Royal College of Physicians

Empowering physicians

Effective job planning for better patient care

Contents

Introduction

This guidance describes the roles that consultant physicians and specialist* doctors deliver within the NHS and beyond. It aims to empower consultant physicians, specialist doctors, clinical leaders and service managers to work collaboratively on job planning for physician teams. It lays out the core principles for effective job planning and emphasises how the different elements of a balanced, professional programme of work should be recognised and rewarded.

By using this guidance, conversations about job planning will become more productive and insightful, balancing the professional needs and development of physicians and enabling the provision of safe, effective and efficient patient care. This will improve outcomes and experience for both patients and staff.

Individual medical specialties have their own job planning guidance. This guidance is intended to enhance and complement specialty guidance.[1–3] Other organisations produce complementary guidance. The British Medical Association (BMA) has published the consultant charter, which includes guidance on good job planning.[4] NHS England gives guidance on the job planning process at an organisational and system level.[5] The BMA and NHS Employers give guidance on terms, conditions and agreed contractual arrangements.[6]

There is considerable variation in the roles of consultant physicians and specialist doctors, depending on their specialty, the clinical case mix, the composition of their clinical team, and the organisation(s) that they work for. Therefore, this guidance does not prescribe specific time allocations for some elements of the job plan, as these need to be appropriate to the individual's role within the specialty and team. Individual specialty guidance should be followed. Discussions and agreements should be supported by evidence of the time taken and required for the components of the job plan that are outlined in this guidance, and in line with specialty-specific guidance.

We recognise that initially, for some physicians and some organisations, this may require significant changes to job plans, supportive processes and staff roles. A phased approach to implementation may be necessary in these circumstances.

As service requirements grow and evolve, so does the need for their supervision of and support to the wider multidisciplinary team (MDT).

How physicians work

Consultant physicians lead multidisciplinary teams that include specialist* doctors, doctors at other stages of their careers and other healthcare professionals. These teams are most commonly for a medical specialty, but individuals may work across specialties.

Consultant physicians and specialist doctors deliver a wide range of professional activities, as shown in Table 1.

The clinical aspects of care range across prevention, diagnosis, treatment planning and monitoring, support for people with long-term conditions and end-of-life care. This is provided in urgent and emergency care, and episodes of planned care. This clinical activity is not confined to hospital settings, but extends to other clinical settings and remote delivery, through multiprofessional teams and in close collaboration with other specialties and sectors.

Table 1. The range of physician professional activities

Clinical	Professional	Governance
Inpatient care	Personal professional development	Safety management
Outpatient care	Clinical leadership	Service development
Clinical procedures	Education and training of others, educational supervision and examinations	Quality improvement, including audit and case reviews
Community care	Advocacy for patient populations	Appraisal preparation and appraisal of colleagues
Liaison services	Clinical research	
Specialist advice to colleagues	Team development	
Supervision of multidisciplinary team		

While all consultant physicians and specialist doctors practise the areas listed in Table 1 to some extent, the balance of these activities will vary considerably between individuals, dependent on their role, experience, place of work and the team that they work in. The mix of activities also changes throughout a physician's career.

It is uncommon for consultants or specialist doctors to follow a consistent weekly work pattern throughout the year, and many planned activities delivered tend to fluctuate daily, weekly or monthly. Therefore, job planning over prolonged periods of time, eg monthly or annually, or over an agreed cycle incorporating fixed and flexible commitments, is more appropriate.

Many physicians choose to work flexibly, eg less than full time, variably throughout the year or in different locations. We strongly support flexible working patterns and recognise the need for open conversations to embrace this.

*Specialist doctor refers to physicians who are specialist grade doctors as per 2021 SAS reforms, or associate specialist doctors.

Current NHS services and changing demands

NHS services are under pressure, and current capacity does not meet demand. Many physicians report being unable to deliver their role within the constraints of their current job plans, and financial pressures and workforce availability limit the staff that can be employed. It is important to balance the need to maximise 'productivity' from current staff (including consultant physicians and specialist doctors) with being realistic about what can be delivered, and ensuring supportive activities for safe and effective care. Failing to do so risks compromising the delivery of high-quality care and the professional needs and development of individuals and teams, leading to demoralisation, stress, burnout, ill health and further workforce depletion.

Clinical care has evolved in recent years due to the COVID-19 pandemic, digital transformation, changing age demographics, new and more effective treatments and people living with multiple conditions. These changes are likely to accelerate as we adapt to meeting the needs of patients within available resources. There is also significant pressure and unmet need in all sectors of health and care, increasing demand for secondary care. Notably, there has been a rise in clinical activities outside traditional clinics and wards.

The widespread use of clinical information systems and electronic patient records has increased the information available for clinical assessments. It has also increased the administrative work associated with clinical contacts, thereby potentially reducing clinician productivity. Consultants and specialist doctors should not be performing tasks than can be delivered by administrative and other support staff.

The increased complexity of patient conditions or treatment requires more detailed or complex assessment, communication, decision making and monitoring. This can require input from other clinical disciplines, specialties or sectors. The need for early and increased senior decision making in urgent care also impacts on wider responsibilities. There is growing demand for informal advice from consultant and specialist doctors to other clinical colleagues and patients, and remote advice through 'advice and guidance' systems, which may not currently be recognised as formal activity.

Consultants and specialist doctors face growing demands on their time. As service requirements grow and evolve, so does the need for their supervision of and support to the wider multidisciplinary team (MDT). The number of medical and wider clinical staff requiring training and education in early career stages continues to increase. There is also an essential need for time to improve or adapt services and lead innovation and research, so that the delivery of care is updated and continues to achieve the expected standards for good practice.

Patients' expectations of safety and quality have also evolved, leading to greater scrutiny and supportive processes. Physicians need to be involved in clinical incident reporting, investigations, case reviews and responding to complaints. This requires attendance at governance meetings, meetings with families, and liaison with and possible attendance at the coroner's court. In addition, consultants support members of the multiprofessional team with these activities.

There has been a rise in clinical activities outside traditional clinics and wards … As outpatient care is modernised, it is expected that this form of clinical activity will increase.

The need for physician leadership has grown in clinical aspects of care, education, research and activities within a clinical governance framework. These are not confined to the employing organisation, and often include local, regional and national systems within the NHS, arm's-length bodies and professional organisations.

The competing needs of these activities reduce flexibility and limit availability for wider professional commitments such as examining, recruitment and networking for service development. These are essential for the delivery of safe and effective care for patients. If flexibility and the professional drive for discretionary activities are squeezed out, these activities will fall to a smaller pool of physicians, risking their wellbeing. Furthermore, these are professionally rewarding activities, and job satisfaction is reduced when they are not possible.

Feedback from consultants and specialists

In the UK 2023 census of consultant physicians by the Federation of the Royal Colleges of Physicians of the UK in December 2023 – January 2024 of over 22,000 consultant physicians working in the NHS across all four nations, over 3,000 gave information about their current job plan.[7]

Consultant physicians reported insufficient time in their job plan for many standard and expected professional activities, prompting many to consider reducing their commitment or leaving the NHS in the next few years. Those activities that are not adequately recognised in job plans despite annual review, and those that get 'squeezed', are shown in Figs 1 and 2.

Fig 1

What are the top three activities that get squeezed out of your week when things get too busy?

- Continuing professional development
- Quality improvement activity
- Education, training and supervision of doctors (of all grades, including appraisal of colleagues)

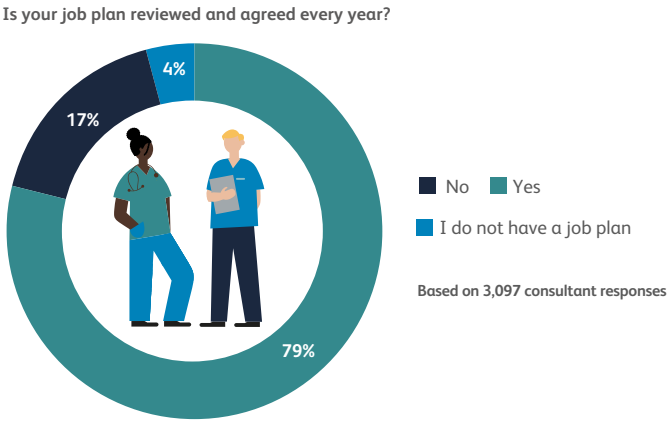
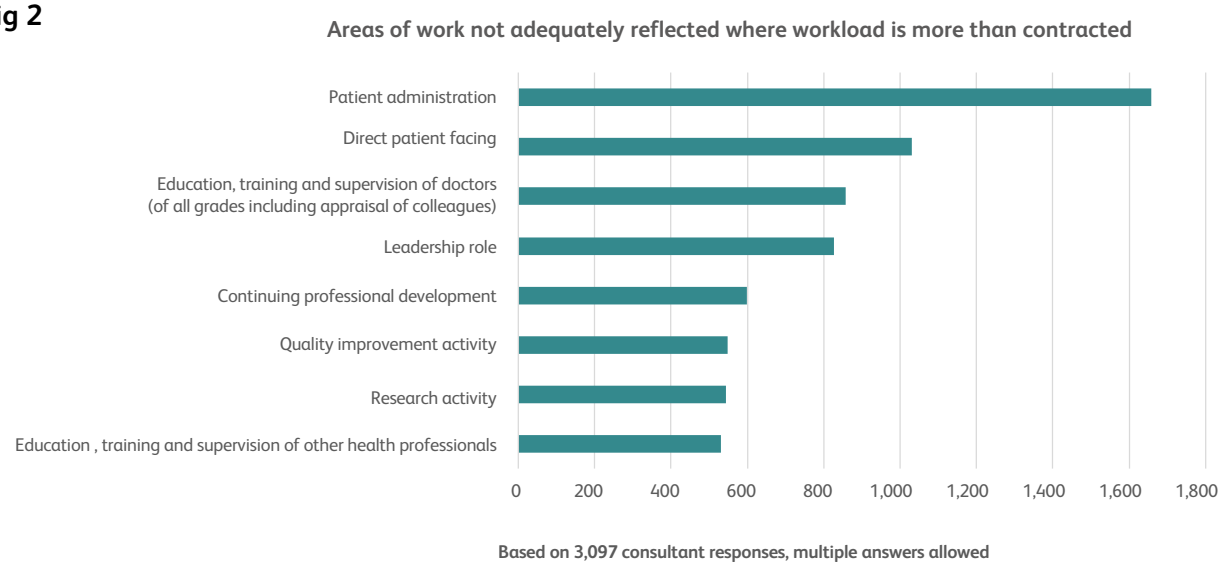


Fig 2



Full-time consultants are contracted for a median of 11 programmed activities (PAs) and work a median of 12 PAs. Less-than-full-time (LTFT) consultants represent 32% of the consultant workforce overall, and are contracted on a median of 8 PAs and report working closer to 8.5 PAs (Figs 3 and 4). The majority report that this work is predominantly direct clinical care (DCC), including patient administration (Fig 5). Anecdotally, physicians report informal clinical advice and care outside wards and clinics, including 'advice and guidance' significantly encroaching on time outside DCC PAs, and not formally in the job plan.

