

Document Control Report

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1. Introduction

This policy sets out Northern Devon Healthcare NHS Trust's best practice approach for Senior Doctors (Consultants and Staff and Associate Specialty) Job Plans. It has been developed with the aim of improving the working lives of senior doctors and to fulfill the stated ministerial aim of the NHS being a model employer.

These guidelines have been agreed between NDHT management and the Local Negotiating Committee (LNC) and will inform the process of implementation within NDHT. They are designed to aid effective local implementation by ensuring consistent application of the Consultant Contract 2003 and 2008 SAS contract within the Trust in an open transparent fashion. They are not intended to replace the agreed contract documents.

Existing agreements within NDHT remain in force unless they are specifically superseded. All such agreements will be reviewed.

Where reference is made to Lead Clinician this can be deemed to mean any appropriate Medical Manager, Clinical Director or Clinical Leader nominated by the Medical Director.

This document will continue to be jointly reviewed and updated as the job planning process proceeds and further guidance is received.

From here on in Consultants and SAS doctors will be referred to collectively as senior doctors

2. Definitions

2.1. Consultant Contract

The new Consultant Contract is described in the following documents agreed between the BMA and the DH:

- Consultant Contract 2003.
- Terms and Conditions of Service 2003 (to include the separately published schedules 22 locum Consultants, 23 Clinical Academics).
- A code of conduct for Private Practice.
- Consultant Job Planning.
- Part-time and flexible working for Consultants.
- Other documents have been published by the Consultant Contract Implementation Team (CCIT) and the BMA and provide useful support.

2.2. SAS Contract

The new specialty and associate specialist contracts negotiated by the Department of Health (DH) and the British Medical Association (BMA) was accepted by a ballot of SAS doctors in March 2008.

The new Contracts are described in the following documents agreed between the BMA and the DH:

- A UK Guide to job planning for specialty doctors and associate specialists
- Employing and supporting specialty doctors (2008)
- Terms and Conditions of Service for Specialty Doctors - England (2008) and Terms and Conditions of Service for Associate Specialists – England (2008)
- Policy for the employment of staff grade and associate specialists (SAS) doctors by NDHT and BMA Statement of Principles and Priorities for the allocation of the additional funding for the training and professional development of SAS doctors

See Appendix 10 - Policy for the Employment of SAS Doctors by Northern Devon Healthcare Trust.

3. Purpose

The following general principles can be applied in order:

- To improve the understanding of the purpose of job planning.
- To define the difference between appraisal and job planning.
- To improve equity between specialty job plans.
- To give guidance to support the EWTD.
- To move towards the maximum level of PAs to be 12 for senior doctors, (i.e. 48 hour week, including premium and non-premium hours)
- That all managerial and external duties will be contained within a maximum 12 PA job plan as a norm. Exceptions will be agreed in advance.
- That there will be a timeframe applied for the annual job planning process
- The job planning process will be supported by using the Allocate e-JobPlan system.

4. Definitions/ Abbreviations

4.1. Contractual and Consequential Services

The work that a senior doctor carries out by virtue of the duties and responsibilities set out in his or her Job Plan and any work reasonably incidental or consequential to those duties. These services may include:

- Direct Clinical Care (including clinical administration)
- Supporting Professional Activities
- Additional NHS Responsibilities
- External Duties

4.2. Direct Clinical Care

Work directly relating to the prevention, diagnosis or treatment of illness that forms part of the services provided by the employing organisation under section 3(1) or section 5(1)(b) of the National Health Service Act 1977. This includes emergency duties (including emergency work carried out during or arising from on-call), operating sessions including pre-operative and post-operative care,

ward rounds, outpatient activities, clinical diagnostic work, other patient treatment, public health duties, multi-disciplinary meetings about direct patient care and administration directly related to the above (including but not limited to referrals and notes).

4.3. Supporting Professional Activities

Activities that underpin Direct Clinical Care. This may include participation in training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.

4.4. Additional NHS Responsibilities

Special responsibilities not undertaken by the generality of senior doctors in the employing organisation – which are agreed between a doctor and the employing organisation and which cannot be absorbed within the time that would normally be set aside for Supporting Professional Activities. These include being a Medical Director, Lead Clinician, acting as a Caldicott guardian, undergraduate dean, postgraduate dean, clinical tutor or regional education adviser. This is not an exhaustive list.

4.5. External Duties

Duties not included in any of the three foregoing definitions and not included within the definition of Fee Paying Services or Private Professional Services, but undertaken as part of the Job Plan by agreement between the consultant and employing organisation. These might include trade union duties, undertaking inspections for the Care Quality Commission, acting as an external member of an Advisory Appointments Committee, undertaking assessments for the National Clinical Assessment Service, reasonable quantities of work for the Royal Colleges in the interests of the wider NHS, reasonable quantities of work for a Government Department, or specified work for the General Medical Council. This list of activities is not exhaustive.

4.6. Emergency Work

Predictable emergency work: this is emergency work that takes place at regular and predictable times, often as a consequence of a period of on-call work (e.g. post-take ward rounds). This should be programmed into the working week as scheduled Programmed Activity. Unpredictable emergency work arising from on-call duties: this is work done whilst on-call and associated directly with the consultant's on-call duties (except in so far as it takes place during a time for scheduled Programmed Activities), e.g. recall to hospital to operate on an emergency basis. For the purposes of Schedule 3, paragraph 6 for Consultants and Schedule 4 paragraph 7 for SAS Doctors, non-emergency work shall be regarded as including the regular, programmed work of senior doctors whose specialty by its nature involves dealing routinely with emergency cases, e.g. A&E consultants.

4.7. Fee Paying Services

Any paid professional services, other than those falling within the definition of Private Professional Services, which a senior doctor carries out for a third party

or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 for Consultants and Schedule 11 for SAS doctors of the Terms and Conditions.

4.8. Private Professional Services (also referred to as “private practice”)

Such services as include:

- The diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under section 65(2) of the National Health Service Act 1977), excluding fee paying services as described in Schedule 10 of the terms and conditions
- Work in the general medical, dental or ophthalmic services under Part II of the National Health Service Act 1977 (except in respect of patients for whom a hospital medical officer is allowed a limited “list”, e.g. Members of the hospital staff).

4.9. Professional and Study Leave:

Professional leave or study leave in relation to professional work including:

- Study, usually but not exclusively or necessarily on a course or programme.
- Research.
- Teaching.
- Examining or taking examinations.
- Visiting clinics and attending professional conferences.
- Participation in training.

For further detail, see Senior Doctor Study Leave Policy.

4.10. Programmed Activity

A scheduled period, nominally equivalent to four hours, during which a senior doctor undertakes Contractual and Consequential Services.

4.11. Premium Time

Any time that falls outside the period 07:00 to 19:00 Monday to Friday, and any time on a Saturday or Sunday, or public holiday. A PA during premium time is equivalent to 3 hours.

5. Local Implementation of the European Working Time Directive

5.1. Normal agreement

The Trust will not normally agree to an individual job plan that exceeds 48 hours on average per week over the relevant reference periods (i.e.; 26 weeks excluding annual leave and bank holidays).

5.2. Waiver for exceptional circumstances

A European Working Time Directive (EWTD) waiver should only be applied in exceptional circumstances, for example where the provision of essential clinical services will not otherwise be possible. Where a waiver is required, specific action plans will be developed to ensure EWTD compliance as soon as possible and these will be monitored by the Lead Clinician assisted by the Human Resources Department to report to the Trust Board. The process for applying a waiver is outlined in Appendix 1.

5.3. Compensatory rest

The compensatory rest arrangements within the “Implementation of the Working Time Regulations for Senior Medical Staff” agreement will be reviewed within the context of the New Contract and it is recognised that the nature of compensatory rest may need revision in the light of ongoing discussion at national/European level. Where practicable, working schedules should be designed with a view to scheduling minimum rest periods so that the need for compensatory rest is avoided. Where an individual is still denied an appropriate rest period they will be entitled to compensatory rest as defined by legislation, in accordance with local and national agreements and guidance – compensatory rest guidance for Consultants can be found in Appendix 9.

6. Building a balanced job plan

6.1. Ten Programmed Activities (10 PAs) Commitment

For full-time senior doctors the Trust will work to reach the position where each doctor is committed to a standard whole time contract of ten (10) Programmed Activities (PAs). This equates to a working week of 40 hours (albeit this could be less if activity is undertaken within premium time) and will secure progress on improving the working lives of senior doctors.

6.2. Twelve Programmed Activities (12 PAs) by April 2016

The Trust is committed to agreeing a maximum 12 PA contract for all senior doctors by April 2016. All managerial work and additional NHS responsibilities roles will be timetabled within these 12 PAs.

6.3. Reviews

Currently, most Consultants with a 10 PA contract have 7.5 DCC and 2.5 SPA's. Job plans with more than 10 PA's have proportionally more DCC PA's. New Consultants will have 1.5 generic SPAs and a further 0.5 SPAs for up to 1 year to facilitate their induction into the organisation.

This will then be reviewed with the expectation of aligning non generic SPAs across the team. There will be an annual review at the time of divisional budget setting that will review the total amount of SPA time available. If agreed by both that this is insufficient, further SPA time will be allocated to the budget. It is for the Lead Clinician / DGM to allocate. It may be allocated on a project by project basis.

Currently most SAS doctors with a 10 PA contract have 8.5 DCC and minimum of 1.5 SPA. Job plans with more than 10 PA's have proportionally more DCC PA's. However it is anticipated that some SAS doctors may require more than 1.5SPA depending on the needs and requirements of the individual and the service.

6.4. Involvement in Divisional & Trust wide projects

The Trust will encourage all senior doctors to develop their involvement and engagement in divisional and Trust wide projects. It is acknowledged that some of these will be on-going and others fixed term and the PA commitment may vary significantly. The Trust will therefore ensure there is sufficient funding within the divisions to support this activity, which will then be allocated as part of the annual job planning cycle.

6.5. Clinical and supporting professional activity

All job plans should include an agreed amount of clinical and supporting professional activity. This will be based upon a typical 42 week working year.

6.6. Direct Clinical Care (DCC) PAs

Direct Clinical Care PAs will include work done whilst on-call, theatre lists, out-patient work ward rounds, patient related administration, diagnostic work and multi-disciplinary team meetings.

Specialty areas will develop a standard list of DCC language to describe the different DCC activities that they undertake and will use these to ensure a consistent approach is taken to identifying activities within their job plan.

6.7. Supporting Professional Activities (SPA)

The Trust recognises the value of Supporting Professional Activities in maintaining high quality patient care. All non-generic SPAs and at least 1 generic SPA should be timetabled in the job plan for indicative purposes. However, it is recognised that flexibility is required as to time and place, and that SPAs may be time shifted. Part time doctors will be required to timetable all but 2 hours (0.5 PA) of their SPA.

Each full time senior doctor job plan it will include 1.5 PA of Generic SPA. (see 22.1 for new consultant appointments). They are the activities that the majority of senior doctors in a department would take part in. These may include:

- Job planning and related service development activities.
- Appraisal as an appraisee.
- Revalidation preparation
- Personal study.
- Mortality & morbidity meetings.
- Work related non-patient administration, including related emails.
- Directorate meetings.

- Other activities such as ad hoc clinical, management and educational meetings, attendance at MAC clinical supervision of trainees and nurses (not educational supervision).
- Governance activities such as SEA's and SIRI's and investigations into clinical incidents
- Clinical Audit Projects.

6.8. Non generic SPAs

Non generic SPAs included in the job plan should be allocated to one of the following domains which may be specialty or role specific:

- Service Development
- Clinical Management
- Research
- Teaching and Training (including for example educational supervision, at 0.25 PA per trainee to a maximum of 1.5 PA)
- Clinical Governance. This includes appraisal as an appraiser, acting as a mentor. Data entry into national audits on the national audit programme
- Senior Doctor appraisals – Each appraiser will be required to conduct between three and ten medical appraisals each year. The time taken for undertaking the role of appraiser may be recognised through additional SPA in Job Plans and will be subject to Job Planning sign-off arrangements, guided by the assessment of time commitments outlined in the existing Appraiser Job Description. This is estimated, based on a maximum of ten doctors, as 0.5 of an SPA per week or ratio thereof. (See Appraisal and Revalidation Policy).

