Consultant job planning for a 7-day service

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ABSTRACT

At a time of competing demands on the National Health Service (NHS), systematic consultant job planning is necessary to ensure that limited resources are being used productively, especially with the prospect of expanded 7-day services. Based on a presentation to the Royal College of Physicians Annual Conference in March 2016, a broad overview of job planning is presented, together with more specific examples relating to acute medicine and gastroenterology/general medicine.

KEYWORDS: 7-day services, consultants, job planning

The principle of 7-day services

Currently, most hospital services are set up on a 5-day model, with emergency and elective activities delivered during office hours from Monday to Friday and selected emergency services available during the evenings and weekends. Whereas nursing cover is relatively uniform throughout the whole week, the provision of medical staffing is based on a model that differentiates between plain time (office hours) and premium rate working (evenings and weekends). Alternative staffing models could enhance access to assessments, investigations and treatments, potentially for emergency and elective patients, 7 days a week.

Concerns have recently been raised about mortality associated with weekend admissions, with one prominent paper suggesting that patients admitted to NHS hospitals on Sundays have a 15% increased risk of dying within 30 days,[1] which has intensified calls for hospitals to run emergency services in a more uniform manner throughout the week.[2] Bruce Keogh, the NHS Medical Director, has also suggested that weekend services should be expanded to improve the experience of patients receiving both urgent and elective care.[3]

Although some funding is being made available to support 7-day services through the Transformation Fund,[4] it is not clear whether this will be adequate to provide additional staffing,[5] or whether it will be a cost-effective (or clinically effective) way of dealing with mortality issues.[6,7]

The Department of Health has suggested that consultants should work up to 13 weekends each year (approximately, a one in four rota) as a way of addressing concerns about mortality and patient experience.[8] Increasing weekend staffing would help trusts to achieve clinical standards for 7-day services outlined by NHS Improvement,[2] including the following key standards, which illustrate the need for early clinical review, multidisciplinary engagement and enhanced access to diagnostic tests:

- Standard 2: all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours from the time of arrival at hospital.
- Standard 3: all emergency inpatients must be assessed for complex or ongoing needs within 14 hours by a multiprofessional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.
- Standard 5: hospital inpatients must have scheduled 7-day access to diagnostic services, such as X-ray, ultrasound, computerised tomography, magnetic resonance imaging, echocardiography, endoscopy, bronchoscopy and pathology.

The need to provide rapid assessments of new admissions and inpatients is a particular focus in our trust because we will move to a new acute hospital, with a smaller overall bed base, in 2018. The feasibility of improving the patient experience by offering access to routine outpatient and diagnostic appointments at weekends is a less clearly defined, although desirable, aspiration.

Consultant staffing for a 7-day service

One prerequisite of providing 7-day services is an adequate number of staff trained in acute medicine, but recent data indicate that almost half of advertised consultant posts fail to result in recruitment[9] and only 58% of ST3 slots are filled.[10] In the absence of acute physicians, both currently or over the next few years, attention turns to consultants with dual accreditation in general (internal) medicine and another specialty (largely gastroenterology, respiratory and geriatrics, with smaller numbers from stroke, diabetes/endocrinology, renal, etc). A 2015 Royal College of Physicians (RCP) census suggested a reasonable willingness to work as generalists, with about half of gastroenterologists, for instance, supportive of 7-day working in acute medicine, approximately the same proportion who currently contribute to general (internal) medicine.

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Principles of job planning

While the details of the revised consultant contract are still awaited, the principles underlying job planning are unlikely to deviate far from the 2003 contract;[11] three key aspects are that it should be: (1) prospective; (2) agreed; and (3) meet the needs of the service, as well as the employee. The basic unit of job planning is the programmed activity (PA), which represents 4 hours work in plain time or 3 hours of premium rate activity. Direct clinical care (DCC) incorporates 'work relating to the prevention, diagnosis and treatment of illness', while supporting professional activities (SPA) comprise 'activities that underpin direct clinical care'; detailed descriptions of additional NHS responsibilities, external duties, emergency work, leave and on-call payments are available through the NHS Employers website.[11]

The first step towards delivering a 7-day service would be to look at the arrangements for the nine bank holidays, which often prevent the delivery of even a 5-day service. Requiring clinical staff to work normally on bank holidays, in return for additional annual leave days, would remove the impact of weeks when normal medical cover is only present for 3 or 4 days.

