

Medical Staff Job Planning

HR71

Additionally refer to: National Terms and Conditions

Managing Conflicts of Interest in the NHS

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Contents

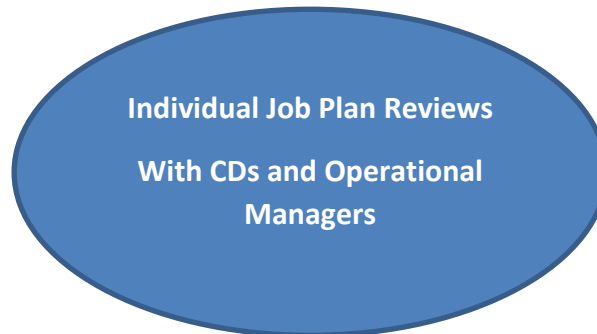
| | |
|--|----|
| Policy on a Page..... | 4 |
| 1 Introduction..... | 5 |
| 2 Key Principles..... | 5 |
| 3 Strategic Goals..... | 5 |
| 4 Work Commitment..... | 6 |
| 5 Direct Clinical Care (DCC)..... | 7 |
| 6 Supporting Professional Activities (SPAs)..... | 7 |
| 7 General Teaching Commitments | 8 |
| 8 Additional NHS Responsibilities..... | 9 |
| 9 External Duties | 9 |
| 10 Joint Contracts/Secondments with Other Organisations | 10 |
| 11 On-call..... | 10 |
| 12 Honorary Consultant Medical Staff with Substantive University Contract..... | 12 |
| 13 Performance Objectives | 13 |
| 14 Pay Progression | 13 |
| 15 Clinical Excellence Awards..... | 13 |
| 16 Travel Time | 14 |
| 17 Private Practice | 14 |
| 18 Additional Clinical Activity | 15 |
| 19 Job Plan Reviews | 15 |
| 20 Records..... | 16 |
| 21 Medical Job Planning Consistency Committee | 17 |
| 22 Training | 17 |
| 23 Equality Impact Assessment..... | 17 |
| 24 Process for monitoring compliance with the effectiveness of this policy | 17 |
| 25 Review arrangements..... | 17 |
| Appendix 1 Examples of Corporate Activities for SPA | 18 |
| Appendix 2 Content of a Job Plan Review | 19 |
| Appendix 3 The Annual Job Planning Cycle | 20 |

Policy on a Page

Step 1



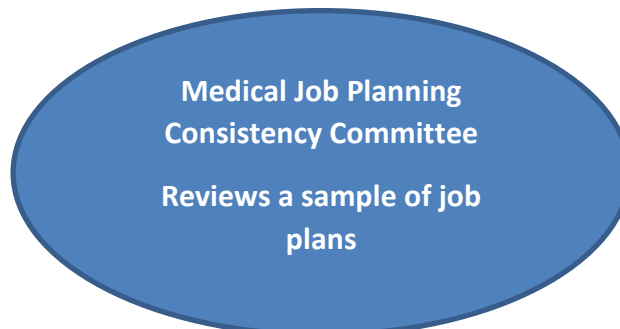
Step 2



Step 3



Step 4



1 Introduction

- 1.1 The 2003 Consultant and the 2008 Associate Specialist contracts included a new and more robust system for job planning. The contracts and the job planning processes allow a reasonable amount of flexibility for local discretion and agreement. The purpose of this paper is to set out SaTH's approach to Consultant, Associate Specialist and Specialty Doctors job planning.
- 1.2 This document is the result of extensive discussion among stakeholders within the Trust, including Medical Staff, Clinical Managers, LNC Representatives, BMA representatives, Education Leads, Trust HR and Information.
- 1.3 Further help and guidance is available from the Medical Director's Office.