There will be an expectation that these activities will be clearly delineated in the job plan and associated with a PA value, specific objective and outcome. The GMC are expecting evidence of training and delivery of supervision of trainees. This will be scrutinised at the annual review by the Deanery. The time and place of these activities will be described in the job plan. It is accepted by management and clinicians that flexibility will be needed, and will not be unreasonably withheld. Such agreed flexibility will be recorded in the job-plan.

The following duties will usually be recognised as qualifying for an appropriate PA allocation per week:

- Clinical Tutor
- Director of Research and Development
- LNC Chairperson (currently 1PA)
- SAS Chair (currently 0.5PA)
- College Tutor
- SAS Tutor (currently 1PA)

Clinical Director posts will be advertised with the specific PA allocation applicable to that post. See additional information in section 6.11.

Medical School activities may form part of non-generic SPA but should be separately identified within the e-JobPlan template. Medical Student activities must be agreed with the Lead Clinician in consultation with the Medical Director or nominated deputy if the total SPA is above 2.5.

The Trust's R&D department will be notified by the medical workforce team of all research duties in job plans. Doctors undertaking externally funded research work can drop DCC work to accommodate this, but the funding must then be used to re-provide the lost DCC.

Research that does not attract external funding must be agreed by the Lead Clinician, and the Director for R&D who will consider whether it is appropriate and viable with a view to improve health or health care outcomes, and who will monitor its progress. Overseeing the research carried out by trainees will be considered generic SPA.

Where the senior doctor does not undertake 1 PA of such non generic SPA, the individual will be expected to substitute Direct Clinical Care activity to produce a 10 PA job plan, or reduce total PAs. Where SPAs are not fixed in time, this activity will be translated into PAs on a plain time basis (i.e. 4 hour = 1 PA).

Please refer to the detailed guidance in [Appendix 8](#) "Supporting Professional Activities - a good practice guide".

6.9. Additional PAs above 10 for specialty groups

Additional PAs above 10 may be offered to senior doctors in a specialty group where additional clinical activity is required. The Trust will expect the department or directorate concerned to investigate possible alternative ways to deliver the service to remove the need for additional PAs and will prioritise at a Trust wide level against Trust strategic objectives.

Additional PA's above 10 will be identified within the job plan as Additional Programmed Activity (APA) in order to distinguish it from the core contracted activity.

6.10. Additional NHS responsibilities

Additional NHS responsibilities will be defined by a formal process appropriate to the responsibility concerned and agreed with the Lead Clinician and DGM. Such responsibilities will have an associated job description, a formal process of competitive appointment or election where appropriate, and be defined in terms of additional pay as PA. It is the responsibility of the Lead Clinician / DGM to ensure that appropriate recharge mechanisms with external organisations are in place, before agreeing additional pay for an individual.

6.11. Senior clinical management role

Where an individual wishes to undertake a senior clinical management role (e.g. Clinical Director, Network Clinical Director), he/ she will in the first instance be expected to discuss his/ her application with colleagues, to consider how the role can be accommodated within a 12 PA job plan. This will usually involve reallocating DCC or non-generic SPA duties amongst the team. For certain very senior roles, the Chief Executive and Medical Director may agree a responsibility payment above 12 PA. In these cases the payments will be specifically linked to objectives, and will be annually reviewed by the Executive. The panel will consist of the Chief Executive, Medical Director, MAC Chair and one other elected member of the MAC, nominated by the MAC Chair.

This activity will be identified within the job plan as Additional Programmed Activity (APA) in order to distinguish it from the core contracted activity.

6.12. Fee paying service & private professional services

Fee paying service and private professional services will not be included within Programmed Activities (see 14 and 15 below), but should be timetabled within the job plan to prevent clashes of scheduling.

6.13. Clinical lead role support

In general, “clinical lead” roles will not be supported with a non-generic SPA allocation, however, Lead Clinicians and/or Clinical Directors may decide on the grounds of clinical quality and efficiency to allocate a specific clinical lead role for a defined period, and to support this with non-generic SPA.

If SPA was allocated then this activity would be identified within the job plan as Additional Programmed Activity (APA) in order to distinguish it from the core contracted activity.

6.14. Additional to Contract

Some doctors may be undertaking additional activity which is above their contract and for which they are not remunerated for. Such activity should be shown within the job plan as Additional to Contract (ATC) so that it is recorded that the work is being undertaken and the time it takes to complete it. Activity listed as ATC can be used as part of a Clinical Excellence Award application to show work that is being undertaken “over and above” contract.

Some SAS doctors may agree to take on additional work as part of their development and therefore ATC would cover this, however the Lead Clinician/Clinical Director may agree to remunerate and therefore it may show as APA if above 10 PAs.

7. Scheduling of Programmed Activities

Senior doctors will work in partnership with their medical managers to agree a schedule or timetable of PAs. The agreed timetable should represent and reflect the best use of

Trust resources and achievement of the Trust's strategic objectives. The Trust will be flexible and agree a schedule which also reflects, as far as possible, the development and personal objectives of the senior doctor.

Where appropriate, to ensure best use of resources, scheduling may be considered on a team, directorate or Trust-wide basis. In particular, Lead Clinicians / DGMs will consider the patient demand on their clinical service, and will try to meet this demand as far as possible from within contracted PAs.

Doctors and clinical managers will endeavour to work flexibly within appropriate team to accommodate the wishes of individual doctors in relation to scheduling.

Non-emergency clinical activities will be scheduled between 7 am and 7 pm Monday to Friday best to meet the needs of the service and the desires of individuals. Non-emergency activity will only be scheduled outside the weekday 7am to 7pm period with the express agreement of the individual consultant and the Trust.

Activity will be scheduled in 30 minute units of time to reflect actual duration including natural breaks and travel time around the work place and then converted to Programmed Activity (PA) values. The timing must follow the format of the approved workload diaries, i.e. the start times are on the hour or on the half hour (0900 or 0930).

Activity may be scheduled over any appropriate number of weeks or annualised. A timetable can be produced for any period of weeks to meet the needs of the service and the desires of the individual.

It is not necessary to schedule all activity at a specific time where the type of work undertaken is not suitable for fixed timetabling or where the variable demands of the service are best met through flexible timetabling. However, the overall number of PAs agreed for such an activity should be recorded in, and form part of, the job plan.

The CCIT document "Annualised Job Planning," and the joint BMA/ NHS Employers "Guide to Consultant Job Planning" and "Guide to Job Planning for specialty doctors and associate specialists" provide some guidance in this respect. Some illustrations of possible annualised job plan approaches are provided in Appendix 2.

For the purposes of improving educational clinical contact, SPA work in the Teaching & Training domain may be allocated to clinical work completed by the trainee, but under direct and planned structured senior doctor supervision. The intensity of the period of activity will be appropriately reduced to allow the supervision to be effective. The example might be a teaching ward round which is anticipated to take longer because of a teaching component.

7.1. Team Job Planning and Flexible Working

Team Job planning and flexible working will usually increase efficiency of clinical teams, therefore wherever possible groups of clinicians should explore and implement through agreement ways of improving efficiency through team job planning, flexible working and annualised job plans. This may involve week-to-week variation in the number of direct clinical care and supporting professional activities carried out by the individuals. But overall the agreed annual DCC: SPA ratio will be maintained. It is recognised that team working that maximises efficient service delivery needs to be linked to an agreed annual leave plan. A worked example is within [Appendix 2](#).

Job plans should be discussed on an individual basis aimed at securing the most effective method of delivering required activity within the team. A review of the clinic and theatre profiles should form part of the job planning and appraisal process but it is recognised that individual clinicians may have different working patterns and case mix.

Consequently the content of the individual job plans should reflect the variable nature of professional practice. In cases where it is not possible to reach agreed consensus then a diary exercise should be undertaken to inform discussions.

8. Rest and Meal Breaks

Rest and meal breaks are generally unpaid and are not included in Programmed Activities (PAs).

Job Plan schedules should reflect rest arrangements by specifying protected break times explicitly or describing flexible arrangements. Where the demands of the service make it difficult to schedule an appropriate meal-break, flexible local arrangements should be made which allow senior doctors to eat during a PA but do not impact on the effectiveness of the service.

Doctors are responsible for ensuring that they take appropriate breaks to comply with the European Working Time Directive where they are working continuously for 6 hours or more.

9. Multi-disciplinary meetings

These include the statutory cancer related meetings as well as those related to routine patient management, and are direct clinical care. Generally they are business meetings where decisions are made about individual patient care and include supervision of supporting staff where the focus of discussion is clinical care. Core members should include all of these in their scheduled activities. Non-core members should allocate time related to the proportion of meetings that they attend as agreed with the Lead Clinician.

Other meetings, such as grand rounds, where there may be some discussion around individual patient care, but this is not the primary purpose of the meeting, should be included within SPAs.

10. Patient Related Administration

The Trust and the LNC recognise that this can be an onerous part of direct clinical care. Usually, not less than 1 PA should be used for this work. Patient admin would include specific patient complaints. Where senior doctors are spending more time on these duties, as shown by diaries etc., the Trust will seek to reduce this by provision of appropriate support services, which will be recorded in the job plan. Where it is not possible to make such a reduction, the Trust will recognise the extra burden, where it is evident. For some specialties a higher threshold may be set by the Lead Clinician, above which senior doctors will need diary evidence to support any claim for extra PAs, as per the generality of senior doctors.

This work will normally be done on site. Where circumstances mean that this work can be more effectively managed off-site the Lead Clinician can agree with a senior doctor that up to 1PA can be allocated as duties to be worked flexibly without a specific location. Work related to patient related administration in excess of 1 PA will be subsequently identified in the job plan. All of this type of work will be translated into PAs on a plain time basis (i.e. 4 hour = 1 PA).

This type of work will include medico-legal reports done on behalf of the Trust and for which there is no fee or where the Trust retains the fee.

11. Additional NHS Duties

All additional responsibilities will be defined by a formal process appropriate to the responsibility concerned. The doctor and their Lead Clinician should find ways of reviewing the job plan to incorporate the work within a 12 PA job plan.

12. External Duties

The Trust recognises the importance and value of External Duties for the individual doctor, the wider NHS and the Trust itself. The Trust accepts that individual practitioners may have now or will develop in the future broader roles with external bodies in connection with the wider functioning of the National Health Service. The Trust will support and encourage External Duties, particularly where these clearly contribute to best practice within the Trust and to personal and professional development.

Senior doctors recognise the value of External Duties in relation to their own professional and career development. They recognise that the Trust may not fund all such activity and that they may perform some part of these duties in their own time.

The Trust will take a flexible approach and make every reasonable effort to accommodate an individual doctor's desire to undertake a particular External Duty. The Trust and the individual doctor should endeavour to minimise the impact on the delivery of service and the ability of the individual to deliver their agreed job plan. Any agreements to accommodate this aim should be discussed at the job planning meeting and recorded on the job plan.

All External Duties require the approval of the Clinical Director and Divisional General Manager and must be listed in the Job Plan each year. These arrangements are intended both to facilitate opportunities for consultants to undertake external duties and protect the level of Direct Clinical Care. The Clinical Director and Divisional General Manager will not refuse any request for External Duty, where a doctor agrees to time shift all affected clinical activity, and where a Lead Clinician can show that there is a mechanism in place to monitor this effectively.

Before applying for an external duty the doctor should discuss the matter with their Lead Clinician and their clinical colleagues. Provided the application is supported by the Lead Clinician, an application to undertake External Duties should be made in writing to the Clinical Director. Lead Clinicians will be expected to discuss their External Duty applications with their Clinical Director.

All approved External Duties must be listed in the job plan together with any conditions or agreements to minimise the impact on the delivery of service.

