

Making hidden work visible

Why work becomes invisible

Daniel's clinic finishes at five. The activity report records the appointments attended, the patients who did not attend and the next available slots. On that account, the afternoon has ended. Daniel leaves the hospital, eats with his family and later spends ninety minutes checking investigations, completing correspondence and resolving two medication queries. None of this surprises him. He has worked like this for years. What surprises him is the assertion, during a review of clinic capacity, that there is unused time immediately after the last booked appointment.

Daniel is the composite experienced Specialty Doctor introduced earlier. For this example he works in England on the 2021 Specialty Doctor contract. His problem is not established by the fact that he works at home, nor solved by calling everything overtime. The first question is what necessary work the clinic generates, how much of it is already provided for and what remains outside that provision. Location and timing are evidence about delivery. They do not, by themselves, establish the correct contractual allocation.

Work becomes invisible when the organisation measures an encounter but not its completion. The clinic is a convenient counting unit; the result reviewed three days later is less convenient. A procedure appears in a theatre system; preparing a patient whose procedure is subsequently cancelled may disappear from the performance report. A service records the meeting but overlooks the decisions prepared beforehand and implemented afterwards. The measurement system may be behaving exactly as designed. Its limitation emerges when the resulting activity count is treated as a complete description of professional work.

Professional habits can reinforce the omission. An experienced doctor may answer queries quickly, coordinate colleagues without a formal meeting or prevent a problem before anyone records an incident. Competence makes work look effortless. Loyalty then makes it difficult to say that the arrangement needs changing. The doctor worries that documenting minutes will appear ungenerous. The manager sees a service that has continued to function and reasonably asks what has changed. Both need a record that explains how the service functions, including the personal time on which its apparent efficiency depends in its usual daily use.

Role growth produces another form of invisibility. A request to advise on one difficult referral becomes a daily referral service. Temporary responsibility for teaching becomes an annual programme. An absent colleague's task remains with the person who covered it because nobody explicitly transfers it back. No single addition seems large enough to trigger a new job plan. Taken together, they can consume the space previously available for development, reflection or recovery. The important comparison is between the agreed role and the present work, not between this week and last week alone.

The purpose of measurement is therefore to reconstruct the work faithfully. It should show useful activity, duplication, waiting, avoidable friction and genuinely uncertain demand. Some findings will support additional time. Others will support fewer appointments, different staffing, better systems or removal of tasks that add little value. An honest diary can reveal that a familiar arrangement is inefficient as well as under-resourced. That possibility strengthens its credibility. A record designed only to prove a predetermined claim is less useful to either party and harder to verify independently.

Start with a limited question: what work is missing from the present description, and what decision would better evidence enable? Daniel does not need to monitor every minute of his career. He needs a representative account of the clinical work generated by his clinics, a comparison with existing provision and an achievable proposal for closing the gap.

Working fewer contracted sessions does not remove the need for this analysis. A less-than-full-time doctor may still have fixed commitments, such as a required meeting or preparation for appraisal, that do not reduce neatly in proportion to clinical sessions. Conversely, some activity will reduce with the number of clinics delivered. Separate fixed, variable and occasional work before comparing colleagues. A smaller contract should not be treated as a compressed full-time job, and a proportional calculation should not replace examination of the actual duties.

Clinical administration

The phrase clinical administration can make skilled clinical work sound like clerical overhead. Reviewing an abnormal result requires interpretation, context and a decision. A referral may need prioritisation or clarification. A prescription query can require reconciliation across several records. A letter communicates a clinical conclusion and distributes responsibilities. These tasks are part of delivering care even when no patient is physically present. GMC standards require appropriate records and effective continuity of care;

the work needed to meet those responsibilities must be considered when a service is designed.^[3]

Begin by separating tasks that require a doctor's judgement from tasks that could be completed by appropriately trained administrative or clinical colleagues. The distinction is practical rather than hierarchical. Copying an appointment date into a letter is different from deciding how urgently a patient needs review. A well-designed pathway may allow another professional to undertake some clinical decisions within their competence and agreed responsibilities. That does not mean a manager can assume the task has disappeared. The proposed recipient needs time, training, access and a clear route for uncertainty.

For Daniel, the first sample covers four weeks in which he undertakes eight comparable clinics. He records the time spent preparing records, seeing patients and completing clinical work afterwards. Within the follow-up category he distinguishes correspondence, results, referrals, prescribing and patient or professional advice. He does not copy patient names into the diary. A short description such as results review and action is enough. If corroboration is needed, aggregate task counts can be obtained through the employer's authorised system rather than creating a private parallel clinical database.