2 Key Principles

- 2.1 The principles in this document were developed in line with the Terms and Conditions of the Consultant Contract (2003) and the Specialty Doctors and Associate Specialist Contracts (2008). The terms and conditions state that the annual job plan review may result in a revised prospective job plan. Although not all Consultants, Associate Specialist and Staff Grade Doctors may have moved to the new contract, the general principles of job planning will apply. The following principles should be observed when conducting job planning with clinicians:
 - **Equity:** the essence of the Medical Staff contract is to remunerate individuals on the basis of the activities they undertake which are in line with the Trust objectives. The Trust's intention therefore is neither to under nor over reward any individual but to pay them fairly for the work undertaken.
 - **Consistency:** it is crucial that a consistent and fair approach is adopted between individuals and specialties. This will be based upon a set of logical and transparent guidelines that will apply to all.
 - **Collaboration:** the fundamental concept is for the Trust to work in partnership with its clinicians to agree mutually acceptable job plans.
 - **Trust:** the Trust regards its Medical Staff body as motivated, ethical and professional, and will treat them accordingly. The Trust's expectation is that clinicians will reciprocate with honesty and openness throughout this process.
 - **Accountability:** as a publicly funded organisation the Trust has a statutory responsibility for probity. For this reason job plans must be based upon fact and evidence.
 - **Prospective approach:** the job planning process is prospective; therefore decisions made will affect further work, future workload and payments.

3 Strategic Goals

- 3.1 To have an accurate and up to date job plan for each clinician that sets out the agreed number of Planned Activities (PAs) and on-call commitments he or she will undertake, plus an understanding of the activities he or she has agreed to perform within those PAs.

- 3.2 To align the objectives of individuals and clinical teams with the objectives of the Trust and to recognise and to reward the work that clinicians undertake within the agreed job plan. Managers will support the job planning process to ensure this is implemented.
- 3.3 To provide support to the clinician in delivering the responsibilities identified in the agreed job plan.
- 3.4 To prioritise the work of clinicians and reduce excessive workload.
- 3.5 To agree how clinical teams can most effectively meet patients' needs and support the wider objectives of the NHS.
- 3.6 To provide the clinician with evidence for appraisal, job planning and revalidation in a timely fashion.
- 3.7 To ensure that the implementation of job planning is clinically-led.
- 3.8 To establish a model job planning template for use across the Trust.

4 Work Commitment

- 4.1 The Terms and Conditions of the Consultant Contract (2003) and Associate Specialist and Specialty Doctors Contracts (2008) are based upon a full-time work commitment of 10 core Programmed Activities (PAs) per week. These core PAs will be clearly identified in the job plan and will include both the predictable and unpredictable activity associated with out of hours emergency work. Any PAs agreed beyond the 10 core PAs will be separately identified as additional PAs on the job plan so it is clear which activity is core and which is additional.
- 4.2 Four hours of work has a value of one PA, unless it has been agreed between the clinician and the Trust to undertake the work in premium time, in which case it is 3 hours.

Premium time is classified as any time that falls outside of the hours 07.00 to 19.00 Monday to Friday. Any time on a Saturday or Sunday or Public Holiday is premium time. Periods of activity less or more than a full PA should be recorded and paid pro rata.
- 4.3 PAs above 10 per week are temporary, Additional Programmed Activities (APAs). The allocation of all APAs is to be negotiated annually as part of the job planning review. APAs must be separately identified in each job plan. Either party may give 3 months notice to terminate APAs. Core activity will be retained (section 4.1). Requirements related to private practice will remain (section 17.7)
- 4.4 This guidance should be read in conjunction with the European Working Time Directive (EWTd). The Trust will not require anyone to work more than 48 hours per week over the cycle of their job plan. Individuals who wish to work in excess of this limit will be required to agree this and sign an opt-out agreement as part of their annual job plan review.
- 4.5 If clinicians choose to undertake a PA in premium time rather than core working hours for their personal convenience, the time allocation for the PA is 4 hours.
- 4.6 The job plan will set out the agreed places of work. The default position is that the clinician is expected to undertake activities at their principal place of work.