Approved external duties should be arranged in accordance with the guidance in the Annual Leave Policy (for Medical and Dental staff)

As per the NHSE/BMA Job Planning Guidance, published in July 2011, in some circumstances, the Trust may seek reimbursement from the external organisation for such work. The panel will take a view as to whether it is appropriate to try to recover the costs and whether the responsibility for this should reside corporately or with the Directorate.

It is expected that expenses will be met by the external organisation as advised by the Director of Workforce, Department of Health, unless agreed by the panel and the relevant Lead Clinician.

The Medical Directors Office will maintain a register of all External Duty agreements. This will be published on the MAC website. The Register will include the following information:

- Description of External Duty.
- Number of days approved.
- Steps taken to mitigate impact.
- Any conditions associated with the approval.
- Review date.
- Action on the recovery of costs.

Trade Union duties are treated separately and are covered by specific statutory requirements in relation to reasonable time off. LNC activity is a trade union duty recognised and supported by the Trust. It is expected, subject to sufficient prior notice, that elected members of the LNC will be released from their job plan duties to attend the meeting. Wherever possible this should be discussed as part of the annual job plan review.

Where local teaching on courses (i.e. life support courses) requires leave from the Trust this will be considered non generic SPA. Involvement on external courses requires the use of study leave, but where this will require more than 6 days of an individual doctor's study leave entitlement in any one year, the balance should be treated as an external duty, and referred to the External Duties Panel.

Where leave for external duties is denied by the Clinical Director and Divisional General Manager, either in general terms or for a specific commitment, the Mediation and Appeals process may be invoked.

13. Private Professional Services

All Private Professional Services must be arranged and undertaken within the requirements of the Private Practice Code of Conduct.

Doctors are required to notify their Lead Clinician in writing of all intended regular private work commitments, prior to agreement of the Job Plan.

Where an doctor wishes to undertake private work and is not already committed to at least an 11 PA job plan (and the equivalent for Part-Time job plans with 1 additional PA pro rata), the Trust may offer an extra Direct Clinical Care PA to the appropriate group of specialists. This offer will be required to be accepted by the doctor concerned or somebody else within the group. Where the extra PA is declined, and the doctor continues to undertake the proposed private work, the individual will not be entitled to receive pay progression during the year in question.

Where the Trust decides not to offer extra PAs it may decide at a later date to do so and the same requirements will apply providing a reasonable period of notice is given consistent with the Terms and Conditions – Consultants (England) 2003 and Terms & Conditions of service for Specialty doctors England (2008) associated Codes of Conduct for Private Practice.

Whilst there is no extra PA being offered the doctor may undertake the proposed private practice without jeopardising pay progression.

The Code of Practice requires that private practice is only undertaken where the interests of the Trust and its patients are not detrimentally affected. As part of this the

Trust will insist that private practice is not undertaken during scheduled Direct Clinical Care PAs without the prior agreement of the Lead Clinician. The Trust will only agree to this where the private care requires the specialist facilities of the relevant department, and where time-shifting arrangements are formally agreed or where the income for the work is passed to the Trust.

The job plan should clearly document any agreed private practice activity to be carried out on Trust premises, including how it is delivered. Please refer to the detailed guidance at the beginning of Appendix 2.

Where such a time-shifting arrangement is agreed, it will be reviewed regularly and either party may end it, provided a reasonable period of notice is given consistent with the Terms and Conditions – Consultants (England) 2003 and Terms & Conditions of service for specialty doctors England (2008) the associated Codes of Conduct for Private Practice.

Where the Trust wishes to schedule a doctor's activity to a time when they have a pre-notified Private activity scheduled, the Trust will give a period of notice consistent with the Terms and Conditions – Consultants (England) 2003 and SAS and Codes of Conduct for Private Practice to allow the consultant to make arrangements to re-schedule their Private Professional Service activity. The Trust recognises the current limitations in the local private health sector and will endeavour to avoid using this provision.

Within the terms of the Private Practice Code of Conduct the Trust will develop consistent arrangements to ensure receipt of fees and reimbursement of costs.

Where a doctor is asked advice by an NHS patient about the opportunity to be treated privately, he or she should only provide reference to the Trust's Statement on Private Practice. A leaflet will be developed by the Trust agreed by the Private Practice Committee, Trust Board, and MAC that describes the access to private healthcare within the locality. This will be part of the Trust's process of informing patients on Choice of care provider available to them (which includes the private sector).

Further advice in relation to the application of the Contract to Private Professional Services within the Trust will be developed by the Private Practice Committee (PPC).

14. Fee Paying Services

The Trust recognises the role played by Fee Paying Services within the broader NHS and Public Sector. The Trust will work flexibly to accommodate such activities whilst securing the interests of the Trust and its patients.

Fee Paying Services should only be undertaken during scheduled Direct Clinical Care PAs with the prior formal agreement of the Lead Clinician and where time-shifting arrangements have been agreed (see below). Where this is the case the consultant may retain the fees.

Where such a time-shifting arrangement is agreed it will be reviewed regularly and either party can end it with reasonable notice, sufficient to allow the other party to make satisfactory alternative arrangements.

Fees for such services may also be retained by the consultant without time shifting where there is no impact on other activities and is explicitly agreed by the Lead Clinician.

The Trust will develop processes to ensure receipt of fees for Fee Paying Services where appropriate and doctors must fully cooperate in this respect.

15. Time shifting

The Trust and the LNC jointly recognise the role of the concept of time shifting in building flexibility into the 2003 Consultant Contract and SAS 2008 contract. Time shifting is crucial to securing the joint desire to retain and maintain the professionalism of Senior Doctors. It will facilitate the accommodation of Private Professional Services, Fee Paying Services for consultants under the new contract and, where applicable, allow the consultant to retain fees and fully protect the capacity and effectiveness of the service. The key principles are that an individual cannot be paid twice for work done and that flexible arrangements must not impact negatively on the efficient use of resources.

Time shifting is the process whereby private practice and fee paying activities are undertaken in place of scheduled Clinical Care PAs, and the equivalent amount of Direct Clinical Care activity is built back into the doctor's job plan as extra activity at another time. This work is undertaken without additional payment. Time shifting may also be used to facilitate External Duties being undertaken in the doctor's own time. Where SPA type duties are undertaken in place of scheduled direct clinical care, then the Trust may agree with the doctor to replace the direct clinical care activity using a similar mechanism.

The Trust will support doctors in making arrangements where practicable to cover and secure the Direct Clinical Care activities originally planned at no additional cost and thus protect the effectiveness and efficiency of the service. The arrangements may be prospective so that a general extension of the contracted working week is recognised as compensation for more regular private or fee paying work undertaken during paid PAs.

Time shifting arrangements will be detailed and agreed formally by the doctor, the senior doctor team and the Lead Clinician. Such agreements will be reviewed regularly and may be altered by a job plan review. Where arrangements made in relation to pre-notified Private Professional Services are ended by the Trust, a minimum of 6 months notice will be provided.

16. On-Call, Availability, and Definitions

On-Call supplement categories will be determined on a specialty by specialty basis alongside individual job planning. A schedule of category definitions for all on-call rotas by specialty is attached in [Appendix 3](#).

The on-call supplement will be based solely on the number of doctors on the rota. Where a doctor participates in two 'dual' rotas, the supplement shall be paid in accordance with the principles laid out in Appendix 3. The supplement will change when necessary, e.g. when a doctor is added / taken off the rota.

Categorisations will be reviewed annually as part of the Job Planning process in accordance with the Terms and Conditions. Where there is a significant change in rota arrangements during the year the Lead Clinician will refer this to the Medical Director for consideration of whether a change in on-call categorisation is necessary. Where this is the case, salary payments will be adjusted with effect from the first full pay period following the decision. Where changes in the number of doctors on an on-call rota lead to a change in the supplement, this will be paid with effect from the date of the change.

Where a doctor is working a Category B rota, he or she may make prior arrangements for short intervals during which they are not available to be contacted straight away (e.g. calls being taken by an answer phone), provided that those calls are dealt with immediately at the end of the period. Such agreements must be specifically recorded in advance.

Normally, doctors with prospective cover will cover each other for on-call duties, consultant of the day/week/month arrangements and for ward emergencies. The cover for on call duties and associated work is included in the contract and does not attract additional payment unless the provisions of the Payment for Additional Work Policy apply.

Where on-call work follows a regular pattern each week through a rota cycle it shall be considered Predictable and doctors should identify within the weekly schedule when and where this takes place. This includes on-call ward rounds and scheduled emergency operating lists. If it can be shown that there is an expectation of say two hours operating each week-end day, but the Trust chooses not to make available a scheduled emergency list for that specialty, then the work shall still be called predictable. All other on-call work is by nature unpredictable.

The Trust recognises that there is no contractual expectation of availability when the doctor is neither on call nor has any scheduled duties. However, in exceptional circumstances, the Trust may ask a doctor to return to site for emergencies if the individual can be contacted.

The e-JobPlan module provides a calculator facility as well as a direct entry method for recording the amount of on-call activity undertaken. It is expected that after the first year of e-JobPlan implementation doctors will utilise the e-JobPlan calculator to record the breakdown of their on-call activity so that a consistent approach is taken across the Trust. Where necessary a period of on-call monitoring will need to be undertaken to assess the levels of activity.

17. Travel Time

Travel time for official duties should be built into the relevant Programmed Activities except for external duties where it has been agreed that only 2 PAs per day overall (including the work) should be allocated.

The Trust has pre-populated the travel time amounts between all of its sites and a number of other hospitals that are regularly visited. The allowed time for all journeys is based on the Google maps website as an independent source with all timings rounded up to the nearest ¼ hour. The Medical Staffing department can provide this information where requested and where necessary can add additional locations if required.

Allowed time should reflect the actual journey made and not include the expected normal travel to and from work on a daily basis. In this scenario the doctor should select "Travel time not applicable" within e-JobPlan to show that they are travelling but that the travel time is not remunerated.

Where an individual travels from home to a location other than the main hospital the travel time allowance will reflect only the additional time taken above that would usually be taken to travel to the main hospital site.

In this scenario the doctor should select "Travel time" from the SPA category and input the additional time only to show the travel time that it is to be remunerated.

18. Payment for Additional Clinical Work

Directorates will plan additional clinical work within the job planning process using a team approach. This should where possible incorporate cross cover for planned leave, see cover absent colleague agreement. Where unpredictable, shorter term and shorter

notice additional activity (less than 8 weeks) is required by the service the Payment for Additional Work Policy will be used to define payment.

Additional clinic work paid at the relevant PA rates for standard and premium time can be offered by the directorate to consultant teams. Each doctor in the team who is able to contribute to the work required should be given the opportunity to be included. A temporary change to the job plan can therefore be agreed for the defined period of additional clinical work, for a minimum period of 3 months. Where agreed in advance clinical teams who are annualising and recording clinical activity provided can receive additional pay at the relevant standard or premium time rate.

In all circumstances, Directorates should be able to demonstrate that the doctor is delivering his/her job plan DCC and SPA commitments.

19. Leave

Please refer to Annual Leave Policy (for Medical and Dental Staff).

Clinical teams are encouraged to develop additional detailed leave guidelines in line with the agreed Leave Policy that meet individual clinical service needs and support effective team working.

Doctors in NDHT are entitled to 33 days study leave in each 3 year period subject to the requirement to maintain essential services.

Where a group of doctors have agreed an annualised or team job plan with their clinical manager, then where practicable leave cover for direct clinical care duties will be included, except where the leave falls into the categories described in the "Payment for Additional Work Policy". Where there is no such commitment, other arrangements may be made to cover these duties.

20. Salary Calculation

For the purposes of salary calculation the total number of PAs agreed within the Job Plan for a particular period (including any proportion of PAs) will be annualised and paid monthly as per normal practice. The final value of the PA as described in the Job Plan will be rounded up to the nearest 0.1 PA.

21. New Appointments

21.1. Initial Job Planning Process

Prior to completion of the initial job planning process all new appointments will be based on a 10 PA activity plan fitting in to the current work structure and expectations.

All senior doctors will be allocated 1.5 **Generic** SPAs as part of the job planning process.

