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# Introducing an annualised contract for a consultant team in a district general hospital

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**ABSTRACT – The majority of physicians work a weekly timetable consisting of programmed activities (PAs) defined by the consultant contract. This paper describes the implementation of an annualised contract within a gastroenterology department, which is located across two district general hospital sites within the same trust. The perceived benefits of the system include the introduction of a new out-of-hours emergency endoscopy service, more efficient backfilling of vacant endoscopy lists and greater transparency of work patterns and workload between colleagues and within the trust.**

**KEY WORDS: Programmed activities, annualised contract, consultant**

## Introduction

The consultant contract (published in 2003)[1] was designed around programmed activities (PAs). A single PA has a timetable value of four hours during the normal working week and three hours during unsocial hours. It consists of a combination of clinical (Direct Clinical Care) and professional activities (Supporting Professional Activity). The contract stipulates that a PA can be either a single block of time or subdivided into smaller units of time. The proportion of PAs allocated to various activities is agreed between the employer and employee through a process of annual job planning, taking into account specialty-specific service demands and other local factors.

For many consultants, the transition to the new contract was made by mapping existing working patterns to the new contract. The current move to increase productivity within the NHS has led to job plans being more tightly scrutinised. This has led to increased transparency, but trying to map consultant activity to a rigid timetable is often difficult and could reduce flexibility.

Until September 2007, the six gastroenterologists employed by Gloucestershire Hospitals NHS Trust were working across two hospital sites (Cheltenham General Hospital and Gloucestershire Royal Hospital). They provided a gastroenterology service to a local population of approximately 600,000 people based on traditional job plans with fixed weekly timetables, typically consisting of two clinics, ward rounds and three endoscopy sessions per week.

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In 2007, the group decided to move to a more flexible way of working based on an annualised contract (AC) in an attempt to address a number of converging challenges: the need to identify clinic and endoscopy space for two new locum consultants; the implementation of a trust-wide on-call service for emergency endoscopy; and the provision of more transparent consultant work with remunerated external roles in the wider NHS. This paper discusses the benefits and issues related to implementing annualised working.

### *Annualised contracts*

The AC is not a new concept and has been utilised in various non-medical fields such as the police force.[2] It is useful in industries where there is seasonal (or other) variation in demand that can be met by employees working more hours per week during busy periods. ACs exist in some parts of the NHS, such as Manchester PCT[3] and the Wales Health Board,[4] but tend to be for non-clinical or administrative staff.

An AC is a method of organising activity so that the employee commits to a set number of hours (or sessions) over a one-year period, rather than on a weekly basis. In this case, the number of endoscopy and outpatient clinics per year were pre-defined and agreed upon by employer and employees.

## Process

The annual number of clinics, ward rounds and endoscopy sessions (the core workload of gastroenterologists) was calculated for

**Table 1. Original calculation (2008–9) of the allocation of PAs for ward work at each site.**

| Site | A | B |
|---|---|---|
| Consultants | 4 | 3 |
| Consultants covering ward at any one time | 2 | 1 |
| Weeks of ward responsibility per year | 26 | 17.3 |
| Ward rounds per week | 2 | 2 |
| Total PAs | 52 | 34 |
| Additional PAs | 0 | 8* |
| PAs per 41-week annualisation | 1.3 | 1 |
| Post-take work (annualised) | 0.2 | 0 |
| Ad hoc ward work (annualised) | 0.5 | 0.5 |
| Total ward work (annualised) | 2 | 1.5 |

*For additional ward presence to reduce length of stay.

each consultant and adjusted for other commitments (see worked example). It was agreed that easily measured activities, such as clinics and lists, would be tracked on a monthly basis. Ward and other commitments were not monitored as they were deemed to require a fixed commitment and would be impractical to monitor.

Information was collected by administrative staff in the endoscopy and outpatient departments and submitted to managers, who kept a cumulative record of activity. Individuals would therefore have the ability to detect, in a timely way, under- or over-performance and to adjust their activity over the remainder of the year. All data were disseminated periodically to promote transparency between colleagues and managers.

### *Worked example*

A standard year consists of 41 working weeks with 11 weeks or 55 days accounted for by:

- 32 days annual leave (6.4 weeks)
- 10 days study and professional leave (2 weeks)
- 8 days bank holiday (1.6 weeks)
- 5 days compensation for newly introduced out-of-hours bleed rota (1 week)

Thus a weekly commitment of three PAs allocated to endoscopy translates to 123 ($3 \times 41$) endoscopy sessions per year. Similarly, a weekly requirement of two PAs for clinics equates to 82 clinics per year.