The follow-up periods after his eight clinics are sixty, seventy-five, ninety, one hundred and five, eighty, one hundred, ninety-five and one hundred and fifteen minutes. Their total is seven hundred and twenty minutes: twelve hours, or an average of ninety minutes per clinic. The spread matters. The evidence does not say that every clinic requires exactly ninety minutes. It says that these eight clinics generated a mean of ninety minutes, with observed values between one hour and nearly two hours. The team should examine whether the sample reflects the expected case mix.

Suppose the current plan already provides thirty minutes per clinic for this work. The sampled difference is then sixty minutes per clinic, not ninety. Across eight clinics the unprovided component is eight hours. This subtraction is essential. A proposal that claims all twelve hours as additional would double count four hours already recognised. Equally, an assertion that the existing thirty minutes must be sufficient because it appears in the job plan would confuse the agreement with evidence of present demand. Both figures belong in the discussion.

Count activity at the level that answers the question. A hundred electronic messages do not necessarily represent a hundred decisions. Several may relate to one issue; one message may require a lengthy review. Record a manageable combination of task volume and time. If the system generates

avoidable duplication, distinguish that from necessary clinical work. The current service still has to deal safely with duplicated messages, but the proposed remedy may be to repair routing rather than permanently fund the duplication.

Preparation and delayed follow-up also need a boundary. A result reviewed this week may arise from a clinic several weeks earlier. Assigning every minute to a specific clinic is often unnecessary. A rolling sample can measure the total weekly burden against the normal clinic programme, provided the opening and closing backlog are recorded. Otherwise a week spent clearing old work may look like ordinary demand, while a week in which work accumulates may falsely look efficient. A short backlog measure helps interpret the time record in that short sample.

Quality must remain visible alongside speed. Finishing correspondence rapidly is not a success if actions remain ambiguous or responsibility for results is uncertain. Daniel can sample whether letters were completed within the service's agreed timescale and whether required follow-up was allocated. He should not invent a national turnaround standard. The relevant measure may be a local pathway requirement or a clinically justified target agreed by the team. Explain what the measure means and who agreed it before using it to support a capacity decision.

The resulting proposal can be specific: protect a further hour of clinical follow-up for each comparable clinic during a defined trial, reduce the appointment template correspondingly if total contracted time remains unchanged, and review completion times and backlog after the trial. Another option is to redesign the workflow and measure again. Neither option assumes that Daniel should simply become faster. Both make the hidden task a visible part of the service that generates it.

Include the practical conditions for remote completion if that remains part of the agreed arrangement. Daniel needs authorised access, an appropriate device, a private place to work and clarity about when messages are expected to be answered. Working from home should be an agreed method of delivering a defined commitment, rather than an unspoken overflow mechanism. If technical access repeatedly fails, record that lost working time separately from clinical judgement. The remedy may be reliable access or protected on-site provision, not an expectation that the doctor repeatedly attempts the task during personal time.

Unpredictable and interrupted work

Some work cannot be scheduled as individual appointments, but unpredictability is not the same as immeasurability. A doctor may not know

when an urgent review will be requested, yet the service may reliably generate several such requests each day. The useful distinction is between uncertainty about the timing of an event and uncertainty about its overall volume. A job plan can make provision for a recurring category of unpredictable demand without pretending to forecast every call.

Interruptions need particular care because a simple elapsed-time diary can mislead. Daniel may spend forty minutes on correspondence between two and three, with twenty minutes diverted to urgent advice. Recording an hour of correspondence and twenty minutes of advice would claim eighty minutes within a sixty-minute period. Instead, record the primary activity and the interruption separately, with a total that reconciles to the actual hour. If he must repeat work because his concentration was broken, record the observable repeated task rather than adding an arbitrary recovery multiplier.

Not every interruption is unwelcome. Timely advice may prevent an unnecessary admission or support a colleague working within a supervised role. The question is whether that function has a place in the service model. A referral-advice role distributed informally through personal familiarity can become concentrated on one approachable doctor. Colleagues may be unaware of its total volume. Counting the category allows a discussion about a designated advice session, rota or shared inbox, including who covers it when the usual doctor is unavailable.