If there is a service development role for the new doctor to undertake e.g. the development of the integrated chronic pain service then the necessary SPA time should be incorporated into the Job plan and identified if time-limited or if a lead role is intended to be continuous

It is expected that all new senior doctors will undertake a formal induction (approximately 15hrs). A departmental induction pro-forma is available to support the induction process.

21.2. New Consultants

New consultants joining the organisation, in particular those transitioning from senior training to consultant, will be temporarily allocated 2 SPAs for up to 1 year from their appointment. This allocation will not be in addition to the final intended job plan but will be allocated from DCC. This acknowledges that whilst embedding within the new organisation/role they may require more time to get up to speed on clinical / administration work.

All new consultants who have just obtained CCT will be expected to participate in the mentoring system which will go live in early 2013.

New consultants with experience at working at consultant level will be offered mentoring.

21.3. Review of New Consultants

There will be a review built into the use of this SPA time at 6 months, or at job planning review, whichever is the sooner which will be undertaken by the CD or LC. At this review a decision will be made as to whether this additional SPA time is still valued and is being used in a productive way. If so it can be continued for up to a maximum of 1 year from appointment. If however, at the 6 month review, it is agreed that it is no longer required it will revert to DCC.

The review will include:

Has the induction been signed off as complete?

If not, what has prevented this?

- Required to change to DCC for the service needs?
- Doctor issues?
- Other

Has mentoring been accessed?

Is there any evidence the doctor is struggling?

- Behind with paper work
- Persistently overrunning with operating or clinics
- Informal feedback from colleagues?
- Complaints
- Incidents

New appointees will be subject to the same team based and individual job planning process as all doctors who have opted for the new contract.

21.4. General

When new posts are created, the Trust expects the job plans of other specialist team members to be reviewed prior to the commencement of the new employee.

Where the new appointee may need to be offered a job plan in excess of 10PA or a different allocation of PAs, the directorate must supply a shadow job plan showing the full job on offer. The sign off procedure by the Trust must take into consideration both job plans. The new doctor is not required to take the alternative plan therefore the directorate should have an alternative view on how the work required is to be provided.

The new doctor is provided with both the 10PA and the shadow job plan (using the formal job plan form) on or before the day of appointment and will be required to have a job plan review with the Lead Clinician within 12 months of appointment and to agree and sign the relevant job plan.

Full time locum consultant appointments will normally be offered job plans with 8.5 DCCs and 1.5 SPAs reflecting the service nature of the posts.

Employers should agree job plans with full time locum SAS doctors which take into account their familiarity or otherwise with local systems and processes and the extent to which their potential contribution may differ from that of their substantive colleagues. The job plan may be different to that of the SAS doctors they are replacing. They may deliver proportionately more direct clinical care but employers are expected to allocate at least the agreed minimum entitlement of one PA per week for SPA time to all locum SAS doctors to meet college and other external requirements

22. Job Planning Process

22.1. General Approach

Job Planning must be undertaken in a manner, which reflects the joint objectives outlined in Section 1 and 2. In particular this should be in a spirit of partnership and professionalism and should balance the needs of the Trust and the wider NHS with those of individual consultants. Within this it is expected that all doctors participate openly in the process and actively consider alternative ways of working and service improvements within the Job Planning context.

Job Planning will take place annually as part of the Trust's planning calendar. Job Planning should commence in October and be completed by the end of February. A timetable showing the key milestones and the responsibilities of Doctors, Lead Clinicians and Divisional General Managers is contained within Appendix 5.

Job Planning may also take place during the year on an 'interim' basis at the request of the doctor(s) or to reflect service improvements, additional doctors within a discipline and other significant changes in workload.

To bring greater clarity, focus and consistency to the process, the Trust has agreed a standard for satisfactory participation in job planning as follows:

- Job plans should be integrated with service line capacity plans and include an agreed annual amount of clinical and supporting professional activity.
- Job planning meetings should be jointly undertaken by the Lead Clinician supported by the Divisional General Manager.
- Job plans must have objectives which are aligned with Trust and service line requirements, and these should incorporate targets related to service improvement, efficiency and the management of resources.

- Job planning should be undertaken electronically using the e-JobPlan module.
- Signed off job plans must be completed and received by the Medical Staffing Department by the last day of February.

The Job Planning principles have been laid out in the agreed documents “Consultant Job Planning – Standards of Best Practice” and “A UK Guide to job planning for specialty doctors and associate specialists drawn up by the BMA and Department of Health. Additional advice on how doctors and the Trust should prepare for job planning discussions is provided in Section 6 of the Consultant Contract Implementation Team (CCIT) workbook – “Step by step guide to job planning”, A UK Guide to job planning for specialty doctors and associate specialist Nov 2012 and in the BMA’s “job planning guide”. These documents should be used by doctors and Lead Clinicians to guide detailed preparation and completion of job plans. The guidelines contained herein only highlight some key points for consideration and should not be used in place of the more detailed agreed documents.

22.2. The Process

Job planning will be informed by the collection of data in relation to prospective capacity requirements and retrospective activity records or diaries. This data should be used to develop prospective job plans for teams and individuals. Where team plans are developed these should be converted into individual contracts.

The printable version of the e-JobPlan template is provided within Appendix 7 to show the different sections that make up the job plan. .

The individual discussion will take place once a generic and or team based job plan has been agreed. This will be focussed on agreeing a plan within the generic and / or team based framework, which also accounts for the individual doctor’s own circumstances, interests and specialist contribution. Both parties will apply their best endeavours to reach agreement, which balances the desires of the doctor with the needs of the service. Individual job plans may be agreed in the context of an agreed team job plan.

Where it is not possible to agree a job plan the doctor and their Lead Clinician should refer outstanding issues to the Mediation and Appeals process described in 7 below.

All specialist groups within the Trust should, where agreed, consider taking active steps toward a team approach to job planning and annualising the contracted PAs. To take team job planning forward an identified team leader for each of those clinical teams should be agreed by the Lead Clinician (s) within which directorate(s) the team lies.

23. Service Improvement

The Trust and the LNC recognise that all concerned need to contribute to the achievement of its strategic aims such as creating a more flexible organisation, increasing capacity, improving resource utilisation and measuring and enhancing productivity as well as reducing excessive working hours. The job planning process is an opportunity to look at current working practices and to consider alternatives within this context. This may involve

consideration of clinical priorities, new ways of working individually and within teams, cover and on-call arrangements, amongst many other possibilities.

Where changes and improvements can be implemented quickly these should be built into the new job plans. Where it is not possible to do this, action plans should be developed to make changes as soon as possible and agree 'interim' job plans at that stage.

Improvement opportunities should be recorded on the job plan in the appropriate section. In addition, participation in service improvement activities should be included within each individual doctor's job plan and objectives.

24. Objectives

An objective is a task, target or development need that the doctor, or the doctor and the Lead Clinician together who have agreed the objective, wishes to achieve. It should reflect the needs of the doctor, the organisation, health community, and health service. In this context, it should arise out of the appraisal process or the job planning process. It should be well thought out, agreed and the resource implications known. The latter could include time, educational pursuit or equipment to name but a few.

Extract from Terms & Conditions of Service

The job plan will include appropriate and identified personal objectives that have been agreed between the consultant and his or her clinical manager and will set out the relationship between these personal objectives and local service objectives. Where a consultant works for more than one NHS employer, the lead employer will take account of any objectives agreed with other employers.

The nature of a doctors personal objectives will depend in part on his or her specialty, but they may include objectives relating to:

- Quality
- Activity and efficiency
- Clinical outcomes
- Clinical standards
- Local service objectives
- Management of resources, including efficient use of NHS resources
- Service development
- Multi-disciplinary team working

Objectives may refer to protocols, policies, procedures and work patterns to be followed. Where objectives are set in terms of output and outcome measures, these must be reasonable and agreement should be reached.

The objectives will set out a mutual understanding of what the consultant will be seeking to achieve over the annual period that they cover and how this will contribute to the objectives of the employing organisation.

They will:

- Be based on past experience and on reasonable expectations of what might be achievable over the next period;
- Reflect different, developing phases in the consultant's career;

- Be agreed on the understanding that delivery of objectives may be affected by changes in circumstances or factors outside the consultant's control, which will be considered at the job plan review.
- Use a framework when discussing and agreeing objectives. The enhanced SMART framework is recommended:
 - Specific.
 - Measurable (quantified or descriptive).
 - Achievable and agreed.
 - Relevant.
 - Timed and tracked.

The doctor should develop draft objectives before the meeting, having consulted with rest of their team.

Throughout the year – don't leave this until the next job plan review. Telephone or email contact may be useful where the doctor and Lead Clinician don't meet regularly.

Divisional General Managers are integral to the objective setting process. They should meet with the specialty group to explain the key service challenges. This is an opportunity for the doctor to hold the manager to account for support requirements identified and to explore what changes need to occur in other staff roles. These will recognise the Trust strategic objectives.

Objectives should reflect the full range of the doctor's roles e.g. clinical quality and activity, supervision, teaching and training, research, service development, personal and professional development.

Consider staged objectives over a period of years where the overall objective can't be achieved in one year. For example, where there is significant service reconfiguration.

Individual and team objectives need to be linked. Where a number of staff need to contribute to a service development or change, clarify the individual's contribution, and decide how involvement of others is going to be assured.

Objective setting should not be used to deal with concerns about conduct or performance.

Objectives should be reviewed each year – they should change to reflect progress and service changes and challenges.

Objectives should be set that consider the provision of adequate supporting resources.

Objectives should be realistic about the pace of change that is possible – whilst being challenging, don't expect too much too soon.

Where an individual recognises that objectives may not be met, for whatever reason, this should be discussed with the Lead Clinician at the earliest opportunity. For those with activity based objectives, failure of provision of resources will be taken into account, as will sick leave and other extenuating circumstances.

Once objectives have been entered within e-JobPlan these should then be linked to an activity within the timetabling section to show the relationship between the objective and the specific activity to which it relates.

25. Activity Monitoring

Job Planning is a prospective process, which involves building activity schedules that reflect the best understanding of service delivery. It is important that each successive job planning process is informed by knowledge of events in the preceding period.

A co-ordinated common approach will be led by the medical management team to maximise the availability of quality detailed activity data, including diary keeping, and minimise the negative distraction of collecting that information. This should also be co-ordinated with collection of Working Time Directive data to avoid duplication of effort. As e-rostering is introduced, this will provide an important data collection tool.

The Trust will work with doctors to develop ways of recording activity including details of all lists/clinics cancelled for whatever reason, including those that have been taken up by colleagues. An individual 'data set' may be created for each senior doctor and supplied to individuals on a regular basis for verification.

Arrangements will be made to publish the key elements of all agreed job plans to encourage consistency and transparency. Generic and team job plans will be published on a Trust wide basis, individual ones within departments only.

26. Pay Progression

To achieve pay progression the appraisal process should be complete and a signed job plan (which is not necessarily agreed) must be submitted to Medical Staffing Department by the last day in February. The preferred method for receipt of job plans is electronically via e-JobPlan.

At end of September a letter will be sent to all doctors from the Medical Director informing them of the deadlines that have to be met (see Appendix 5).

At the end of January a letter will be sent to all doctors by the Director of Workforce and Development confirming that those doctors with job plans above 10PA must have a signed completed job plan to continue to receive additional payment in the following financial year (see Appendix 6). This letter will be emailed to provide an audit trail.

The e-JobPlan system will also contain automatic reminders to prompt the doctor, Lead Clinician and Clinical Director of key milestones in the job plan process.

The doctor must have made reasonable effort to meet the time and service commitments in the job plan. The confirmation that this has been achieved is at the job plan review (1st level sign off) with the Lead Clinician and Service / Divisional General Manager whereby the e-JobPlan system will be updated by the Lead Clinician to confirm that "1st level sign off" has been achieved.

The doctor must have participated satisfactorily in the appraisal process. The doctor is solely responsible for achieving the appraisal within the times set. The completed and signed Appraisal summary documentation and PDP (paper or electronic) must be submitted to the Medical Directors office by the last day in February. If there are mitigating circumstances the doctor must write to the Medical Director for an extension.

