be measures in place to prevent any overlap with scheduled work and the allocation of time should be proportional to the time required to deliver the service – i.e. consultant of the day would represent 2 PAs (DCC), consultant of the week would be 10 PAs of scheduled emergency work with additional allocation for weekend working and 11 hours of compensatory rest for each 24-hour period.

7-day working and the ten clinical standards

Ten clinical standards for seven-day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven-day services should achieve, no matter when or where patients are admitted (7 &8) and have become the primary driver for Trusts/Health Boards to deliver consistent in-patient and emergency cover across all 7 days of the week (7&8).

These standards include four key elements relevant to gastroenterology. These are intended to ensure that by 2020 patients admitted to hospital in an emergency:

- don't wait longer than 14 hours to initial consultant review
- get access to diagnostic tests with a 24-hour turnaround time — for urgent requests, this drops to 12 hours and for critical patients, one hour
- get access to specialist, consultant-directed interventions

- with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds

All Trusts provide some elements of their services seven-days per week. All Trusts are trying to increase seven-day working in order to work towards meeting the ten standards set by the AORMC. The four priority standards and standard 2, 5, 6 and 8 – the first three of which are very relevant to gastroenterologists. Standard 2 relates to the time to first consultant review (under 14 hours from admission). Standard 5 relates to access to diagnostic tests and Standard 6 relates to access to interventions including access to therapeutic endoscopy such as for GI bleeds.

An out-of-hours/7-day in-patient service in addition to the endoscopy cover described above, would require additional PA allocation. A consultant would often be expected to review inpatients within the gastroenterology bed-base. The patients for review are usually limited to those that are acutely unwell, patients new to the ward/gastroenterology team and potential discharges. There often would also be an expectation to provide in-reach to a Medical Admissions Unit (MAU) and see Gastroenterology referrals on other wards e.g. ITU.

Calculations: There are 104 weekend days and 8 bank holidays giving a total of 112 days that are not usual working days. If a service is expected to provide consultant cover 4 hours per day this would equate to 448 hours in total which would equate to 149.3 PAs (in view of premium hours and three hours per PA). If there are 8 consultants on the rota then this would equate to 18.66 PAs per consultant which divided by 42 would equate to approximately 0.5 (0.44) PAs per week worked.

In this example there is already an on-call supplement for the GI bleeding rota so there would be no additional supplement for the in-patient cover. In the case of a service where there is no out of hours GI bleeding cover but there is in-patient cover including being on-call for advice and to review patients beyond the scheduled ward rounds this would carry an on-call supplement that could be category A or category B depending upon local agreement and the likelihood of having to be called into the hospital on an urgent basis. If the inpatient cover was restricted to scheduled timed ward rounds there would be no on-call supplement.

All principles discussed elsewhere apply in terms of PA allocation, clearly if a Trust is aiming to increase consultant contribution to seven-day working then this should be agreed in team and individual job planning meetings. Unfortunately, the current workforce shortages, with many advertised posts unfilled, can place pressure on consultants to work increasingly longer hours. It must be remembered that consultants cannot be contractually compelled to undertake elective work out of hours, and that additional PAs above 10PA currently create a real risk of a significant increase in pensions taxation even though they are non-pensionable. All consultants can give 3 months-notice to drop PAs above 10PA, and if these are not specified in their job plan then the choice of which are dropped can be negotiated with their employer.

Scheduled weekend working must incorporate an appropriate amount of compensatory rest (in line with the European working time directive).

Unscheduled emergency work (on-call)

Most gastroenterologists will be expected to provide on-call cover for out-of-hours endoscopy and management of gastrointestinal emergencies. This is above and beyond any provision for scheduled/sessional reasonably predictable work as described above. This will include telephone calls for advice and the need on occasions to attend the hospital to review patients and or perform endoscopies. With our increasing understanding of sleep disruption, each telephone call should be allocated 1 hour of time (remembering each PA at night is 3 hours) and total time awake should be considered. The number of telephone calls will usually far exceed the number of actual hospital attendances. Accommodating unpredictable on-call commitment within job planning should be done by an estimated PA allocation.