Fig 3

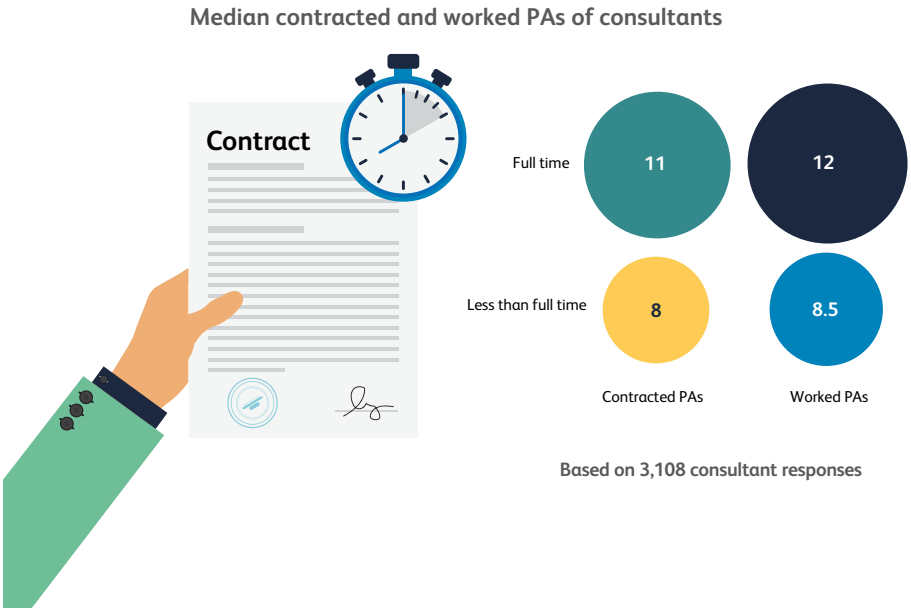


Fig 4

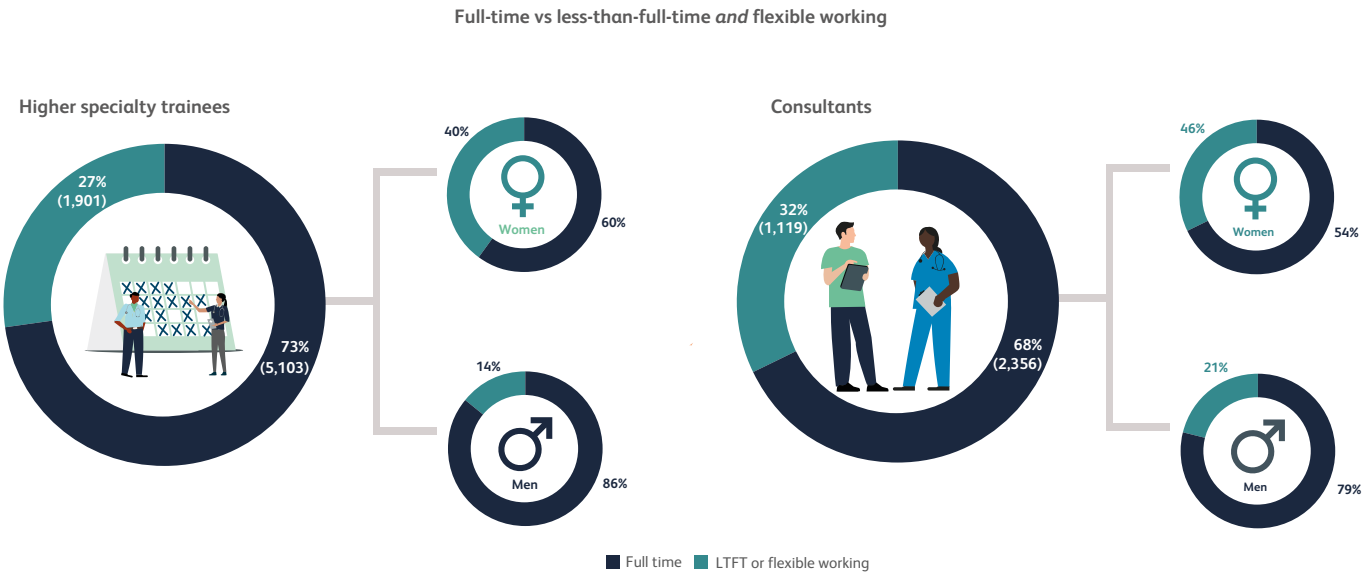
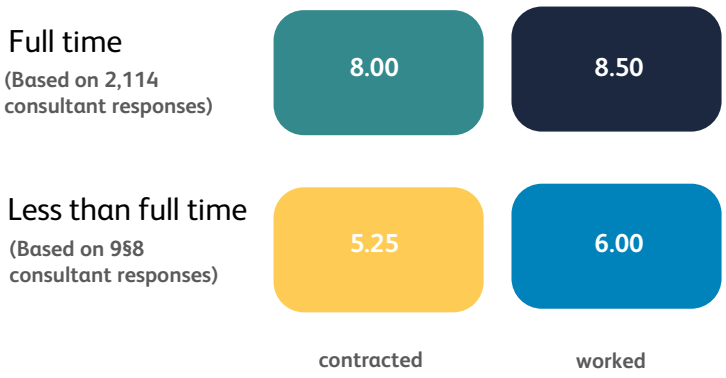


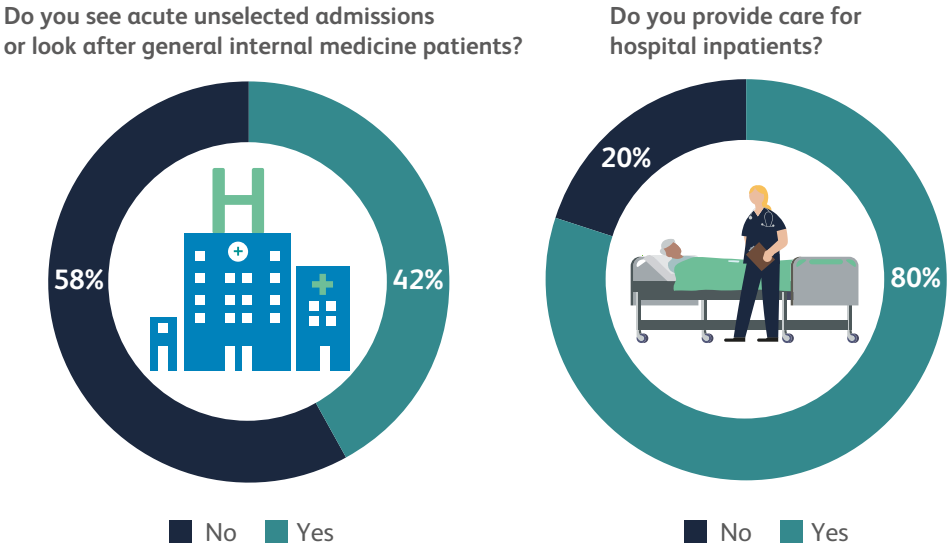
Fig 5

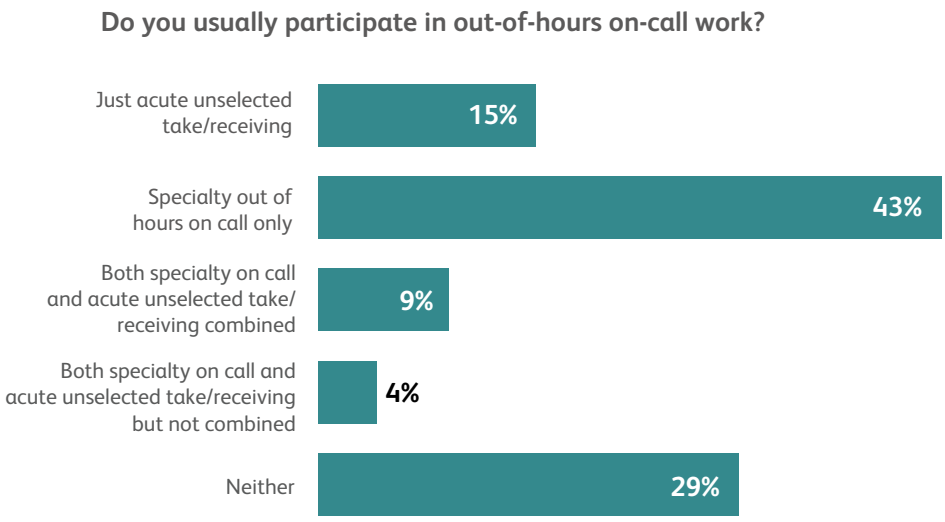
Median contracted and worked DCC PAs of consultants



Of those who replied, 80% reported caring for hospital inpatients and 42% reported that this included taking part in the acute unselected take. Data were not sought on care of general internal medicine patients after the initial receiving phase (Fig 6).