The doctor must have participated satisfactorily in reviewing the job plan and setting personal objectives. It will include appropriate and identified personal objectives that have been between the doctor and their clinical manager and will set out the relationship between these personal objectives and local service objectives. Where a doctor works for more than one NHS employer, the lead employer will take account of any objectives agreed with other employers.

The doctor should have met the personal objectives in the Job Plan, or where this is not achieved for reasons beyond the doctor's control, made every reasonable effort to do so. The meeting of these criteria is demonstrated by the Lead Clinician, in consultation with the Service / Divisional General Manager confirming that "1st level sign off" has been achieved within e-Job Plan.

The doctor must have worked towards any changes identified in the last Job Plan review as being necessary to support achievement of the employing organisation's objectives. The meeting of this criteria is demonstrated by the Lead Clinician, in consultation with the Service / Divisional General Manager, confirming that "1st level sign off" has been achieved within e-Job Plan.

The doctor must have taken up any offer to undertake additional Programmed Activities that the employing organisation has made to the doctor in accordance with Schedule 6 (Consultants) and Schedule 7 (SAS Doctors) of these Terms and Conditions. The meeting of this criteria is demonstrated by the Lead Clinician, in consultation with the Service / Divisional General Manager, confirming that "1st level sign off" has been achieved within e-Job Plan.

The doctor must have met the standards of conduct governing the relationship between private practice and NHS commitments set out in Schedule 9 (Consultants) and Schedule 10 (SAS Doctors). The meeting of this criteria is demonstrated by the Lead Clinician, in consultation with the Service / Divisional General Manager, confirming that "1st level sign off" has been achieved within e-Job Plan.

Second level sign-off of the agreed job plan will then be undertaken by the Clinical Director, in consultation with the Divisional General Manager.

An electronic job plan signed off at first and second level on the e-Job Plan system or a letter to the Medical Director attaching the contested draft job plan must be received by the last day in February. For all job plans in excess of 10PA failure to complete one of these two actions will result in the return to a 10PA pay level for the next financial year, or until one of the above actions has been completed.

If there are extenuating circumstances why a doctor cannot meet this timetable e.g. long term sickness or a career break, this will be notified by the Lead Clinician to the Medical Director prior to the end of February.

27. Mediation and Appeal

The mediation and appeals process is a key part of efforts to work in partnership to implement the Contract and to maintain and build upon the existing goodwill and professionalism within the relationship between the Trust and doctors. The aim is to resolve issues quickly and consistently across the Trust.

Doctors and Lead Clinicians are encouraged to seek informal advice from the Chair – LNC, Chair – MAC and / or a member of the Medical Staffing team. This will help in most circumstances to clarify issues and allow the job planning process to proceed.

Separate agreement has been reached with the LNC detailing arrangements for both formal mediation and appeals processes in line with national agreement Schedule 4 (Consultants) and Schedule 5 (SAS Doctors).

28. Job Planning Advisory Panel

The Job Planning Advisory Panel is a group of senior doctors, agreed by the Director of Operations and LNC chair whose role is to maintain a corporate overview of job

planning practice, and to act as a point of referral for consultants, Lead Clinicians, Clinical Directors, Divisional General Managers or the Medical Director.

The Panel will review job plans of groups or individuals on request in order to inform a job plan review. The relevant Lead Clinician, Clinical Director and Directorate Manager will be invited to attend each meeting. The panel will offer job planning advice based on their knowledge of current guidelines and best practice in the organisation. For 2015/16 all job plans will be reviewed for equity by the panel.

The Job Planning Advisory Panel may also act as a source of advice to the Medical Director, who may refer job plans he/she considers unsuitable for sign-off. The Panel also has a role, as described in section 1.4 above, in considering any concerns expressed by consultants during the process of setting job planning objectives and resource management and service improvement targets.

29. Education and Training

Responsibility for education and training lies with the Medical Director.

30. Monitoring Compliance and Effectiveness

Monitoring of implementation, effectiveness and compliance with these guidelines will be the responsibility of the Medical Director.

This agreement and its implementation will be reviewed on an annual basis by the LNC, such review to include all relevant statistics demonstrating the extent of its use and the costs associated therewith.

31. References

- Terms & Conditions – Consultants (England) Contract 2003.
- Terms & Conditions for Specialty doctors – England (2008)
- Terms and Conditions of Service 2003 (to include the separately published schedules 22 locum Consultants, 23 Clinical Academics).
- A code of conduct for Private Practice.
- Consultant Job Planning.
- Part-time and flexible working for Consultants.
- Other documents have been published by the Consultant Contract Implementation Team (CCIT) and the BMA and provide useful support.

32. Associated Documentation

- [Study Leave for Consultants, Staff and Associate Grade Doctors Policy](#)
- Payment for Additional Work Policy (Senior Doctors)
- A charter for Staff and Associate Specialist and specialty doctors (NHSE Royal Academy BMAS – joint policy)

Appendix 1: European Working Time Directive 'Waiver' process

1. All efforts must be made in the job planning process to ensure all staff are working within the EWTD (12PA). The Trust will only contract a senior doctor in excess of the EWTD in exceptional circumstances where alternative solutions have not been possible to implement.
2. A waiver of the EWTD is only possible as a voluntary offer by the senior doctor. The Lead Clinician or management team should not request that a member of staff exerts his/her right to waiver.
3. An annual review of EWTD waivers will be completed by the Medical Staffing Team to ensure that up-to-date waivers are on file for all senior doctors on job plans in excess of 12 PAs. The reasons for needing to contract the senior doctor for work in excess of 48 hours need to be documented within the job plan and a set of objectives defined that will return the workload to within 48 hours indicating responsibilities for delivering the objectives.
4. The activities that take the workload in excess of the EWTD should be clearly defined in the agreement between the senior doctor and Lead Clinician.
5. It is expected that all senior doctors working in excess of 12 PAs will undertake a minimum 4 week diary monitoring exercise on at least an annual basis.
6. As part of the Trust's job planning process the consistency panel will consider 12 PA+ job plans to ensure that these are kept under review.
7. The Trust may decide not to contract senior doctors for additional clinical work beyond the EWTD under any circumstances in specialties where there is a high risk. A formal letter will be sent from the Lead Clinician to the senior doctor indicating the end of the period of agreed work in excess of the EWTD.

Appendix 2: Illustrations of Annualised Job Planning, Activity Planning and Time shifting

1. Time shifting Private Practice Operating

- 1.1. If agreed with the Lead Clinician operating on private patients can be undertaken in time originally allocated/scheduled to Direct Care activity provided the access of patients to theatres with a higher clinical priority and the achievement of waiting list targets are not affected.
- 1.2. The period of time lost within the Direct Care PA to the private patient is declared to the Lead Clinician. The directorate organises an auditable system to record such time due back to the clinical service.
- 1.3. The consultant will make him/herself available for additional work as Direct Care PA (either as operating or other clinical activity depending on the demands of the service) to replace the 'time shifted' activity.
- 1.4. To ensure that the work can be delivered back to the NHS gaps in the consultant schedule can be included where there are no allocated activities. These gaps will allow for slots where the consultant can 'pay-back' the time shifted work.
- 1.5. Over-runs are considered to net off against under-runs and to be part of the flexible operation of the contract. They are not considered when calculating the amount of time and activity to be replaced.

2. Annualising Private Practice Operating

- 2.1. If a department has a predictable level of private practice activity but delivered during the course of a year in an unpredictable pattern the directorate can calculate the level of such private activity and allocate this to individual consultants.
- 2.2. In the calculation of the job plan for the year the activity taken up by treating private patients can be deducted from the weekly PA allocation for that consultant for the purposes of job planning and salary calculation.
- 2.3. The directorate establishes an auditable system for the close monitoring of such activity and adjusts the agreement on an annual basis.

3. Maximising use of theatre capacity (and also applied to Outpatient capacity)

- 3.1. It is known in many directorates that a great deal of theatre capacity is lost due to annual leave and cancelled sessions because a surgeon was not allocated.
- 3.2. In the job plan a consultant can be allocated a component of operating that is regular and forms part of their weekly timetable. In addition to this the job plan can allocate an annualised allocation of further direct care PA. An example may be an additional ½ PA per week allocated to each 26 week period.
- 3.3. The annualisation must allow for leave in that period (say 5 weeks) so that the surgeon will be allocated a pool of 10 ½ PA for operating to be used on a more flexible basis to be worked in each 26 week period.
- 3.4. If there is a team of 6 surgeons all allocated to 2 PA of regular timetabled operating per week in each 26 week period there will be 60 PA of operating sessions lost due to annual leave (6 consultants x 5 weeks leave x 2 PA).

- 3.5. As a team they have 63 PA (10 ½ PA x 6 surgeons) which can be used flexibly for operating. The 60 PA of lost operating sessions are then covered by this allocation.
- 3.6. An auditable system for monitoring will be required to ensure the arrangement increases direct clinical care overall.
- 3.7. A similar approach to the allocation of outpatient clinics can be taken.

4. Making space in the job plan and reducing the overall PA

- 4.1. Initial construction of a job plan might look as though the pressure of work is so excessive that it is impossible to consider reductions in the allocation of PA to cover all the work and reduce below the EWTD limits or approach the 40 hour week.
- 4.2. Not all the weeks in the job plan need to have allocated work. Gap weeks can be timetabled into the job plan. If for example you have a 12 PA job plan and you timetable in 2 'gap' weeks in each 26 week block. 24 PAs are gained in each 26 week period, or 0.92 per week. The job plan can then be reduced by 1 PA.
- 4.3. If there is a team of 6 consultants in each 26 week period there will be 42 weeks of leave (6 consultants x (5 weeks leave + 2 weeks gap)). If an agreement is made that only 2 consultants are away at one time then an additional consultant can be added without the need of any additional theatre sessions, or clinic space to maximise activity.
- 4.4. Making space in the job plan also provides the theatre or clinic sessions to repay time shifted activity and is also a good way of improving the working lives of consultants who have other interests that need blocks of time which are often difficult to achieve.
- 4.5. The essence of this approach is a team approach. It requires advanced booking of annual and study leave, planned allocation of 'gap' weeks and a clearly detailed activity schedule planned in advance.

5. Lost clinical activity due to meetings, cross departmental audit

- 5.1. If a consultant knows in advance that a direct care session is to be lost so that he/she can attend a meeting the directorate should run a system whereby this loss of activity is notified.
- 5.2. The time-shifting here is between Direct Care PA and Supporting Professional Activity PA. The time lost is therefore included in the SPA allocation, which is agreed within the job plan to a 2.5 PA per week maximum.
- 5.3. The consultant then owes back the direct care session to the clinical service to be taken in a similar way to the time-shifted work from private practice work.
- 5.4. Where such meetings are regular and more predictable then this should be prospectively included in the job plan.

6. Total job annualisation

- 6.1. Some specialties are more suited to full annualisation. An example is anaesthesia where a number of sessions need to be covered by a single group of doctors.

- 6.2. As the EWTD is applied over a 26 week period consultants can be allocated intense and quiet weeks which may be more suited to their specialty.
- 6.3. A mostly ward based service such as ITU or Acute Medicine may also be best approached by an annualisation in a period equivalent to a multiple of the number of staff sharing the duties.
- 6.4. This type of arrangement may take a wide variety of forms. Provided an auditable review mechanism is in place to ensure the impact of annualisation is to at least maintain levels of Direct Clinical Care activity these approaches will be helpful in providing flexibility to consultants to manage their professional lives.

