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British Society of Gastroenterology consultant gastroenterologist job planning guidance

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ABSTRACT

Job planning is a mandatory part of the national terms and conditions for National Health Service (NHS) consultants. Gastroenterology and hepatology services are experiencing increasing demand, workforce pressures and evolving models of care. This document aims to provide detailed guidance for consultant gastroenterologist job planning aligned with national standards and current NHS service requirements. Guidance was developed by the British Society of Gastroenterology Job Planning Advisory Group, informed by national policy, Royal College of Physicians recommendations and expert consensus. Key areas addressed include direct clinical care, supporting professional activities, outpatient services, endoscopy, inpatient care, emergency and on-call commitments and single point of access services. Recommendations are provided to support equitable and sustainable job planning. In conclusion effective job planning is essential to deliver safe, high-quality patient care while supporting workforce sustainability. A structured, transparent and collaborative approach is required.

INTRODUCTION

Job planning is a mandatory part of the national terms and conditions for National Health Service (NHS) consultants.[1] A job plan is a prospective agreement between the individual gastroenterologist and their employing organisation. It should take place on an annual basis, considering the organisation's goals and the wider NHS objectives.

Currently the NHS is under pressure, and in gastroenterology and hepatology, the demand continues to rise, on a background of long waiting lists and workforce shortages.[2] COVID-19 catalysed change in the delivery of patient care, with increased use of non-face-to-face communication with patients. Electronic systems have replaced much administration support and increase both the information available and the time needed for patient and General Practitioners (GP) contacts. The NHS workforce plan and other evolving changes in the NHS make job planning a dynamic process for the consultant gastroenterology team. For this reason the British Society of Gastroenterology (BSG) felt that it was vital to update its previous 2020 job planning guidance (https://www.bsg.org.uk/getmedia/7c69f1fa-e671-4f93-b3d9-93181507a664/BSG-Consultant-gastroenterologist-job-planning-guidance.pdf).

Gastroenterologists and hepatologists need to meet both the demands of a growing specialty and the needs and expectations of patients, in addition to engaging in research, innovations, quality improvement (QI) and service development initiatives. The wider multiprofessional team requires training, supervision and support; and research, leadership and education remain essential parts of the gastroenterology team's activity. Team job planning can facilitate these roles within the consultant gastroenterology team, with flexibility between individual job plans.

These are job planning recommendations for consultant gastroenterologists, on the background of recommendations by Royal College of Physicians (RCP) London, relevant to physicians.[3] Job planning must be aligned with the terms and conditions of the national consultant contract[1] and the British Medical Association (BMA) also has published guidance.[4] NHS job planning guidance has been published[5] and NHS Scotland's was updated in 2025.[6]

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.

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. It should be negotiated and fully agreed by both parties. It should not be imposed.

METHODOLOGY

The BSG Clinical Services committee commissioned the formation of a job planning working group to develop this document. The guidance is based on current national job planning guidance, with specialist view on gastroenterology and hepatology. This guidance is for all 4 nations of the UK, recognising that service and delivery structures vary across the UK. This guidance was reviewed and endorsed by the BSG Clinical Services committee as well as the BSG Executive committee. The guidance was developed with input from the BSG Clinical Services committee, Council and Executive, training and Supporting Women in Gastroenterology committees and BSG workforce planning lead with the clinical services committee having representation from all four nations. A glossary of terms is provided in online supplemental appendix 1.

DEFINITIONS AND CONTRACTUAL FACTORS

A job plan is a prospective, professional agreement describing duties, responsibilities, accountabilities and objectives. It sets out how a consultant's working time is spent on direct clinical care (DCC) and specified supporting professional activities (SPA), any additional NHS responsibilities, both within the trust and wider, for example, clinical director, and external duties, those that bring benefit to the NHS but not connected to the agreed job plan outcome, for example, RCP work.

1 Programmed Activity (PA) is 4 hours in England, Scotland and Northern Ireland in normal working hours (7:00 to 19:00, Monday to Friday in England and 8:00 to 20:00 in Scotland) or 3 hours of activity at other times. In Wales, 1 PA is 3.75 hours in duration (7:00 to 19:00, Monday to Friday).