The allocation of PAs paid for emergency work is covered in Schedule 5 of the national contract. With many consultants now working a consultant of the week model for in-patient cover an additional calculation is still necessary for work out of hours (i.e. in premium time).

Average emergency work per week likely to arise during Premium Time from on-call duties	Possible allocation of Programmed Activities (PAs)
0.5 hour	1 PA every 6 week or 0.5 PA every 3 weeks
1 hour	1 PA every 3 weeks
1.5 hours	1 PA every 2 weeks or 0.5 PA per week
2 hours	2 PAs every 3 weeks
3 hours	1 PA per week
4 hours	3 PAs every 2 weeks
6 hours	2 PAs per week

On-call Frequency will vary from Trust to Trust. It is recommended that the maximum reasonable frequency for on-call/weekend working is 1:8. It is acknowledged that in some localities this might not be easily achievable. No on-call frequency should be more than 1:6 and in such circumstances Trusts/Health Boards should explore opportunities for shared rotas with neighbouring organisations.

Consultants are strongly advised to keep their own work diary, recording time for telephone calls, travel and administration as well as direct patient contact time (i.e. an on-call episode starts when the first call is received).

Out-of-hours endoscopy service

An out-of-hours (OOH) endoscopy service may range from an emergency therapeutic endoscopy service for high-risk upper GI bleeding alone at one end of the spectrum, with the provision of full 7-day cover for all inpatient requests at the other (and this is likely to be the direction of travel as Trust and Health Board try to meet Standard 5 of the standards set by the AORMC. The PA implications and overall cost implications to the organisation and individual consultant of the OOH endoscopy service will depend on the nature of the inpatient service provided, the population served and the number of consultants on the rota. This type of activity can ideally be assessed using a prospective full-rota cycle diary by several, or preferably all rota members. Activity data can also help to determine the appropriate PA allocation.

Endoscopy on-call will command Category A salary supplement (Schedule 16 of the national contract)

Frequency of on-call	Value of availability supplement as a percentage of full-time basic salary (Category A)
High Frequency 1 in to 1 in 4	8.0%
Medium Frequency 1 in 5 to 1 in 8	5.0%
Low Frequency 1 in 9 or less frequent	3.0%

The work load for these services can be made up of up to four main elements, emergency endoscopy workload that cannot wait more than a few hours and will include: the usually relatively small number of procedures required to be delivered in the middle of the night (use of the BSG Upper GI Bleed care bundle may reduce this number further); urgent cases that should be undertaken within 24 hours and can usually be undertaken on weekday and weekend morning lists; non-urgent inpatient referrals that might be undertaken at weekends or during bank holidays as part of seven-day working and routine elective outpatient workload to help provide sufficient capacity to meet demand.

The elective element is predictable, the 7-day working relatively predictable, the within 24 hours less so and the emergency workload the least predictable. The infrequent overnight cases usually have a relatively large time impact per case and can often take four hours or more from first call to the endoscopist returning home. This is covered in an earlier section

Worked Examples

The overall impact of such cases on weekly PA allocation is however usually quite small (for example 4 overnight call-outs per consultant per year each taking four hours each (from call to return home) would equate to just 0.13PAs per week (16 hours divided by 3 hours per PA and divided by 42 weeks). Over the course of a year, for every case that requires an endoscopist to attend there will usually be many more calls for advice and these will usually make a greater annual time impact (45 on-call days on a 1 in 8 rota with an average of 1 call per on-call night would give 22.5 hours per year which equates to approximately 0.18PAs). Taking these both together would give approximately 0.3PAs for the ***unpredictable*** element of out of hour endoscopy cover (this does not include endoscopies that can wait until the following morning or more routine in-patient endoscopy as part of 7-day working).

Compensatory Rest

Under the Working Time Regulations, consultants have a right to compensatory rest when they do not rest for 11 hours in any 24-hour period. The BMA states 'that if a consultant does not have a period of 4 hours continuous rest during a night when they are on-call, as a result of being called, they should be given eleven hours of compensatory rest which should be taken within 24 hours of the disruption.'

