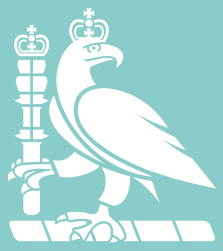

Royal College of Surgeons of England

ADVANCING SURGICAL CARE

Surgical Job Planning Guidance

August 2026

Contents

Foreword

The delivery of modern surgical care now takes place in an increasingly complex healthcare environment. Surgical teams are managing rising demand, workforce pressures, greater clinical complexity and evolving models of care, while continuing to maintain high standards of patient safety, education and professional development.

In this context, effective job planning has never been more important. When undertaken collaboratively and supported appropriately, job planning provides a vital framework for aligning clinical activity, workforce wellbeing, training responsibilities and service priorities. Good job planning is not simply a contractual exercise; it is a key enabler of safe, sustainable and productive surgical services.

NHS England has undertaken significant work in recent years to support improvements in medical job planning across the National Health Service (NHS), recognising the importance of transparent, evidence-based and collaborative approaches to workforce planning and service delivery. This guidance from the Royal College of Surgeons of England (RCS England) complements that work by providing a practical surgical perspective on how these principles can be applied within the realities of contemporary surgical practice.

Importantly, this document recognises that surgical practice extends far beyond operating theatres and outpatient clinics. Surgeons play a critical role in multidisciplinary care, perioperative decision making, education and training, governance, quality improvement, innovation, research and system leadership. The guidance also acknowledges the contribution of the wider surgical workforce, including consultant surgeons, specialist and associate specialist surgeons, locally employed doctors and resident doctors.

Vitally, this document recognises the need for flexibility of working practices and the requirement to support colleagues across an entire career pathway, including the need to support senior colleagues and retain a wealth of experience and skill within the NHS.

As the NHS moves forward with implementation of the Ten Year Health Plan — with its focus on prevention, neighbourhood health services, digital transformation and new models of care — meaningful job planning will become increasingly important. Supporting surgeons and multidisciplinary teams to contribute to innovation, transformation and service redesign will be essential if we are to deliver sustainable improvement for both patients and staff.

The RCS England is to be commended for producing guidance that recognises both the operational pressures facing surgical services and the need to protect workforce sustainability, professional development and high-quality training. I hope this document will support constructive local discussions between clinicians and organisations, strengthen collaborative leadership and contribute to the continued development of safe, effective and sustainable surgical care across the NHS.

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Executive summary

- Surgical services across the National Health Service are operating in an increasingly complex and demanding environment, characterised by growing demand for surgical care, workforce pressures and increasing administrative requirements.
- Healthcare organisations must balance the need to increase surgical productivity and reduce waiting lists with maintaining patient safety, high-quality training and workforce sustainability.
- Effective job planning plays a central role in addressing these challenges by providing a structured framework for aligning the work of surgeons with service demand, workforce capacity and professional responsibilities.
- This guidance provides a practical framework for collaborative job planning to support consultant surgeons, specialist and associate specialist surgeons, resident doctors, clinical leaders and healthcare organisations in developing job plans that reflect the realities of modern surgical practice.
- The guidance draws on themes identified in the Royal College of Surgeons of England's workforce census, including:
  - limited access to operating theatres
  - workforce shortages and recruitment challenges
  - increasing administrative workload
  - pressures on surgical training
  - concerns about workload sustainability and burnout
- Modern surgical practice extends beyond operative care and includes a broad range of responsibilities, such as:
  - outpatient assessment and perioperative decision making
  - multidisciplinary team working
  - training and supervision
  - governance and quality improvement
  - research, leadership and service development
- Surgical job plans should therefore recognise the full scope of professional responsibilities undertaken by surgeons.
- Surgical leadership, innovation and service development are important components of modern surgical practice and should be recognised in job plans to support service transformation, workforce sustainability and improvements in patient care.
- The guidance outlines a number of core principles for surgical job planning, including:
  - reflecting the real workload of modern surgical practice
  - supporting productivity and efficient theatre utilisation
  - promoting workforce sustainability and wellbeing
  - protecting time for training and supervision
  - recognising the contributions of the whole surgical team
- The document also describes the core components of a surgical job plan, including:
  - direct clinical care activities such as operating lists, clinics, triage, inpatient care and emergency work;
  - supporting professional activities including training, governance, research and service development.
- Achieving an appropriate balance between clinical activity and supporting professional responsibilities is essential for maintaining safe and sustainable surgical services.
- Finally, the guidance emphasises that job planning should be viewed as a collaborative and dynamic process, requiring regular review and alignment with service demand, workforce planning and organisational priorities.
- When implemented effectively, surgical job planning can strengthen surgical services, support workforce wellbeing and ensure the continued delivery of safe, high-quality patient care.

A. Introduction

1. Aim of this guidance

This document provides a practical framework to support collaborative job planning within surgical services. Its purpose is to empower consultant surgeons, specialist and associate specialist (SAS) surgeons, resident doctors and clinical leaders or managers to work together in developing job plans that enable the delivery of high-quality surgical care for patients.

Effective job planning is central to the sustainability of surgical services. It provides a structured approach to ensuring that the workload of surgeons and surgical teams is aligned with service requirements, training obligations, governance responsibilities and the wellbeing of the workforce. When undertaken collaboratively and transparently, job planning allows organisations to balance productivity with safety, quality and education.

This document is intended as a framework for best practice rather than a prescriptive set of rules. Surgical practice varies significantly between specialties, institutions and individual clinicians. Job plans must therefore be adaptable to local service configurations, casemix, workforce availability and organisational priorities.

The guidance is designed to support:

- consultant surgeons and SAS surgeons
- resident doctors and surgical trainees
- clinical directors and departmental leaders
- medical managers and workforce planners
- National Health Service (NHS) organisations and healthcare providers

We expect all surgeons from all specialties and all career stages, including resident doctors, to actively engage with the job planning process and their own job plan. The principles outlined in this document can support both individual job planning discussions and wider departmental service and workforce planning across the spectrum of surgical specialties and career grades, including resident doctors. We also expect that the surgical specialty associations may adapt the framework presented here to develop specialty-specific job planning guidance reflecting the particular demands of their clinical practice. Further appendices may also be developed to adjust this document for the specific needs of different groups of surgeons, including resident doctors and SAS surgeons.

This guidance takes into account workforce recommendations arising from the Royal College of Surgeons of England (RCS England) workforce census. It aligns with and can be complemented by the following documents:

- NHS England, Medical job planning improvement guide (2025);
- NHS Employers/British Medical Association, A guide to consultant job planning (2011);
- British Medical Association, An overview of job planning (2023);
- RCS England, Guidance on the requirements for a new consultant post (2024);
- Guidance produced by individual surgical specialty associations on job planning.

This guidance should be read alongside the national NHS consultant contract, which sets out the terms and conditions governing consultant job planning within the NHS. This document is intended to complement the framework of the NHS consultant contract, by providing additional considerations specific to contemporary surgical practice.

Some consultant contractual arrangements and service structures vary across the UK four nations, including differences in programmed activity allocation and working patterns. Although this guidance is primarily informed by the NHS consultant job planning framework used in England, the broader principles of collaborative, realistic and sustainable surgical job planning are applicable across all UK healthcare systems and should be interpreted in line with local contractual arrangements and national guidance.

2. How surgeons work

Modern surgical care is delivered by multidisciplinary teams (MDTs). The work of surgeons extends beyond operative practice to encompass a broad range of clinical, professional and leadership responsibilities.

Surgical teams typically include a range of professional groups, many of whom will themselves be subject to workforce planning and job planning processes:

- consultant surgeons
- SAS surgeons and locally employed doctors (LEDs)
- resident doctors at different stages of training
- advanced practitioners and members of the extended surgical team
- anaesthetists and perioperative physicians
- theatre teams, nurses and allied health professionals
- administrative and managerial staff

The complexity of contemporary surgical practice means that the delivery of care depends on effective collaboration between these different professional groups.