5 Direct Clinical Care (DCC)

- 5.1 DCC activity relates directly to the prevention, diagnosis or treatment of illness. This comprises operating sessions, outpatient clinics, direct patient related administration, ward rounds, clinical diagnostic work, emergency duties and other patient treatments.
- 5.2 A Multi-Disciplinary Team (MDT) meeting is counted as DCC time. Mixed meetings should be explicitly divided into time for planning patient care and time for other purposes. Preparation for an MDT meeting (for example diagnostics) is also counted as DCC.
- 5.3 The amount of DCC time allocated to direct patient related administrative activity may vary according to the requirements of a particular role but will be broadly similar for all doctors. The requirement of 4 hours administration in excess of clinic allocation and additional allocation for theatre activity would be the expected norm for most job plans.
- 5.4 The PA allocation to various activities depends on the time spent and so the allocation to outpatient clinics will depend on the clinic template. There is an expectation that clinics will run for 3 ½ hours with an allocation of ½ hour for administration associated with completion of the clinic. Operating theatre lists that involve both pre- and post-operative assessment of patients would be expected to last for 4 hours for the surgical session and 1 hour for the other activities associated with the session.
- 5.5 PAs required for prospective cover for annual leave and study leave should be calculated during the job planning review.
- 5.6 Through the job planning process there may be opportunities for agreement that some DCC activities may be worked flexibly e.g. an annualised hours/PAs approach.

6 Supporting Professional Activities (SPAs)

- 6.1 SPAs are activities that underpin and improve DCC.
- 6.2 All doctors will require 1.0 SPA to complete the requirements for appraisal and revalidation and this includes attendance at monthly audit/governance meetings and statutory and mandatory training. If there are requirements for greater than monthly audit/governance meetings then these should be job planned separately to this core SPA time.
- 6.3 The majority of doctors will require 0.5 SPA to contribute to activities such as clinical supervision, clinical guidelines, completion of national audits, completion of responses to NICE Technology appraisals, quality improvement work and guidance, mortality reviews, contribution to incident investigations (eg root cause analyses and high risk case reviews) and response to complaints.
- 6.4 One further SPA is available to most doctors for corporate activities and examples may be found on Appendix 1. It is expected that this corporate PA will be performed on-site and the timetable should be agreed by the Consultant's Clinical Director.
- 6.5 SPA activities must be relevant to the individual clinician and to the Trust. The content should be discussed and agreed at the both group and individual job planning sessions.
- 6.6 The 2003 contract and BMA guidance states that a full time consultant will "typically" undertake 2.5 SPAs per week. 2.5 is neither a minimum nor a maximum, nor is it an allowance. It is envisaged that a contract for a newly appointed full time Consultant will typically include an allocation of 7.5 DCC PAs and 2.5 SPAs. There is flexibility to alter this balance where, in order to best meet the needs of the population served and the Trust, a clinician's level of duties

for SPAs, Additional NHS Responsibilities and/or External Duties is significantly different from these norms.

It is envisaged that a contract for a newly appointed full time Associate Specialist or Specialty Doctor will include an allocation of 9 DCC PAs and a minimum of 1 SPA.

- 6.7 Clinicians must be able to demonstrate that the time identified is needed for the agreed activities and that these activities are undertaken. Evidence for this can be provided in the following two ways:
- The output from this SPA time (research, articles, teaching etc.) will be reviewed and discussed during job planning discussions.
 - Clinicians may keep a work diary which includes details of SPA activities.
- 6.8 Clinicians have an obligation to attend key sessions (e.g. audit and governance meetings) and must aim to achieve attendance of at least 75%, excluding the time they are away from work due to leave. These activities are included within core SPA time. Those not doing so without valid reason (e.g. leave or urgent clinical care) may be expected to account for their absence. The Trust and individual clinician should agree job plans that facilitate this.
- 6.9 SPA time may legitimately be undertaken at a variety of locations, but it is expected that typically no more than 1 of these SPAs will be offsite. Exceptions would require specific agreement at the job planning meetings. Supporting resources such as office space and access to a computer will be provided by the Trust to facilitate this.
- 6.10 Meeting objectives is an integral part of the Consultant contract. Objectives are derived from the job planning process, and to be a combination of personal and corporate objectives and job planning needs to be linked to the Trust strategy.