> The European Working Time Directive specifies that there must be 11 hours of continuous rest in any 24-hour period, and for consultants woken at night this must be adhered to or the doctor will potentially fall foul of the GMC Fitness to Practice Guidelines. No fixed DCC commitments should be timetabled for the mornings of a week on call.

A regular weekend list on both Saturday and Sunday for urgent cases and/or non-urgent inpatient and/or elective outpatients would equate to 1 PA per 3 hours list – using this example two four-hour lists (including starting and finishing time) per week on a 1 in 8 would equate to 0.43 PAs (8 hours per weekend, occurring 6.5 times per year on a 1 in 8 rota, divided by 42 weeks worked and divided by 3 hours per PA). This would be slightly more if bank holidays are also included (some services offer emergency cover only for bank holidays).

In addition to the weekend and bank holiday workload the on-call endoscopist may also have to cover both early morning and evening time slots to deal with urgent cases. If this equates to 1 hour every other day on-call this would have a PA impact of 0.13 (calculation: 52 x 5 weekday less eight bank holidays equates to 252 days; divided by 8 for a 1 in 8 rota gives 31.5 days; allowing for an average of 0.5 hours per night gives a total of 15.75 hours per year per consultant which divided by 42 weeks worked and divided by 4 hours per PA give 0.13PAs)

The worked example above, which is purely to provide endoscopy cover on a 1 in 8, equates to approximately 1PA (0.86 from above) PAs in total (a regular weekend list, telephone calls, a small number of very urgent cases that need to be done immediately and slots to cover cases that need to be undertaken within 24 hours) – this does not include any time allocated to reviewing new or existing inpatients or new referrals.

Public (Bank) Holiday in-patient service

Public (Bank) Holidays would be expected to be covered by existing local arrangements for 7-day working and on-call. Consultants working any part of a given Public (Bank) Holiday would be entitled to a day off in lieu (Schedule 18 national contract) (1)

Prospective cover

Ward and on-call arrangements are usually covered internally of "prospectively" i.e. if you are on leave you need to swap them rather than simply cancel them. This needs to be very carefully considered when calculating PAs and agreeing job plans within departments. Emergency/on-call work needs to run for 52 weeks of the year whereas any given consultant will work for no more the 42 weeks in a year.

Example calculation – Impact of Prospective Cover

If we take ward cover on a 1 in 5 basis then this activity will occur for just over ten weeks per year (52/5 = 10.4) which is more than the just over 8 weeks per year that you might expect if there was no prospective cover (42/5 = 8.4).

Conversely, if during your other weeks where a job plan includes elective sessions that only occur when you are off-the-ward then these will occur for just over 31 weeks per year (42 weeks less 10.2 weeks on the wards = 31.8 weeks) rather than the near 34 weeks as you might first expect if there was no prospective cover (4/5 x 42 = 33.6).

E-job planning software/programmes *might* calculate this automatically but the principle must be clearly understood by doctors and departments.

Nutrition service

This service will vary from the management of type 1 & type 2 intestinal failure in all hospitals to treatment of type 2 & 3 intestinal failure and management of a home parenteral nutrition service in specialist centres. The non-specialist hospital would usually require 1 or 2, 2-hour nutrition ward rounds per week or 0.5-1PAs per week. A specialist unit would usually require a minimum of two 4-hour ward rounds per week plus specialist nutrition clinics and MDT meetings with additional SpA time dedicated to helping manage the service (a minimum of 6 PAs per week). In both cases the size of the secondary and tertiary catchment areas would clearly impact on the workload and in some centres the PA allocation for this workload will be over 10PAs (not including the contribution the nutrition specialists will make to all other elements of the service including on-call, endoscopy and general clinics.)

Supporting Professional Activities (SPAs)

Supporting professional activities includes a wide range of roles, activities and tasks. These include training, personal study, preparation and undertaking of personal appraisal, revalidation, quality improvement activity such as audit, governance meetings, mandatory training, quality improvement cycles, guideline writing and development and involvement with departmental meetings etc. These have been given codes from S1 to S8 by the BMA and DOH when the contract was agreed in 2003 e.g. S1 for training, S2 for continuing professional development etc.