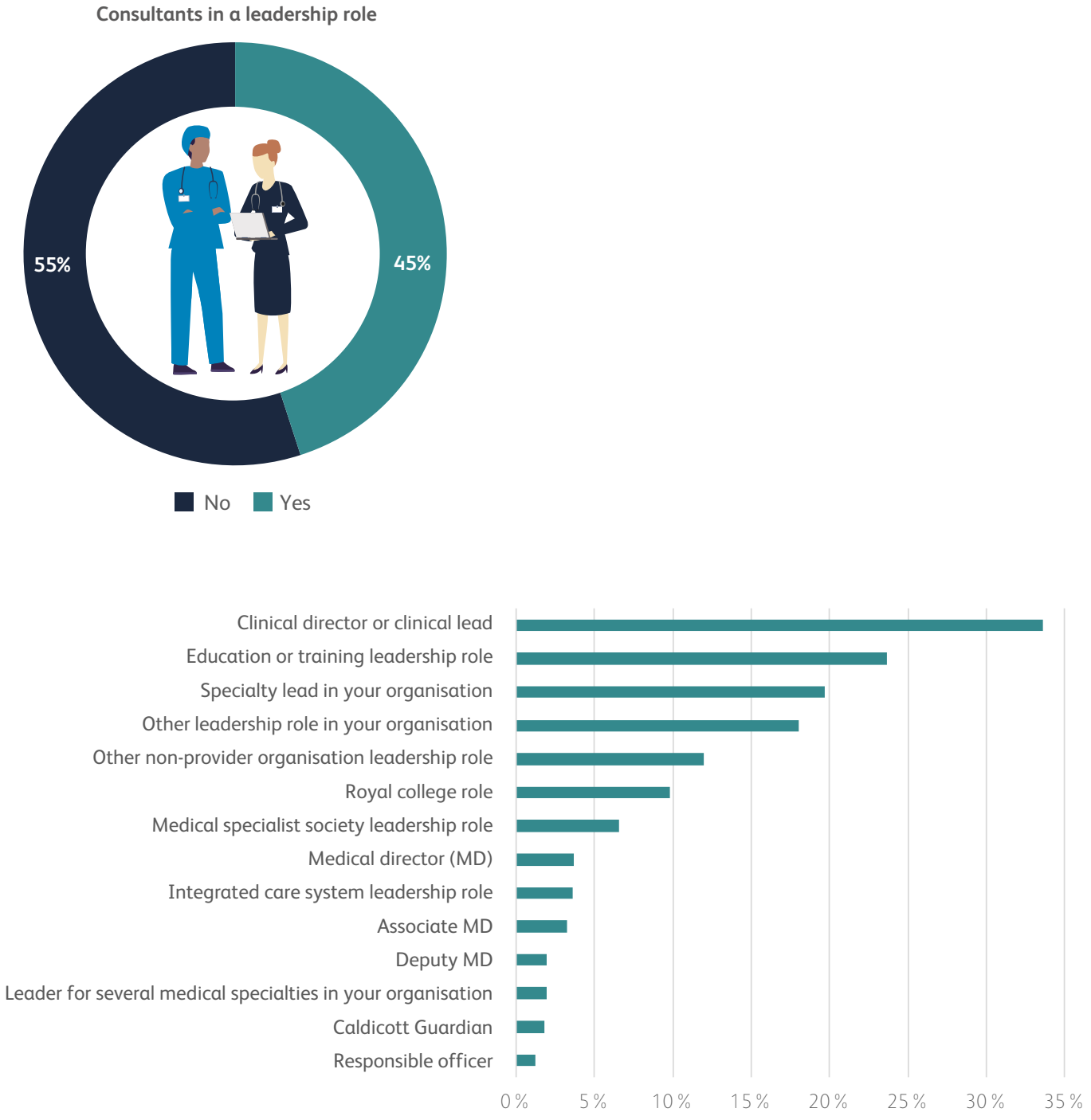
Fig 6





Almost half (45%) reported having a leadership role, the most common being clinical lead. The remuneration of external leadership roles was not specifically asked about, but is reported anecdotally to vary widely across providers (Fig 7).

Fig 7



Principles of job planning

We propose 10 principles to shape local approaches to job planning.

1	**Balanced portfolio** Job plans facilitate a balanced professional portfolio for individual physicians that aligns their personal and professional needs with those of their department and employing organisation.	6	**Appropriate variation** Variation in the contribution to the team's requirements between individuals is necessary for different elements of care delivery and supportive activities, influenced by expertise and interests.
2	**Flexible delivery** Job plans are indicative, and professionalism enables optimised use of time to deliver the activities by the individual within a team.	7	**Recognition of career stage** A physician's contribution to the team capacity and capability adapts throughout their career.
3	**Professionally rewarding** A balanced job plan should provide professional reward and help manage fluctuations in demand effectively.	8	**Flexible working** Flexible careers and flexible working are embraced as a reality of modern teams and organisations. This is facilitated by open conversations in team-based workload planning, and agreements for flexible working are included in individual and team job plans.
4	**Matched to team workload** Job planning commences with clinical team/specialty workload assessment to understand the total service demands/requirements and the capacity/expertise within the team to meet these. This includes direct clinical care, education, research, governance, appraisals, leadership and service improvement.	9	**Additional activity** Additional activity that is delivered in any of the professional practice domains is recorded, so that increased demand for the development of adequate capacity within the team is recognised in subsequent workload and job planning rounds.*
5	**Consistent support** Common activities within the team and consistent mechanisms and support for delivery are agreed and documented.	10	**Organisational support** The employing organisation supports physicians to deliver their job plan and enables the provision of evidence of delivery.

*The cessation of local clinical excellence awards means that additional activities cannot be recognised through this former mechanism.

RCP recommendations

1. Balanced professional programme of work

The RCP advocates for job plans to facilitate a balanced professional programme of work for consultant physicians and specialist doctors as part of a team, to create a productive and adaptable medical workforce that is equipped to meet current and future demands and needs.

Direct clinical care (DCC) for patients will comprise the majority of most physicians' job plans. This includes all tasks, including administrative and governance tasks for individual patients. Supporting professional activities (SPAs) enable clinical care, while additional NHS responsibilities and external professional duties are essential for a functioning NHS.

For consultants working a job plan of 10 programmed activities (PAs), it is expected that SPAs would comprise at least 2.5 PAs. The minimum time required for continuing professional development (CPD), core team and individual clinical governance, non-clinical administrative demands, appraisal and revalidation is 1.5 SPAs; this might be referred to as 'core SPA' time. **Additional** SPA time should include key consultant/specialist doctor activities, such as formal teaching, educational supervision of doctors and other members of the team, leadership activities, governance, morbidity and mortality review, research and service improvement. We recognise that some elements of education and training and clinical research will be delivered as part of DCC. Some physicians will also have additional NHS responsibilities and external professional duties; these should be recognised separately from SPAs, but may reduce the time available for other leadership roles.

Annualised activities help to incorporate the flexibility required for current service demands and wider commitments. The consistent weekly job plan for a physician is an outdated construct.

Supportive activities, additional responsibilities and external duties are commonly not fully recognised in current job plans.

> The consistent weekly job plan for a physician is an outdated construct.

The RCP makes the following recommendations:

1.1 Job plans must outline time commitments that recognise the role of the individual within the team, the organisation, the NHS and a wider health and care system.

1.2 All consultants working a 10 PA job plan should have a minimum of 1.5 SPAs for continuing professional development, clinical governance, non-clinical administrative demands, appraisal and revalidation activities.

1.3 Additional SPAs are required for formal teaching, educational and research roles, governance, morbidity and mortality review, service improvement and other leadership activities.

1.4 For physicians working less than 10 PAs, SPAs are likely to be a higher proportion of the job plan, with1.5 PAs seen as the absolute minimum SPA requirement. For those working 6 or less PAs, this should be proportionate to balance their professional activities. To enable additional leadership opportunities, the balance between DCC and SPA may be different for less-than-full-time consultants and specialist doctors from colleagues working full time.

1.5 Wider leadership roles should be recognised as additional responsibilities, and external duties as external responsibilities. The time for these is usually best annualised, in order to facilitate the flexible working that these roles require.

1.6 Objectives for each element of the job plan should clearly set out what can be delivered during the relevant time commitment in the job plan, and the facilities and administrative support needed to ensure that the time is both productive and professionally rewarding. Objectives should follow SMART principles.

1.7 Job plans must be considered over a minimum cycle of several weeks or as annualised commitments, taking into account leave allowances.

1.8 Activities should be designated as fixed or flexible. Fixed commitments are timebound, as they rely on other staff and facilities available during these times. Flexible commitments enable the individual to manage their time more effectively to deliver fluctuating demands.

2. Team workload planning

Team workload planning is fundamental to good job planning and productive teams. See NHS Improvement's *Consultant job planning: a best practice guide*.[8] Physicians must be involved in team workload planning for all teams that they work in. This includes all teams where they have clinical, educational, research, governance and leadership commitments. Consistent delivery of care by all clinical teams supports effective and efficient practice.

The RCP makes the following recommendations:

2.1 If the consultant works in multiple teams, there should be an agreed primary clinical manager who will sign off the job plan, and liaise with other departments.

2.2 Locum physicians should be included in team job planning. Job plans for locums in post for more than 3 months should consider duties for clinical supervision, educational supervision if appropriately trained, and other departmental non-clinical demands.

2.3 Team workload planning processes should include an agreed service map, reviews of data on service demands, trends, and known or predicted service changes.

2.4 The team and individual contribution to general internal medicine (GIM), both inpatient care (eg unselected medical take and ward-based clinical care) and outpatient care (eg undifferentiated illness or post-admission follow-up), should be agreed.

2.5 The relative contribution to subspecialty and general specialty care should be agreed across the department and for individual team members.

2.6 For common duties such as 'consultant of the week', outpatient clinics or procedure lists, an agreed time commitment and delivery model should be reached for consistency within the specialty.

2.7 For those with subspecialty roles, there must be an adequate annual caseload to maintain competence in this area of practice.

2.8 Clinical leadership roles within the team/department should be agreed, alongside the time commitment required for these.