Use representative sampling agreed before the outcome is known. A four-week sample may be adequate for a regular clinic programme but inadequate for an infrequent on-call rota or seasonal service. Record why the period was chosen and what it excludes. A week with a vacancy, unusual outbreak or major system failure should not be deleted simply because it is exceptional. Label it and show both the ordinary pattern and the exceptional burden. Managers need to know whether the proposed plan addresses routine delivery, foreseeable peaks or temporary disruption.

For brief advice, a tally in broad time bands can be more sustainable than timing each conversation. The bands are an approximation, so report them as such. For longer episodes, start and finish times may be realistic. A count of twelve brief calls, three intermediate reviews and one prolonged escalation is more informative than a retrospective statement that the afternoon was constantly interrupted. It also invites examination of which requests needed Daniel specifically and which could safely have followed another pathway.

Record displaced work as well as interruption time. If an urgent review consumes a planned teaching session, the teaching has not been delivered merely because the doctor remained busy. The diary should show which

activity took place and which agreed commitment was deferred. This is particularly important when progression objectives later depend on the cancelled work. The same hour cannot simultaneously satisfy an urgent clinical commitment and an educational objective requiring undivided preparation. A service that routinely substitutes one for the other needs to revise its expectations.

Do not convert a workload diary into an incident log. Immediate concerns about deteriorating patients, unsafe staffing or failed escalation require the clinical and organisational response appropriate at the time. The later diary can record a non-identifying category and the existence of a separate incident report. It should not become the only place a safety concern is documented. GMC guidance requires doctors to respond when safety is compromised; assembling evidence for next month's job-planning meeting is not a substitute for action today.^[37]

When presenting variable demand, show a central estimate and a practical range. Explain the consequence of providing only the average when several urgent tasks arrive together. A buffer might require protected flexibility, access to another clinician or a threshold for reducing routine activity. It should not be a vague request for unlimited spare time. The strongest proposal identifies what the service will do when demand exceeds the planned allowance, who decides and how deferred work will be recovered.

This approach makes uncertainty discussable. It does not eliminate pressure, but it prevents unpredictable work from being treated as work that somehow requires no capacity.

There is also work that never starts because another demand displaces it. A diary of completed tasks alone can understate this problem. Alongside time, record a small number of outstanding commitments and why they remain outstanding. Avoid listing every aspiration. Concentrate on agreed work with a real deadline or consequence: an overdue review, a cancelled supervision meeting or a report needed for a service decision. This allows the discussion to distinguish productive flexibility from persistent failure to provide capacity for an agreed function.

Travel and cross site responsibility

A timetable can contain two apparently compatible commitments that cannot both be reached on time. A clinic ends at one site at noon and a meeting begins at another at noon. The problem is visible once the journey is included, but frequently the schedule records destinations without the transition between them. Cross-site work must be considered as an actual

sequence undertaken by a person, including handover, departure, travel, parking, access and preparation for the next duty.

First distinguish ordinary commuting from travel required in the course of work. The relevant contract, designated base arrangements and employer travel policy determine the treatment of time and expenses. A change of base, travel between employers and a journey from home to an emergency call-out can raise different questions. Do not assume that reimbursement of mileage settles whether time is recognised, or that recognition of time establishes entitlement to a particular expense. Keep the two questions separate and seek a written answer where the arrangement is unclear.

For a worked planning example, suppose Daniel is required to move between two hospital sites during a normal working day. The expected road journey is twenty-five minutes, and leaving one clinical area and reaching the next reliably adds fifteen minutes. The transition therefore needs about forty minutes in the operational timetable. This is an illustrative measurement, not a national travel allowance. If the timetable contains only the road journey, it still asks him to perform an impossible transition. If congestion frequently changes the journey, the range belongs in the evidence.

Remote attendance can reduce travel but should be tested against the task. A governance meeting may work well online. A clinical review requiring examination cannot be replaced merely because the video link is convenient. An educational discussion may be remote while a trainee's observed procedure requires presence. The decision should ask what the activity requires, not assume that all cross-site work can be compressed into telephone availability. Reliable technology, appropriate privacy and access to records are part of the proposed arrangement.

Travel time should not automatically be filled with another duty. A doctor driving between hospitals cannot also be treated as fully available to conduct complex clinical consultations. Even as a passenger, a confidential discussion may be inappropriate or the connection unreliable. If a manager proposes remote work during travel, test whether the conditions allow safe, effective performance. The fact that some calls have previously been taken on the move is evidence of a coping arrangement, not proof that it is a sound service design.