Consultant job planning must be aligned with the terms and conditions of the national consultant contract.[1] 7-day working, particularly emergency work, must adhere to the recommendations of the European Working Time Directive (EWTD).[7] This is especially important with respect to periods of compensatory rest.

It should be noted that sessions that are less than 4 hours in duration would usually be allocated less than 1 PA, 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 4 hours giving a 1 PA allocation. This should not be double counted elsewhere in the job plan, that is, if the 1 PA for clinic includes administration time, then the clinic cannot contribute to administration time allocated elsewhere within the job plan. For best use of resources it is recommended clinics be 4 hours, where possible, and the administration undertaken at another time. Another exception discussed below could include an endoscopy list that lasts three and a 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.

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. 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, General Medical Council (GMC), Care Quality Commission (CQC) or BMA) consultants may need to 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.

CATEGORISATION OF ACTIVITIES WITHIN A CONSULTANT JOB PLAN

Table 1 demonstrates how activities should be categorised within the job plan. DCC relates to work that directly relates to patient care and directly benefits patients. This may be patient-facing, such as clinics, ward rounds or endoscopy lists, or non-patient-facing clinical activity such as patient-related administration or multidisciplinary team (MDTs). Virtual clinics, whether by telephone or video software, are considered patient facing.

OUT-PATIENT CLINICS

An out-patient clinic event will comprise:

- Preclinic preparation including reviewing referral and previous letters and any relevant results.

Table 1 How activities should be categorised within the job plan

Programmed activity categories	Role	Examples and comments
Supporting professional activities (SPA)	Activities which contribute to ongoing professional development and drive efficiency, service improvement and productivity	► Teaching and training ► Medical education ► Continuing professional development ► Clinical governance ► Appraisal and revalidation ► Service development ► Medical research ► Clinical leadership
Direct clinical care	Care of patients	► Emergency duties (including emergency work carried out during or arising from on-call) ► Endoscopy sessions, including pre-endoscopy and post-endoscopy care ► Ward rounds and inpatient or day case work ► Outpatient activities ► Multidisciplinary meetings to direct named patient care ► Patient-related administration linked to clinical work ► Advice and guidance, triage ► Travel between sites for patient care
On-call and emergency work	This is recognised in two ways: an availability supplement and a PA allowance for time worked	► All consultants on the same rota at the same frequency should have the same availability supplement and the same PA allowance for hours worked ► On-call rotas should be monitored by a diary exercise at least every 2 years, more often if a change has taken place or if a review is required
Additional or extra programmed activities or sessions	Work in addition to the contracted number of sessions while maintaining existing clinical and SPA commitments	► To maintain clinical service provision ► To recognise additional responsibilities ► Leadership roles such as clinical lead
Additional responsibilities	Duties carried out on behalf of the employer or another relevant body and which are beyond the normal range of SPAs. Roles will have an associated job description and formal process of appointment	► The agreement to provide additional PAs over and above a standard contract can be ended with 3 month's notice by the doctor or the employer
External duties	External duties are not done directly for the NHS employer but are also vital to the functioning of the health systems across the UK	► A category of work within terms and conditions and so no expectation that reasonable quantities of this work will be unpaid if the work is agreed to within the job plan. Roles will have an associated job description and formal process of appointment

DCC, direct clinical care; NHS, National Health Service; SPA, supporting professional activities.

- The consultation with the patient including a clinical examination where appropriate.
- The ordering of ongoing tests and management, including prescribing.
- The recording of the visit including the generation of a clinic letter.

Out-patient exchanges with patients may be by telephone consultations or virtual with video consultation clinics. Although a physical examination of the patient is not possible it should not be assumed that the time taken to conduct such work is any less than a traditional clinic visit, particularly for follow-up. The GMC provides guidance.[8]

Consultants have different approaches with, for example, dictating all clinic letters at the end of the whole clinic or dictating after seeing each patient. Ambient voice recognition usage may reduce the time taken. The speed with which patients can be safely seen by one consultant, and his/her team will be dependent on the consultants' level of experience, specialist nurse support, outpatient clinic nursing support, the quality and efficiency of Information Technology (IT), need for a translator for non-English speakers and case mix. 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 min each, and this assumes reasonably efficient IT systems and full outpatient nursing support. 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 min per patient.