In addition to all the activities above that most consultants would be expected to undertake it also includes a wide range of additional roles. These additional roles would include educational roles such as educational supervision and clinical supervision, university teaching roles, endoscopy training, training committee involvement etc., research roles such as senior investigator, trial recruitment, laboratory work, grant writing etc. These all also need to be recorded within job plans. Often the demands for this type of work increase as consultants become more experienced, equally additional time on this activity may be required in the early years of a consultant's career

Personal

As an absolute minimum each consultant should be allocated 1.5 PA for appraisal and revalidation and for the personal study, mandatory training, involvement in audit, and preparation involved. This will include some (but not all) of an employer's mandatory training. Mandatory training is overseen by each Trust/Healthboard although some elements are mandated Nationally.

The BSG supports the RCP recommendation of an absolute minimum of 1.5PAs (SPA) for each consultant to sustain their professional standing (i.e. revalidation and appraisal). Less than full time (LTFT) posts require equivalent time for revalidation, appraisal, study and professional leave. This requires case by case consideration.

Quality Improvement Activity

This is an extremely important component of SPAs and is directed to maintain and improve the quality of care. Additional PAs for each consultant are required for this work which would encompass departmental audit, mortality and morbidity analysis, local guidelines and any additional clinical governance activities as well as improvement methodologies and projects such as Plan, Do, Study, Act or PDSA cycles.

Organisational duties including clinical management

SPAs allocated to roles in Trust clinical management and leadership should be negotiated and agreed locally. To act as clinical director for a service (be that gastroenterology and/or endoscopy) would usually require at least 4 hours (1PA) of time and potentially significantly more depending upon the size and complexity of a service and where possible should be undertaken within working hours (i.e. timetabled within a working week). Additional roles such as clinical lead for IBD, nutrition lead, MDT chair should also be formally recognised and might command as much as 1 PA depending on work volume and complexity. These roles are key to the development and maintenance of a high quality, patient-centred service.

Gastroenterologists and job planners alike should be discouraged from believing that such work can always fitted around a full timetable. These are important roles for patient safety and quality of care as well as for the appropriate management of staff. Given the current significant tax implications for many in relation to pensions it may often be preferable to drop one PA to accommodate this work rather than adding it as additional PAs to the job plan.

Consultant Mentoring

Mentorship can provide valuable support to consultants at any stage in their career and perhaps never more so than when newly appointed to their first consultant post. This support can cover a wide range of issues including service development, personal development, understanding new systems and cultures as well as with job planning.

Most new consultants are initially employed on a 10PA contract if full-time. In many cases the work commitment is often more that 10PAs worth of work. This is often a result of patient related administration and inpatient workload being under-estimated. New consultants should be offered a mentor who should be able to support them in a range of areas including with the job planning process. A job-planning diary is often helpful and can help to ensure that a job plan is reviewed in a timely manner. The BSG has a successful and active mentorship scheme (9)

Mentoring can be an extremely supportive process for those taking on complex new roles including senior roles in management, leadership, education and research.

Supporting activity (SPA) should incorporate the increasing import role of mentoring. Appropriate time needs to be acknowledged for both senior clinicians (often as mentors but also as mentees) and newly appointed consultants (as mentees).

Supervision of doctors in training

Consultants should provide protected time for the supervision of doctors in training. As a guide, a trainee doctor of any grade would require a minimum of 0.25 PA (SPA) for supervision.

Undergraduate and locality teaching

Many consultants commit a significant amount of time to teaching undergraduates (i.e. medical students). This should be represented within an agreed job plan. In most instances this will be agreed locally with the relevant medical school. Consultants might be encouraged to take on additional educational roles with their local medical school. Such arrangements need to be agreed locally within the department as well as with the Trust/Health Board and responsible university.

In addition, consultants should be encouraged to provide, where appropriate, teaching to other health care professionals (e.g. local GPs, nursing staff, endoscopy teams). This work might be undertaken in a relatively *ad hoc* fashion but the BSG recognises this as an important contribution to wider aspects of healthcare.