The next step is to agree how many weeks per year a consultant should be expected to work and, according to the calculations illustrated (Table 1), the answer should be 42 (ie 52 weeks minus 10 weeks' leave). With this in mind, we need to provide prospective cover for sessions that run 52 weeks per year and, using the calculation 52/42=1.24, this equates to an additional 24% PAs. Determining which services operate on a 52-week basis is often a matter for local discussion; although prospective cover is mandatory in emergency care, the requirement to deliver a uniform service across outpatient clinics or procedures is more related to questions of patient experience, demand and capacity, than safety. It is also worth remembering that prospective cover would normally only apply to the clinical elements of the job, and not to supporting activities.

Examples of the job-planning process

To provide a 7-day service, job planning needs to take place within the team, mapping out the requirements of the hospital against the available resources, before agreeing job schedules with the individuals who deliver the service. The examples given below relate to acute medicine and gastroenterology (with a commitment to general internal medicine) and, although they are somewhat idealised, they help to illustrate broad approaches to job planning.

Table 1. Days deducted from working year

Annual leave	33 days*
Study leave	10 days
Bank holidays	8 days
Total	51 days
	51 days = 10 weeks and 1 day

*35 days after 7 years as a consultant.

Table 2. Example of programmed activity (PA) calculations for the acute medical unit

Day of the week	PAs required for hours worked				Total
	08:00–12:00 h	12:00–16:00 h	16:00–19:00 h	19:00–21:15 h	
Monday	1.00	1.00	0.75	0.75	**3.50**
Tuesday	1.00	1.00	0.75	0.75	**3.50**
Wednesday	1.00	1.00	0.75	0.75	**3.50**
Thursday	1.00	1.00	0.75	0.75	**3.50**
Friday	1.00	1.00	0.75	0.75	**3.50**
Saturday	1.33	1.33	1.00	0.75	**4.41**
Sunday	1.33	1.33	1.00	0.75	**4.41**
Total	**7.66**	**7.66**	**5.75**	**5.25**	**26.32**

Acute medicine

The acute medicine unit (AMU) requires clinical cover to be available throughout the day, 7 days a week, 52 weeks a year; thus, the provision of prospective cover within the contract is essential. Assuming the current rates of pay for premium rate hours, a weekly timetable demonstrates the need for 26.3 DCCs to permit one consultant to be present during all of these sessions (Table 2); given that this element of the service must be covered uniformly throughout the year, the budget would need to be increased by 24% to 32.6 DCCs to allow for prospective cover.

Assuming that each consultant receives 2.5 SPAs and 1 DCC for general administration (which, admittedly, might appear generous in some trusts), one consultant on a 10-PA job plan would offer 6.5 DCCs, so six consultants could deliver this service. The way that this service is provided could be adapted to the particular wishes of the doctors to work mornings, evenings or weekends, and so on, as suggested in the model in Table 3.

Table 3. Example of allocation of shifts in an acute medical unit

Day of the week	Programmed activities required for shifts worked				Total
	08:00–12:00	12:00–16:00	16:00–19:00	19:00–21:15	
Monday	1.00	1.00	0.75	0.75	**3.50**
Tuesday	1.00	1.00	0.75	0.75	**3.50**
Wednesday	1.00	1.00	0.75	0.75	**3.50**
Thursday	1.00	1.00	0.75	0.75	**3.50**
Friday	1.00	1.00	0.75	0.75	**3.50**
Saturday	1.33	1.33	1.00	0.75	**4.41**
Sunday	1.33	1.33	1.00	0.75	**4.41**
Total	**7.66**	**7.66**	**5.75**	**5.25**	**26.32**

Shading indicates allocation of shifts between four different individuals.