Surgeons also undertake a wide range of professional activities beyond direct patient care. These include:

- training and supervision of resident doctors and other staff
- clinical governance and quality improvement
- research and innovation
- service leadership and organisational roles
- participation in national professional bodies
- recruitment, assessment and voluntary roles

The distribution of these responsibilities varies between individuals depending on their experience, expertise and professional interests. For this reason, job plans often require a combination of fixed and flexible sessions, sometimes planned over periods longer than a single week. In some cases, monthly or annualised planning models reflect the realities of surgical work better.

The integration of the extended surgical team has become an increasingly important element of service delivery. However, experience across the NHS has shown that integration of these roles can present challenges if responsibilities, supervision arrangements and training opportunities are not clearly defined. Job planning therefore plays a key role in clarifying expectations and ensuring that all members of the surgical team contribute effectively to patient care.

3. Current NHS service environment and changing demands

The context in which surgical job planning takes place has changed significantly in recent years. Surgical services face increasing demand at a time when workforce and financial pressures constrain the capacity of healthcare systems.

Several factors have contributed to this challenge:

- The demand for surgical care continues to grow as a result of demographic and non-demographic changes, increasing prevalence of chronic disease, and advances in surgical treatment that expand the range of conditions that can be managed operatively and need longer-term surveillance.
- Workforce shortages affect many parts of the perioperative system, including surgical staff, anaesthesia, theatre teams and diagnostic services. These shortages can create bottlenecks in patient pathways, limiting the ability of surgical teams to deliver care efficiently.
- The balance between productivity, safety and training has become increasingly complex. Although there is strong pressure to reduce waiting lists and maximise surgical throughput, this must be balanced against the need to maintain high standards of patient safety and to provide adequate training opportunities for the next generation of surgeons.
- Digital transformation is also reshaping surgical practice. Electronic patient records, digital imaging systems and electronic consent platforms have the potential to improve efficiency, but in many organisations they have also increased administrative workload for clinicians.

- Finally, the role of surgeons continues to evolve. In addition to clinical responsibilities, surgeons are expected to contribute to leadership, research, education and service innovation. These activities are essential for the development of surgical services but require appropriate recognition within job plans.

For all of these reasons, modern surgical job planning must reflect the complexity and diversity of contemporary surgical work.

4. Advantages of stable consultant-led care teams

A consultant-led care team structure, adapted to contemporary healthcare systems, can help address several of the challenges currently facing the surgical workforce. While the traditional “firm” model relied on stable hierarchical teams working closely under a consultant, many of its core strengths — continuity, mentorship and team cohesion — remain highly relevant. In modern surgical services, where shift-based rotas and service pressures can fragment teams, establishing more stable consultant-led clinical teams can improve continuity of care and create clearer professional relationships between consultants, trainees and other members of the surgical workforce. This stability can support more effective supervision and apprenticeship-style learning, which remains a cornerstone of surgical training, while also strengthening accountability and communication in MDTs.

Consultant-led care teams can also help support workforce wellbeing and sustainability. By organising services around consistent clinical teams rather than purely service-based rotas, departments can foster stronger professional support networks, more mentoring opportunities and a clearer sense of shared responsibility for patient care. This approach can improve team cohesion, facilitate better handover practices and support the integration of SAS surgeons and members of the extended surgical team.

Importantly, such stable teams must be compatible with contemporary workforce regulations and flexible working patterns, meaning they should emphasise collaborative team leadership, transparent governance and balanced workloads rather than rigid hierarchies. When thoughtfully implemented, such models can help surgical departments retain the benefits of continuity, mentorship and professional identity that characterised traditional firms while adapting to the realities of modern surgical practice.

B. Workforce census themes and their implications for job planning

RCS England's workforce census highlighted a number of challenges affecting the delivery of surgical services across the NHS. These challenges influence not only the capacity of surgical teams to deliver care, but also the sustainability of the workforce and the effectiveness of training.
Understanding these themes is essential when developing surgical job plans, if they are to reflect the realities of contemporary surgical practice:

1. Productivity challenges, equipment and theatre access

Access to operating theatres remains one of the most significant constraints on surgical productivity across many hospitals. In many surgical specialties, consultant surgeons report having limited scheduled operating sessions each week despite high demand for surgical care. This restriction on theatre access can significantly limit the ability of surgical teams to deliver elective care and reduce waiting lists.

In addition to limited theatre availability, delays elsewhere in the patient pathway also affect productivity. Diagnostic investigations such as imaging and endoscopy may introduce delays before a surgical decision can be made. Similarly, bottlenecks in preoperative assessment processes can slow the progression of patients to surgery.

Surgical productivity can also be affected by access to equipment and emerging technologies. Limited availability of specialist equipment, including robotic surgical platforms and advanced imaging systems, can restrict operative capacity and influence how surgical services are organised.

Such pathway delays can reduce the effective utilisation of theatre sessions and may require surgeons to spend additional time coordinating patient pathways and clinical decision making.

These factors have important implications for job planning:

- Job plans should ensure that protected theatre and procedure room time is clearly identified and appropriately allocated. Operating sessions are essential not only for the delivery of surgical care, but also for maintaining operative competence and supporting training. Job plans should therefore include sufficient programmed activities dedicated to operative practice.
- Job planning discussions should take account of the availability of equipment and emerging technologies when considering theatre activity and service delivery.
- Trusts should seek to minimise conflicts between elective and emergency commitments. Where possible, elective operating should be protected from disruption caused by on-call duties. In some services this may involve separating elective and emergency rotas.
- Job planning should recognise that surgical time is also taken up by activities beyond the operating theatre. Surgeons are involved in multidisciplinary case discussions, imaging review, triage of referrals and complex shared decision making with patients. These activities require time and should be recognised in job plans, alongside time for clinical administration such as electronic patient records' documentation.
- Some trusts may benefit from adopting more flexible approaches to theatre utilisation. In particular, annualised planning models may allow surgical teams to make more effective use of theatre capacity across the year. However, where annualised approaches are adopted, care must be taken to ensure that surgeons maintain regular operative exposure so that technical competence is preserved.

2. Unsustainable workload and burnout

The census demonstrated that many surgeons experience high levels of workload pressure. A substantial proportion of consultants report regularly working beyond their contracted hours, and concerns about workload and work–life balance are increasingly recognised as factors influencing career decisions within surgery.

Current job plans tend to underestimate the intensity of surgeons' work, and many time-consuming professional activities are unrecognised and unaccounted for in job plans. These include follow-up investigations, reviewing test results, preparation for MDT meetings, patient reviews and others.

Burnout among healthcare professionals has been associated with reduced job satisfaction, increased staff turnover and potential impacts on patient safety. In the surgical profession, burnout may arise from a combination of factors including high clinical workload, administrative burden, service pressures and conflicts between clinical priorities and organisational targets.

These challenges highlight the importance of ensuring that surgical job plans are realistic and sustainable:

- Job planning should focus on aligning expected workload with available capacity. Job plans that are aspirational end up relying on clinicians routinely working beyond their contracted hours. These are unsustainable in the long term and contribute to workforce attrition and dissatisfaction.
- In addition to clinical activity, job plans should also recognise the time required for administrative work, governance activities and the full spectrum of professional responsibilities. Failure to account for these tasks can lead to an imbalance between direct clinical care (DCC) and the broader professional activities required for safe surgical practice.
- Job planning can play an important role in supporting wellbeing. Ensuring that job plans incorporate appropriate rest periods following on-call duties, balanced distribution of responsibilities and opportunities for professional development can help reduce the risk of burnout.
- Job plans should not be overly focused on DCC at the expense of supporting professional activities (SPA). Time for leadership, innovation, quality improvement and service development is essential for maintaining and improving surgical services.
- Career-phase job planning can help align job plans with the evolving responsibilities of surgeons throughout their careers. Recognising that early-career, mid-career and senior surgeons may face different pressures and make different contributions to surgical services may help support professional development, workforce sustainability and reduced risk of burnout (see Section C “Principles of surgical job planning”).