It was agreed that each consultant should have 2.5 supporting programmed activities (SPAs) per week and those with significant national commitments should have just 1.5 PAs per week, there being a presumption that the difference would be accounted for by their national contracted hours. It was also agreed (on the basis of trust guidelines) that for every clinic or endoscopy session 0.25 PAs should be allocated for the administrative work generated by that session.

It was estimated that, in addition to ward rounds, the ad-hoc work associated with responsibility for inpatients amounted to 0.5 PAs per week. Total ward work was slightly different for each site as there were two consultants covering the wards at any one time on site A and one consultant on site B (Table 1).

Other ad-hoc work and annualised PAs varied and were allocated according to subspecialty interests, and regional and national roles: management of the gastroenterology sub-division, Bowel Cancer Screening lead, input into the Regional Training Centre and Joint Advisory Group (JAG) accreditation visits; national clinical lead; and regional programme director. PAs were only allocated for such additional work if there was funding. PA allocation for each activity was mapped from existing weekly timetables where possible and estimated for activities that occurred less frequently (eg quarterly training courses), subject to adjustment as necessary at annual review (Table 2).

## Experience after 3 years

When the AC was introduced, concerns were raised regarding its impact on service provision. Continuity of care is ensured for inpatients and emergencies through an agreement that consultants will only take time off for annual or study leave if they can arrange cover (there is a departmental rule that existed prior to the AC stating that minimum staffing is one consultant per site), thereby ensuring that there is no interruption of care on the wards or for emergencies. Inevitably there are occasions, principally at the time of national specialty meetings, when many consultants wish to take study leave simultaneously. This can result in diminished elective work in endoscopy and outpatients, but it does not affect urgent or emergency care.

The AC allows greater flexibility in a job that has natural fluctuations in workload (ie inpatient ward commitments) and it allows improved work planning, particularly with respect to additional service development – for example, a new out-of-hours (OOH) rota and the new bowel cancer screening programme. The latter is possible with a traditional weekly timetable, but was facilitated by the AC with improved utilisation of vacant endoscopy slots. Developing new services risks diverting manpower from existing services. With each cycle, more activities were annualised and included in the AC job plan (see Table 2) so as to ensure that existing services were safeguarded.

Positive impacts (the actuality) of the AC include:

- clarity of job plans
- new OOH rota for upper gastrointestinal bleeding
- monitoring of performance
- flexibility to backfill
- clarity of consultant-capacity shortfall
- clarity and recognition of work required outside of regular clinical work (in addition to ward rounds, clinics and endoscopy lists)
- reassurance for management that consultants are fulfilling their contract
- no requirement to track study leave or annual leave.

Negative impacts of the AC include:

- workload tracking activity
- OOH can be very variable and possibly underestimated (solution in operation)
- the perception that the gastroenterology team is 'working to rule'
- process tracks input, but not outputs or outcomes, such as how many patients seen, quality and safety, and impact on patient experience
- inability to demonstrate improved activity as there is no baseline (see below).

It has not been possible to compare the number of endoscopy procedures or outpatients seen before and after implementation of the contract because of the patchy nature of data collection before this period, and because of other variables after the change, such as the appointment of two additional consultants.

**Table 2. This table summarises the job plans of each consultant in 2011–2. The PA commitments for clinics, endoscopy lists and training centre work are used to calculate how many sessions of that activity are required for each consultant. Core activities differ slightly reflecting other roles and interests.**

| | Site A | | | | | Site B | | | |
|---|---|---|---|---|---|---|---|---|---|
| | A1 | A2* | A3 | A4 | A5 | B1 | B2 | B3 | B4 |
| Specialty director role | | | | | | | 1.00 | | |
| Endoscopy | 3.17 | 2.00 | 2.30 | 3.67 | 4.00 | 2.92 | 2.92 | 2.00 | 3.42 |
| Clinics | 1.75 | 1.75 | 2.00 | 0.00 | 1.42 | 2.00 | 1.50 | 1.00 | 1.75 |
| Wireless capsule endoscopy | | | 1.00 | | | | | | |
| Wards | 1.24 | | 1.24 | 1.24 | 1.24 | 1.24 | 1.24 | | 1.24 |
| MDT meetings (various) | 0.50 | | 0.12 | 0.25 | 0.25 | | 0.50 | | |
| Management | | | 0.50 | 0.50 | | | | | 0.50 |
| Information support | | | | | | | 0.25 | | |
| Endoscopy training centre | 0.25 | | | 1.50 | | | 0.25 | 0.25 | 1.00 |
| Bowel cancer Screening lead | 0.25 | | | | | | | | |
| National | | | | | | | | 6.00 | |
| Med St Teaching | | | | | 0.25 | | | | |
| Core SPA | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 |
| Extra SPA | 1.00 | | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | | 1.00 |
| Admin | 1.50 | 1.00 | 1.50 | 1.00 | 1.50 | 1.50 | 1.50 | 0.75 | 1.25 |
| Research | | | | | | 1.00 | | | |
| Regular OOH | 0.34 | | 0.34 | 0.34 | 0.34 | 0.34 | 0.34 | | 0.34 |
| **Total** | **11.50** | **6.25** | **11.50** | **11.00** | **11.50** | **11.50** | **12.00** | **11.50** | **12.00** |

*Dr A2 is part time.