7. Annualised resource utilisation within Teams

- 7.1. A specialty team of 5 consultants, each with 3 theatre lists a week, each lasting at least 4 hours (a total of 15 allotted theatre sessions per week) recognise that when they are on leave no-one uses the sessions (potentially $15 \times 52 = 780$ theatre sessions per year of which $15 \times 10 = 150$ are not used).
- 7.2. The team agrees an Annualised job plan within which they are expected to deliver 15×42 weeks = 630 theatre sessions between them. Spread out over a 51 week year (assume New Year week is not operational for elective Theatre work) that works out at 12 sessions a week (rounded down from 12.34). The team agrees to do that number of theatre sessions a week. In addition they will do an additional 17 Theatre sessions in total to be planned as required to make up for the rounding down. More sessions may be worked where time is freed up from other activities. External Duties agreed at job plan review should be included in the calculation for annualised working.
- 7.3. Three sessions per week are now available to be used by another specialty team and overall theatre utilisation should be increased.
- 7.4. The team agree with their Lead Clinician how best to sort out their holidays and study leave. This should be done in a manner which spreads theatre work smoothly so that no one individual is expected to carry out too high a proportion of the theatre sessions in any one week. This will require advanced planning within the team to ensure a fair distribution of leave.
- 7.5. A similar arrangement could be set up for outpatient clinic resources.

Appendix 3: On Call rota classification (Consultants only)

Further more complex work is required alongside individual job planning. A completed table for guidance will be published shortly when this work is complete.

Specialty	A&B or 0 (no on-call)		Specialty	A&B or 0 (no on-call)
A & E	A		Oral & Maxfac	A
Anaes – Cardio	A		Orthodontics	No on-call
Anaes – ICU	A		Orthopaedics	A
Anaes – Pain	B		Paediatrics - General	A
Anaes – Neuro	A		Paeds - Community	No on-call
Anaesthetics	A		Paeds - Neonates	A
Cardiology	A		Palliative Medicine	No on-call
Cardiothoracic Surgery	A		Pathology - Chemical	B
Clinical Chemistry	No on-call		Pathology - Histo	No on-call
Clinical Oncology	B		Pathology - Neuro	No on-call
Dermatology	B		Plastic Surgery	A
ENT	A		Psychiatry / Child	A
G U Medicine	No on-call		Radiology (Breast)	No on-call
Haematology	A		Radiology (Neuro)	A
Immunology	No on-call		Radiology (General)	A
IVF	B		Restorative Dentistry	No on-call
Medicine	A		Rheumatology	B
Medicine - Renal	A		Surgery - Breast	No on-call
Medicine – On-Take	A		Surgery	A
Medicine - Gastro	A		Transplant Surgery	A
Microbiology	A		Thoracic Surgery	AI
Neurology	A		Urology	A
Neurophysiology	No on-call			
Neurosurgery	A			
Nuclear Medicine	No on-call			
Obs & Gynae	A			
Ophthalmology	A			

Dual Rota's

Where there is a dual rota in operation, the consultant would need to work out how many days/nights in a year they end up on call. This is because sometimes people on dual rotas cover both duties on the same nights. If this does not happen, then the commitment is worked out on the basis of how many on-calls days/nights for the rota A and the same for rota B. These can then be added together to make a total number of on-call days/nights which can then be divided into 365 i.e. 365/number of on-call days/nights which will give the frequency.

The category of on-call should be defined according to the most onerous rota.

Availability Supplement

Category A: this applies where the consultant is typically required to return immediately to site when called or has to undertake interventions with a similar level of complexity to those that would normally be carried out on site, such as telemedicine or complex telephone consultations.

Category B: this applies where the consultant can typically respond by giving telephone advice and / or by returning to work later.

Frequency of rota commitment	Category A	Category B	SAS doctors only
1 in 1 – 1 in 4 rota (1-4 senior doctors)	8%	3%	6%
1 in 5 – 1 in 8 rota (5-8 senior doctors)	5%	2%	4%
1 in 9 or less (9 or more senior doctors)	3%	1%	2%

If the consultant covers colleague's on-call duties when they are away on study leave and annual leave, this prospective cover should be taken into account when assessing the workload for both types of emergency work. Prospective cover is not taken into account when calculating the on-call supplement.

Appendix 4: Reminder letter from Medical Director

To: All Senior Doctors

Dear Colleague

I am writing to remind all senior doctors that the terms and conditions of service set out in your contract of employment make it clear that each of you should participate in an annual job planning process and appraisal. These are required so that you may be eligible for both Clinical Excellence Awards (Consultants) and for Pay Progression; they are also contractual obligations. It is important to recognise if the timelines are not followed, this may affect your income.

The purpose of this letter is to inform you of the agreed Trust standard for job planning and to remind you of the timescales. The attached timetable details the responsibilities of Senior Doctors, Lead Clinician, Clinical Directors and Divisional General Managers.

To bring greater clarity, focus and consistency to the process the Trust is specifying a standard for satisfactory participation in job planning. This standard formalises the integration of the key elements of best practice within the Trust's Job Planning Policy into all job plans:

1. job plans should be integrated with service line capacity plans as outlined in the attached timetable and include an agreed annual amount of clinical and supporting professional activity as described in the Trust's Job Planning Policy
2. job planning meetings should be jointly undertaken by the Lead Clinician supported by the Divisional General Manager
3. job plans must have objectives which are aligned with Trust and service line requirements and these should incorporate service improvement objectives and productivity targets
4. The job planning process will be supported by using the e-Job Plan system.
5. Signed off jobs plans (at first and second sign off levels) should be available on the e-Job Plan system by the last day of February

You also need to have an appraisal each year. The summary document and PDP (paper or electronic) Form 4 should be received in the Medical Directors office by the last day of February. I suggest that you arrange to meet with your appraiser well in advance of this date, so as to ensure that the appraisal meeting happens in good time.

If there is any reason, why you are unable to meet these deadlines, please contact me in writing explaining your situation and an extension to the deadline will be considered.

With best wishes

Professor George Thomson
Medical Director

Appendix 5: NDHT Senior Medical Staff Job Planning Stages Timetable

Actions	Responsibility	Timescales/ Deadlines
Letter to all Senior doctors informing them of the job planning timetable and the Trust's expectations	Medical Director	End September
Circulate to all Senior Doctors: 1. Specialty capacity requirements (*) 2. Specialty service improvement objectives 3. Current & required productivity 4. Other clinical requirements 5. Specialty based job plan 6. Specialty non-generic SPA requirements by type and number of PA's aligned to Trust objectives	Divisional General Manager and Clinical Director	End of October
Publish job plans on e-Job Plan. This releases the new job plan template to the doctor. It can either be a copy of a previous job plan, a copy of a colleague's job plan or a blank template.	Project Team	End October
E-Job Plan in "discussion" stage. Job Plan viewable by the doctor and relevant specialty clinical managers. View and edit rights for both the 1 st sign-off manager and the doctor (with any changes visibly recorded). Either party can request 1 st level sign-off.	Usually Lead Clinician (1 st sign off manager) and senior doctor	End October
CD/DGM/Service Manager/ LC (as appropriate) meet with all Senior Doctors to discuss and agree the job planning requirements (above)	Clinical Director	Mid November
CD/DGM/Service Managers to finalise and circulate specialty service improvement objectives and productivity requirements	Clinical Director	End November
CD/ DGM/Service Managers LC (as appropriate) to draft individual/personal objectives and productivity requirements and circulate to senior doctors (at least 1 week prior to the job plan meeting)	Clinical Director	End November
1 st sign-off. No longer editable. The party who requested sign-off must either approve it or move it back to discussion so further amends can be made	1st sign off manager / DGM/Service Managers and consultant	Anytime from when job plan published through till mid-January

Doctors to notify CD & MD in writing / via e-Job Plan message board if they have significant concerns about objectives or productivity requirements	Senior Doctor	End December
Letter to all Senior Doctors reminding them of the end of February deadline	Director of Workforce & Development	Early January
2nd/3rd level sign off. Job Plan is no longer editable at these stages. The 2nd sign-off manager must either approve or move back to discussion stage for further amendments. 3rd level sign-off locks down the job plan once approved by 2nd sign off manager	Clinical Director (2 nd level) / Medical Director (3 rd level)	By end February
Job Planning Panel to review any significant concerns raised by Senior Doctors	Job Planning panel and Medical Directors	March
All job plans to be agreed or mediation instigated where either party disagree at first or second sign off stages. Mediation stage allows process to be tracked and relevant documentation to be attached	Senior Doctors / Clinical Director	End March

Note: () Initial capacity plans should be based on current year requirements, and amended once commissioner intentions are available.*

Appendix 6: Reminder letter from Director of Workforce and Development

DIRECTOR OF WORKFORCE AND DEVELOPMENT

Insert date

Dear Colleague

You will be aware that the terms and conditions of service set out in your contract of employment require senior doctors to participate in an annual Job Planning and Appraisal process.

I am writing to remind you of the dates regarding these processes.

Our records show that you are currently paid in excess of the standard 10 PA Job Plan and I would like to remind you that the Trust needs evidence that these additional programmed activities are continuing so that you will continue to be paid for them. For audit purposes, this evidence is taken to be a signed (but not necessarily agreed) Job Plan for 2015/16. A signed off job plan should be submitted within the E-Job Plan by the last day of February 2015.

You must also have an appraisal each year and the summary and PDP (paper or electronic) should be received by the Medical Directors office by the last day of February 2015.

In line with agreed procedures, in the absence of such a plan, this letter constitutes the required three months notice of a change to your contract, reducing your pay to 10 PAs effective 1st June 2015.

Please be assured that I am not writing to you because the Trust wants you to work and be paid for 10 PAs but because the Trust needs an agreed Job Plan for 2015/16. Naturally when a signed Job Plan is received this period of notice will be rendered null and void and we will agree your Job Plan in the normal way.

If there is any reason why you are unable to meet these deadlines, please contact me in writing explaining your situation and an extension to the deadline will be considered.

If you need any further advice please contact the LNC or MAC Chair or the Medical Director.

Thank you for your co-operation.

Yours sincerely

Darryn Allcorn
Director of Workforce and Development

Appendix 7: E-Job Plan Template

Northern Devon Healthcare NHS Trust

This job plan starts 01 April 2015.

Job plan for Dr XXX, in XXX

Basic Information

Job plan status	In 'Discussion' stage
Appointment	Full Time
Cycle	Rolling cycle - 1 week
Start Week	1
Report date	XXX
Expected number of weeks in attendance	42 weeks
Number of weekdays for on-call purposes	5 (Monday to Friday)
Alternate employer	None Specified
Contract	New

Job plan stages

Job plan stages	Comment	Date stage achieved	Who by
In 'Discussion' stage		XXX	Dr Zircadian Support

PA Breakdown

	Main Employer PAs	Core PAs	APA PAs	Total PAs	Core hours	APA hours	ATC hours	Total hours
Direct Clinical Care (DCC)	9.911	9.911	0.000	9.911	39:39	0:00	0:00	39:39
Supporting Professional Activities (SPA)	2.500	2.500	0.000	2.500	10:00	0:00	0:00	10:00
Total	12.411	12.411	0.000	12.411	49:39	0:00	0:00	49:39

On-call availability

Works on-call?	Yes
----------------	-----

General Settings:	
What is your on-call frequency?	1 in 8
Other Information:	
Where does your on-call work take place?	*North Devon District Hospital
Category	Category A (Return immediately to site or lengthy phone consultation)
PA Count:	
The number of PAs arising from your predictable on-call work is:	1.000
The number of PAs arising from your unpredictable on-call work is:	1.250
Your on-call availability supplement is:	5%
Link your predictable on-call work to a personal or service objective:	No linked objective
Link your unpredictable on-call work to a personal or service objective:	No linked objective

Sign off

Role: Clinical Manager	Role: Clinical Director	Role: Project Manager
Name: Dr XXX	Name: Dr XXX	Name: XXX
Signed:	Signed:	Signed:
Date:	Date:	Date:

Timetable

Week 1

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
07:00								
07:15								
07:30								
07:45								
08:00	Theatre - Theatre 1	WR - ICU / HDU		Theatre - Theatre 1				
08:15								
08:30								
08:45								
09:00								
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18:00								
18:15								
18:30								
18:45								
19:00								