Follow-up patients in a consultant clinic should be allocated 20 min 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 to patient-initiated follow-up (PIFU),[9] 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—particularly those selected for face-to-face consultations as these are more likely to require an examination or complex discussions, including the breaking of bad news, and an average of 20 min is in anticipation of these factors. The use of digital tools for routine blood monitoring and with PIFU, such as in inflammatory bowel disease, increasingly allows consultants to focus on complex unwell patients. This increases the consultant new to follow-up ratio, and job and service planning should consider the resource of the whole MDT.

Consultants will also require time to supervise trainees and other staff, and scheduling debriefing time at the end of clinic should be considered, particularly for those in the early years of training.

An out-patient clinic taking 4 hours in total (3.75 in Wales) is equivalent to 1 PA of 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 min, and follow-up appointments 20 min (aiming for eight new patients or 12 follow-ups in a 4-hour clinic). These times reflect the needs of the patient rather than the experience of the gastroenterologist.

MULTIDISCIPLINARY MEETINGS

Gastroenterology is a specialty that has a large number of associated MDTs, including upper GI cancer, lower GI cancer, hepatobiliary (HPB) cancer, advanced liver disease, nutrition and inflammatory bowel disease (IBD). Often one or more consultants will be core members, and one will often be the chair.

If there is intermittent attendance to 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 if there is a significant amount of preparation work—for example, someone is chairing a session and needs to review notes, histology results, endoscopic and radiological findings beforehand, this should be included.

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 or unpredictable, unrelated to fixed sessions. Each needs to be considered separately in calculations of total clinical activity.

Clinical administration unrelated to fixed DCC sessions. This might include review of referral letters, email, advice and guidance (A&G) and telephone advice. Asynchronous consultations, a consultation where the patient and clinician interaction occur at different times, are increasingly common.

There is no absolute formula for calculating the expected volume of administration work that is directly related and unrelated to DCC sessions but in general, for a gastroenterologist, one would expect this to be in the region of 50% of time spent on direct patient-facing activities.

Pooled endoscopy lists, non-medical endoscopists, straight-to-test pathways and other providers delivering additional sessions to meet demand, all create clinical administration, and this does not stop when the consultant is on annual leave. Local arrangements for cover need consideration particularly for leave of more than 1 week.

Work diaries will be particularly useful in the calculation of unpredictable clinical administration.

The BSG advocates that patient-related administration requires a minimum of 1.5 PA (DCC) for a 10 PA 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.

SINGLE POINT OF ACCESS: ENHANCED CLINICAL TRIAGE, ADVICE AND REFER AND ADVICE AND GUIDANCE

The use of senior enhanced clinical triage and A&G to primary care is increasing in consultant workload. These pathways collectively are increasingly being called single point of access (SPoA), which encompasses triage, advice and refer and A&G services. This activity should be job planned sessionally.[10]

Not all trusts receive all referrals via an SPoA model, although almost all are now electronic. Several models of SPoA/triage currently exist, and the guidance notes below are designed to inform the job planning process, recognising that each model may require different levels of consultant involvement and time.

Patient referral triage activity may take about an hour for 20 referrals. However, A&G takes considerably longer, around 4 hours for 20 referrals, although this can take less time if there is consultant support in place, such as to request investigations.

The BSG advocates that A&G should be job planned sessionally and that no more than 20 cases can be managed/4 hours, unless there is further support.

Additionally, there is increased associated administrative demand:

- Requests direct-to-test scopes themselves, or whether this is done by their administrative teams.
- Investigation requests, for example, blood tests and scans.
- Actioning results, or whether this is delegated to the endoscopist/team that sees patient in the clinic or endoscopy unit.
- Responds, including discussion with primary care as to why a referral may be unnecessary, directly through the NHS e-Referral Service only or uses the electronic patient record with requirement that additional letter

to the patient and GP be typed or dictated. The latter process is far more time consuming.