Since the implementation of the AC the below changes have been made:

1 annualisation has increased from 41 to 42 weeks after OOH bleed work was included in the contract (0.34 PA allocation)
2 contribution to the Training Centre is annualised and monitored
3 the SPA activity has been split into core SPA (1.5) and additional SPA (1.0) (the additional SPA activity has to be accounted for)
4 calculation of ward allocation has changed to cover three consultant ward rounds per week with removal of a post-take ward round and ad-hoc work
5 activity is now tracked by each consultant (or secretary) submitting a proforma each month.

## Flexibility of the annualised contract

It was agreed before implementation that if demand for endoscopic work exceeded that for clinics or vice versa, PA allocation would shift as appropriate in response. This has been the case and those consultants who are more involved with endoscopy training or bowel cancer screening have tended to 'over-perform', ie to have more activity in endoscopy, compensating for 'under-performance' in outpatient clinics.

Since the adoption of an AC, individual weekly timetables consist of fixed and flexible sessions. This allows for efficient backfilling of endoscopy or clinic sessions and enables relatively quick responses to increased waiting times in either endoscopy or outpatients. An AC review meeting is held yearly to enable allocations to be adjusted in line with demand (if needed) and to review other allocations.

Annual targets can be changed in 'real time'; for example, if a new role is adopted mid-year that impacts on availability for endoscopy or outpatients, the end-of-year target can be adjusted appropriately. Other unforeseen circumstances, such as jury service or sick leave, have prompted this type of adjustment (Fig 1). It must be emphasised that while the annualised contract enabled the implementation of an OOH bleed rota, this would not have been possible without the requisite staffing.

Miscellaneous work, such as bank holiday ward rounds, are easily accounted for by allocation as an endoscopy or outpatient session. This is because time back in lieu is not applicable to the annualised contract.

## Compliance

Activity data was initially collected and checked by the general manager, but it is now the responsibility of each consultant to submit a