Activities

Additional To Contract

None identified

Additional Programmed Activities

Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
						Total:	Core APA ATC	7.661 0.000	30:39 0:00 0:00
Mon	08:00 - 18:00		Theatre - Theatre 1	Northern De..	*North Devo..	DCC	42	2.500	10:00
Tue	08:00 - 13:30		WR - ICU / HDU	Northern De..	*North Devo..	DCC	42	1.375	5:30
Tue	13:30 - 17:30		WR - ICU / HDU Comments: Anaesthesia Care/ Resuscitation clinical lead	Northern De..	*North Devo..	DCC	42	1.000	4:00
Wed	13:00 - 17:00		OPD - ICU / HDU Comments: Once a month (entered as 12 times a year)	Northern De..	*North Devo..	DCC	12	0.286	1:09
Thu	08:00 - 18:00		Theatre - Theatre 1	Northern De..	*North Devo..	DCC	42	2.500	10:00

No specified day

Additional To Contract

None specified

Additional Programmed Activities

Normal Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
				Total:	Core	2.500	10:00

Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
						APA Replaced ATC	0.000 (0.000)	0:00 (0:00) 0:00
2:00	0:00	Educational supervision	Northern Devon Healthcare NHS Trust	*North Devon District Hospital	SPA	42	0.500	2:00
2:00	0:00	Appraisal - appraiser Comments: Senior Medical Appraiser	Northern Devon Healthcare NHS Trust	*North Devon District Hospital	SPA	42	0.500	2:00
6:00	0:00	Generic SPA including personal CPD, statutory and mandatory training	Northern Devon Healthcare NHS Trust	*North Devon District Hospital	SPA	42	1.500	6:00

On-call

Type	Normal	Premium	Cat.	PA
			Total:	2.250
Predictable	n/a	n/a	DCC	1.000
Unpredictable	n/a	n/a	DCC	1.250

Resources

Staff
Equipment
Clinical Space
Other

Additional Comments

Appendix 8: Supporting Professional Activities – a good practice guide

Supporting Professional Activities – a good practice guide

April 2008

Introduction

Supporting Professional Activities are at the heart of what it means to be a senior doctor and exemplify the added value that senior doctors bring to the NHS. It is during the time made available through SPAs that senior doctors are able to improve and hone their skills, research, innovate, develop new techniques and build new services.

The 2003 consultant contract makes clear reference to a typical number of supporting professional activities, 2.5 per week on average (para 7.31), available to the full time consultant. This means that 2.5 SPAs defines a typical consultant contract, and variance from this (more or fewer) should be supported by robust reasons justified with reference to the agreed expectations and performance and not simply by the wishes of one party or the other.

The 2008 specialty doctor contract Schedule 4 refers to a minimum of 1 supporting professional activities being available to full time specialty doctors and Schedule 15 (para 13) supports reassessment of the balance between supporting professional activities and direct clinical care as the doctor becomes more experienced and takes on a broader role as they move between thresholds

Background

Health services develop and undergo continual improvement through the efforts of consultants: by their professional commitment to remaining in lifelong education, by continuing to innovate and by taking the initiative to develop and introduce new services, thereby increasing the value of the employer's business and the quality of the service to patients. In addition, there are certain aspects of essential supporting work that can only be performed by consultants. These include the management and supervision of clinical governance, clinical audit, complaints and litigation matters.

The Contract

A contract is an agreement between two parties under which an agreed amount of work is performed. It is important to remember that in contracting to perform 1.5 SPAs per week on average, a senior doctor does not receive an allowance of PAs to do with as he or she wishes, but rather agrees to perform a certain amount of work appropriate to the senior doctor grade and to the service objectives of the employer. This gives an employer the right to monitor the performance of the senior doctor during SPA time, looking at time spent and outcomes achieved, in the same way as the employer has the right to look at time spent and outcomes achieved in direct clinical care (DCC) PAs.

This does not mean, however, that all SPA work has to be fixed to specific times and locations. Consultants and Specialty Doctors are senior and professional employees who should be trusted to operate effectively and responsibly. Employers should not establish process simply in order to exert control over their senior doctors.

At their best, senior doctors work flexibly, often combining different types of work in one small time period in order to perform efficiently. Such flexibility is clearly of benefit to employers. The point is to get the balance right. We recognise that this may make the time-tabling of SPA activity difficult. Senior doctors should remain accountable to their employer for the achievement of agreed objectives in both DCC and SPA time.

Scheduling SPAs – time

Whilst it is clearly appropriate to schedule SPA work in the job plan it would be bad practice to be too restrictive. SPAs should be scheduled intelligently with thought given to who needs to be present, what resources should be available and other such considerations. The purpose of flexibility is to allow consultants the freedom to do a job well and at a convenient time and place. A pragmatic view is that some SPA work should take place at defined times, even where these times are expressed as a series of regular meetings or events, and some should be flexible. In agreeing flexibility, it is important for the consultant to satisfy the employer that, for example, the code on private practice is being followed with regards to declaration of protected time. The annualisation of job plans or, at least the SPA part, is strongly encouraged. The CCSC has produced guidance on this which can be found here:

<http://www.bma.org.uk/ap.nsf/Content/Annualisationconsultants?OpenDocument&Highlight=2,annualisation>.

Model consultant contract, version 3 – 30 June 2006, available here:

<http://www.bma.org.uk/ap.nsf/Content/NewcontractTCSJune2005>

Scheduling SPAs – location

It is reasonable to agree a location for SPAs as long as that is not restrictive on professional performance.

Many senior doctors, for example, are able and willing to spend time on CPD, clinical management and teaching away from their office, or at home, and it is appropriate to agree this. Many consultants' work benefits from remote access to trust emails and servers.

Where SPA work is scheduled to be done in a specific location, that location must be capable of supporting consultant-level work. Requirements may vary by specialty and activity but in general, the location needs privacy in order to preserve patient confidentiality, computer, internet and email access, to be free from undue disturbance and in an environment that is appropriate for senior professional employees.

Monitoring SPA work

Both parties to a contract should be able to be content that the contract is performing as it should – allowing a consultant to deliver professional work while at the same time allowing

an employer to know that the work is being done. It is appropriate to monitor SPAs in terms of time and outcomes.

Monitoring performance – time

Occasional time monitoring is an important aspect of a contract that was, in part, agreed nationally in order to allow senior doctors some control over the extent of their working lives. It is useful for a senior doctor to monitor from time to time how much SPA work they are doing, and this data should be shared with the employer at the regular job planning reviews. This is best done by keeping a diary for a representative number of weeks.

Given the nature of some of the work involved and the flexibility noted above, it should not be surprising if in some weeks the agreed allocation is not used. However, if the average matches the amount of SPA time agreed then there should be no problem. If the time spent is greater than the allocation, then the nature of the work should be examined, with a view to remunerating appropriate work or eliminating inappropriate work. This may include passing on a responsibility to another consultant in the department or hospital, or providing support (both medical and non-medical) and thus increasing efficiency.

If the average shows that less work is being performed than agreed, then both parties should reflect on the typical allocation of 2.5 SPAs (consultant) or minimum of 1 SAP (Specialty Doctor). It is important for the reasons given above that this work is available to the employer and it would be appropriate to agree further objectives that would need this time to achieve.

In the event that both parties agree to reduce the number of SPAs below 2.5 (consultants) then this would be appropriate but only insofar as sufficient SPA time remains available for the consultant to revalidate and recertify. However, an agreement to reduce SPAs does call into question the commitment of both parties to the nationally agreed role of the consultant in the National Health Service.

Monitoring performance – outcomes

It is important to remember that the consultant contract was not designed to be supported by clocking in or out. Deciding on the predominant activity within a time period can be difficult. It is vital therefore to look at outcomes of SPA work, and in some cases this may be the only monitoring required.

A senior doctor should reasonably be expected to bring to the job plan meeting evidence of the outcomes generated during SPA time. This could be in terms of guidelines reviewed or generated, audit performed and completed, skills acquired or revised, experience or training shared with colleagues and developments initiated and followed through. A useful analogy here would be the information normally found on an application form for clinical excellence awards; although much of the important work reported there will be direct clinical care, it can also be SPA work.

Summary

SPAs are not an allowance for the comfort of senior doctors and nor are they of no value to employers.

Performing an agreed amount of supporting professional work is part of the role of the consultant.

Senior doctors are accountable for the performance of this work; it is reasonable for this accountability to take the form of occasional monitoring of the time spent doing such work and its outcomes

Appendix 9: Guidance on implementing the EC directive on working time for consultants

Please click on attached link to access BMA guidance on working time and compensatory rest.

<http://bma.org.uk/practical-support-at-work/ewtd/ewtd-consultants>

Appendix 10

Policy for the Employment of SAS Doctors by Northern Devon Healthcare Trust

Doctors of the staff and associate specialist group (SAS) – formally described as non-consultant career grade doctors- are senior hospital doctors comprising Associate Specialists, Specialty Doctors, Staff Grades, Clinical Assistants, CMOs and SCMOs, Hospital Practitioners and other non-standard, non-training “Trust” grades.

Northern Devon Healthcare Trust employs a substantial number of SAS doctors and wishes to provide a working environment which recognises their diversity of background, the major contribution they make to the delivery of care to patients and one which adequately rewards, motivates and develops this essential group of doctors. The Trust is committed to ensuring that the role of SAS doctors it employs is fully acknowledged and respected by the management, colleagues and patients. In order to deliver this aspiration, the following recommendations have been agreed by the Trust and doctors’ representatives.

The recommendations are as follows:

The SAS group of doctors is recognised by the Trust management. This group shall meet regularly and elect a Chairman and Deputy who will represent the group and ensure that the recommendations contained herein are implemented. It will also act as a policy setting group for SAS doctors and a forum for discussion, making recommendations to be referred to the LNC and joint LNC for agreement. The group will be represented at both LNC and JLNC meetings.

There should be an adequate representation of SAS doctors employed throughout the trust on the SAS group. In addition attendance at Departmental/Directorate, by SAS representatives from within those individual departments/directorates should be facilitated by the Trust.

The Trust will work towards every SAS Doctor having the following conditions as a minimum –

- an appropriate contract of employment incorporating National Terms and Conditions of Service (in accordance with national and local collective agreements – including the Peninsula Agreement for the implementation of the 2008 Associate Specialist and Specialty Grade Contracts (where applicable);
- For those SAS doctors remaining on the pre-2008 Terms and Conditions of Service, the opportunity to move to the new 2008 contract and Terms and Conditions of Service at any time. Associate Specialists will be allowed to move to the 2008 Associate Specialist Contract and Staff Grade doctors will be allowed to move to the Specialty Doctor Contract;

- The 2008 Specialty Doctor Contract shall be offered to any doctor employed on local Terms and Conditions, provided they meet the entry requirements for the Specialty Doctor grade;
- No individual should be disadvantaged by choosing to transfer to the new contractual arrangements or to remain on the pre-2008 arrangements;
- An appropriate agreed job plan that may be changed by mutual agreement between the SAS doctor and the relevant clinical manager in accordance with the agreed process for the review of job plans and any recommendations following appraisal, such job plan to include clear provision of office facilities, secretarial and other resource support;
- An adequate session or programmed activity allocation with separate and identifiable time allocated for administration, education, audit and teaching commitments etc as provided for in the 2008 Contracts of Employment. The precise amount will depend on the requirements of the particular post and the Trust will give due regard to the recommendations of the appropriate Royal College etc. It is noted that the Academy of Medical Royal Colleges recommends a minimum allocation of 1.5 SPAs (6 hours) in order to allow SAS doctors to fulfill their CPD and revalidation obligations;
- Access to office accommodation, telephone and computer facilities in each department/directorate where SAS doctors are employed, to include email and suitable storage facilities for confidential/private work related papers, books etc;
- Adequate secretarial support to enable the efficient discharge of patient related correspondence and other administrative work for the Trust;
- Adequate support and time allocation to allow SAS doctors to participate in the Trusts' appraisal process and the necessary CPD and study leave requirements which are a necessary consequence of appraisal;
- Adequate and fully funded study leave;
- Equitable access to further developmental opportunities in accordance with the Statement of Principles and Priorities for the Allocation of the Additional funding for the Training and Professional Development of SAS doctors (see Appendix 1);
- SAS doctors should be supported within the Trust by the appointment of an SAS Tutor with protected sessions or programmed activity time to promote their professional and educational interests;
- For those Specialty Doctors and Associate Specialists on the 2008 Terms and Conditions of Service the opportunity to progress through the pay thresholds

in accordance with the Terms and Conditions of Service and any local agreement for threshold progression;

- For those SAS doctors remaining on pre-2008 Terms and Conditions of Service, access to a fair and appropriate mechanism for the award of optional points to Staff Grade Doctors and discretionary points to Associate Specialists where eligible;
- Adequate rest facilities particularly for SAS doctors who are required to work at night;
- Adequate training and educational facilities;
- As senior hospital doctors, all SAS doctors are entitled to attend and fully participate in meetings of the Trusts' medical staff committee and shall be included in the circulation list for agendas etc;

Progress in achieving these aims should be monitored by an annual survey of SAS doctors and reviewed annually by the JLNC.