Cross-site responsibility also extends beyond journeys. A doctor may be asked to maintain clinical oversight of two units while physically present in one. Record the agreed response expectations, the local staff available, the route for urgent help and the work generated by remote oversight. A nominal forty-minute journey does not establish that a doctor can leave a clinic

immediately, arrive at the other site and meet every urgent need. Capacity and availability must be examined together. Chapter 9 develops the safety implications when expected cover exceeds those arrangements.

A practical improvement may involve clustering duties by site, changing meeting times, creating a local first-response arrangement or sharing cross-site work. It may also require fewer simultaneous responsibilities. Present the proposed sequence as a realistic day, with transition time shown explicitly. Where a new service spans organisations, identify who authorises travel and who owns the resulting work. The aim is a timetable that can be delivered safely in the world as it is, with the contract and expenses arrangements documented alongside it.

Teaching governance and leadership

Teaching is often measured by the hour in which learners are in the room. That hour may depend on reviewing material, adapting examples, arranging cases, preparing accessible resources and providing feedback afterwards. The amount varies with the task. Repeating a familiar tutorial differs from creating a new course. Rather than applying a universal preparation ratio, describe the programme, the audience and the work needed to deliver it to the agreed standard. A sample of actual preparation can support a more credible estimate.

The BMA's SAS guidance recognises a broad range of supporting activities, including development, teaching, audit, appraisal preparation and service-management contributions. Its examples help identify omitted work; they should not be read as a guarantee that every doctor receives the same allocation for every activity. The agreed duties, relevant national terms and task requirements remain the basis for the individual plan.^[36] A minimum allocation for professional maintenance should not silently become the assumed resource for an expanding portfolio of additional roles.

Clinical supervision during patient care and a formal educational-supervisor role need separate descriptions. Advice delivered while reviewing a patient may be part of the clinical encounter. Scheduled progress meetings, reports, assessment review and liaison about a learner's difficulties generate additional work. Do not count the same clinical hour twice, but do not treat the supervisor title as cost-free. Specify the number and type of learners, the required outputs and the arrangements when someone needs more support than the normal allocation allows.

Governance work has a similar sequence. A meeting may require reading incident themes, checking a pathway, discussing evidence with colleagues, drafting an action and reviewing whether it was implemented. Attendance

alone gives little indication of the contribution. A doctor who takes responsibility for an action should identify what completing it entails and whether authority, data and administrative support exist. Otherwise a meeting minute can create an obligation without creating the conditions for its delivery.

Consider a further composite, Leena, a Specialist in an English service. She is asked to lead a quarterly review of prescribing quality and deliver a teaching programme in response. The timetable shows four one-hour meetings a year. Her proposed ledger adds the actual work categories: defining the question, reviewing authorised aggregate data, discussing findings, preparing teaching and checking subsequent performance. She does not claim sole credit for the team's improvement. She identifies her own contribution and the support needed from pharmacy, administration and clinical colleagues.

The right discussion is then about the function, not whether four meetings deserve an arbitrary number of PAs. Could data preparation be undertaken by an analyst? Can existing teaching be adapted? Who implements changes? Which parts require Leena's clinical judgement? The resource estimate may fall when tasks are distributed sensibly, or rise when previously omitted responsibilities become clear. Either outcome is preferable to a title that allows everyone to assume someone else is doing the work.

Leadership includes work between formal meetings: resolving rota problems, preparing recruitment, coordinating a service change, reviewing risks and explaining decisions. Record purpose and output rather than every email. A series of short conversations might belong to one recruitment episode or one service-design decision. This grouping makes the account readable and avoids portraying ordinary collegial contact as a separate paid event each time. The unit of analysis is the responsibility being discharged, supported by a reasonable estimate of its demands.

Time and authority should be tested together. Allocating a session to a lead role will not solve the problem if the doctor cannot access the necessary information or obtain decisions from those responsible. Conversely, granting a title or committee seat does not provide time to perform the function. A role description should identify its boundaries, expected outputs, escalation route and review point. If additional work is accepted temporarily, record how it will end, transfer or become part of a revised agreement.

This evidence also improves succession. A successor should inherit a described role, not discover its true demands through evenings spent

catching up. A realistic account respects the work already undertaken and makes it possible for someone else to perform it sustainably.

Annual programmes need particular attention because their workload is uneven. Recruitment may involve intense shortlisting and interviews during one month, followed by little activity in another. A course may require substantial redevelopment before its first delivery and less work when repeated. Record these patterns as annual commitments with delivery windows. A weekly average can support the overall allocation, but the timetable still needs room for the period when the work actually occurs. An average alone cannot put a doctor in two meetings at once.