Research

Patients increasingly recognise the opportunity to engage in clinical trials as a reflection of a quality clinical service and all consultants should be aware of their responsibility to contribute to clinical research.

In line with the expressed philosophy of the RCP, the BSG recommends that employers support consultants with a research interest, and encourages as broad a participation as possible for the benefit of patients, their organisation and the wider NHS. The RCP recently published Delivering research for all, calling for more research to be conducted in NHS trusts to support high-quality patient care. Trusts should use job planning to protect time for clinical research within the SPA allocation while maintaining 1.5 SPA for appraisal/revalidation. In future trusts should move towards including patient facing research within the DCC allocation, and RCP is working with BMA to develop viable templates. (13)

SPAs allocated for research should include adequate time for training, meetings, recruitment and patient contact time. Examples of time allocation for specified research roles include:

- acting as principal investigator: 0.1–0.5 SPAs
- acting as chief investigator: 0.1–1 SPAs
- research and good clinical practice (GCP) training: 0.125 SPAs.

Professional roles and responsibilities (i.e. regional and national committees)

Consultants undertake a wide range of regional and national roles, usually but not exclusively as they become more senior and experienced. These roles play a vital role to running of the NHS. These roles include work for the Royal College of Physicians, the BSG itself and NHS organisations such as NICE, BMA, Specialised Commissioning, Cancer Alliances, Clinical Networks and Clinical Senates. The work covered includes educational work, assessments, policy development, quality improvement activity and guideline development. The BSG strongly believes that these roles should be supported wherever possible.
Contractually, Trusts are obliged to offer 30 days per 3 years of professional or study leave. Many roles will realistically take more than this time and consultants should negotiate this with their employer. Some organisations offer secondments, which back pay the time the consultant is to be released for. All Trusts are encouraged to support the wider NHS (10) Such activity should be clearly recorded in job plans including clarity regarding how the time required will be accounted for.

Every consultant should be encouraged to contribute to the wider needs of gastroenterology through involvement in recognised regional, national and international associations and collaborations.

Additional Responsibilities

Some additional roles are classified as additional responsibilities due to the level of responsibility, time commitment and other factors. There can be some blurring of the two definitions, for example different Trusts might include a specialty lead role within SPAs and another within Additional Responsibilities, but in practice as long as the PA allocation is

correct and the role is recorded in the job plan it doesn't matter too much if it is recorded under the heading of SPAs or Additional Responsibilities.

Additional Responsibilities Codes are as follows -

A1 Caldicott Guardian

A2 Audit lead or Governance lead

A3 Clinical Tutor

A4 Medical Manager

A5 Other responsibilities

Additional considerations

Departmental job planning

The BSG supports team or departmental job planning wherever possible although an individual job planning meeting to finalise plans is still recommended (an individual job plan is a contractual right and doctors can decline to engage with team job planning). Team job planning if done well encourages transparency and can help foster a highly functional department. It also can help to ensure there is parity within a team for the same or very similar activities. Activities that are infrequent such as out of hours upper GI bleeding cover can be discussed and work diaries if recorded can be compared and an appropriate and fair PA allocation can be agreed (in a given year there will be some variation in the number of call-outs). Team job planning also allows the department to include the relevant line managers to consider demand and how many sessions are required for each type of activity, where any shortfall might occur and how any gaps might be bridged. There usual the need for individual meetings to occur in addition to team meetings to discuss matters specifically relevant to the individual doctor but in most cases, following a high-quality team meeting these individual meetings could be relatively brief.

Less than full time (LTFT) consultant posts

There is an increasing number of consultants that work less than full-time. This can be for a variety of personal reasons including childcare and other career responsibilities (for both men and women) and those wishing to return to work post-retirement. The principles and examples used elsewhere in this guideline apply equally to those on a less than full-time contract. One would expect most elements of the job plan on average to be similar in proportion to those on a full-time contract. This would include for example a reduced on-call frequency and a reduction in patient-related administration.