7 General Teaching Commitments

- 7.1 Individuals will vary in their responsibilities and the time needed to deliver these commitments.
- 7.2 All clinicians are expected to participate in education as part of their employment and those who clinical or educationally supervise trainees are expected to fulfil the GMC requirements for trainers.
- 7.3 Time spent teaching in clinics and ward rounds is included in the DCC allocated for these duties and is not additional.
- 7.4 Workplace-based teaching may affect the volume of activity which can be undertaken within a clinical session. Variations in activity will be identified and accommodated as part of the job planning process (up to 30 minutes per PA).
- 7.5 Some doctors will be appointed to specific undergraduate teaching roles with time seconded to University activities. This activity will be funded by Educational tariff reimbursed by the undergraduate department. Doctors must agree any proposed change to their job plan with their line manager/Clinical Director prior to accepting these roles.
- 7.6 For Postgraduate Educational Supervisor roles an appropriate allowance of corporate SPA activity will be agreed, the usual expectation is of 0.25 SPA per trainee up to maximum of 1.0 SPA ie 4 trainees. This equates to spending approximately 1 hour per week with each trainee. This allocation will include the time required for completion and review of educational portfolios and attendance at educational supervisor meetings as defined by the Director of Medical Education or nominated educational lead. Time can only be included in the job plan if there is a trainee allocated to the supervisor.

- 7.7 The same principal of SPA allocation can be applied to Educational Supervision of other Health Care Professionals if agreed at the time of job planning eg ACPs, PAs, Trust doctors etc.

8 Additional NHS Responsibilities

- 8.1 The nature of the additional NHS responsibility should be discussed and agreed before any role is accepted. It is advisable for Consultants to agree this prior to application for any role since appointment panels for many external roles will expect agreement to have been reached in advance. The time required for these roles should be clearly identified in the job plan with associated objectives and supporting resources. For some doctors this may be agreed as an alternative to other corporate SPA work. For other doctors this may be agreed either as additional programmed activities or as substitution for core DCC. The Trust wishes to encourage clinicians to undertake roles within the wider NHS. There is a cost to the Trust and to other members of the clinical team when clinicians undertake such activities because it takes them away from their duties within the Trust. However, some additional NHS responsibilities will require additional SPA time.
- 8.2 A reasonable assessment of the time taken to discharge the responsibility is brought into the job plan discussion.
- 8.3 The time required for substantial internal SaTH additional responsibilities will be explicitly stated in job descriptions. Typical examples of such roles include:
- Deputy Medical Director
 - Care Group Medical Director
 - Clinical Director
 - Director Medical Education
 - Cancer Lead
 - Royal College Tutor
 - Informatics Lead
 - Research and Development Lead
 - SAS Tutor
 - LNC Chair
 - Appraisal Lead
 - Some senior management posts may attract additional remuneration as a responsibility allowance which will be identified within the job plan.
 - Undergraduate and postgraduate lead /training programme director roles to which appointments are made by the educational partner in conjunction with the Trust.

9 External Duties

- 9.1 The Trust wishes to encourage clinicians to undertake roles within the wider NHS. There is a cost to the Trust and to other members of the clinical team when clinicians undertake such activities because it takes them away from their duties within the Trust. Some examples include:
- Royal College work and examinations
 - National representation on committees and teaching
 - Health Education England activities
 - NICE
 - CQC
 - GMC
 - NHS England

- NHS Improvement
- External lectures.

9.2 The clinician concerned is responsible for informing the Clinical Director of their intention to apply for any external duty so that a full understanding of responsibilities is reached. The Trust may request formal confirmation of such activities.

9.3 All external duties should be agreed in advance of the appointment by the clinical director as part of the job planning process. If there is a dispute with the Clinical Director, the Consultant may ask for the decision to be reviewed by the Care Group Medical Director, and following the escalation process. The Trust will adopt a pragmatic approach to the issue on an individual basis and will support external duties so long as:

- There is a demonstrable benefit to the individual, the Trust or the wider NHS
- The Medical Director, Clinical Director or relevant line manager for the department supports the request
- It should be agreed whether any loss of service delivery within the speciality/department should be replaced or not and whether the time required can be incorporated within corporate SPA time or by allocation of professional leave.