2.9 Clinical supervision requirements should be agreed at departmental/team level and the contribution of different members of the team.

2.10 Individual consultants' roles outside the department must be noted and will affect the team's capacity.

2.11 Research commitments and opportunities should be identified, and the relative contributions of team members agreed.

2.12 Leadership roles within the multidisciplinary team do not need to be confined to doctors.

2.13 Prospective cover arrangements for periods of leave within the team should be explicit for clinical and non-clinical activities, and calculated within time commitments and remuneration.

3. Appraisal

Appraisal should be a formative experience that provides an opportunity for reflection on an individual's practice and performance, planning for professional learning and development, and provides evidence to inform the responsible officer's recommendation to the GMC about revalidation.

The RCP makes the following recommendations:

3.1 A formative annual appraisal should cover the full breadth of professional practice and feed into job planning.

3.2 Job plans should include time for individuals to build the evidence required for annual appraisals. This can be achieved within SPA time planned for personal development, governance, teaching, research or leadership activities.

For common duties … an agreed time commitment and delivery model should be reached for consistency within the specialty.

Professional activities – direct clinical care

Direct clinical care (DCC) is working directly with patients for the prevention, diagnosis or treatment of illness, including emergency work carried out during or arising from on-call work. For physicians, this may include inpatient care, same-day emergency care, outpatient care, community care and procedural care. It will also include care outside clinics, wards and procedures, previously termed clinical administration, that we now consider core components of clinical care (see **Clinical care outside consultations**). We have considered each of these areas in more detail below.

4. Inpatient care

Inpatient care for patients who have been admitted to hospital can include consultations/advice, admission triage, post-admission senior review, day-to-day responsibility for a cohort of patients (both specialty and GIM), and leadership and education of an MDT.

The RCP's earlier work has informed our guidance in this section. In particular:

- *Modern ward rounds* describes how consultant-led MDTs should work on wards.[9]
- *Guidance on safe medical staffing* estimated that, for a 30-bedded ward, the consultant requires between 20.5 and 24.5 hours per week to lead board rounds and ward rounds, MDT meetings, targeted patient reviews, communication with patients, families and other specialties, oversight and education of the MDT, and associated clinical correspondence.[10] The time required will depend on the size of the 'ward' and the seniority of the other staff within the ward team. It will also vary significantly with the complexity of the patient cohort. The amount of time required to deliver this care safely will therefore need to be agreed locally.

There may also be a need to see medical patients in non-medical wards, often termed 'outliers' or 'boarders'. These patients should be paired with a medical ward, and therefore their review linked to the medical ward's responsibilities. The time for review is likely to be longer for these patients than those on the medical ward.

Some medical specialties will have a significant inpatient bed base; others will operate a consulting and liaison model. The consultant with responsibility for each patient must be clearly indicated.

Inpatient duties and responsibilities should be standardised by the specialty team, rather than being dependent on individual physicians. Continuity of care improves outcomes as condition changes are observed, increases efficiency by preventing duplicate assessments, reduces length of stay, and improves both patient experience and teaching opportunities. Mechanisms to maximise continuity of care should therefore be implemented.

The 'consultant of the week' model of practice, which enables continuity of care, is common within medical specialties. In this model, a consultant or specialist doctor's duties focus on inpatient care for that week. This may extend over several consecutive weeks in many specialties, or for less than a week in high-intensity acute receiving specialties.

Other specialties will require inpatient consultations. These may be delivered by ward-based consultants or by consultants without 'bed-holding' responsibilities. Education and training of the referrer, and physicians in training should be a key component of consultations.

In most NHS hospitals, the acute medical model involves admission of patients to assessment units for up to 48–72 hours. Acute medical units and other specialty receiving units, eg acute frailty / acute respiratory / cardiac care units, require consultants or specialist physicians to assume clinical responsibility for admitted patients. They should provide senior review within 6 hours of admission during the day shift and within 14 hours for patients admitted overnight.[11] Acute medical units will be led by consultants in acute medicine and delivered in partnership with consultants and specialists delivering GIM. These units also require daily consultant and MDT in-reach from specialties. While some advice can be given remotely, face-to-face review and interaction with the acute receiving team will be required for patients with more complex needs.

Ideally, all patients accepted onto the acute medical intake should transfer quickly to acute medical units or other receiving units. However, in the NHS – as in many healthcare systems – transfer delays occur because of inadequate transfer from, or capacity of, assessment units. Senior decision makers, often consultants or specialist doctors, should deliver triage of the acute take, as early advice and navigation to the best clinical pathway can improve outcomes. If transfers are significantly delayed, time-dependent assessments should take place in the emergency department, although this takes longer and reduces the number of patients assessed within a session. Other factors, such as the number, clinical experience and seniority of other MDT members working with the consultant or specialist doctor, will impact patient assessment capacity.

Many medical specialties are expected to provide GIM as well as specialty work. For inpatient care, this may be contribution to acute receiving and on-call duties, and/or the care of GIM patients beyond the acute medical unit.

Some patients require follow-up remote care, such as reviewing investigation results and further communications.

Many consultants and specialist doctors now routinely work outside traditional hours, including extended shifts in urgent and emergency care, 7-day working on inpatient wards, out-of-hours procedures, and evening or weekend clinics.

Bank holidays should be treated differently from weekends. Some organisations staff bank holidays like normal working days for urgent and emergency care. An overnight on-call service for acute specialties is necessary.

The RCP makes the following recommendations:

4.1 The contribution of each specialty to GIM inpatient care, both acute receiving and ongoing ward-based care, should be agreed at directorate level (ie across medical specialties), followed by the contribution of individual consultant and specialist doctors to GIM from within the specialty. This may vary within the team, dependent on interests, expertise (including accreditation) and other duties.

4.2 We strongly recommend 'consultant of the week' models for inpatient care. The overall workload must be considered, including the number of patients under each consultant, the benefits of continuity over weekends, the contribution of less-than-full-time colleagues, other consultant responsibilities that might be difficult to 'stand down' for those weeks or extended number of days, and patients' length of stay in the clinical cohort.

4.3 'Consultants of the week' should aim to have no other fixed commitments during this time. Flexible commitments may be appropriate, or clear cover arrangements when fixed commitments cannot be rescheduled.

4.4 The pattern of inpatient duties and responsibilities should be standardised by the specialty team, rather than being dependent on individual consultants or specialist doctors.

4.5 Inpatient board rounds and ward rounds should occur at the start of the working day to enable early decision making that facilitates patient flow, including discharge.

4.6 A cohort of inpatients under a single consultant should, wherever possible, be located on a single ward or unit.

4.7 The expected working pattern and staffing for the delivery of inpatient ward care follow the principles outlined in the RCP's *Modern ward rounds* and *Guidance for safe medical staffing*.[9,10] The time required for consultant or specialist doctor working will depend on the size of the 'ward', the seniority of the other ward staff and the complexity of the patient cohort.

4.8 Time to review 'outliers' or 'boarders' must also be included; these reviews will take longer than on the 'home ward'.

4.9 For non-bed-holding consultants or those with a small bed base, it may be appropriate for other consulting duties, eg remote advice, hot clinics or specialty same-day emergency care (SDEC), to be incorporated into 'consultant of the week' activities.

4.10 When the 'consultant of the week' changes, patient handover should be built into expected working patterns and accounted for within the job plan.

4.11 After an inpatient episode, follow-up remote consultations should either be handed over to the consultant or specialist doctor taking over the inpatient duties and incorporated into those sessions, or incorporated into outpatient remote care.

Inpatient consultations

4.12 Consultations with inpatients based in other specialties should be planned according to demand. They should be delivered the same day or the next day, depending on the urgency and time of the request. This work may need to be delivered by a separate consultant or specialist doctor than the 'consultant of the week', depending on their workload.

4.13 Inpatient medical consultations should not be left to less experienced members of the team, unless this is structured as a supervised learning activity.

4.14 For consulting specialties with a small or without a fixed bed base, the pattern of working should be standardised within the team, and dependent on the expected daily number of referrals and consultations.

Acute medical units and the acute medical take

4.15 Consultants or specialist doctors on acute medical units and the acute medical take should have continuing responsibility for a cohort of patients throughout their shift, with robust handover responsibilities at the end of the shift.

4.16 Most admission units will require more than one consultant, at least for the morning shift. Twice-daily rounds or continuous review of admitted patients by consultants and specialist doctors is appropriate.

4.17 The RCP's *Guidance on safe medical staffing* estimated that a consultant requires at least 4.25 hours to adequately deliver care for 10 patients during the initial stages of their acute admission.[10] This may take longer, dependent on the composition and seniority of the medical team.

- The first senior assessment is likely to take around 15 minutes, unless there has been no prior asessment.
- Assessment within the emergency department rather than the assessment unit may be necessary if there is an inadequate flow of patients; this will take considerably longer, and therefore fewer patients will be assessed within a session.
- Time for follow-up discussions and assessments, and ongoing communication with the patient, family, carers and MDT members will be required within the time allocated for each patient, additional to the first senior assessment.
- Training and informal clinical supervision of other members of the medical team and MDT should be incorporated in this overall time commitment.
- Time is required for consultants and specialist doctors to coordinate the assessment unit and 'take' through board rounds and huddles.

Locally agreed models of care based on demand should be agreed as a team, then planned into an average number of hours per day/week and annualised.

4.18 Daily consultant or specialist doctor in-reach by medical specialties to acute medical units should be planned within workloads.

Out-of-hours working, including 7-day working

Out-of-hours working, including 7-day working, requires planned activities and consideration of rest requirements.

4.19 Extended daytime and weekend working in most medical specialties should be included in PAs (shifts), not on call.

4.20 For acute admission units, there should not be a differentiation in service between weekdays and weekends.

4.21 The RCP's *Guidance on safe medical staffing* recommends a minimum of 2 hours per day of consultant time per 30-bedded ward at weekends.[10]

4.22 Physicians' time during weekends should be dedicated to urgent and emergency care of acute medical patients.

4.23 Weekend and out-of-hours working may also require the availability and flexibility of urgent or emergency procedures. The frequency will determine work intensity and appropriate duties.