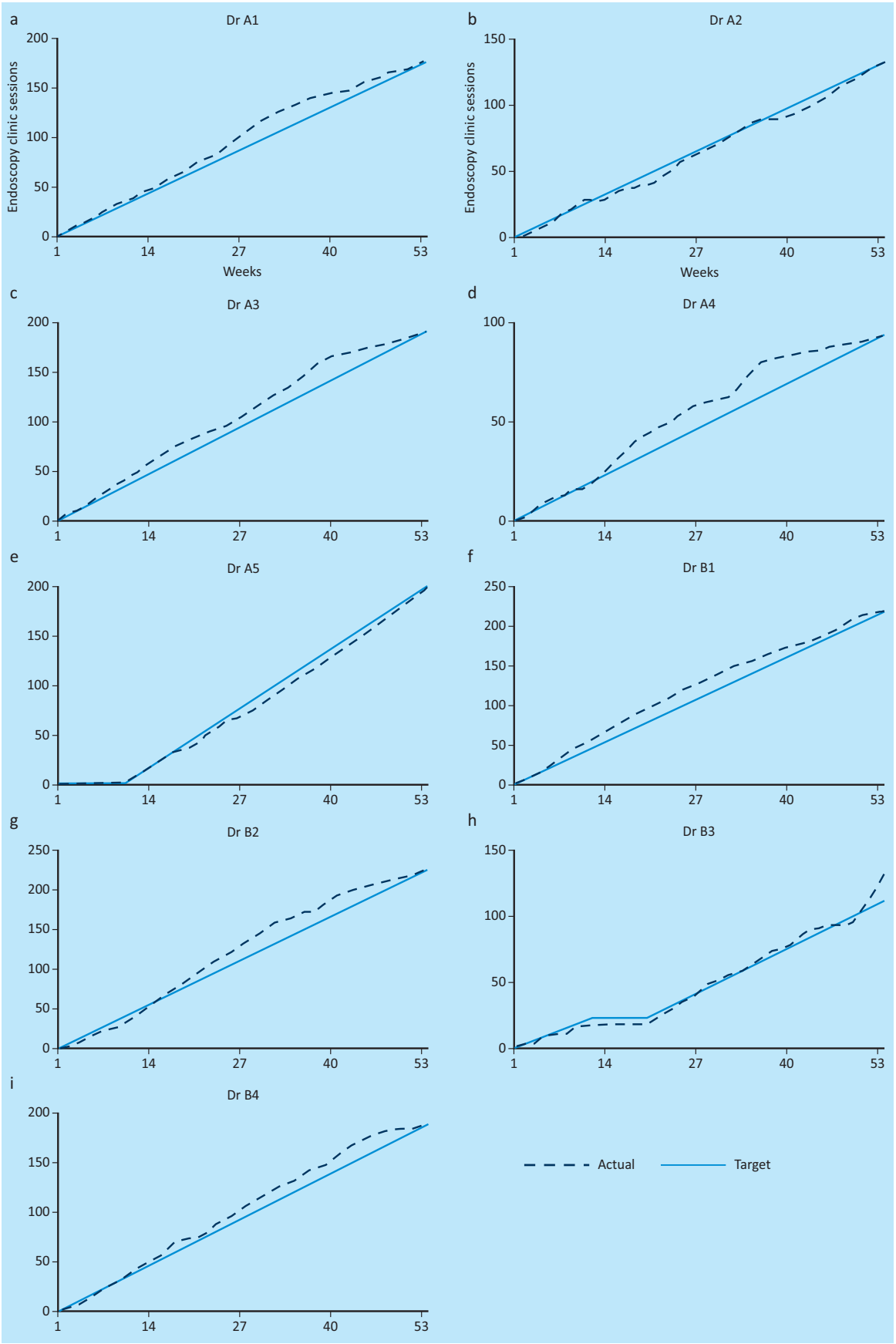


**Fig 1. An example of the end-of-year review of performance against contract for nine consultants.** Only clinics and endoscopy lists are included in these charts. Note the varying scale on the y-axis: Dr A5 (e) starts approximately 10 weeks into the cycle; the target plateaus for Dr B3 (h) during sick leave for several weeks.

monthly activity return that is checked against PAS (patient administration system) data. The manager circulates activity data every two months to the whole team, so each individual can see how others are performing against the contract. The annual target is adjusted for sick leave if this is cumulatively more than one week.

Over-performance has been the trend and claims are generally made at the end of the year. Part sessions are carried forward and the annualised totals for the next year reduced accordingly. Under-performance, when this occurs, is carried forward in a similar manner (Fig 1).

## Wider applicability

ACs are being implemented in other specialties within our medical division: acute physicians and emergency department consultants have their 'shop floor' sessions annualised.

Working patterns are changing and the drivers for this are increasing specialisation, seven-day working, the desire for a consultant-delivered service, increased productivity and the extended roles of consultants in leadership, education, research and governance.[5] In this environment, the ability to demonstrate the actual work carried out is essential. It could be argued that such careful definition of work and monitoring is a threat to the professionalism and independence of consultants, but there are benefits for the organisation that employs them and for the consultants themselves. The trust can be reassured that its workforce is doing what it expects it to do and can demonstrate value for money. The annualised contract makes the non-clinical roles and responsibilities of consultants much clearer, and allocates recognised time for them to be executed.

Many gastroenterology departments are moving towards a 'consultant of the week'[6] system during conventional working hours, whereby one consultant takes responsibility for gastroenterology inpatients, urgent endoscopy work and referrals. In some departments, all other commitments are cancelled for this period. With the increasing prominence of emergency medicine and the value of specialist input, many subspecialities such as cardiology, gastroenterology, neurology, renal and respiratory medicine are developing rotas for 24-hour-per-day cover.

These changes are driven by increasing recognition of variable outcomes, such as mortality, on different days of the week[7] and a better understanding of how senior medical input can not only improve patient outcomes but also save resources by reducing length of stay. ACs will enable these new work patterns to be implemented more easily, more openly and more fairly for both trusts and consultants.

## Conclusions

The stimulus in our department for switching to an AC was the introduction of an OOH emergency gastrointestinal bleed rota. The principal advantage of the contract is that it provides clarity of performance to managers and peers. This is particularly useful when substantial external roles makes it more difficult to keep track of work done in the trust. It provides increased flexibility to backfill endoscopy sessions, enabling more efficient use of endoscopy resources. Implementing the AC has required close collaboration between managers and clinicians, and the ability to track performance against contract accurately enhances transparency: a win-win situation for both parties. The AC system has evolved over 3 years to become more sophisticated and better able to reflect consultant workloads. Such an annualised scheme is an option for all specialties (not just those that are procedure-based), particularly if 24-h rotas are being introduced. It is likely to become more widespread as trusts scrutinise job plans more closely, as 7-day working becomes commonplace and as consultants take on more extended roles.

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