10 Joint Contracts/Secondments with Other Organisations

10.1 Some doctors will have time seconded or employed with other organisations and in these circumstances both the DCC and SPA allocation must be agreed by both organisations with an expectation that SPA resource is balanced between the two.

11 On-call

11.1 On-call is defined as when an individual is timetabled to be available to respond to an emergency situation but is not necessarily required to remain on site. Predictable on-call on site should be largely allocated within fixed DCC sessions. Unpredictable on-call activity should be recorded as an average weekly allocation in the job plan and should include time for return to work, telephone calls etc and any directly related required admin. On-call arrangements will vary between specialties and this will need to be clarified through the job planning process. For non-resident on-call arrangements to annual expectation of delivery should be identified within the job plan with the allocation of time for return to work, telephone calls, etc.

11.2 Definitions

Consultant of the week

Many specialties operate a Consultant of the Week. In these circumstances all or a proportion of the normal weekly activities will be substituted for predictable emergency activities. These substitutes will be reflected in the annual PA calculation.

On-call category A

Availability for immediate recall to work means that the clinician should be contactable via a telephone or pager for complex consultations and, if determining that personal attendance is appropriate, the clinician shall be present on site within thirty minutes of that determination.

On-call category B

This typically applies when the clinician can respond by giving telephone advice and/returning to site later. Availability supplements are appropriate where the clinician's level of availability is

lower than immediate. Details of on-call availability arrangements will be determined and agreed for each specialty grouping and on call rota.

11.3 Consultants

- 11.3.1 Consultants on an on-call rota are paid an on-call availability supplement in addition to basic salary. The level of supplement depends upon the overall Consultant's contribution to the rota and the typical nature of response when called.

| Number on On-Call Rota | Value of supplement as % full-time basic salary | |
|--------------------------------------|---|------------|
| | Category A | Category B |
| High frequency: 1 – 4 Consultants | 8% | 3% |
| Medium frequency: 5 - 8 | 5% | 2% |
| Low frequency: 9 or more Consultants | 3% | 1% |

N.B. It should be noted that prospective cover arrangements cannot be considered when determining the frequency of a rota.

- 11.3.2 There are some Consultants on more than one rota. For these individuals a calculation will be undertaken to identify the overall frequency of their on call commitment. Complex cases may be referred to the Medical Job Planning Consistency Committee.

11.4 Associate Specialists and Specialty Doctors

- 11.4.1 Associate Specialists and Specialty Doctors are paid an on-call supplement in addition to their basic salary if the on-call work is not part of their DCC allocation. The level of supplement depends on the frequency of non-resident on-call.

| Number on On-Call Rota | % of Basic Salary |
|--|-------------------|
| More frequent than or equal to 1 in 4 | 6% |
| Less frequent than 1 in 4 or equal to 1 in 8 | 4% |
| Less frequent than 1 in 8 | 2% |

- 11.4.2 The expected time that a doctor is likely to spend on unpredictable emergency work each week whilst on-call will contribute towards the number of DCCs in the job plan. Where on-call work averages less than 30 minutes per week, compensatory time will be deducted from normal programmed activities on an *ad hoc* basis.

- 11.4.3 Tables 1 and 2 below set out illustrations of the relationship between the average weekly emergency work arising from on-call duties and the number of programmed activities that this work is regarded as representing. The tables indicate how the individual clinician can calculate the PA allocation depending on whether the work is within normal time (1 PA = 4 hours) or premium time (1 PA = 3 hours).

Table 1 Possible allocation of Programmed Activities where emergency work does not arise during Out of Hours

| Average emergency work per week likely to arise from on-call duties | Possible allocation of Programmed Activities (PAs) |
|---|--|
| ½ hour | 1 PA every 8 weeks, or a half-PA every 4 weeks |
| 1 hour | 1 PA every 4 weeks, or a half-PA every 2 weeks |
| 1½ hours | 3 PAs every 8 weeks |
| 2 hours | 1 PA every 2 weeks, or a half-PA every week |
| 3 hours | 3 PAs every 4 weeks |
| 4 hours | 1 PA per week |
| 6 hours | 1 ½ PAs per week, or 3 PAs every 2 weeks |
| 8 hours | 2 PAs per week |