3. Workforce gaps and retention issues

The sustainability of the surgical workforce represents a major challenge for healthcare systems. The census indicates that a significant proportion of experienced consultant surgeons are approaching retirement age, with many expected to retire in the coming decade.

At the same time, some organisations face difficulties recruiting to new or replacement consultant posts. Delays in recruitment can increase the workload for existing staff and may place additional strain on surgical services.

Retention of experienced surgeons and succession planning are therefore important priorities:

- At the departmental level, succession planning should be incorporated into workforce planning processes. Anticipating retirements and planning recruitment in advance can help ensure continuity of surgical services. It is important to ensure that retiring surgeons have some overlap with incoming surgeons to give them the opportunity to share their experience, and provide advice and mentoring where possible.
- Job planning can support retention strategies by providing flexibility that allows surgeons to adapt their working patterns as their careers progress. In particular, opportunities for flexible working, reduced programmed activities or portfolio roles may enable experienced surgeons to remain in the workforce for longer.
- Portfolio roles may include contributions to training, mentorship, governance, leadership or service development. These roles can provide valuable opportunities for experienced surgeons to share their expertise while reducing the physical demands associated with intensive on-call commitments.
- Job planning discussions should consider the changing needs of surgeons throughout their careers. For senior surgeons, adjustments to on-call commitments and greater emphasis on mentorship, training and service improvement activities may support continued engagement in the workforce.
- Trusts should avoid relying on informal arrangements, whereby individual surgeons regularly extend their working hours to compensate for workforce gaps. Although such arrangements may temporarily support service delivery, they are unlikely to be sustainable in the long term.

4. Training pressures and lack of protected training time

The delivery of high-quality surgical training is a central responsibility of surgical departments, but workforce pressures and service demands can limit the availability of training opportunities for resident doctors.

One of the most commonly cited challenges in surgical training is limited access to operating lists. When training sessions are heavily focused on service delivery, opportunities for trainees to develop operative skills may be reduced.

Rota arrangements can also affect training opportunities. In some cases, resident doctors may be required to cover service commitments that limit their ability to attend operating lists or outpatient clinics.

These challenges highlight the need for job plans that explicitly recognise the time required for training and supervision:

- Consultant job plans should include protected time for educational and clinical supervision. This may involve dedicated training lists, supervision meetings, workplace-based assessments and structured feedback sessions.
- Job planning should seek to ensure that service rotas support rather than undermine training opportunities. For example, rota arrangements should allow resident doctors to attend operating lists and clinics where possible, particularly when they are not required for emergency cover.
- Training opportunities should be supported across all locations where surgical care is delivered. This includes surgical hubs and independent sector facilities used to deliver NHS care. Where such facilities are used, arrangements should be made to ensure that trainees have access to appropriate training opportunities.
- Departments should also consider the potential impact of insourcing arrangements on training opportunities. Policies may be required to ensure that service pressures do not inadvertently reduce access to operative training.
- When new techniques are introduced in a department, educational supervision should be made available for all relevant doctors, including resident doctors and LEDs.

Ultimately, maintaining high-quality surgical training requires a deliberate commitment within job planning processes.

5. Integration of SAS surgeons and LEDs

SAS surgeons and LEDs play an increasingly important role in surgical services. With their numbers expected to grow in the coming years, it is essential that the job planning process is used effectively to support their continued integration and development in the surgical workforce.

However, feedback from the workforce census indicates that these clinicians often feel excluded from decision making processes or lack access to career development opportunities. In addition, there is great variability of practice for this group of surgeons across surgical departments and organisations, as well as differences in the quality and availability of training and supervision opportunities, which leads to lack of consistency, recognition and structured career development.

It should be noted that SAS surgeons and LEDs are employed under different contractual frameworks and may have distinct roles, responsibilities and career development pathways. SAS surgeons are employed under nationally agreed contracts, whereas LEDs are typically employed through local contractual arrangements.

The SAS workforce encompasses a broad range of experience and practice. Some SAS surgeons work with a high degree of autonomy and may undertake roles comparable with independently practising consultants within their agreed scope of practice, whereas others work under varying levels of supervision as they develop their skills and experience. Job planning should recognise this diversity and be tailored accordingly.

Addressing these concerns is essential for maintaining a motivated and engaged workforce.

Job planning should support the effective integration of SAS surgeons and LEDs by ensuring that their roles are clearly defined and recognised in departmental structures. In particular, job plans should include:

- a clearly defined scope of clinical practice
- access to training opportunities where appropriate
- protected time for SPA
- personal development plans with clearly defined objectives.
- support for autonomous practice for senior SAS surgeons where appropriate

These arrangements can help ensure that SAS surgeons and LEDs are supported in their professional development while continuing to contribute to service delivery.

Job planning should also ensure that the roles of SAS surgeons complement rather than compete with training opportunities for resident doctors. Clear and transparent role definitions and open communication within surgical teams are essential for achieving this balance.

Avoiding roles that are exclusively service-focused is important for maintaining job satisfaction but also for supporting long-term career development and retention. By ensuring that SAS surgeons have opportunities to participate in teaching, leadership, quality improvement and research through the job planning process, organisations can strengthen both individual careers and the wider surgical workforce.

6. Administrative burden and digital system challenges

Administrative workload has increased significantly in recent years. The introduction of electronic patient records, digital imaging systems and electronic consent platforms, although promising in the long term, has also created additional documentation requirements for clinicians. Although these systems have the potential to improve efficiency, they often also increase the time required for administrative tasks.

The introduction of electronic patient record systems specifically, has altered the nature of outpatient consultations. These systems have the potential to improve information access and continuity of care; however, they are often associated with increased administrative burden during clinics. In many settings, surgeons report that they are required to navigate multiple digital interfaces and complete real-time documentation, which can reduce the time available for direct patient interaction and has an impact on their overall clinic productivity.

Furthermore, surgeons frequently report spending substantial amounts of time completing documentation, reviewing results, managing referrals and responding to correspondence.

These tasks are essential components of patient care and should therefore be recognised in job plans.

Job planning should therefore include protected time for administrative work, particularly tasks associated with digital workflows such as electronic patient records, referral triage and results management.

At an organisational level, job planning can also highlight the need for adequate administrative support. Delegating appropriate administrative tasks to trained staff can allow clinicians to focus on clinical decision making and patient care.

Organisations should ensure that administrative systems support rather than hinder clinical productivity.

7. Flexible, annualised, specialty-specific and career-stage-sensitive job plans

Traditional job planning models often rely on fixed weekly sessional arrangements. Although these models may provide simplicity, they do not always reflect the variability of surgical work.

Surgical activity can fluctuate because of factors such as emergency workload, seasonal demand and workforce availability. Fixed weekly job plans may lack the flexibility needed to accommodate these variations.

For this reason, we recommend that trusts should explore more flexible approaches to job planning:

- Annualised job plans allow clinical activity to be distributed across a longer period rather than being constrained by weekly schedules. Such approaches can provide greater flexibility in managing theatre sessions, on-call commitments and training activities. However, annualised job plans must be implemented carefully to ensure that surgeons maintain regular operative exposure and that patient care remains consistent. This can be supported by modern more-innovative approaches such as preference rostering.
- Career-stage-sensitive job planning is also important. Surgeons' professional responsibilities evolve throughout their careers, and job plans should reflect these changes. Early-career surgeons may require greater opportunities for supervised operating and professional development. Mid-career surgeons often carry the highest clinical workload while also contributing to leadership and training. Senior surgeons may increasingly focus on mentorship, governance and service development. Flexible job planning can support these transitions

while ensuring that surgical services continue to operate effectively (see also Section C “Principles of surgical job planning”).
- Surgical job plans should be specialty-specific, recognising that the nature of clinical work, patient pathways and professional responsibilities varies significantly between surgical disciplines. A standardised, one-size-fits-all approach to job planning risks failing to reflect the true workload and requirements of different specialties.

8. Efficient patient pathways and team-based approaches

Surgical care depends on efficient patient pathways that integrate multiple components of the healthcare system.

Delays in diagnostics, outpatient appointments or theatre scheduling can reduce productivity and increase waiting times. Addressing these challenges requires coordinated working across surgical teams and supporting services.