Triage is a specialty skill. Depending on which triage system used, and the functionality of the IT, the numbers of cases that could reasonably be dealt with in a 4-hour session (1 PA) will vary and we have therefore suggested activity levels as a starting point for job planning conversations.

Given that SPoA services must be delivered 52 weeks per year, analogous to the on-call rota, PA's associated with this work must be annualised appropriately.

For example, a consultant delivers 1 session of SPoA activity per week as part of a team, but will be expected to cover their team members' SPoA work during periods of leave.

To make the job plan a consistent weekly figure that accounts for leave, the total annual PAs are averaged over the *actual* number of weeks the consultant is expected to work (the 'available working weeks').

- Available working weeks: approximately 42 weeks (52 weeks total−10 weeks leave/holidays etc).
- Annualised weekly PA: 52 PAs/year/42 available working weeks/year ≈ 1.24 PAs per week.

The consultant's prospective job plan will therefore show 1.24 PAs allocated to the SPoA activity each week. This higher weekly figure accounts for the fact they provide cover for colleagues during the 10 weeks they are not working, and their own leave is covered by colleagues in turn.

In this example, SPoA work continues over the on-call periods, but this may not be appropriate and therefore adjustments to the annualisation should take place on this basis, for example if each team member provides 6 weeks of on call per year, then the available working weeks would drop to 36, and the resulting calculation is as follows:

Annualised weekly PA: 52 PAs/year/36 available working weeks/year ≈ 1.44 PAs per week.

ENDOSCOPY

Gastroenterologists usually provide a range of endoscopy services. In addition to elective 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. These may be on dedicated lists or if emergency cases are added to lists provided by consultant gastroenterologists, then the time taken on average is significantly longer than other purely elective lists, then this should be reflected in job plans with a higher PA allocation per session.

1 PA is 4 hours of work. Joint Advisory Group (JAG) recommends that endoscopy should include approximately 30 min for starting and finishing, including changing into scrubs, team brief, World Health Organisation (WHO) checklists.[11] There is evidence from bowel cancer screening that that performance declines during a list and so lists in excess of 210 min endoscopy should be avoided. The number of cases booked in each session has to be decided based on the complexity of cases, including whether diagnostic, therapeutic or emergency cases.

Emergency bleeds often require anaesthetic cover and may be performed on a dedicated operating theatre list for emergency surgeries, which can be very time consuming. This should be taken into account during job planning and a clear pathway developed.

The time allocation for complex therapeutic work should be decided at a local level and each department performing complex work should have a system in place to plan and allocate appropriate time for such cases.

Endoscopy lists generate administration both during the list, such as the ordering of additional investigations, and also displaced from the list, reviewing, communicating and acting on histology results.

TRAINING LISTS

A training list for any of the endoscopic procedures requires the number of procedures to be reduced proportional to the composition of the list and the experience of the trainee. Training lists have more administration per patient than service lists, patient-related administration and recording of the training episode.

IN-PATIENT WORK

There are various models currently used in hospitals and NHS Trusts. The PA allocation will be dependent on factors including: workload; General (Internal) Medical component; the ward model such as on-the-ward and off-the-ward; the availability of resident doctors especially middle-grade doctors, physicians' associates 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 for by a single consultant will be dependent on the availability and experience of the other team members as well as the time allocated for this time for DCC.

Job plans must avoid clinical conflicts such as 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, further investigations and documentation of the outcomes. The BSG supports the RCP recommendations of *Ward rounds in medicine: principles for best practice*,[12] and *Safe Medical staffing*[13] of 10 min per patient interaction meaning that during a ward round (1 PA, DCC) an individual consultant should look after no more than 16–25 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.