4.24 When weekend working is added to a normal working week, rest days should be included to prevent a 12-day continuous working stretch.

4.25 Bank holiday activities for urgent and planned inpatient reviews and procedures will be required and should be recognised in job plans as planned activities. Time in lieu of bank holiday working, ie additional leave, is expected and should be recognised in job plans.

4.26 Over bank holidays, on-call arrangements are required in most medical specialties if not covered by planned activities, and should be recognised in job plans.

4.27 Overnight on call should be recognised with an availability allowance, and payment for time worked. Arrangements should be in place so that if overnight working is required, rest the following morning is possible.

4.28 For non-bed-based specialties providing on-call arrangements, consider the frequency of advice required and whether this advice needs to be given on site, or can be given remotely. Appropriate on-call banding should be applied.

4.29 It is not appropriate for a consultant or specialist doctor to be on more than one on-call duty at the same time.

4.30 If the consultant/specialist doctor is expected to act down to fulfil the inpatient duties of other members of the team who are unexpectedly absent, eg medical registrar, this is additional workload. It is compatible with terms of employment and professionalism. Acting down cannot be predicted or, therefore, included in the job plan. However, agreed processes, payments and supplementary workforce should be in place and applied consistently.

5. Same-day emergency care (SDEC)

Same-day emergency care may be delivered in SDEC units or 'hot clinics', and is provided for patients who require urgent assessment but whose care can be delivered by the specialist team without admission to hospital.

The RCP makes the following recommendations:

5.1 Most medical specialties should provide specialty same-day or next-day urgent and emergency ambulatory care.

5.2 Consultants in acute medicine should lead SDEC for unselected adult medical patients.

5.3 Depending on the number of patients and assessments required and the composition of the assessing team, this may be as standalone acute shift-based duties, or incorporated into outpatient duties or consulting duties.

5.4 The demand for specialty SDEC should be monitored, and job plans, workforce and activities should be adjusted to incorporate this demand.

6. Outpatient care

Outpatient care is a large component of physician-delivered and -led care. The nature of outpatient care has changed considerably over recent years.

Outpatient care includes:

- specialty advice, often with primary care through advice and guidance electronic systems
- referral triage
- requesting pre-consultation investigations
- remote communication with GPs, patients and other specialties
- outpatient clinical consultations, including appointment preparation and action completion
- continuing care, which may include:
  - communication with the patient and other healthcare professionals involved in their care
  - prevention of predictable disease complications
  - remote monitoring
  - management of shared care
  - responding to patient and primary care queries about care.

Outpatient care is delivered by a physician-led MDT, so physicians will spend a considerable proportion of their 'outpatient time' supervising and supporting other team members and working across MDTs to achieve best patient outcomes and experience.

The RCP's *Modern outpatient care* guide describes the principles and recommendations as a clinical framework for effective service planning and delivery in the current NHS by physicians.[12, 13] The RCP's recent publication with the Patients Association, *Prescription for outpatients*, describes how care is expected to change in the next few years.[14]

Outpatient care will include general specialty, subspecialty and GIM.

The RCP makes the following recommendation:

6.1 A contribution to GIM outpatient care should be included in the team or individual job plan, either for undifferentiated illness or post-admission specialty follow-up.

Specialty advice and referral management

Specialty advice is likely to be shared between a number of consultants or specialist doctors within the team, and, for some specialties, may also be undertaken by other senior healthcare professionals.

Demand for remote specialist advice and referral management has increased considerably over recent years, and is expected to continue to increase. When estimating this demand, it is important to look at recent and predicted trends.

Effective referral management takes time and consideration. For patients who do not require clinical consultations, it is important to have good communication with the referrer and the patient, to explain or propose the next steps in management. For some patients, there is a benefit of organising investigations before a consultation. The results of these investigations benefit from review before a clinical consultation, and will determine the most appropriate timing and method of the consultation. Referral management will also enable prioritisation of patients with the greatest need and the timing of investigations or consultations, including whether additional support is required (eg access or language needs).

Distinct protected time for referral management will enable high-quality assessment and communication, and reduce the need and increase the efficiency of other clinical consultations. This protected time should include communication with the patient to ensure that they are fully prepared for the clinical consultation.

Given the current waiting times for clinical consultations in many specialties, it is necessary to dedicate time to managing waiting lists, ie ensuring that patients who have waited longer have not had a change in their condition that changes their priority. It is important that this is considered for existing patients as well as new referrals. Patients should be provided with 'waiting well' information to manage their symptoms while waiting, and details of 'red flags' that should prompt a request to expedite an appointment.

Patient engagement portals or other direct access systems can help to identify patients whose condition has changed, and who need further assessment.

The RCP makes the following recommendations:

6.2 Specialty advice and referral management must be planned in team workload planning.

6.3 Referral management with specialist advice should be recognised as distinct clinical activity, with dedicated time within the job plan that replaces or occurs in addition to other clinical consultation time and post-consultation administrative activities.

6.4 Time for waiting list management of new referrals and those awaiting further assessments should be built into job plans.

6.5 While some elements of referral management can be flexible commitments, it is recommended that fixed commitments for team members are distributed throughout the week to enable timely management.

6.6 Time should be recognised within the job plan to teach, advise, and provide guidance and referral management to resident doctors.

6.7 The time required to respond to patient communications from patient portals should be incorporated into workload planning and job planning, this might include supervision of other clinical team members.

Clinical consultations (clinics)

Clinical consultations may take place face to face or remotely. Remote consultation may be via videoconferencing or telephone.

The method of consultation must be agreed with the patient and, if remote, the patient must have access to the appropriate equipment and a confidential environment.

The historical approach to assigning a set time for new consultations and a shorter time for follow-up consultations may not now be appropriate, depending on clinical need, as many shorter consultations are now conducted through asynchronous communication (eg letters or emails) or by shorter telephone consultation. In general, remote and face-to-face clinical consultations should be allotted the same amount of time. The RCP provides guidance on clinical consultation planning.[13]

Most clinics will run in parallel with other members of the MDT, or other medical staff at earlier stages of their career.

Follow-up after consultations can be via letters or emails between the clinician, patient and primary care practitioners. Follow-up phone consultations can also be appropriate to communicate and explain the results of tests, or to monitor the patient's condition. The staff required to support these consultations will vary by specialty. Time allowed for follow-up activity should be agreed at team job planning meetings and benchmarked against similar departments and organisations. This time may vary within a single team depending on the complexity of the individual clinician's case load, eg associated with multispecialty, multisystem disease clinics or patients with more complex needs.

Specific teaching clinics may be organised that have a smaller number of patients and a greater length of time for supervision and training.

The facilities required for consultations should be confirmed as available in job planning to support delivery (see Appendix).

The RCP makes the following recommendations:

6.8 Video and telephone consultations should be scheduled in the same way as face-to-face consultations, and use an appropriate method agreed by the patient and clinician. Interpreting services should be available when required.

6.9 Clinical consultation time should be measured in units of clinical activity, set locally. We recommend 15 minutes for a unit of clinical activity, which includes preparation time for the consultation and completing both clinical records, and ongoing plans.

6.10 For the first clinical consultation with a patient, more than one unit of activity is normally required to undertake adequate assessment and establish the clinical relationship.

6.11 Subsequent clinical consultations will take variable time or units of activity, depending on the complexity of conditions and other patient factors.[13]

6.12 Clinical consultation sessions (clinics) may last up to 4 hours. These should be fixed commitments. The number provided per year should be agreed.

6.13 Clinical supervision time must be built into these sessions for the consultant and specialist doctor when supervising other staff, and will affect the number of clinical encounters.

6.14 One consultant or specialist doctor should not be supervising more than four staff, unless they have considerably reduced clinical activities or consultations themselves at that time.

6.15 Initial clinical communications and record-keeping should be completed during the clinical consultation time.

Clinical care outside consultations

Traditionally, time in physician job plans was separated into clinical and administrative duties. Advancements in communication, consultation and assessment methods, coupled with efficient use of clinical consultation time and resources, has resulted in large components of clinical care being carried out remotely from the patient and through asynchronous communication or ad hoc telephone consultation. Clinical care between clinical consultations should be seen as clinical care time outside the consultation suite; it can no longer be seen as an additional proportion of clinical consultation time. The time required will vary by specialty and the individual's case mix. This is separate from the preparation time for a clinical consultation, and the immediate post-consultation actions. A considerable amount of activities in clinical pathways will be in this format and must be appropriately accounted for in job plans, so they do not encroach on other activities. As outpatient care is modernised, it is expected that this form of clinical activity will increase. This is particularly the case for complex patient management, providing guidance and decisions with the wider MDT.

The RCP makes the following recommendations:

6.16 A consistent time allocation for clinical care outside consultations should be agreed across the clinical team for a set case load.

6.17 Clinical care outside consultations can be planned on a flexible basis, but the number of PAs per month/year should be agreed.

Other models of care

Group clinics

Group clinics are an efficient way of delivering concurrent care to multiple patients, especially for patient education or treatments for the same condition.[15] Such innovations make up an important part of modern outpatient care, and job planning should not hinder their implementation. A flexible approach to job planning will be required.

Adequate time should be set aside for preparing group clinics. Time will be required for managing post-clinic follow-up, including communicating outcomes to the patient and other healthcare professionals involved in their care, and addressing individual patient queries as required.

Super clinics

Super clinics involve a senior clinical decision maker supervising multiple members of the clinical team, eg resident doctors and allied health professionals, delivering care in a single clinical environment. This can be an efficient way of delivering care to a larger cohort of patients simultaneously. Clinical decision making is most efficient when the senior clinician does not have any patients allocated to them, and this should be the case where they are supervising more than four members of the team.