Job planning should therefore reflect the importance of team-based service delivery, underpinned by an understanding of service-level activity. Key considerations include:

- shared rota arrangements across surgical teams
- coordinated use of theatre capacity
- structured time for MDT meetings
- clear allocation of responsibilities within patient pathways

In addition, job planning should recognise system-level activities such as referral triage, advice and guidance services, and virtual consultations.

Defining both responsibilities and support mechanisms in job plans can help ensure that surgeons are able to deliver care effectively while maintaining clear expectations regarding workload.

C. Principles of surgical job planning

Job planning should be guided by a set of core principles that ensure job plans are realistic, sustainable and aligned with both service needs and professional standards. The principles outlined in this section provide a framework for developing job plans that support high-quality patient care, maintain workforce wellbeing and enable the continued development of surgical services.

1. Reflecting the real workload of modern surgical practice

- Surgical job plans should accurately reflect the full scope of modern surgical practice, rather than focusing solely on easily quantifiable activities such as operating lists and outpatient clinics.
- In addition to operative and clinic activity, surgeons undertake a wide range of responsibilities including MDT meetings, triage, review of diagnostic investigations, coordination of patient pathways, trainee supervision and governance activities.
- Clinical administrative work, such as reviewing results, completing documentation and managing referrals, forms an integral part of patient care and should be recognised in job plans.
- The increasing complexity of surgical patients, including multiple comorbidities and multidisciplinary perioperative management, may increase the time required for clinical decision making and consultations.
- Surgical job planning should also be flexible and individualised, reflecting the specific specialty needs, roles, responsibilities and professional interests of each surgeon while remaining aligned with service needs.
- Ensuring that job plans recognise the full range and variation of these activities helps ensure workload expectations are realistic and supports safe, sustainable surgical practice.

2. Supporting productivity and optimising theatre utilisation

- Improving productivity in surgical services requires efficient organisation of clinical activity and effective use of operating theatre capacity to meet rising demand for surgical care.
- Productivity should be viewed across the entire surgical pathway, including referral, diagnosis, perioperative preparation and postoperative care, rather than focusing solely on the number of procedures performed.
- Protected operating sessions are essential and job plans should clearly define theatre commitments to support both service delivery and the maintenance of operative competence.
- Where possible, service models should separate elective and emergency responsibilities to minimise disruption to scheduled operating lists and improve theatre efficiency.
- Departments may benefit from flexible approaches to theatre utilisation, including coordinated scheduling across surgical teams or annualised planning models.
- Theatre productivity depends on the effective coordination of MDTs, infrastructure and administrative systems, and job planning should take account of these wider organisational factors.

3. Supporting a sustainable surgical workforce

- A sustainable surgical workforce is essential for maintaining high-quality surgical services but is challenged by workforce shortages, increasing workload pressures and the potential retirement of experienced clinicians.
- Job planning can support sustainability by ensuring balanced workloads and recognising the full range of clinical, administrative, training and governance responsibilities undertaken by surgeons.
- Job plans that rely on clinicians regularly working beyond contracted hours are unlikely to be sustainable and may contribute to burnout, reduced job satisfaction and difficulties in recruitment and retention.
- Ensuring that programmed activities accurately reflect professional responsibilities can help reduce workload pressures and support workforce wellbeing.
- Flexible working arrangements, including less-than-full-time roles, portfolio careers and phased retirement, may help retain experienced surgeons in the workforce.
- Effective job planning requires collaboration between clinicians and healthcare organisations to ensure that working patterns support both workforce wellbeing and high standards of patient care.

4. Supporting career progression across the lifespan (career-stage job planning)

- The responsibilities and priorities of surgeons evolve throughout their careers, and job plans should be flexible enough to reflect these changes.
- Early-career surgeons (in the first years following completion of specialty training) may benefit from increased opportunities for supervised operating, mentorship and professional development as they establish independent clinical practice.
- Mid-career surgeons (established consultants) often carry substantial clinical workloads while also contributing to leadership, training and service development; job plans should ensure adequate time for these responsibilities.
- Senior surgeons (highly experienced consultants) bring significant expertise and may increasingly contribute through mentorship, governance and strategic leadership; job plans may evolve to emphasise these roles while potentially reducing physically demanding duties such as intensive on-call commitments.
- Adopting career-phase approaches to job planning can support professional development, improve workforce retention and help reduce the risk of burnout across the surgical career lifespan.

5. Prioritising surgical training

- Training the next generation of surgeons is a core responsibility of surgical departments and is essential for maintaining high standards of patient care and the future sustainability of the profession.
- Service pressures can limit training opportunities, particularly when operating lists are focused primarily on service delivery rather than trainee development.
- Job plans should explicitly recognise training and supervision responsibilities, including time for supervising trainees in theatre, teaching activities and providing structured feedback.
- Dedicated training lists and protected educational time may help ensure that resident doctors gain sufficient operative experience and develop their clinical skills.
- Job planning should also align service rotas with training needs, enabling trainees to attend operating lists, clinics and multidisciplinary activities wherever possible.
- Without explicit recognition in job planning, training opportunities may be eroded by service pressures, potentially affecting the quality of future surgical training.

6. Integrating the whole surgical team

- Effective job planning should consider the roles and responsibilities of the entire surgical team, ensuring that clinical work is organised in a coordinated and collaborative way.
- SAS surgeons and LEDs play a vital role in maintaining service capacity and should have clearly defined roles, access to professional development and opportunities to contribute to training, leadership and governance.
- Providing protected time for SPA can help ensure SAS clinicians remain engaged and supported within their roles.
- The extended surgical team, including advanced practitioners and specialist nurses, increasingly supports patient pathways and service delivery; their contributions should be recognised in workforce planning discussions.
- Recognising the contributions of all members of the surgical team helps create cohesive, well-functioning services and strengthens the sustainability of the surgical workforce.

D. Components of a surgical job plan

A surgical job plan should provide a clear and realistic description of the work undertaken by surgeons and the time required to deliver that work safely and effectively. It should reflect the full range of professional activities involved in surgical care, including operative work, outpatient care, trainee supervision, governance responsibilities and service development.

Surgical job plans are typically structured around DCC and SPA, alongside additional NHS and external professional responsibilities. The balance between these elements will vary depending on specialty, organisational context and career stage.

This section outlines the core components of a surgical job plan and their contribution to the effective delivery of surgical services.

1. Direct clinical care

DCC encompasses the activities directly involved in diagnosing, treating and managing patients. In surgical practice, DCC includes operative care, outpatient assessment, perioperative management and emergency work. It also includes the clinical administrative work required to support patient care.

a. Operative activity

Operative activity forms a core component of surgical job plans. This typically includes elective operating lists, emergency theatre sessions, trauma surgery, day-case procedures and, in some specialties, endoscopic interventions.

Protected operating time is essential to maintain surgical productivity and ensure that surgeons retain operative competence. Regular operative exposure is also critical for supporting the training of resident doctors and maintaining team efficiency in theatres.

However, access to operating theatres is often constrained by workforce shortages, infrastructure limitations or scheduling inefficiencies. As a result, job planning discussions should ensure that theatre sessions are realistically allocated and protected wherever possible.

Particular care should be given to ensuring that trainees are included in the team allocation and rota/list planning in the independent sector and in surgical hubs.

In situations in which theatre access is limited, organisations will need to consider alternative approaches to maximise utilisation. These may include:

- dual-consultant operating lists for complex procedures (even in cases when theatre space is not limited);
- coordinated use of theatre capacity across surgical teams;
- flexible or annualised theatre scheduling.

Regardless of the model adopted, job planning should ensure that surgeons maintain regular operative exposure to sustain their skills and deliver safe surgical care.

b. Outpatient activity

Clinics provide the primary interface between surgical services and patients, and are central to the diagnostic and decision making processes that determine whether surgery is appropriate.