One area that cannot and should not always be reduced in direct proportion is SPA allocation for appraisal and revalidation (see above). A part-time consultant, especially early in their career, should not be allocated less than 1.5 PA for baseline SPAs in order to ensure that they have time to undertake internal CPD, a minimum level of quality improvement activity and personal appraisal and other activities. Similarly, study and professional leave should be 30 days per 3 years. A LTFT consultant has exactly the same revalidation needs and GMC expected standard as a FT consultant.

Annualised Job plans

Increasingly Trust/Health Boards and/or consultants are considering annualised job plans. The drivers for this include week-to-week timetable variation, other commitments that occur on a slightly unpredictable basis, the need to have flexible sessions to help back fill endoscopy etc. Such an arrangement might also appeal to consultants with young families with child-care needs, who may then choose to work more PAs during term time and take more time off during school holidays. Indeed, consultants can, with agreement from their employer, ‘store up’ extra PAs and then take time off as a sabbatical.

This can be determined manually or electronically with e-job planning software. It is important in determining annualised job plans to consider which types of work include prospective cover and those that do not (see above).

Work diaries

Job planning diaries can be very helpful and are strongly recommended if and when there are any areas of disagreement or anticipated areas of disagreement. When undertaken they should be prospective, and for team job planning may be undertaken by each team member (or as many team members as possible) and carried out for a full rota cycle. They should never be seen as the sole input to the process. Information recorded will include work agreed with the previous job planner, work not previously agreed but essential due to clinical pressures and may also include work that an individual has chosen to take on without prior agreement. The BMA has produced an app. Dr Diary, that can be used to this purpose (12)

Electronic Job Planning

Many Trusts now use e-job planning software either from commercial providers or using in-house systems. These can be useful and are broadly supported by the BSG if they are set up properly to include all elements of a consultants working week. It is clearly important that a system is chosen that meets each hospital's needs and it is then equally important that job planners and consultants undertake appropriate training. Every team should try to determine, using job planning diaries and other data, the PA allocation for each type of activity such as taking part on a bleeding rota. If this is agreed then this can be set up on the system so that individuals do not need to attempt to calculate it for themselves.

Objectives

Good job planning should include a discussion regarding each consultant's personal objectives shaped with the help of appraisal, and departmental, divisional and organisational objectives. The aim should be to ensure that where possible the job plan will enable the doctor to achieve these. Where this is not possible three should be a constructive discussion with subsequent agreement from both parties. Objectives should be included in the Job Planning Agreement.

The Impact of Pandemics such as COVID-19

The normal pattern for most consultants means that an annualised job plan is sufficient with either no in-year variation or relatively limited in-year variation. In special circumstances such as recently experienced during the COVID-19 pandemic major changes have needed to be implemented at short notice and often consultant and Trusts have had to agree changes to working patterns on several occasions during their response. In these situations the BSG expects both parties to work collaboratively with an aim to return to more standard job planning processes during the restoration phase.

Private Professional Services

Good job planning should include a discussion and agreement regarding private practice. This should include an agreed timetable so the organisation agrees and understands when a doctor will not be available for other work.

Fee paying services

Any regular fee-paying services should be agreed and recorded in the job plan

Travel Time

Travel time to and from a doctor's usual place of work should not be recorded. Travel time between places of work should be and if this is in order to deliver clinical work this is included as DCC. If a doctor is appointed to work on two sites that are relatively close together and there is no requirement to travel between the sites on any given day then this does not usually need to be recorded. If a doctor's is subsequently expected to work on a new site following appointment then if this leads to additional travel over and above usual commuting time this should be recorded.

Annual Leave, Study Leave and Professional Leave

The amount of annual leave and study leave is laid out in the consultant's contract. There may be reasons to restrict leave at particular times of the year and indeed there will usually need to be a system in place to allow equitable access to National and International clinical meetings – these are often agreed in departmental meetings but should be considered in the job planning process and could be usefully covered in team job planning meetings.

Supporting Resources

All doctors require appropriate resources to undertake their job safely and effectively. Job planning is an appropriate opportunity to discuss the required resources. This could include endoscopy equipment and availability of outpatient clinical rooms or endoscopy rooms. This could also include the need to appropriate IT systems such as endoscopy reporting software.