Specialty 'centres'

Some medical specialties deliver outpatient activities in specialist centres, eg diabetes or sexual health centres. In these models, other members of the multiprofessional team often carry out consultations, with consultants or specialist doctors supervising. These centres may also allow patients to 'drop in' for advice and care when needed. Physician time in these specialist centres is likely to be a mixture of fixed clinical consultation time, and ad hoc clinical supervision and consultation. The ad hoc clinical supervision and consultation time should incorporate flexible activities, but are likely to be held in a fixed place so the consultant or specialist doctor is available for ad hoc clinical care. Diarising activity may be helpful to understand the mix of DCC and other activities during the flexible sessions.

Multispecialty clinics

Multispecialty clinics can efficiently deliver care to patients with multisystem disease or multiple commonly associated health conditions. They also improve the patient pathway and patient experience.

Job planning should support multispecialty clinics where there is sufficient demand and where efficiency of care can be demonstrated.[13]

'Patient not present' clinics and virtual clinics

'Patient not present' clinics and virtual clinics are MDT meetings or clinics, where members of the MDT review results and information from multiple sources (including primary care data, patient-reported assessments, assessments by other healthcare professionals and other clinical information) to make a decision about patient care without the patient being present. This method facilitates efficient, rapid clinical decisions about patients and actioning next steps, including triage of next encounter.

Job planning should support 'patient not present' and virtual clinics where there is evidence that they are efficient and effective in moving patients along their pathway of care.

Meeting outcomes must be communicated to the patient, with time allocated in the job plan for this task.

The RCP makes the following recommendations:

6.18 Job planning is flexible to allow innovative and efficient models of outpatient care delivery where evidence of increased efficiency or improved patient care outcomes and experience exist.

6.19 Models such as super clinics, group clinics and 'patient not present' clinics often have significant administrative needs. Job plans should allocate appropriate time for this work and appropriate administrative support should be provided.

Administrative support for outpatient care

Administrative support includes scheduling work (including when information is available for the next clinical action), support with clinical communication, and ensuring that all relevant results and communications are available to the clinician prior to a patient consultation. Administrative staff play an important role as patient contact points, care coordinators and patient navigators, and should ensure that both clinicians and patients are well prepared for the consultation. Enhanced roles such as clinical support workers can increase clinician efficiency and productivity. Administrative staff should have formal development opportunities to enhance their role in care coordination and patient navigation.

The RCP makes the following recommendations:

6.20 It is essential that all members of the clinical team have adequate administrative support for outpatient care.

6.21 Administrative burden on the clinician should be minimised by allocating tasks to administrative support staff wherever appropriate to maximise clinical productivity.

7. Community-based care

Many consultants and specialists deliver community-based care, often in combination with hospital-based care. This is in addition to clinics or procedure lists that may be provided at locations other than the hospital or base hospital.

Community-based care can include:

- case discussion with other community-based staff
- clinical consultation within the patient's home (including care and nursing homes)
- case discussion, joint consultation and education with primary care practitioners.

While some community-based care may be regularly timed within the week or month, there is a need for flexibility in when it can be performed or needed.

There will need to be considerable flexibility within these timed commitments to deliver direct clinical care via multiple modalities, eg home visits, supervision of other clinicians, case discussions, remote advice.

The RCP makes the following recommendations:

7.1 The time for community-based direct clinical activities should be agreed within the team and then included in job plans for individual consultants and specialist doctors who undertake these.

7.2 Community-based clinical activities can be fixed or flexible commitments.

7.3 Community-based activities require administrative support for planning, coordination and to support clinical communications.

7.4 Physicians and other members of the team require access to hospital, community and primary care records for these direct care activities.

7.5 Community clinical contacts require recording to validate activities in the job plan.

Consultants and specialist doctors should not be performing tasks than can be delivered by administrative and other support staff.

8. Procedural care

Procedural care may be planned, unpredictable or provided for emergencies.

Appropriate facilities for the safe performance of procedures are required and may include structural facilities, multidisciplinary clinical and support staff, and equipment.

Planned procedural care sessions should be considered as part of team workload planning. Procedural care should be measured in units of clinical activity. We recommend a fixed period of time for a unit of clinical activity, which includes preparation time for the procedure, consenting, the procedure itself and completing clinical records, communication and ongoing plans. The unit of activity will vary by specialty, eg 15 or 20 minutes. These must be fixed within individual plans, with units of activity increased according to the complexity and number of cases on a procedure list. Procedural clinical duration needs to take into account training, teaching and supervision of resident doctors and other multiprofessional team members.

The RCP makes the following recommendations:

8.1 Procedural care time should be measured in units of clinical activity. We recommend 15 or 20 minutes (determined by specialty) for a unit of clinical activity, which includes preparation time, consenting, procedural duration, team member training and completing clinical records and ongoing plans.

8.2 Procedural care sessions can vary in duration, depending on the complexity of conditions and other patient factors. Administrative mechanisms should support appropriate case selection to ensure adequate time to complete procedures safely.

8.3 Procedural care sessions may last up to 4 hours. These should be fixed commitments. The number provided per year should be agreed.

8.4 Clinical supervision time must be built into these sessions for the consultant and specialist doctor.

9. MDT clinical case meetings

The complexity of patient care and treatments can require formal multidisciplinary clinical case meetings. These can often involve other specialties such as radiology, pathology and surgical specialties.

The meetings may be held within the clinical team or include clinicians from across different teams. Clarity about leadership and coordination of the MDT clinical case meeting is essential.

Administrative support for MDT clinical case meetings is also essential for planning, scheduling and ensuring communication and actions. The method for recording outcomes in clinical records and communicating them must be agreed and consistent.

The RCP makes the following recommendations:

9.1 Time for MDT clinical case meetings should be specifically recorded in job plans.

9.2 The time required for MDT clinical case meetings will vary by specialty and case mix.

9.3 Wherever possible, MDT clinical case meetings should be planned at a regular time, so that each participant's job plan can protect the time.

9.4 Clinical leadership of the MDT case meeting will require additional time to prepare the meeting and follow on with communication and actions.

9.5 MDT case meetings must be structured so that clinicians are providing significant input during their attendance.

10. Electronic health records

Electronic patient records are increasingly used to access and record clinical information. They make more information readily available for clinicians, which can paradoxically increase the preparation time for clinical consultations. Recording clinical notes can also take longer than handwritten notes for some clinicians, unless personalised adaptations are made. It is essential that electronic patient records do not increase administrative aspects for clinicians; these need to be supported by administrative staff. While it is hopeful that technology, including voice recognition and artificial intelligence (AI), may create efficient recording from clinical consultations, this is not yet in place for many clinicians, and needs testing and evaluation in real-life scenarios before implementation. Currently, clinical encounters using electronic records therefore take longer than with paper records. Numbers of patients seen in a clinic have often had to be reduced with the introduction of electronic patient records.

Electronic records, with or without videoconferencing, enable remote clinical opinions based on the clinical record. While this might be seen to increase efficiency and access, it is important to recognise when face-to-face consultation is required for assessment and communication, and where key clues and closeness of communication, including opportunities for the patient to ask questions, may be lost.

Physicians reported in the UK 2023 census of consultant physicians that the poor functioning or availability of IT infrastructure is the commonest cause of inefficiency and reduced workforce morale.[7]

The RCP makes the following recommendations:

10.1 The effect of electronic health records on the impact on the total time taken to see both inpatients and outpatients must be considered in team and individual workload and job planning.

10.2 When recording activity for job plans, and when agreeing workload for teams, the proportion of remote and face-to-face reviews for clinical referrals should be estimated.

10.3 Well-functioning and available IT infrastructure is essential for the benefits of electronic health records to be realised without a detrimental effect on clinical care and productivity.

Supporting professional activities (SPAs)

We have outlined earlier in this document the importance of an appropriate balance of SPAs and DCC.

11. Professional development and study leave

All clinicians require continuing professional development (CPD) to stay up-to-date and develop their abilities to provide the best possible care. This includes clinical and wider professional knowledge and skills. Consultants and specialist doctors need to stay up to date by reading journals and other forms of medical literature, including accessing online CPD materials. They should attend departmental, divisional, trust-wide, system-wide and regional educational events, both to support their own learning and to contribute their knowledge and experience.

Additional professional development materials and events will be available nationally or internationally, either in person or online. Attendance at these should be agreed within appraisal CPD plans and can be supported by study leave.

Writing for medical journals and other medical literature, as well as peer-reviewing articles, should be encouraged in personal development time and can be supported by study leave.

The RCP makes the following recommendations:

11.1 Professional development time is a key component of core SPA time, and should be used flexibly. Time must be protected for this to be given adequate priority.

11.2 Depending on frequency and consistency, time for educational or development events may be best annualised for flexibility.

11.3 For formal CPD external events and some internal programmes, time to participate should be taken as study leave, in addition to core professional development time.

11.4 Study leave may also be appropriate for research grant writing, preparation and editing of peer-reviewed articles if a significant commitment emerges outside job plan agreements.

It is essential that electronic patient records do not increase administrative aspects for clinicians.

12. Education and training

All physicians are educators and act as mentors and clinical supervisors – it is a central part of the role. Some physicians will develop this area of practice further and will have more dedicated educational roles and time, as well as personal professional development for education.

Physicians are educators for all members of modern multiprofessional teams. Education and training of doctors will and should predominate training time and commitments, and be prioritised. While education and training are integrated into clinical practice for all physicians, many take formal educational roles at undergraduate and postgraduate levels.

Funding from NHS educational contracts should transfer to enable educational time to be funded. The model for distribution of funds into job plans may differ between trusts/boards. Integrating time for training 'on the job' and direct clinical supervision as part of clinical practice will inevitably reduce the number of patients directly reviewed by consultants and specialist doctors, reduce procedural efficiency/numbers or lengthen the duration of clinical activities, and this must be recognised. For example, clinical supervision time must be incorporated into clinic templates, procedure lists or dedicated ward duties. This should be seen as part of DCC rather than SPA.

As well as direct clinical supervision, consultants and specialist doctors are expected to deliver formal education and training to other healthcare professionals across the healthcare system.