The Responsibilities of every SAS doctor include:

- Decline to undertake duties for which you have not been trained, or which you feel you would not be able to undertake safely;
- A responsibility to ensure that your colleagues and all patients/clients receive the same treatment, care and attention regardless of race, colour, religion, ethnic origin, gender, marital status, age, sexuality or disability;
- A responsibility to work cooperatively with your colleagues and to respect and value their contribution to patients/client care and their dignity in the workplace;
- A responsibility to ensure at all times the confidentiality of information about individual patients, clients and staff. Such information should not be released without the consent of the patient/client/staff concerned unless required by court order. You also have an implied duty of confidentiality and loyalty to the Trust;

Agreed and adopted LNC 29th March 2011



Appendix 1 (of Appendix 10)

STAFF AND ASSOCIATE SPECIALISTS COMMITTEE

Statement of Principles and Priorities for the Allocation of the Additional Funding for the Training and Professional Development of SAS Doctors

£12 million recurrent funding has been made available by the Department of Health under Modernising Medical Careers and in line with Choice and Opportunity Recommendations 5 and 6 to support the development of SAS doctors working in Trusts in England. SAS grade doctors in general should be considered to be “developing” doctors and adequate resource and planning should be made to effect the development of the grade and individual doctors within the grade.

The level of funding given to the Strategic Health Authorities has been calculated as a per capita amount against head count using data from the March 2006 census.

Introduction

The purpose of this paper is to set out the principles and priorities for the allocation, purpose, management and accounting of this funding.

The BMA UK Staff and Associate Specialists Committee (SASC UK) believes this funding should be used for innovation and opportunities not normally funded by Trust study leave budgets (which should fund the normal CPD expectations of SAS doctors).

SASC UK carried out a survey of SAS doctors in September 2008 and a similar local survey was carried out in the South West. As expected, these surveys showed a variety of aspirations. SASC has condensed these into the following principles and recommendations. The full survey report (which includes a breakdown by deanery) is available on the BMA website (www.bma.org.uk).

SASC funding suggestions are in line with the aims of the Department of Health/NHSE’s ‘Employing and supporting specialty doctors: a guide to good practice’ which is also available on the BMA Website.

Principles

Funding distribution

Whilst the monies are allocated to Strategic Health Authorities and passed on to Trusts on a per capita basis, the distribution should not be strictly on an individual per capita basis. We would urge Trusts to involve deaneries in the process as much as possible and would suggest that deaneries lead on distribution. When distributing the funding SHAs/deaneries should remember peripheral district general hospitals and sites.

Appendix 1

Background

This additional funding must be regarded as entirely separate from existing study leave monies; present and future study leave budgets should not be compromised by this additional funding.

Agreement with SAS doctors

Each Trust should seek agreement with its SAS doctors in regard to the priorities for the allocation of funding and the monitoring, reporting and audit thereof. Such agreement may be via the Trust's SAS representatives or LNC where there is no separate SAS representative body.

Consistent Approach

There should be a consistent approach in each area based on the outcomes of the SASC survey and recommendations below. SAS development needs should be identified for the local group and individuals through appraisal and consultation. It is the responsibility of the Strategic Health Authority to ensure fair distribution, monitoring, reporting and policing. The postgraduate medical deaneries will act in an advisory capacity to the SHA to identify and recommend priorities for SAS development.

Consistent Mechanism

As indicated above, the mechanism for allocation of the funds should be consistent across the Strategic Health Authority region, involving Directors of Medical Education and Trust SAS Tutors along with the SAS Doctors themselves. It is suggested the process for application be agreed by the Directors of Medical Education in consultation with Trust SAS Representatives and the SAS Tutor (in those Trusts that have one).

Monitoring & Review

There should be ongoing monitoring arrangements which feature consultation by the SHA with Regional SASC representatives, Postgraduate Deaneries and Trust Representatives.

There should be a mandatory annual review of the system following monitoring and reporting by the Strategic Health Authority to enable continuous improvement of the process. The DH/NHSE guide to employing and supporting specialty doctors also says that employers should keep a database of SAS doctors' development plans and aspirations and of their status and intentions, for instance with regard to Article 14 applications, skill levels and specialty interests.

SASC Recommended spending priorities

The results of the SASC Surveys indicate that priority should be given to requests which involve the development of all SAS Doctors. This is in line with the DH/NHSE guidance.

Within current SHA funding

Several suggestions came out of the survey that should already be funded within current SHA budgets and should not usually necessitate use of the additional funding. These are:

- SAS representation of SAS Doctors at regional and national level for educational planning (eg. MEE).
- Development needed for Article 14 progression
- Training for processes involved in recertification/revalidation
- Work needed for movement between service and training posts
- Support/time for interaction with SAS tutors
- Opportunities to develop new skills and innovative initiatives
- Opportunities in the independent sector
- Support for Trust-based CPD opportunities aimed at SAS Doctors collectively.
- Backfilling posts when SAS doctors are seconded for training purposes.

Within new funding

Additional resources and infrastructures should be provided from the additional funding to meet CPD, CME, revalidation and training needs. In particular, the following are suggested, specific uses for the additional funding:

- Top-up training to meet requirement for an Article 14 or CESR application or for CPD, CME or revalidation. Employers could also consider weekly sessional commitments to a specific specialist unit where applicable or providing other Specialist clinic or theatre placements.

- Secondment opportunities - Time limited post/secondment for a specific training opportunity or requirement.
- Workplace based Assessment – A system should be put in place to monitor and assess experience and skills and to assist in identifying a training element in the work that SAS doctors are doing for those that require this.
- Introduce a voluntary Record of Independent Assessment similar to the SpR type RITA for those that request it to certify SAS doctors to work autonomously within agreed boundaries for use as part of portfolios. This should be signed at the time of appraisal and a copy should be kept by the deanery.
- Specific clinical management or other educational skills courses/ workshops could be provided; where not already funded within study leave budgets. Leadership training, master classes, coaching/mentoring and management training were all identified in the SAS survey as popular and necessary courses. Distance learning could also be considered as a practical alternative.
- A Regional Study Day for SAS doctors.
- It is recommended that all Trusts consider, as a minimum, appointing an SAS Clinical Tutor, to oversee the development of SAS Doctors generally.

Appendix 11 - Equality Impact Assessment screening form

Equality Impact Assessment Screening Form			
Title	Job Planning Policy		
Author	Jo Holmes		
Directorate	Workforce Development		
Team/ Dept.	Human Resources		
Document Class Policy	Document Status Final	Issue Date 05/05/15	Review Date 05/05/18
1	What are the aims of the document? This policy sets out Northern Devon Healthcare NHS Trust's best practice approach for Senior Doctors (Consultants and Staff and Associate Specialists) Job Plans		
2	What are the objectives of the document? This policy has been developed with the aim of improving the working lives of senior doctors and to fulfill the stated ministerial aim of the NHS being a model employer. <ul style="list-style-type: none"> • To improve the understanding of the purpose of job planning. • To define the difference between appraisal and job planning. • To improve equity between specialty job plans. • To give guidance to support the EWTD. 		
3	How will the document be implemented? This document will be made available on Bob and as a link within E-Job Plan so that senior doctors and managers can refer to it when job planning.		
4	How will the effectiveness of the document be monitored? Monitoring of implementation, effectiveness and compliance with these guidelines will be the responsibility of the Medical Director. This agreement and its implementation will be reviewed on an annual basis by the LNC, such review to include all relevant statistics demonstrating the extent of its use and the costs associated therewith.		
5	Who is the target audience of the document? Senior Doctors (Consultants and Staff and Associate Specialists)		
6	Is consultation required with stakeholders, e.g. Trust committees and equality groups? Yes		

7	<p>Which stakeholders have been consulted with?</p> <ul style="list-style-type: none"> • Senior Medical Staff and Operational Management via M&D Policy Group • Local Negotiating committee (LNC) 																																																		
8	<p>Equality Impact Assessment</p> <p>Please complete the following table using a cross, i.e. X. Please refer to the document “A Practical Guide to Equality Impact Assessment”, Appendix C, on Tarkanet for areas of possible impact.</p> <ul style="list-style-type: none"> • Where you think that the policy could have a positive impact on any of the equality group(s) like promoting equality and equal opportunities or improving relations within equality groups, put a cross in the ‘Positive impact’ box. • Where you think that the policy could have a negative impact on any of the equality group(s) i.e. it could disadvantage them, , put a cross in the ‘Negative impact’ box. • Where you think that the policy has no impact on any of the equality group(s) listed below i.e. it has no effect currently on equality groups, , put a cross in the ‘No impact’ box. <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #cccccc;"> <th style="width: 15%;">Equality Group</th> <th style="width: 15%;">Positive Impact</th> <th style="width: 15%;">Negative Impact</th> <th style="width: 15%;">No Impact</th> <th style="width: 40%;">Comments</th> </tr> </thead> <tbody> <tr><td style="text-align: center;">Age</td><td></td><td></td><td style="text-align: center;">x</td><td></td></tr> <tr><td style="text-align: center;">Disability</td><td></td><td></td><td style="text-align: center;">x</td><td></td></tr> <tr><td style="text-align: center;">Gender Reassignment</td><td></td><td></td><td style="text-align: center;">x</td><td></td></tr> <tr><td style="text-align: center;">Marriage and civil partnership</td><td></td><td></td><td style="text-align: center;">x</td><td></td></tr> <tr><td style="text-align: center;">Pregnancy and maternity</td><td></td><td></td><td style="text-align: center;">x</td><td></td></tr> <tr><td style="text-align: center;">Race</td><td></td><td></td><td style="text-align: center;">x</td><td></td></tr> <tr><td style="text-align: center;">Religion or Belief</td><td></td><td></td><td style="text-align: center;">x</td><td></td></tr> <tr><td style="text-align: center;">Sex</td><td></td><td></td><td style="text-align: center;">x</td><td></td></tr> <tr><td style="text-align: center;">Sexual Orientation</td><td></td><td></td><td style="text-align: center;">x</td><td></td></tr> </tbody> </table> <p>If you have identified a negative discriminatory impact of this procedural document, ensure you detail the action taken to avoid/reduce this impact in the Comments column. If you have identified a high negative impact, you will need to do a Full Equality Impact Assessment, please refer to the document “A Practical Guide to Equality Impact Assessments”, Appendix C, on BOB</p> <p>For advice in respect of answering the above questions, please contact the Equality and Diversity Lead.</p>	Equality Group	Positive Impact	Negative Impact	No Impact	Comments	Age			x		Disability			x		Gender Reassignment			x		Marriage and civil partnership			x		Pregnancy and maternity			x		Race			x		Religion or Belief			x		Sex			x		Sexual Orientation			x	
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9	<p>If there is no evidence that the document promotes equality, equal opportunities or improved relations, could it be adapted so that it does? If so, how?</p>																																																		

Completed by:

Name	Jo Holmes
Designation	Assistant Director of HR (Acute)
Trust	Northern Devon Healthcare NHS Trust
Date	5 th April 2015