Outpatient activity typically includes:

- triage and assessment of new referrals
- follow-up appointments after surgery
- review of diagnostic investigations
- shared decision making discussions with patients
- management of long-term surgical conditions

In recent years, outpatient practice has evolved significantly. Increasing case complexity and the growth of shared decision making mean that consultations often require more time than in the past. In addition, digital innovations such as virtual consultations, advice and guidance services, and electronic referral triage have changed how surgical services interact with patients and referring clinicians.

Job plans should therefore recognise that outpatient care may include a variety of consultation formats, including face-to-face clinics, virtual consultations and remote triage activities.

Clinic templates should also be flexible enough to accommodate variations in case complexity. Some specialties may require longer consultation times for new referrals or complex follow-up cases, particularly when detailed discussions regarding treatment options are required.

In addition, time may need to be allocated for reviewing imaging, pathology results and other investigations that inform clinical decision making. Future considerations include supporting neighbourhood and community services outside a traditional hospital model.

c. Inpatient care and perioperative management with the MDT

The management of surgical inpatients includes preoperative assessment, ward rounds, perioperative decision making and coordination of multidisciplinary care.

Inpatient responsibilities involve:

- daily ward rounds for surgical patients
- review of postoperative complications
- coordination with multiprofessional teams including anaesthetic and critical care
- communication with patients and families regarding treatment plans
- discharge planning and follow-up arrangements

The complexity of surgical inpatients has increased in recent years because of ageing populations and higher rates of comorbidity. As a result, inpatient care often involves collaboration with other specialties such as medicine, anaesthesia and critical care.

Job planning should therefore ensure that sufficient time is allocated for ward rounds and inpatient review in consultation with other teams, particularly in services where surgeons are responsible for managing large numbers of hospitalised patients.

In some trusts, perioperative care models are evolving to include dedicated perioperative medicine services or enhanced recovery programmes. These developments may influence how inpatient responsibilities are structured within job plans.

d. Emergency and on-call work

Emergency surgical care represents a critical component of many surgical services. On-call commitments may involve managing emergency admissions, performing urgent surgical procedures and providing specialist advice to other clinicians.

The intensity and frequency of on-call commitments can vary significantly between specialties and organisations. In some services, emergency work may account for a substantial proportion of the overall workload.

Job planning discussions should carefully consider how on-call responsibilities are distributed across the surgical team. Emergency care is rarely delivered by individual clinicians working in isolation; rather, it depends on

coordinated teamwork in the surgical unit. A team-based approach to the organisation of emergency and on-call work can help ensure that responsibilities are shared appropriately and that sufficient flexibility exists to accommodate the skills, experience and availability of different team members. This approach may also support service resilience, reduce the risk of excessive workload for individual surgeons and help maintain continuity of patient care.

It is also important to recognise the impact that emergency work can have on elective activity. Where possible, elective operating lists should be protected from disruption caused by on-call duties. Some trusts have implemented models such as “consultant-of-the-week” systems to separate elective and emergency responsibilities and estate changes such as surgical hubs.

Job plans should also incorporate appropriate rest periods following on-call shifts. Adequate recovery time is essential for maintaining patient safety and supporting clinician wellbeing.

e. Clinical administrative work

Administrative tasks are an integral part of modern clinical practice. Surgeons are required to complete documentation, review diagnostic results, manage referrals and communicate with patients and other healthcare professionals.

Examples of clinical administrative work include:

- completing electronic patient records
- reviewing laboratory and imaging results
- preparing clinic letters and operative notes
- responding to patient queries
- triaging referrals
- travelling across trust sites

The introduction of electronic systems has increased the volume of documentation required for patient care. Although digital systems offer potential efficiency gains, they also require clinicians to spend significant time completing administrative tasks.

For this reason, clinical administrative work should be explicitly recognised in job plans. Failure to account for these tasks can result in clinicians performing administrative work outside their contracted hours, contributing to workload pressure and dissatisfaction.

f. Travelling time

Where a surgeon is expected to spend time on more than one site during the course of a day, travelling time to and from their main base to other sites will be included as working time forming part of their DCC.

Travel to and from work for NHS emergencies, and “excess travel” will count as working time. “Excess travel” is defined as time spent travelling between home and a working site other than the surgeon’s main place of work, after deducting the time normally spent travelling between home and the main place of work. Trusts and surgeons may need to agree arrangements for dealing with more complex working days. Travelling time between a surgeon’s main place of work and home or private practice premises will not be regarded as part of working time.

2. Supporting professional activities

SPA are essential for maintaining professional standards and supporting the development of surgical services. Although these activities may not involve direct patient contact, they play a critical role in ensuring the quality, safety and sustainability of healthcare delivery. They underpin not only governance and training, but also innovation, research and the long-term development of surgical and NHS services.

RCS England recommends that full-time surgeons should normally have a minimum allocation of 2.5 SPAs in their job plans. Data from the workforce census show that many surgeons are given a lot less than the recommended SPA time.

Reductions in SPA time may create short-term increases in apparent clinical capacity, but are likely to have negative consequences for training, governance, workforce development and long-term service quality. For this reason, SPA allocation should be restored to realistic levels. It should be protected in job planning arrangements as a core component of professional practice and not be viewed as discretionary or optional. Ensuring adequate SPA allocation

is particularly important in the context of increasing clinical complexity, evolving technologies and expanding regulatory requirements.

The SPA requirements of surgeons will vary depending on career stage, role and organisational responsibilities. Job planning should therefore adopt a flexible and individualised approach to SPA allocation, while maintaining an appropriate minimum baseline.

a. Core SPA activities (typically 1.5 SPA time)

i. Continuing professional development

Continuing professional development (CPD) is not limited to attendance at formal courses or conferences, but includes regular engagement with emerging clinical evidence, new technologies and evolving standards of care. In surgical practice, maintaining competence may also require participation in simulation training or upskilling in new techniques, including robotic surgery, where available.

The SPA allocation for CPD should therefore reflect both specialty-specific requirements and individual scope of practice. Surgeons working in rapidly evolving fields or adopting new technologies may require additional CPD time to maintain safe and effective practice.

ii. Appraisal and revalidation

Annual appraisal and the revalidation process require preparation, reflection and documentation, in addition to formal appraisal meetings.

Adequate SPA time should be allocated to ensure that appraisal is meaningful and not reduced to a purely administrative exercise. This includes time to review clinical outcomes, reflect on practice and identify learning needs.

iii. Audit, quality improvement and clinical governance

Audit and quality improvement activities extend beyond data collection and attendance at meetings. They include active participation in improvement cycles, implementation of changes and evaluation of outcomes.
SPA time should therefore recognise the full scope of these responsibilities, including:

- participation in local and national audit programmes;
- involvement in quality improvement initiatives;
- attendance at morbidity and mortality meetings;
- review of adverse incidents and patient complaints.

These activities require preparation, analysis and follow-up, in addition to formal meeting attendance. Without adequate SPA allocation, there is a risk that governance work is either undertaken outside contracted hours or not completed to the required standard, potentially impacting patient safety and organisational learning.

iv. Mandatory and statutory training

Mandatory and statutory training is a requirement for all clinical staff and includes training in areas such as safeguarding, infection prevention and control, information governance, resuscitation, and equality and diversity.

Although these activities may be perceived as routine, they require dedicated time for completion, particularly where training involves face-to-face sessions, simulation or assessment. In surgical practice, some mandatory training — such as resuscitation or human factors training — will also have direct relevance to clinical care and team performance.

Ensuring that this time is formally recognised in job plans can help avoid reliance on clinicians completing training outside contracted hours and supports compliance with organisational and regulatory standards.

b. Enhanced SPA allocation (typically an additional 1.0 or more SPA time)

In addition to core SPA requirements, surgeons undertake a range of professional activities that support the development of individuals, teams and services. The extent of these activities will vary depending on individual roles, career stage and organisational responsibilities. Job planning should adopt a flexible and individualised approach to allocating SPA time for these contributions.

i. Education, training and clinical supervision

The delivery of high-quality surgical training requires time for supervision, feedback and structured educational activity. This extends beyond direct supervision in theatre to include mentoring, career support and educational planning.