WARD COVER MODELS

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 undertake fewer clinics and/or lists than those off the wards. The RCP recommends 'consultant of the week' models for inpatient care, with no other fixed commitments during this time, or if they cannot be rescheduled, clear cover arrangements.[3] Time to review 'outliers' or 'boarders' must also be included; these reviews will take longer than on the 'home ward'.[3] Full calculations on time to staff the ward, dependent on different patient numbers and staff mix, are given in *RCP Safe Medical staffing*.[13] A Consultant of the Week model will inevitably result in a reduction of the number of weeks of elective activity provided by that individual.

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 (a PA is 3 hours out of hours)—such models would usually equate to a minimum of 12 PAs (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 EWTD, that there should be a minimum of 48 hours rest over 14 days.[7] Regardless of EWTD compliance, the BSG supports trusts and consultants to move away from 12-day periods of continuous working wherever possible.

In-patient cover is provided 52 weeks of the year. 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 (ie, have a day off per week). For this reason (among others), the BSG advocates that such work be shared among consultants (ie, 1-in-8 rota).

Depending on the extent of resident 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

A worked example of inpatient care is as follows.

The inpatient service is shared between all or most consultants in the specialty team with team members rotating between different roles. 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.[14]

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).
- Ad hoc meetings with patients and relatives plus ward-related admin (1 PA).

This would give a total of 10.0 to 12.75 DCC PAs per week. 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, the trust would need to agree approximately 12.5 PA divided between the covering consultants). If there were eight 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) almost two whole-time equivalents would be required. This approach would be difficult to deliver with fewer than six 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 advocates 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 EWTD.

SCHEDULED EMERGENCY WORK

Scheduled emergency work is delivered in sessions or shifts where 1 PA equates to 3 hours of premium time (weekends and 19:00 to 07:00 weekdays). In-patient ward work including the review of new admissions will be variable, but most teams will be able to determine a realistic average, accepting that there will be some week-to-week variation. Scheduled emergency work should not overlap with planned work, such as an outpatient clinic or elective endoscopy list.

7-DAY SERVICES AND THE 10 CLINICAL STANDARDS

10 clinical standards for 7-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 on consultant-delivered acute care. These standards define what 7-day services should achieve, no matter

when or where patients are admitted 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.[15] These standards include four key elements relevant to gastroenterology. These are intended to ensure that patients admitted to hospital in an emergency:

- Do not wait longer than 14 hours for 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, 1 hour.
- Get access to specialist, consultant-directed interventions.

Hospital inpatients must have timely 24-hour access, 7 days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. These interventions would typically include interventional endoscopy.

Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, 7 days a week, unless it has been determined that this would not affect the patient's care pathway.

An out-of-hours (OOH)/7-day in-patient service in addition to the endoscopy cover described above, requires additional PAs. The gastroenterology patients for review are usually those that are acutely unwell, new patients and potential discharges. There is often an expectation to provide in-reach to an MAU and see gastroenterology referrals on other wards, for example, intensive care. An example of how this can be calculated is shown in figure 1.

If a trust is aiming to increase consultant contribution to 7-day working then this should be agreed in team and individual job planning meetings. The current consultant workforce shortages, with many advertised posts unfilled, can place pressure on consultants to work increasingly longer hours. Consultants cannot be contractually compelled to undertake elective work out of hours. All consultants can give 3 months' notice to drop PAs above 10 PA, the choice of which should be negotiated with their employer.

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

UNSCHEDULED EMERGENCY WORK (ON-CALL)

Most gastroenterologists will be expected to provide on-call cover for OOH endoscopy and management of gastrointestinal emergencies. This is above and beyond any provision for scheduled/sessional reasonably predictable work. This includes telephone calls for advice and attending 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 usually far exceeds the number of actual hospital attendances. Accommodating unpredictable on-call commitments 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.[1] 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 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 advised to keep their own work diary, recording time for telephone calls, travel and administration as well as direct patient contact time (ie, an on-call episode starts when the first call is received).

7-DAY WORKING AND PLANNED CARE INCLUDING ENDOSCOPY

If there is planned scheduled work at weekends, it is imperative that this does not conflict with other commitments such as emergency work/on-call.