On call work and recovery

An on-call rota describes when a doctor is available. It does not, on its own, measure the work performed during that availability or the effect on the following day. Frequency, intensity, predictable duties and actual unpredictable activity need separate accounts. A one-in-eight rota can be more demanding than another one-in-six rota if the former covers a larger or less supported service. Comparing the ratios alone answers only part of the question.

BMA guidance distinguishes the availability supplement from the programmed activity needed for work arising on call. It recommends an agreed reference period that captures telephone work, associated records and necessary return journeys, and attention to adequate rest. The precise calculation and supplement depend on the applicable contract and pattern.^[39] Do not assume that receiving an availability payment means all clinical work undertaken during that period has already been accounted for. Equally, do not count an entire non-resident period as continuous active work without examining the relevant working-time and contractual rules.

A useful on-call record begins with the rota commitment and adds actual episodes. For each episode, record approximate start and finish, remote or resident activity, associated travel where relevant and necessary documentation. Keep separate the scheduled ward round that everyone knows will occur and the unscheduled deterioration that might occur. If predictable work routinely fills much of the period, the service should examine whether the arrangement is accurately described. The name on the rota cannot make an intensive working pattern less demanding.

Suppose an illustrative doctor undertakes four comparable non-resident nights in a reference period. Active work totals one, three, two and six hours. The mean is three hours, but the final night is important rather than inconvenient. It may reveal exceptional demand, an unsupported site or a

recurring concentration of admissions. Examine what happened before deciding whether twelve hours divided by four is a sufficient planning description. Averages help allocate resources; they should not conceal a foreseeable unsafe peak.

Recovery requires its own operational agreement. Record when work ended, whether sleep was materially interrupted and what was scheduled afterwards. A doctor who finishes prolonged clinical work in the early morning should know whom to contact about fitness for the next duty and how the service will arrange cover. This should not depend on negotiating from scratch while exhausted. The relevant working-time requirements, contractual protections and local rest arrangements need to be translated into a usable process for the actual rota.

The diary should avoid asserting a medical diagnosis of fatigue or estimating sleep from the duration of every phone call. Describe what is known: work episodes, available rest intervals and the doctor's concern about safe performance. An occupational-health assessment may be appropriate where health or repeated difficulty affects the arrangement. Immediate patient-safety decisions remain distinct from later negotiations about payment. Paying for additional work does not restore lost sleep or make simultaneous duties compatible.

Prospective cover also changes the real frequency of work. If the nominal rota assumes a full team but the working arrangement regularly covers colleagues' planned absence, count the duties actually expected across a representative cycle. Keep agreed prospective cover separate from unexpected short-term absence and a persistent vacancy. These situations may require different contractual treatment and different service responses. A diary provides the factual starting point; it does not authorise an employer to rely indefinitely on exceptional cover without a fair review.

The proposal should therefore describe three linked requirements: recognition of the availability commitment, allocation for the work expected and a workable recovery and escalation arrangement. Reducing any of those to a single rota fraction loses information the doctor and employer need to plan safely.

From diary to defensible proposal

Raw data rarely persuades on its own. A manager presented with forty pages of timestamps may struggle to see the decision required. Convert the diary into a short account of the current agreement, the observed work, the difference and the available options. Retain the underlying sample so the summary can be checked. The aim is neither a courtroom bundle nor a

polished assertion without supporting evidence. It is a proportionate explanation that another person can follow and test for the stated decision.

The hidden-work ledger can use six fields: activity, why it is required, current provision, observed demand, consequence of the gap and proposed response. Add the sampling period and any major exclusions at the top. For Daniel's clinic follow-up, the relevant row would identify the work generated by eight clinics, four hours already allowed, twelve hours observed and eight hours currently displaced beyond the allowance. The proposed response might be protected time or a redesigned workflow, with a named review date.

Annualisation needs an explicit denominator. Suppose, purely for this planning example, the service expects Daniel to deliver eighty comparable clinics in the coming year after accounting for his actual pattern of leave and other duties. At the observed mean, those clinics would generate one hundred and twenty hours of follow-up. The existing half-hour allowance would provide forty hours. The estimated gap is eighty hours. This is a projection from a limited sample, not a universal annual entitlement, and it should be reviewed against changes in case mix and workflow.