Table 4. Example of weekly job schedules for a team of 10 consultants in gastroenterology and general medicine

Week	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
1				MDT/SPA		OP clinic	OP clinic	MDT/SPA	Gastro ward	Gastro ward	Gastro ward	Endo	Gastro ward	Endo
2	Gastro ward		AMU	MDT/SPA	AMU		AMU	MDT/SPA	OP clinic					
3				MDT/SPA	Endo	OP clinic	Endo	MDT/SPA	OP clinic	Endo				
4	Endo	Endo	Endo	MDT/SPA		OP clinic	OP clinic	MDT/SPA		OP clinic				
5		OP clinic	Gastro ward	MDT/SPA	Gastro ward	Gastro ward	Gastro ward	MDT/SPA	Endo	Endo				
6	Endo	Endo	Endo	MDT/SPA		OP clinic	OP clinic	MDT/SPA	AMU		AMU	OP clinic	AMU	
7	AMU			MDT/SPA	Endo		Endo	MDT/SPA		OP clinic				
8		OP clinic		MDT/SPA		OP clinic	Endo	MDT/SPA	Endo					
9	Gastro ward	Gastro ward	Gastro ward	MDT/SPA	Gastro ward		Gastro ward	MDT/SPA	Gastro ward					
10	Endo	Endo	Endo	MDT/SPA		OP clinic		MDT/SPA	OP clinic	OP clinic				

AMU = acute medical unit; Endo = endoscopy; Gastro = gastroenterology; MDT = multidisciplinary team, OP = outpatient; SPA = supporting professional activity.

However, this assumes tight teamwork, with only one consultant being on leave at any time and no provision for multidisciplinary meetings, quality improvement sessions, or on call rotas; in all likelihood, this level of rigidity would be impractical and some additional sessions would be required to make the department run smoothly.

Gastroenterology

This specialty is an example of one that might provide cover across several different areas (including endoscopy, wards, outpatients and AMU), as well as helping to fill the gap in general (internal) medicine. In building team job plans, it is useful to start with those elements that are essential, or fixed (in this instance, starting with ward cover, weekend sessions and shared multidisciplinary team/SPA times); other activities that can be adjusted more flexibility, such as outpatients clinics, can be added subsequently (Table 4).

This team job plan assumes that there are ten consultants, each working ten PAs, and is underpinned by the following principles:

- Ward cover should be provided in blocks of several days, with attendance on the ward each morning and limited fixed commitments during the rest of the day.
- Blocks of ward cover should overlap with those running before and after to ensure good handover of clinical care.
- Some elective weekend activity can be provided by the on-call gastroenterologist.
- Departments need to have coordinated, fixed sessions together to carry out quality improvement sessions, multidisciplinary meetings and other activities that strengthen the team, not least when clinicians are working across different sites.
- It should be possible to take annual leave during most of the weeks, with colleagues in other weeks being able to provide some cross-cover.
- Administrative work related to DCCs would be conducted within the 4-hour period (ie clinics will only involve 3 hours 30 minutes of patient-facing time, with 30 minutes of dedicated administrative time available in-line with the clinic, or on a separate occasion).

Again, any sessions that required 52 weeks cover per year would need to be paid with 24% uplift – this would apply to all aspects of weekend work, as well as weekday sessions on the ward, clinic and endoscopy. For instance, providing prospective cover for the 15 gastroenterology ward sessions per week would require consultants in other rows to work through their SPA, administration or rest periods; because these would need to be repaid, the overall PA allocation would rise by 3.6 PAs (15x1.24=18.6), or 0.36 (3.6/10) PAs per consultant.

Given that the terms of the new consultant contract are yet to be agreed, it is not possible to judge the length of sessions in premium rate periods, such as weekends (currently 3 hours). However, it appears likely that physicians from most acute specialties be will expected to work approximately one weekend every month.

Finally, in a service that spreads across 7 days, there will inevitably need to be carefully constructed handovers to ensure continuity of care, which is also addressed in the Clinical Standards:

- Standard 4: handovers must be led by a competent senior decision-maker and take place at a designated time and place, with multiprofessional participation from the relevant incoming and outgoing shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across 7 days of the week.

Implications for the future

Effective job planning allows finite NHS resources to be used to the greatest effect, potentially improving the quality of care, reducing mortality and enhancing patient satisfaction. This paper aims to stimulate discussion about the ways in which best practice can be implemented nationally.

For consultants, job planning should produce a clearly constructed, consistent and fair work schedule, underpinned by a transparent payment structure. Ideally, this would allow consultants to contribute flexibly to work patterns that will be required in hospitals of the future – typically on 5, 6 or 7 days – either on the existing contract or in line with new terms and conditions.

Equally, trusts need to be assured that they are employing staff in a standardised fashion that offers good value for the public purse. Agreeing the complex process of job planning on both sides of the table will make it easier for patients, consultants and hospitals to achieve their shared objectives. ■

Conflicts of interest

The author has no conflicts of interest to declare.

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