OOH ENDOSCOPY SERVICE

An OOH endoscopy service may range from an emergency therapeutic endoscopy service for high-risk upper GI bleeding alone at one end of the spectrum, to the provision of full 7-day cover for all inpatient requests at the other. 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

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.

Figure 1 Worked calculations.

Table 2 Endoscopy on-call salary supplement defined by 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 4 or more	8.0%
Medium frequency 1 in 5 to 1 in 8	5.0%
Low frequency 1 in 9 or less frequent	3.0%

can ideally be assessed using a prospective full-rota cycle diary by several, or preferably all, rota members.

Endoscopy on-call will command a Category A salary supplement (Schedule 16 of the national contract[3]) (table 2).

The workload consists of:

- Emergency endoscopy that cannot wait more than a few hours (unpredictable). If taking place in the middle of the night can take 4 hours from telephone call to returning home.
- Urgent cases that should be undertaken within 24 hours and can usually be undertaken on weekday and weekend morning lists (less predictable).
- Non-urgent inpatient referrals that might be undertaken at weekends or during bank holidays as part of 7-day working (relatively predictable).
- Routine elective outpatient workload to help provide sufficient capacity to meet demand (predictable).

A worked example of how on-call can be calculated is given in figure 2.

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 EWTD 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 inpatients and/or elective outpatients would equate to 1 PA per 3-hour list—using this example, two 4-hour lists (including starting and finishing time) on a 1-in-8 rota 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).

4 overnight call-outs per consultant per year, each taking four hours each (from call to return home) would equate to just 0.13 PAs 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 0.18 PAs).

Taking these both together would give approximately 0.3 PAs for the unpredictable element of out of hours 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.

Figure 2 Worked example on-call calculations.

Ward cover 1 in 5 will occur for just over ten weeks per year (52/5 = 10.4).

(If no prospective cover this is just over 8 weeks per year (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).

Figure 3 Worked example of prospective cover calculation.

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 a 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 'prospectively', that is, if you are on leave, you need to swap them rather than simply cancel them. Emergency/on-call work needs to run for 52 weeks of the year, whereas any given consultant will work for no more than 42 weeks in a year. A worked example is shown in figure 3.

E-job planning software/programmes usually calculate this automatically, but the principle must be clearly understood by doctors and departments, and the annual job planning cycle is depicted in figure 4.

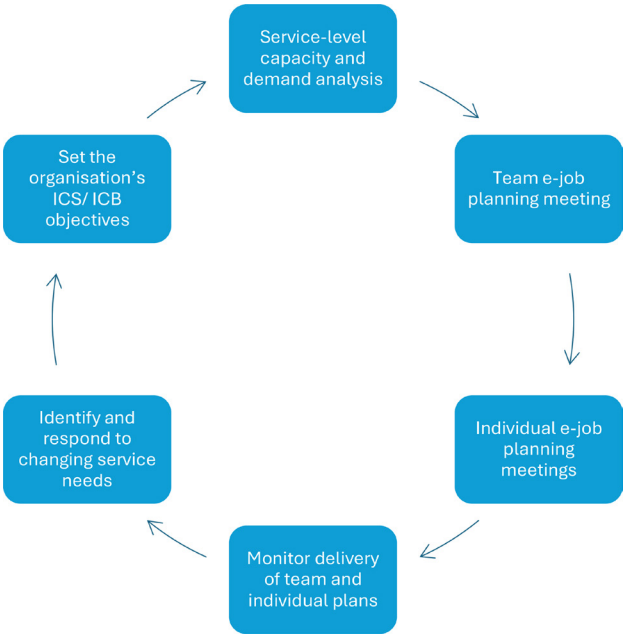

Figure 4 The annual job planning cycle aims to match capacity and demand, Integrated Care System (ICS), Integrated Care Board (ICB).[22]

SUPPORTING PROFESSIONAL ACTIVITIES

This relates to professional, educational, administrative and academic responsibilities, 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 service. SPAs also enable consultants to build a portfolio of evidence for their annual appraisals to ensure they can be revalidated.