The SPA requirements for training will vary across the workforce:

- Consultant surgeons require protected time for educational supervision, training lists and trainee assessment.
- SAS surgeons and LEDs may increasingly contribute to supervision and teaching and should be supported with appropriate SPA allocation to do so.
- Resident doctors require protected time for educational development, which should be reflected in rota design and workforce planning, even if not formally expressed as SPA.

Recognising these differences is essential to ensure that training responsibilities are delivered effectively across the whole surgical team.

ii. Research

Research is fundamental to the advancement of surgical practice and the delivery of evidence-based care. Surgical innovation, improvements in patient outcomes and the adoption of new techniques and technologies all depend on sustained engagement with research activity across the surgical workforce.

Research activity may include participation in clinical trials, translational research, innovation projects, registry studies, academic collaborations and audit-related research. In many specialties, research-active departments also play an important role in attracting and retaining high-quality staff and supporting the delivery of high-quality training.

However, increasing service pressures can make it difficult for surgeons to maintain meaningful engagement with research activity, particularly where SPA time is reduced or prioritised primarily towards operational demands. Failure to protect research time risks undermining innovation, limiting academic career development and weakening the evidence base that underpins surgical care.

Where research forms part of a surgeon's role, SPA allocation should therefore reflect the time required for study design, governance processes, recruitment activity, data analysis and dissemination. Job planning processes should recognise that research contributes to not only academic development, but also service improvement, workforce sustainability and the long-term development of surgical practice.

3. Additional NHS responsibilities

a. Leadership, innovation and service development

Surgeons play a significant role in leadership, service redesign and the introduction of new techniques and new technologies. Such roles are key for responding effectively to system pressures, improving patient pathways and enhancing quality of care. They include roles such as clinical/medical director, and responsibilities such as rota management, quality/safety improvement, organisational governance, digital innovation, service planning and workforce management.

The time required for leadership and service development activities can vary significantly depending on individual roles. Surgeons with formal leadership responsibilities should have SPA allocations that reflect these duties, while broader participation in service improvement should also be recognised in job plans.

Furthermore, protecting time for research and innovation is important for not only academic development, but also maintaining high-quality surgical services and supporting the future evolution of surgical care.

4. External professional duties

Many surgeons contribute to the wider profession through roles in royal colleges, trade unions, surgical specialty associations and national advisory groups. These activities support the development of standards, training and policy across the surgical profession, and may involve examining for professional qualifications, contributing to national guidelines, independent Advisory Appointment Committee panel members, undertaking visits (e.g. Care Quality Commission) or participating in professional committees.

Where surgeons undertake such roles, job plans should recognise the time required for preparation, participation and follow-up. These contributions should not be assumed to be undertaken outside contracted hours but should be formally recognised in job plans because they provide important benefits to both the profession and local services.

5. Balancing the components of a job plan

A balanced job plan, developed collaboratively and reviewed regularly, supports high standards of patient care, workforce sustainability and the ongoing development of surgical services.

Although job plans are often expressed as a numerical distribution of programmed activities, their effective design requires careful consideration of how different elements interact. The balance between DCC, SPA and other responsibilities should reflect both service needs and the professional role of the surgeon.

Service pressures can drive an increased focus on DCC. Although this may appear to improve short-term productivity, reducing time for education, governance, research and service development may undermine the quality and sustainability of surgical services. Job planning should therefore maintain an appropriate balance between clinical and professional responsibilities.

Departments should also recognise that surgical productivity depends on not only operating capacity, but also the effective functioning of the wider system, including coordination with anaesthetic teams, theatre staff and administrative processes. Job plans that do not account for these interdependencies may underestimate the time required to deliver care.

Surgical job plans should therefore be viewed as part of a broader process of workforce and service planning, rather than simply a contractual arrangement between an individual surgeon and their employer.

A full-time role is not capped at 10 Professional Activities (PA) but may require 12–14 PA depending on various factors. These job plans must be revisited annually, if not more frequently, to ensure support for health and wellbeing.

Importantly, job planning for surgeons working less than full-time should not rely solely on simple pro rata reductions across all activities. Certain core elements of practice, such as maintaining sufficient clinical exposure to sustain competence, and undertaking appraisal and revalidation, require a minimum time commitment regardless of overall working pattern. Job plans should therefore be adjusted thoughtfully to ensure that reduced hours do not compromise clinical skills, professional standards or patient safety.

E. Key considerations for the effective implementation of the surgical job plan

Although the structure of a job plan provides the framework for allocating professional time, the effectiveness of surgical job planning ultimately depends on how these plans are implemented in departments and organisations. Implementation requires careful consideration of team structures, workforce development, governance obligations and the practical realities of delivering surgical care in complex healthcare systems. The following considerations highlight key factors that can support the successful implementation of surgical job plans.

1. Job planning for different delivery settings

Surgical services are delivered in a variety of organisational models across the NHS. These may include district general hospitals, tertiary referral centres, surgical hubs and collaborative networks that share specialist services across multiple sites.

The design of surgical job plans should therefore reflect the specific service delivery model within which surgeons are working.

For example, surgeons working in major specialist centres may have a higher proportion of complex elective work, multidisciplinary decision making and tertiary referrals. Their job plans may therefore require greater allocation of time for MDT meetings, case planning and complex outpatient consultations.

By contrast, surgeons working in district general hospitals may have a larger emergency workload and greater involvement in general surgical admissions. Their job plans may therefore include more frequent on-call commitments and ward-based clinical activity.

The development of surgical hubs has introduced additional complexity into job planning. In many regions, elective surgery is increasingly delivered in dedicated facilities designed to protect operating capacity from emergency pressures. Although these hubs can improve productivity, they may also require surgeons to work across multiple sites.

Job plans should therefore consider the practical implications of multisite working, including travel time, coordination of operating lists and continuity of patient care.

Similarly, the increasing use of the independent sector to support NHS elective activity may require surgeons to undertake operating sessions in facilities outside their primary hospital. In such cases, job plans should clearly recognise the time required for these activities and ensure that training opportunities are preserved where appropriate.

2. Aligning job plans with service needs and patient demand

One of the most important considerations in implementing surgical job plans is ensuring that individual plans are aligned with the broader needs of the surgical service.

Surgical departments operate in complex healthcare systems that must respond to fluctuating levels of patient demand. Waiting lists for surgical procedures, emergency admissions and diagnostic capacity can vary significantly over time. Job plans must therefore be sufficiently responsive to these changing circumstances.

When job plans are developed in isolation from service needs, there is a risk that they may not reflect the actual workload required to deliver patient care. For example, a job plan that allocates a fixed number of outpatient clinics or operating sessions without considering current demand may either underutilise available capacity or place unrealistic expectations on clinicians.

Departments should therefore approach job planning as part of a broader process of service-level activity planning. This may involve analysing data such as waiting list volumes, theatre utilisation rates, outpatient activity and emergency workload to understand how surgical services are currently functioning.

Using this information, departments can ensure that job plans are designed to meet patient demand while maintaining safe and sustainable working patterns.

In some cases, aligning job plans with service needs may require changes to existing working arrangements. For example, if demand for elective surgery increases significantly, departments may need to review how theatre sessions are distributed across surgical teams. Similarly, if emergency workload rises, adjustments to on-call rotas may be necessary.

Weekend working is also becoming an increasingly common feature of surgical services. Although consultants are not contractually required to undertake routine weekend activity, where such arrangements are agreed, services should ensure that they are appropriately supported. This includes access to the full MDT, availability of senior advice where required, and ensuring that casemix is aligned with available staffing and infrastructure. Weekend operating should not take place in isolation from the systems and support that underpin safe surgical care during the working week.

Transparent communication between clinicians and managers is essential when making these decisions. Surgeons should have opportunities to contribute their expertise to discussions about how services are organised and how job plans should evolve in response to changing demand.

3. Maintaining operative competence

Maintaining operative competence is a fundamental requirement for surgical practice. Surgeons must undertake a sufficient volume of procedures to maintain their technical skills and ensure that they remain familiar with current surgical techniques.