Consultants and specialist doctors often have formal educational roles with universities and other education and training organisations, usually funded directly by those institutions. Trusts/boards will charge back these organisations for the appropriate funds. Undertaking work for outside roles should ideally be discussed and agreed with the primary employer prior to applying, to ensure support. Roles and responsibilities should then be defined, alongside any changes required within individual job plans and team workload planning to accommodate the new role.

Each department and employing organisation will have educational leadership roles (see section on leadership below). Employers should ensure pre-specified SPA allocation for educational roles such as named clinical supervisor, educational supervisor, college tutor, undergraduate specialty tutors or other similar undergraduate roles. Recommendations for the level of SPA time for these roles should be as referenced in the CoPMED *Reference guide for postgraduate foundation and specialty training in the UK*.[16]

Educational supervisors' commitments will affect the overall team capacity. Additional leadership roles should be incorporated into the local job planning process under the remit of the director of medical education (DME) or regional deanery as appropriate. Such roles include the DME, deputy DME, college tutor, SAS tutor, educational leads, training programme directors, foundation programme directors and other postgraduate and undergraduate education faculty posts.

Each department, directorate or hospital may have 'grand rounds', where clinical staff meet to learn together. These should be encouraged and are part of SPA for both personal professional development and educating others. They are likely to be a fixed commitment, and other clinical activity (other than emergencies) should not be planned at this time.

The RCP makes the following recommendations:

12.1 Consultants and specialist doctors who take on formal educational roles must have dedicated time for this within their job plans as part of SPA.

12.2 For a named clinical supervisor or educational supervisor, 0.25 PAs per supervisee should be recognised in the job plan. This includes for supervising non-medical practitioners, including physician associates and advanced nurse practitioners.

12.3 Educational supervision time must be included in formal job plans. It is likely to be delivered at flexible times of the week, but must be within normal working hours for both supervisor and supervisee.

12.4 The total clinical supervision time required for a department should be agreed at team workload planning. These are likely to be flexible commitments but require time allocation, which may be different for individuals depending on their professional interests and duties. The effect of educational supervision time should also be considered when reviewing team capacity.

12.5 Formal education of other healthcare professionals across local systems is likely to be sporadic and should be explored in the team's workload planning. It should be recognised within the flexible component of job plans.

12.6 Medical or hospital 'grand rounds' should take place on a regular basis to facilitate learning and sharing of practice across specialties.

13. Research

Doctors undertaking research and clinical academics are vital for healthcare innovation and improving patient outcomes. Evidence indicates that research-active hospitals see better patient results, even for those not in trials. Participation in research activities also boosts doctors' job satisfaction and retention, and reduces burnout.[17] All interested doctors should have the opportunity to undertake research alongside their clinical roles, with dedicated time allocated in their job plans.

The Health and Care Act 2022 strengthened research expectations of NHS providers, setting new legal duties for integrated care boards (ICBs).[18] Each ICB must facilitate or promote research on matters relevant to the health service, and the health service must use evidence obtained from research. ICBs should be assessed annually for performance, including their research duties. This means that embedding research should be a higher priority for the NHS – regions are expected to take action to enable clinicians to undertake research, and for the outcomes of research to inform services. Therefore, NHS providers should facilitate research activity for doctors, for example through dedicating time in job plans.[17]

However, the 2023 census of UK consultant physicians found that while 41% of respondents undertook research, 36% of respondents said that they were interested in undertaking research but didn't.[7] The main barrier reported (by 52% of respondents) was a lack of time in job plans. The Academy of Medical Sciences has found that the healthcare system often struggles to embed health research, largely due to clinical delivery pressures and undervaluing the contribution that research makes.[19] This has consequences for both physicians and clinical academics: physicians may not have adequate time, or support, given by their employers, and clinical academics can find it harder to develop dual careers between the NHS and academia.

Enabling clinical research careers must be a priority. In the RCP *Research for all* framework and report published in 2020, the RCP committed to influencing job planning to increase clinical time for research.[20, 21] Following this, our 2022 joint statement with NIHR, *Making research everybody's business*, called for ringfenced time in job plans for those who wanted to undertake research, and set recommendations for NHS England, trusts and health boards, integrated care systems, regulators and funders to enable all doctors to be able to access research opportunities.[22]

NHS organisations and funders should work together to develop a pilot in which dedicated time for research is available to a proportion of interested healthcare professionals.

The RCP makes the following recommendations:

13.1 Ring-fence time for research in job plans of those who want to have a substantive research leadership role.

13.2 NHS trusts should explore viable ways to allow clinicians more time to participate in patient-facing research through job planning, whether this is on an individual or team basis.

13.3 Research training positions (or the research time allocation) must be supernumerary to the clinical service need, to prevent regional NHS service requirements competing with research time and enable national/international mobility during research training.

13.4 Portfolio careers should be incentivised to make it easier to work on research across the NHS, academia and industry. This could include the use of open-ended contracts.

13.5 Clinical trial activity can be considered DCC.

Ring-fence time for research in job plans of those who want to have a substantive research leadership role.

14. Governance and team development

Clinical governance is a central part of professional practice. Many clinicians will take a lead role for certain elements of clinical governance within a department.

This includes:

- morbidity and mortality reviews
- patient safety learning
- clinical pathway development and updates
- quality improvement activities
- service development and quality assurance
- participation in local and national and, where appropriate, international clinical audit, improvement and assurance programmes.

As many of these are shared activities requiring interaction between clinicians, service managers and other staff, dedicated departmental time for this should be planned. This is likely to involve regular departmental meetings/protected time, so that all staff can participate whenever possible. This requires that scheduled and planned clinical activities do not conflict with these activities. They may be combined with other activities, such as educational updates. Longer periods of dedicated time will be required periodically, and should be planned so that routine clinical activities do not take place at those times.

Time for clinical governance activities must not be confined to departmental meetings, as many of these activities for consultants and specialist doctors will happen more informally through individual activities, or activities with a small number of team members.

The RCP makes the following recommendations:

14.1 All consultants and specialist doctors should be involved in clinical governance activities, and this time should be recognised in SPAs in job plans.

14.2 Significant time within job plans must be dedicated to team/departmental clinical governance activities, with no routine clinical activities planned at those times.

14.3 Team-based governance activities should take place at least monthly, for a minimum of 2 hours.

14.4 Time and support for clinical governance lead roles must be recognised in the departmental plans, and the individual's job plan.

14.5 Other than team/departmental or other regular meetings, clinical governance activities are appropriately flexible components of the job plan schedule. A minimum of the equivalent of the time for departmental meetings is given for flexible application to clinical governance activities.

The RCP recommends that team-based governance activities take place at least monthly, for a minimum of 2 hours. They may be combined with other activities, such as educational updates.

15. Quality improvement activities

Quality improvement is delivered by clinical teams (rather than individuals). As care is now commonly delivered as integrated care pathways, it requires time from multidisciplinary team members across organisational boundaries to come together to explore, plan and then test and adapt changes to the way care is delivered. In some organisations the approach may require time across a number of consecutive days. Consultants and specialists should contribute to this activity beyond their employing organisation at a place, system, regional or national level.

The RCP makes the following recommendations:

15.1 The time for quality improvement activities should be annualised, so that it can be used flexibly.

15.2 Quality improvement activity should be planned so that other activities can be adapted to incorporate this time in the consultant's or specialist doctor's job plan.

16. Administrative work

Administrative work for individual patients is part of DCC activities. Where the administrative activities apply more widely than individual patients, this should be incorporated into SPA.

Consultants and specialist doctors have administrative duties related to clinical care, education, research and clinical governance.

There will also be core administrative work that is common to all senior employees of an organisation, such as reading and responding to organisational or departmental communications. This is likely to take some time each day and week.

The RCP makes the following recommendations:

16.1 The administrative aspects of education, research and clinical governance should be recognised in job plans as part of these activities and, where externally funded, included in these activities.

16.2 Administrative SPA work can be delivered flexibly across the week, month or even longer periods of time.

16.3 Core employee administrative work should be recognised as part of core SPA, with time expected each day and each week.

17. Professional leave

Consultants and specialist doctors are entitled to professional leave, as well as study leave. This must be agreed with their clinical lead. It replaces other activities. Annualisation of other activities can enable this.

The contractual requirement is for 30 days of paid professional/study leave over 3 years. It can be appropriate to negotiate additional days of professional/study leave for certain duties, eg supporting postgraduate examinations, roles for external NHS and non-NHS bodies including royal colleges. This should ideally happen as part of job planning.

The RCP makes the following recommendations:

17.1 Professional leave is appropriate for the following activities:

- undergraduate and postgraduate examining (can also be classified as study leave)
- recruitment of resident doctors
- attending external meetings, eg coroner's court
- peer review of services
- other requests for expert opinion for the NHS, arms-length bodies or professional organisations that are not predicted or included in other activities.

17.2 It can be appropriate to negotiate additional days of professional/study leave over the standard contract as part of job planning, for limited external duties.

18. Professional activities – additional responsibilities and external duties

Leadership duties, including for external bodies, and patient advocacy

Consultants and specialist doctors are clinical leaders. They are expected to have leadership roles within the department for an aspect of the clinical service, education, governance or research.

Senior departmental or trust/board leadership roles will require significant time in job plans. There may in addition be responsibility allowances that enhance pay; however, this must not replace the planned time in job plans for the roles.

Job shares for clinical leadership roles should be encouraged, as this supports flexible working.

Increasingly, clinical leadership roles exist at a system level for consultants and specialist doctors. Where these clinical leadership roles are with an external organisation (whether or not they are remunerated or 'backfilled'), agreement from senior leaders within the employing organisation is necessary.

Other external roles may include professional examining, journal editorial boards, governance roles, research, education and training commitments, and leadership roles in the specialty professional societies. These should be recognised.

RCP roles

The RCP has multiple roles and opportunities for its members and fellows, enabling them to contribute to the profession and have a wider impact on healthcare. Officer roles involve an agreement between the individual, their employer and the RCP to release them for the time commitment of the role. A clinical release grant for the employer may contribute to the cost of releasing the individual.