Most consultants would be expected to undertake additional roles such as educational supervision and clinical supervision, university teaching roles, endoscopy training, management, research roles such as senior investigator, trial recruitment, laboratory work, grant writing. These all also need to be agreed within job plans. Often, the demands for this type of work increase as consultants become more experienced.

As an absolute minimum, each consultant should be allocated 1.5 PA for appraisal and revalidation and for 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 BMA and RCP recommendation of an absolute minimum of 1.5 PAs core SPA for each consultant to sustain their professional standing (ie, revalidation and appraisal). Less than full-time (LTFT) posts require equivalent time for revalidation, appraisal, study and professional leave.

QI ACTIVITY

QI is required 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. This work would be classified as DCC when dealing with named patients, and otherwise would be SPA.

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, in gastroenterology and/or endoscopy, would usually require at least 4 hours (1PA) of time and potentially significantly more, depending on the size and complexity of a service, and where possible, should be undertaken within working hours (ie, 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 should be discouraged from believing that such work can always be fitted around a full timetable. These are important roles for patient safety and quality of care, as well as for the appropriate management, support and development of staff within the MDT.

CONSULTANT MENTORING

Mentorship can provide valuable support to consultants at any stage in their career particularly 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 10 PA contract if full-time. In many cases the work commitment is often more that 10 PAs worth of work, especially if patient related administration and inpatient workload is underestimated. 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.[16]

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

SPA should incorporate the role of mentoring. Appropriate time needs to be acknowledged for both senior clinicians (as mentors or mentees) and newly appointed consultants (as mentees).

SUPERVISION OF DOCTORS IN TRAINING

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

UNDERGRADUATE AND TEACHING

Many consultants commit a significant amount of time to teaching medical students. This should be agreed in the job plan, usually agreed locally with the relevant medical school.

In addition, consultants should be encouraged to provide, where appropriate, teaching to other healthcare professionals, such as 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, 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 advocates 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 research for all, calling for more research to be conducted in NHS trusts to support high-quality patient care.[17] Trusts should use job planning to protect time for clinical research within the SPA allocation while maintaining 1.5 core SPA for appraisal/revalidation.

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.

PROFESSIONAL ROLES AND RESPONSIBILITIES (IE, REGIONAL AND NATIONAL COMMITTEES)

Consultants undertake a wide range of regional and national roles outside the employer, often as they become more senior and experienced. These roles play a vital role in running the NHS and trusts are encouraged to support the wider NHS.[18] These roles include work for the RCP, the BSG itself and NHS organisations such as NICE, BMA, Specialised Commissioning, Cancer Alliances, Clinical Networks and Clinical Senates. Significant international roles should also be supported as they often contribute to enhancing the care of UK patients. The work covered includes educational work, assessments, policy development, QI activity and guideline development. The BSG strongly believes that these roles should be supported wherever possible. The time taken for these roles should be incorporated into the job plan as specific agreed activities; either as external duty PAs or additional responsibilities and awarded as SPA time. For less regular or one-off activities, these can be managed through paid special leave (TCS Schedule 18).

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. 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 does not 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.

CLINICAL ACADEMICS

Clinical academics are usually either jointly employed by Universities and NHS Trusts or University employed with Honorary NHS contracts. Job planning should adhere to the Follet principles.[19] An integrated job plan needs to be agreed jointly by the university, NHS Trust and the clinical academic—ideally with representatives from both employers present at the job planning meeting.

Clinical academics require the same minimum 1.5 SPAs for revalidation. Teaching and supervision activities may be attributed to either the NHS or university component depending on the learner group (undergraduate medical students typically university; postgraduate trainees typically NHS).

Research activity will typically be covered within the university component of the job plan, though NHS Trusts may also allocate protected research time within SPAs where agreed, for PI work.

On-call commitments should be proportionate to the clinical PA allocation (eg, a clinical academic with five clinical PAs might reasonably participate at half the frequency of full-time NHS colleagues).

Weekend ward cover participation should similarly reflect the clinical PA allocation.