Job planning therefore must ensure that surgeons have adequate access to operative activity.

Where operating lists are limited, departments may need to consider how operative opportunities are distributed across surgical teams. Transparent allocation of theatre sessions can help ensure that surgeons maintain their competence while also supporting training for resident doctors.

In some specialties, surgeons may have highly specialised practices with relatively low case volumes. In these situations, regional collaboration between hospitals may be required to ensure that surgeons maintain adequate procedural exposure.

Job planning should also recognise that maintaining competence involves more than performing procedures. Surgeons must also remain up to date with developments in surgical techniques, technology and clinical evidence. Time for professional development activities such as attending courses or participating in simulation training may therefore be necessary.

4. Supporting multidisciplinary working

Modern surgical care increasingly relies on multidisciplinary collaboration. Complex cases are often discussed in MDT meetings involving surgeons, radiologists, pathologists, oncologists and other specialists.

MDT discussions play a crucial role in determining appropriate treatment pathways and ensuring that patients receive coordinated care.

Participation in these meetings requires preparation time, including reviewing imaging, pathology reports and patient records. MDT meetings themselves can also be time-intensive, particularly in specialties in which large numbers of cases are reviewed.

Job plans should therefore include appropriate recognition of MDT participation in DCC allocations.

In addition to formal MDT meetings, surgeons frequently collaborate with colleagues in other specialties when managing complex patients. For example, perioperative management of patients with significant comorbidities may require consultation with physicians, anaesthetists or critical care specialists.

These collaborative activities are an integral part of patient care and should be recognised in job plans.

5. Recognising the full scope of surgical practice

Historically, surgical job plans have often been centred on operating lists and outpatient clinics. However, the scope of surgical practice has expanded significantly.

Surgeons now play an important role in areas such as service design, digital transformation and clinical leadership. Many surgeons contribute to initiatives aimed at improving patient pathways, reducing waiting times or introducing new technologies.

These activities are essential for the development of modern surgical services. However, they require time and expertise.

Job plans should therefore recognise the broader contributions that surgeons make to healthcare systems. Allocating time for service improvement and innovation enables surgical departments to adapt to changing patient needs and technological developments.

Similarly, surgeons often contribute to regional or national initiatives aimed at improving surgical quality. Participation in programmes such as national clinical audits, quality improvement collaboratives and guideline development can help drive improvements in patient care.

These contributions should be recognised within SPA where appropriate.

6. Transparency and collaboration in job planning

Successful job planning depends on open and collaborative discussions between clinicians and managers. Job plans should be developed through a transparent process that allows both parties to understand the rationale behind workload expectations and service requirements.

Departments should ensure that job planning discussions take into account:

- the needs of the service
- the professional responsibilities of surgeons
- training requirements for resident doctors
- workforce wellbeing and sustainability

Where disagreements arise regarding workload expectations or PA allocation, it may be helpful to review objective evidence such as theatre utilisation data, clinic activity levels or waiting list performance.

Using evidence-based approaches to job planning can help ensure that decisions are fair and transparent.

Job planning discussions should be conducted collaboratively and in good faith, with the aim of reaching a mutually agreed outcome that reflects both service requirements and professional responsibilities. In many cases, concerns can be resolved through constructive discussion between the surgeon, clinical leads and management teams, supported by transparent use of workload and activity data.

Where agreement cannot be reached, organisations should ensure that the formal mediation and appeal processes set out in the relevant national consultant contract and associated guidance are followed. In England, these processes are described in Schedule 4 of the NHS Consultant Contract. Equivalent arrangements exist within the devolved nations.

Surgeons should be made aware of their rights within these processes and given the opportunity to present concerns relating to workload, patient safety, training, professional responsibilities or service sustainability. Surgeons experiencing difficulties in job planning discussions should be encouraged to seek advice and representation from appropriate professional or recognised trade union bodies, such as the British Medical Association or Hospital Consultants and Specialists Association, where relevant.

7. Periodic review and adaptation

Surgical services operate in a dynamic environment. Changes in workforce availability, patient demand or organisational priorities may require adjustments to job plans over time.

For this reason, job plans should not be viewed as static documents. Regular review allows departments to ensure that job plans remain aligned with service requirements and professional responsibilities.

Annual appraisal provides an opportunity to review the effectiveness of job plans and consider whether adjustments are necessary. However, mid-cycle reviews may also be required when significant service changes occur.

Reviews should be informed by objective evidence wherever possible. Relevant data sources include:

- theatre utilisation rates
- outpatient activity levels
- waiting list metrics
- administrative workload records
- training delivery logs
- documentation of SPA
- workforce forecasts including recruitment of additional surgeons, anticipated retirements, recruitment delays or other staffing shortages

Trusts should aim to establish clear triggers for mid-cycle job plan reviews. These may include significant service changes, such as significant increases in emergency workload, staffing shortages, rota redesign and the introduction of new clinical services.

8. Team-based workload planning, underpinned by an understanding of service-level activity

Surgical services are delivered by teams rather than individual clinicians, and job planning should therefore take a whole-team perspective when considering workload and responsibilities. Effective job planning requires a shared understanding of the total workload (service-level activity) within a specialty, including theatre sessions, outpatient clinics, emergency cover, teaching responsibilities, governance activities and administrative tasks.

Departments should periodically review the overall distribution of work across the surgical team to ensure that responsibilities are allocated equitably and that service demands are met. This includes determining how duties such as consultant-of-the-week arrangements, trauma cover, emergency operating responsibilities and subspecialty elective activity are distributed among consultants.

It is also important to recognise that surgical services depend on close coordination with other clinical and operational teams. The productivity of surgical departments is influenced by factors such as anaesthetic staffing, theatre availability, access to diagnostics and the capacity of critical care services. Job planning discussions should therefore consider these interdependencies and ensure that surgical activity is aligned with the wider organisational context.

Ensuring that surgeons have sufficient clinical exposure to maintain competencies in their subspecialty areas is another important consideration. Job plans should provide adequate opportunities for surgeons to undertake the procedures necessary to maintain and develop their technical skills.

Prospective cover arrangements should also be considered carefully during job planning discussions. When surgeons provide cover for colleagues during periods of leave, this may increase workload and should be reflected appropriately in programmed activity allocations.

Evidence from the workforce census has highlighted concerns that surgical teams do not always function optimally where roles are unclear or workloads are unevenly distributed. Departments should therefore undertake periodic whole-team reviews of clinical activity, including clinic commitments, theatre capacity, emergency workload and administrative responsibilities.

Shared rota design can also support more effective service delivery. Involving the wider team in rota planning may help ensure that training opportunities are preserved while maintaining safe service provision. In some settings, resident-led rota planning has been shown to improve access to theatre time for trainees by protecting opportunities for supervised operating. However, such approaches require continued engagement from trainers, ongoing monitoring of operative numbers and appropriate organisational support.

Departments may also benefit from adopting longer-term workforce planning approaches. Annualised modelling of team capacity can help anticipate future workforce changes, such as consultant retirements, and support the planning

of service models such as consultant-of-the-week arrangements. These approaches may also help balance elective and emergency capacity across the surgical service.

9. Career-stage-sensitive and specialty-specific job planning

Job planning for different career stages

The responsibilities and professional priorities of surgeons evolve throughout their careers. Job planning processes should therefore be flexible enough to recognise the different needs and contributions of surgeons at various career stages. The different career stages described below are fluid and the needs of each surgeon should be considered flexibly for their individual circumstances.

Early-career consultants, who are in the initial years following completion of specialty training, may benefit from job plans that provide additional opportunities for supervised operating and professional development. Access to mentorship from experienced colleagues can support the transition from training to independent clinical practice and help early-career surgeons develop confidence in their clinical decision making.

Mid-career consultants often carry the greatest clinical workload in surgical departments while also assuming increasing responsibilities in leadership, education and service development. During this stage of a surgical career, job plans should ensure that sufficient time is available for activities such as supervising trainees, contributing to governance processes and participating in service improvement initiatives.