Example Job Plan for a Newly Appointed Consultant

Example - programmed activity allocation for a newly appointed consultant

Supporting Professional Activities (SpA)

Personal	1.5
*Additional (e.g. teaching, junior supervision)	1
Total SpA	**2.5**

* This could include educational supervision, medical school teaching and for the first 6 to 12 months' time for mentorship and to allow the consultant to familarise themselves with the Trust's systems and processes

Direct Clinical Care (DCC)

Ward rounds (to include weekend ward cover 1:8)**	1.5
2 clinics	2
Predictable admin (0.25 per clinic)	0.5
2 endoscopy lists	2
On-call (1:8)**	0.5
Unpredictable admin	1
Total DCC	**7.5**
Total DCC + SPA	**10**

** Assumes prospective cover

Example – annual job plan checklist
Based upon "Consultant Job Planning: A Best Practice Guide". NHS Improvement revised 2017

- The job plan is approved by the consistency committee.
- The job plan is available and loaded in electronic format onto the job plan system.
- Activity accurately reflects what will be delivered during the effective period and service requirements.
- Activities have start and end times detailed.
- Core supporting professional activities (SPAs) meet the requirements of the job planning framework and site described.
- SPA activity with objectives and outcomes are detailed.
- Objectives are agreed in SMART form (specific, measurable, achievable, realistic and timed).
- A diary card supports on-call activity and programmed activity (PA) allocation; if no diary card, PA allocation is consistent.
- A private practice declaration form is completed; all external activity is identified on the timetable.
- A conflict of interest declaration form is completed.

References/Source Documents

1. Terms and Conditions – Consultants (England) 2003 (Version 10, April 2018) https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Consultants---LCEA/Consultant-contract-Terms-and-Conditions-April-2018.pdf?la=en&hash=2260CE8D563CD881275A69EA452B4661DA9559B1
2. A Guide to Consultant Job Planning, July 2011, NHS employers and BMA- https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Guide_to_consultant_job_planning.pdf?la=en&hash=97A7C9434A2D30B60FC23EFD8CF6CAD21104A02C
3. Consultant Job Planning: a best practice guide, NHS Improvement 2017- https://improvement.nhs.uk/resources/best-practice-guide-consultant-job-planning/
4. NHS Employers Job Planning Toolkit 2017 --https://www.nhsemployers.org/jobtoolkit
5. European Working Time Directive https://ec.europa.eu/social/main.jsp?catId=706&langId=en&intPageId=205
6. Later careers: Stemming the drain of expertise and skills from the profession. April 2018. https://www.rcplondon.ac.uk/file/9429/download
7. 7-day services clinical standards. NHS England 13th September 2017 (First Published 2015)
8. https://www.england.nhs.uk/publication/seven-day-services-clinical-standards/
9. 7-day consultant present care Association of Royal Medical Colleges 3/12/2012 – https://www.aomrc.org.uk/reports-guidance/seven-day-consultant-present-care-1212/
10. BSG mentoring scheme
11. https://www.bsg.org.uk/blogs/my-experiences-of-bsg-mentoring-scheme.html
12. Letter supporting the release of consultants for wider NHS role. 23rd June 2017. https://www.resus.org.uk/EasySiteWeb/GatewayLink.aspx?alId=22797
13. www.thejag.org.uk
14. https://www.bma.org.uk/advice/employment/job-planning/dr-diary
15. Delivering Research for All, RCP 2019. https://www.rcplondon.ac.uk/guidelines-policy/delivering-research-all-expectations-and-aspirations-nhs-england
16. NHS England. The NHS Constitution for England. NHS, 2015. www.gov.uk/government/publications/the-nhs-constitution-for-england
17. The GMC 'Remote Consultations.' https://www.gmc-uk.org/ethical-guidance/ethical-hub/remote-consultations
18. The BMA 'Video Consultations' https://www.bma.org.uk/advice-and-support/covid-19/adapting-to-covid/covid-19-video-consultations-and-homeworking