Other clinical roles at the RCP, eg regional advisers, RCP Council members, examiners, exam question writers, editorial board members, committee or working party members, have unpredictable or variable time commitments. The time required should be clear, annualised and delivered flexibly, with agreed objectives and support. This should be recorded in the job plan as a flexible activity, either as an external duty, or agreement for professional or educational (for examinations) leave to undertake the role.

The NHS and government leadership expects NHS organisations to support these roles.[23]

The RCP makes the following recommendations:

18.1 Clinical leadership time must be recognised within the job plan, and evidenced by the consultant physician or specialist doctor.

18.2 Significant clinical leadership roles (eg clinical director) should be recognised as additional responsibilities rather than SPAs. Adequate time for the roles must be agreed.

18.3 For external duties, the RCP recommends an agreement between the external body, the individual physician and their employer. This should confirm the role, time commitments, tenure, role responsibilities, funding arrangements, and risks to any of the parties. Once the role is agreed, time should be protected in job plans, regardless of external funding.

19. Travelling between professional commitments and meal breaks

Time to travel and have breaks, including meal times, is essential and the time for these activities should be recognised as part of job planning.

The RCP makes the following recommendations:

19.1 Time for travel between clinical or professional commitments should be agreed and incorporated into the job plan, either as part of the clinical activity or as separate time.

19.2 Meal breaks should not be combined with travel time in job plans.

Significant clinical leadership roles (eg clinical director) should be recognised as additional responsibilities rather than SPAs.

20. Preparing for and returning from leave

Annual leave is essential for any employee. For the medical workforce, preparing for leave and returning from leave can be particularly challenging. There is a need to ensure that work is up to date and handed over, to facilitate effective cover arrangements for patients and catching up on activity on return.

The RCP makes the following recommendations:

20.1 Clear agreements are required within teams and departments on which duties are handed over during periods of leave.

20.2 Flexibility and annualisation of job plans and activities should be implemented, to prioritise handover duties before and on return from leave , replacing other activities when necessary.

21. Career stages

Consultants and specialist doctors will develop and adapt throughout their careers, and the balance of their professional practice will change over time. For example:

- individuals at early career stages are less likely to have leadership roles, but more training in aspects of the specialty or professional practice will be required
- time commitments for GIM change at different career stages, dependent on the individual's interests and service demands
- overnight and out-of-hours commitments may become more onerous for individuals when they are in the later stages of their career, or if they have health conditions
- less-than-full-time working may be valued at different career stages, and more consultants and specialist doctors are opting to work this way throughout their career
- research, leadership and teaching opportunities may increase in later career stages, with a corresponding reduction in time available for other commitments.

Also see guidance on *Later careers 2023*.[24]

Consultants within the first 3 years of working in the role would expect significant changes in the job plan over that time. They require flexibility, and may require time for further subspecialty development. They will develop education, governance and other leadership roles during this period.

The RCP makes the following recommendations:

21.1 Job plans should reflect the stage of career, with appropriate flexibility applied to team planning and with individual consultants and specialist doctors.

21.2 Flexibility is required particularly in the first 3 years of a consultant's career, to adapt to development needs and developing wider roles.

21.3 On-call activities should reduce and potentially stop in the later stages of the consultant and specialist doctor's career, as agreed with individuals.

22. Measurement and monitoring

Objectives should be common to job plans and appraisals. It is the physician's responsibility to demonstrate that the job plan's activities and objectives have been delivered. It is the employer's responsibility to provide the data required to support job planning conversations.

Digital systems are available to support both job planning and appraisal. They can help with recording information and recording sign-off of agreed job plans.

The RCP makes the following recommendations:

22.1 Digital job planning systems should be seen as supporting conversations at both team and individual levels, and should not be the primary method for job planning.

22.2 Digital job planning systems must have the ability to annualise and/or record activities that are variable or infrequent.

22.3 The mechanism for measuring clinical activity and achievement of objectives, as well as delivery of the support required, should be agreed.

22.4 Clinical activities should be annualised, meaning that the number of sessions delivered over 12 months should be demonstrated by the consultant or specialist doctor as part of job planning and appraisal conversations.

22.5 The delivery and outputs from agreed supportive professional activities should also be documented as part of job plan monitoring.

References

1. Association of British Neurologists. *Job planning for NHS consultant neurologists and clinical academic neurologists*. ABN, 2024. https://cdn.ymaws.com/www.theabn.org/resource/collection/DFE4DB8D-9E8C-4F56-A829-608374E2CA45/ABN_Job_Planning_Document_2024.pdf [Accessed 2 May 2025].

2. Dashora U, Flanagan D, Rayman G, Mustaf OG, Walden E, Dhatariya K; Joint British Diabetes Societies. Optimal staffing for a good quality inpatient diabetes service. *Diabet Med* 2023;40:e15151. https://doi.org/10.1111/dme.15151

3. British Association of Dermatologists. *A guide to job planning for dermatologists*. BAD, updated 2022. https://cdn.bad.org.uk/uploads/2022/11/17161530/Job-Planning-for-Dermatologists-2022-.pdf [Accessed 2 May 2025].

4. British Medical Association. *Valuing consultants: The consultant charter for the NHS in England*. BMA, 2025. www.bma.org.uk/media/vxcgycuy/bma-consultant-charter-2025.pdf [Accessed 2 May 2025].

5. NHS England. Medical consultant job planning. *Improvement guide: sharing learning from across organisations for impactful change*. Interim version – updated in April 2025. www.england.nhs.uk/long-read/medical-consultant-job-planning/ [Accessed 2 May 2025].

6. NHS Employers, British Medical Association. *A guide to consultant job planning*. NHS Employers, BMA, 2011. www.nhsemployers.org/system/files/2021-11/Guide_to_consultant_job_planning%20July2011.pdf [Accessed 2 May 2025].

7. Federation of Royal Colleges of Physicians of the UK. *Focus on physicians: the UK 2023 census of consultant physicians*. RCP, 2024. www.rcp.ac.uk/media/dzdbho0o/focus-on-physicians-the-uk-2023-census-of-consultant-physicians.pdf [Accessed 2 May 2025].

8. NHS Improvement. *Consultant job planning: a best practice guide*. NHS Improvement, 2017. www.england.nhs.uk/wp-content/uploads/2022/05/consultant-job-planning-best-practice-guidance.pdf [Accessed 2 May 2025].

9. Royal College of Physicians. *Modern ward rounds*. RCP, 201. www.rcp.ac.uk/improving-care/resources/modern-ward-rounds/ [Accessed 2 May 2025].

10. Royal College of Physicians. *Guidance on safe medical staffing*. RCP, 2018. www.rcp.ac.uk/policy-and-campaigns/policy-documents/guidance-on-safe-medical-staffing/ [Accessed 2 May 2025].

11. NHS England, GIRFT, Royal College of Physicians. *Principles for acute patient care*. NHS England, 2024. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2024/07/GIRFT-Acute-Patient-Care-Principles-July-24.pdf [Accessed 2 May 2025].

12. Royal College of Physicians. *Modern outpatient care: Principles and practice for patient-centred outpatient care*. RCP, 2023. https://rcp.ac.uk/media/lggnebtp/cqid_qi_modern-outpatient-care.pdf [Accessed 15 July 2025].

13. Royal College of Physicians. *Modern outpatient care: Using resources to add value. An implementation guide for local and regional teams*. RCP, 2024. https://medicalcare.rcp.ac.uk/media/1z2jbu22/rcp-modern-outpatient-care-using-resources-to-add-value-implementation-guide.pdf [Accessed 15 July 2025].

14. Royal College and Physicians and the Patients Association. *Prescription for outpatients: reimagining planned specialist care*. RCP, 2025. www.rcp.ac.uk/media/nidhufre/prescription-for-outpatients-final.pdf [Accessed 8 July 2025].

15. British Society of Lifestyle Medicine. *A guide to group consultations*. https://bslm.org.uk/a-guide-to-group-consultations [Accessed 2 May 2025].

16. Conference Of Postgraduate Medical Deans (UK). *A reference guide for postgraduate foundation and specialty training in the UK*. The Gold Guide, 10th edition. COPMeD, 2024. www.copmed.org.uk/publications/gold-guide/gold-guide-10th-edition [Accessed 2 May 2025].

17. Royal College of Physicians. *Making the case for research: Resource kit for doctors*. www.rcp.ac.uk/policy-and-campaigns/policy-documents/making-the-case-for-research-resource-kit-for-doctors/ [Accessed 8 July 2025].

18. UK Government. Health and Care Act 2022. www.legislation.gov.uk/ukpga/2022/31/contents [Accessed 1 July 2025].

19. The Academy of Medical Sciences. *Future-proofing UK health research: a people-centred, coordinated approach*, 2023. https://acmedsci.ac.uk/policy/policy-projects/future-proofing-uk-health-research [Accessed 2 May 2025].

20. Royal College of Physicians. *Research for all: Developing, delivering and driving better research*. RCP, 2020. www.rcp.ac.uk/improving-care/resources/research-for-all-developing-delivering-and-driving-better-research/ [Accessed 2 May 2025].

21. Royal College of Physicians. *Research for all? An analysis of clinical participation in research*. RCP, 2020. www.rcp.ac.uk/improving-care/resources/research-for-all-an-analysis-of-clinical-participation-in-research/ [Accessed 2 May 2025].

22. Royal College of Physicians, National Institute for Health and Care Research. *Making research everybody's business*. RCP, 2022. www.rcp.ac.uk/policy-and-campaigns/policy-documents/rcp-nihr-position-statement-making-research-everybody-s-business/ [Accessed 2 May 2025].

23. NHS England. Appropriate release of medical colleagues for the purposes for carrying out work for the wider health system. www.england.nhs.uk/wp-content/uploads/2022/05/B1659-letter-appropriate-release-of-medical-colleagues-may-2022.pdf [Accessed 2 May 2025].

24. Royal College of Physicians, Royal College of Physicians of Edinburgh, Royal College of Physicians and Surgeons of Glasgow. *Later careers 2023*. www.rcp.ac.uk/news-and-media/news-and-opinion/rcp-later-careers-guidance/ [Accessed 2 May 2025].

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