Senior consultants bring valuable experience that can contribute significantly to the development of surgical services. As surgeons progress towards the later stages of their careers, job plans may evolve to place greater emphasis on mentorship, teaching, governance and strategic leadership roles. In some cases, it may be appropriate to reduce physically demanding responsibilities such as frequent on-call duties.

Flexible approaches to late-career working may support workforce sustainability. Options such as phased retirement, retire-and-return arrangements or modified job plans that emphasise day-case surgery, outpatient work or educational responsibilities can allow experienced surgeons to continue contributing to surgical services while reducing workload pressures.

Recognising career-stage differences in this way can help support professional development, retain experienced clinicians in the workforce and reduce the risk of burnout across the lifespan of a surgical career.

Specialty-specific job planning

The structure and demands of surgical work differ considerably across specialties. These differences influence how time should be allocated across DCC and SPA. More specifically:

- Operative practice varies widely. Some specialties involve long, complex procedures (e.g. major cancer surgery), whereas others may involve shorter, high-volume or day-case activity. This affects theatre scheduling, recovery time and operative frequency.
- Outpatient workload and complexity differ. Certain specialties require longer consultations because of complex decision making, shared decision making discussions or longitudinal care, whereas others may involve higher-volume, protocol-driven clinics.
- Emergency workload is unevenly distributed. Specialties such as general surgery or trauma have significant emergency commitments, whereas others are predominantly elective. This has implications for on-call intensity and disruption to planned activity.
- Multidisciplinary working requirements vary. Some specialties require frequent, time-intensive MDT meetings (e.g. oncology), including preparation and case review.
- Technology and infrastructure needs differ. Access to equipment such as robotics, imaging or specialised theatres varies by specialty and influences how services are organised.
- Training and supervision demands are not uniform. The intensity and structure of training differ between specialties, particularly where procedures are complex or infrequently performed.

10. Surgical training, supervision and workforce development

Job plans should include protected time for training and supervision activities. These may include supervising trainees in theatre, conducting teaching sessions, completing workplace-based assessments and providing structured

feedback during training reviews or Annual Review of Competence Progression processes.

Workforce expansion in recent years has led to an increase in the number of resident doctors in surgical training programmes. At the same time, advances in surgical techniques and increasing patient complexity mean that supervision requirements may be greater than in the past. Job planning should therefore recognise the time required for safe and effective supervision, particularly in complex surgical procedures.

Dedicated training lists may help ensure that trainees gain sufficient operative exposure. These lists allow additional time for supervision and teaching during procedures and can support the development of technical skills.

Training opportunities should also be protected when surgical activity takes place outside the traditional hospital setting. Increasingly, surgical procedures are undertaken in surgical hubs or in the independent sector. Where this occurs, departments should ensure that trainees are able to accompany consultants to these facilities so that training opportunities are not inadvertently reduced.

Similarly, organisations should consider policies that mitigate any potential impact of insourcing arrangements on surgical training. Training placements should continue to meet the quality standards set by the Joint Committee on Surgical Training.

Access to training activities should also be individualised, and explicitly aligned with the specific requirements of each trainee, rather than relying on ad hoc access to clinical activity. Each training placement should be underpinned by a clear educational plan that sets out the competencies, procedural experience and capabilities expected to be achieved during the attachment, in line with curriculum requirements.

At the start of a placement, consultants and trainees should work collaboratively to develop an individualised training plan. This should identify the operating lists, clinics, on-call activities and other clinical exposures most relevant to the trainee's stage of training and learning needs. It should also clarify which consultants or teams are best placed to support specific aspects of training.

Where possible, rota and job planning arrangements should support this individualised approach by enabling trainees to attend the clinical activities most relevant to their development. Moving beyond generic rota allocation towards more tailored scheduling can help ensure that training requirements are met in a consistent and structured way.

Embedding this approach within job planning can support more effective training delivery, improve progression through training and ensure that service pressures do not inadvertently limit the ability of trainees to achieve required competencies.

Job planning should also support the professional development of SAS surgeons and LEDs by providing structured access to supervised training opportunities and clearly defined educational objectives.

Finally, experienced consultants can play an important role in mentoring newly appointed consultants, as well as SAS surgeons and LEDs. Formalising mentorship arrangements within job planning may help support early-career surgeons and strengthen professional development across the surgical workforce.

11. Governance, quality and safety

Clinical governance activities should be recognised explicitly in job plans. These activities ensure that surgical services maintain high standards of quality and continuously improve patient outcomes.

Governance responsibilities may include participation in morbidity and mortality meetings, clinical audit programmes and quality improvement initiatives. Surgeons may also be required to participate in incident investigations, respond to patient complaints or contribute to coroner's inquests and medicolegal processes.

The time required to fulfil these responsibilities has increased in recent years as regulatory expectations and medicolegal obligations have expanded. Job plans should therefore allocate sufficient time for governance activities to ensure that they can be undertaken effectively.

Departments should also consider how job planning aligns with national quality initiatives, such as the Getting It Right First Time programme, national surgical quality improvement initiatives and emerging standards in perioperative care.

12. Administrative support, theatre efficiency and digital workflows

Administrative overload has been identified as a major barrier to productivity in surgical services. Modern surgical practice requires clinicians to interact extensively with digital systems, including electronic patient records, electronic consent processes and referral triage platforms.

Job plans should explicitly recognise the time required for these activities. Failure to account for administrative workload can result in clinicians undertaking these tasks outside contracted hours, contributing to workload pressures and reduced job satisfaction.

Healthcare organisations also have an important role in ensuring that surgeons are supported by appropriate administrative and operational infrastructure. This includes providing adequate administrative staff, theatre scheduling systems, access to utilisation data and efficient preoperative assessment pathways.

Where possible, organisations should seek to ensure that consultants are not required to perform tasks that could be undertaken by administrative or junior clinical staff. Appropriate delegation can improve efficiency and allow surgeons to focus on activities that require specialist expertise.

13. Wellbeing, culture and safe working

The wellbeing of the surgical workforce is an important consideration in job planning. Surveys of the surgical workforce have highlighted burnout as a significant challenge affecting many clinicians.

Job plans should therefore support safe and sustainable working patterns. This may include ensuring that surgeons are able to take their full annual leave entitlement, providing adequate rest periods following on-call duties and allowing time for reflective practice and professional development.

Departments should also ensure that workplace culture supports professional wellbeing. Clear processes for addressing bullying, harassment or workplace conflict are essential for maintaining healthy professional environments.

By incorporating wellbeing considerations into job planning discussions, organisations can help create working environments that support both workforce sustainability and high-quality patient care.

The Royal College of Surgeons of England

The College welcomes feedback from surgeons and surgical teams on the practical implementation of this guidance, including areas where challenges or barriers are encountered in local practice. This feedback will help inform future development of the guidance and broader work on surgical workforce and service planning. Comments can be sent to psd@rcseng.ac.uk.

Useful resources

- British Medical Association (2023) An overview of job planning. https://www.bma.org.uk/pay-and-contracts/job-planning/job-planning-process/an-overview-of-job-planning
- NHS Employers (2003) Consultant contract. https://www.nhsemployers.org/publications/consultant-contract-2003
- NHS Employers/British Medical Association (2011) A guide to consultant job planning. https://www.nhsemployers.org/publications/consultant-contract-2003
- NHS England (2025) Medical job planning improvement guide. https://www.england.nhs.uk/long-read/medical-consultant-job-planning/
- Royal College of Surgeons of England (2024) Guidance on the requirements for a new consultant post. https://www.rcseng.ac.uk/-/media/Files/RCS/Standards-and-research/Support-for-surgeons/Consultant-Job-Planning-Guidance-and-Checklist-REVISED-v10.pdf
- Surgical Specialty Associations. Guidance produced by individual associations on job planning, including:
  - British Association of Plastic Reconstructive and Aesthetic Surgeons (2023) A guide to job planning for plastic surgeons. https://www.bapras.org.uk/docs/default-source/default-document-library/bapras-job-planning-for-plastic-surgery-consultants-agreed-by-council-281123.pdf