Do not automatically multiply every weekly number by fifty-two, nor assume a standard number of working weeks without checking the arrangement. Some duties occur throughout the year with cover; others occur only when the individual is present. Annual leave, study leave, public holidays and planned service cancellations must be handled consistently. A calculation that removes leave from one side but not the other can create a misleading gap. Ask a colleague or manager to check the arithmetic and assumptions before the meeting.

Time recorded in minutes should remain in minutes until the relevant contractual conversion is agreed. A four-hour weekday example is not a licence to apply that value to every PA, session or out-of-hours period across the UK. Chapter 6 explains the contractual framework. Here the key discipline is to separate observation from conversion: this work took a stated time; the relevant agreement determines how that time is represented in the plan. Keeping those steps distinct makes disagreement easier to locate.

Offer more than one practical response where appropriate. Daniel might protect follow-up time by reducing appointments, maintain activity by agreeing additional capacity, or redesign tasks with clinical and administrative colleagues. Each option has consequences. A larger paid commitment may be unacceptable to him or unsafe in combination with other work. Reducing appointments may affect access and require a service-level decision. Delegation may require investment before it produces

savings. A defensible proposal acknowledges these constraints rather than presenting extra payment as the only possible outcome.

Agree what would count as improvement during a trial. Useful measures might include work completed within the agreed pathway, backlog, cancellations, time spent outside the scheduled allocation and the experience of the staff receiving redistributed tasks. More appointments alone would not show that the arrangement is working. Nor would a reduced diary total if unfinished work has simply moved to another person. Review the whole process sufficiently to detect those substitutions.

End the discussion with a record of what is agreed, what remains disputed and who will do what next. If the evidence itself is challenged, agree a further sample with a clear question and endpoint. Repeatedly requesting more measurement without identifying the remaining uncertainty is not a meaningful review process.

After a change, reconcile the new plan with the old one. Identify which duties have been added, removed, shortened, transferred or rescheduled, and obtain agreement from those receiving transferred work. This prevents an apparent solution in which new time is allocated while all previous activity is still expected. The revised document should show a deliverable total, not a collection of individually reasonable promises that cannot coexist. Keep the previous version so the reason for the change remains understandable at the next review.

Keeping the record proportionate

A workload diary should reduce ambiguity, not create a second job. Choose the least burdensome method that can answer the agreed question. A few categories and a short daily entry may be enough. Existing calendar records, clinic totals and authorised system reports can corroborate the account. The purpose is to understand a work pattern, not to produce continuous surveillance of professional life or a permanent record of every interruption.

Keep clinical information where it belongs. The ledger does not need names, dates of birth, hospital numbers, detailed histories or copied messages. Even an apparently anonymous description can identify someone if it contains an unusual combination of facts. Use broad categories and aggregate counts. If a specific incident must be investigated, refer to the authorised reporting system through the appropriate process. A personal workload file is not the place to retain an alternative version of the clinical record.

Use employer-approved storage when the material concerns work, and clarify who will see it. Do not place workplace data into a personal

application simply because it offers convenient charts. Check the organisation's information-governance requirements before using a new tool. This is especially important where the tool synchronises with external services or processes text automatically. A simple secure spreadsheet can be entirely adequate; sophistication in software does not compensate for uncertainty about confidentiality or purpose.

The record should be fair to colleagues. It can state that a task arrived through a particular pathway without judging another professional's motives. Describe missing information, repeated requests or delayed access in observable terms. If a disagreement concerns conduct, it requires its own fair process. A diary assembled for job planning should not quietly become a dossier of accusations. Keeping these purposes separate protects both the usefulness of the evidence and the working relationships needed to improve the service.

Set a retention and review point. Once the agreed summary and relevant employment record are established, retain supporting material only as required by employer policy, the purpose of the exercise and any advice about an ongoing dispute. Avoid accumulating years of unnecessary detailed logs. For future reviews, a short repeat sample may be more informative than a vast archive describing a service that has changed.

Allow correction. If Daniel discovers that a recorded interval included a break or duplicated another entry, he should amend it transparently and recalculate the summary. Credibility does not depend on a flawless first attempt. It depends on a method that is understandable and responsive to error. Where estimates were entered retrospectively, label them as estimates rather than giving them the appearance of precise observation. A candid range is more defensible than an exact-looking number produced from uncertain recollection. The aim is enough accuracy for a fair decision, with the limitations visible to everyone considering it.

Stop when evidence is sufficient. Daniel must establish the care-completion mismatch and agree a deliverable arrangement. A successful ledger becomes unnecessary as the job plan describes reality. Hidden work is then recognised.