LTFT CONSULTANT POSTS

There is an increasing number of consultants that work LTFT. This is often for personal reasons of caring responsibilities, and increasingly those returning to work post retirement and trusts should support these individuals through the job planning process. The principles and examples used elsewhere in this guideline apply equally to those on an LTFT contract. Most elements of the job plan on average are similar in proportion to those on a full-time contract, including 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 core SPAs in order to ensure that they have time to undertake internal CPD, a minimum level of QI activity and personal appraisal and other activities. Similarly, study and professional leave should be 30 days per 3 years. An LTFT consultant has exactly the same revalidation needs and GMC expected standard as an FT consultant.

ANNUALISED JOB PLANS

The drivers for annualised job plans include week-to-week timetable variation, other commitments that occur on a slightly unpredictable basis, the need to have flexible sessions to help backfill endoscopy. 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.

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 in 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 for this purpose.[20]

TEAM 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. In most cases, following a high-quality team meeting, individual job planning meetings can be relatively brief.

Team job planning, if done well, encourages transparency and can help foster a highly functional department. It also helps 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. New ways of working such as A&G require specific skillsets, and where possible the team job planning process will reflect the range of skills within the team, deploying consultants to their areas of expertise to deliver the best possible service.

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. If there is a shortfall 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.

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 recognised by NHS England.[18] 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.

ELECTRONIC JOB PLANNING AND THE JOB PLANNING CYCLE

The NHS Long Term Plan committed to electronic job plans and gave standards of attainment and best practice guidance.[21] Level 0 has <10% dedicated e-job planning software in place, through to level 4 with organisational e-job planning with board level accountability for e-job planning for all workforce groups. Electronic job planning allows trusts to calculate capacity in terms of DCC, rather than whole-time equivalents (figure 2).[22]

Objectives

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

Private professional services

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

There should be no detrimental effect on NHS patients or services, or conflict of interest between NHS and private work.[5]

Fee-paying services

Any regular fee-paying services and contractual arrangements with other providers 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 need to be recorded. If a doctor 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.[4] 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 for appropriate IT systems such as endoscopy reporting software and appropriate secretarial and administrative support. It is also necessary for consultants to be provided with appropriate office space to undertake

administrative responsibilities and have confidential conversations and perform appraisals. Figure 5 is a job planning checklist based on "Consultant Job Planning: A Best Practice Guide" NHS Improvement revised 2017.[5]

VARIED PATTERNS OF WORK

For most consultants working in the NHS, the weekly timetable is not the same for each week of the year. Commonly there are periods on and off the wards, with 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, that is, 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 (19:00 to 7:00) in England 1 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 will calculate the allocation automatically.

LATER CAREERS

The BSG supports the later careers work undertaken by the RCP.[14] The NHS needs to retain the expertise and experience of senior consultants, and this should include using their skills in leadership, teaching and training, mentoring and coaching of more junior consultant colleagues and other NHS staff. Proper succession planning allows senior consultants to give additional training and support to newly appointed consultants to develop skills in ERCP, therapeutic endoscopy, hepatology, IBD, functional gastroenterology 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.[14]

FURTHER SOURCES OF GUIDANCE

RCP London: Empowering physicians: Effective job planning for better patient care | RCP

BMA Job planning.

NHS Employers: Guide to consultant job planning July2011.pdf

NHS England consultant-job-planning-best-practice-guidance.pdf

NHS Scotland Job Planning Guidance (supersedes DL(2016)[14]

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 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.

Figure 5 Annual job plan checklist. NHS, National Health Service; SPA, supporting professional activities; SMART, simple, measurable achievable realistic timely.

NHS Wales Policy, Procedures and other Written Control Documents Template

NHS Northern Ireland: Consultants' contract documents | Department of Health

CONCLUSION

Effective job planning is essential to deliver safe, high-quality patient care while supporting workforce sustainability. This guidance offers a structured, transparent and collaborative approach to job planning, which allows adaptation to newer ways of working. It is likely that the changing situation will mean further updated guidance will be required within the next 5 years.

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