Table 2 Possible allocation of Programmed Activities where emergency work arises during Out of Hours

| Average emergency work per week likely to arise from on-call duties | Possible allocation of Programmed Activities (PAs) |
|---|--|
| ½ hour | 1 PA every 6 weeks, or a half-PA every 3 weeks |
| 1 hour | 1 PA every 3 weeks |
| 1½ hours | 1 PA every 2 weeks, or a half-PA per week |
| 2 hours | 2 PAs every 3 weeks |
| 3 hours | 1 PA per week |
| 4 hours | 3 PAs every two weeks |
| 6 hours | 2 PAs per week |

12 Honorary Consultant Medical Staff with Substantive University Contract

- 12.1 Clinical Academics, as well as undertaking clinical commitments within the NHS, undertake teaching and research commitments in both the NHS and University setting.
- 12.2 The Follett principles must be applied to these posts and joint job planning must be undertaken to ensure that the job plan is mutually agreed by the University/Medical School, the NHS Trust and the Clinical Academic and that all parties are aware of the Clinical Academic's full range of commitments.
- 12.3 Equal importance should be given to NHS and university commitments and wherever possible there should be identification of when and where the Clinical Academic is working for each of the organisations, or when working for both.
- 12.4 The SPA entitlement for these post-holders should be allocated by mutual agreement between the Trust and the Medical School.
- 12.5 The responsibility to acknowledge and resource SPA time should be shared by both employers.
- 12.6 As with all job plan discussions, agreement about a Clinical Academic's SPA entitlement should be evidence based and focused around the individual's development requirements and both organisations' needs.

13 Performance Objectives

- 13.1 Service standards and performance objectives will be discussed and agreed within the job planning review.
- 13.2 Supporting resources will be identified and agreed so that the objectives can be achieved. The Trust and clinician have joint responsibility for working together to promote efficient and effective working arrangements.
- 13.3 Key Performance Indicators agreed within Care Groups and nationally recognised specified standards including for example, NICE/NCEPOD and Royal College standards may be used as triggers for assessing performance.
- 13.4 Working patterns and performance objectives will need to be reviewed through the job planning process to reflect changing technologies, service requirements and changing clinical practice.

14 Pay Progression

- 14.1 Schedule 15 of the Consultant Terms and Conditions (2003) and the Associate Specialist and Specialty Doctor (2008) Terms and Conditions make provision for a salary that rises through a series of pay thresholds. Pay progression is not automatic; however, it will be the norm for clinicians who:
 - satisfy the criteria set out in Schedule 15, and
 - for those doctors undertaking private practice, have taken up any offer to undertake additional PAs in accordance with Schedule 7 of the Terms and Conditions of Service and met the standards governing the relationship between private practice and NHS commitments set out in Schedule 10 of the Terms and Conditions of Service.

A copy of the national terms and conditions is available on the Trust intranet.

- 14.2 The Clinical Director will confirm each year whether the clinician has met the criteria for pay progression purposes.
- 14.3 Where a doctor disputes a decision that he or she has not met the required criteria to progress either incrementally or through a threshold, the mediation procedure and the appeal procedure should be followed. These are set out in the national terms and conditions of service (a copy of which is on the Trust intranet).

15 Clinical Excellence Awards

- 15.1 Please refer to local policy and process for clinical excellence awards. Clinical excellence awards only apply to Consultants.
- 15.2 Completion of annual job planning and appraisal processes will be required for an application to be considered for clinical excellence awards.
- 15.3 Clinical Excellence Awards are allocated for work carried out over and above the agreed job plan.

16 Travel Time

- 16.1 Travelling time between a clinician's main place of work and home or private practice premises will not be regarded as part of working time.
- 16.2 Where clinicians are expected to spend time on more than one site during the course of a day, travelling time to and from their main base to other sites will be included as working time.
- 16.3 Travel to and from work for NHS emergencies and 'excess travel' will count as working time. 'Excess travel' is defined as time spent travelling between home and a working site other than the consultant's main place of work, after deducting the time normally spent travelling between home and main place of work.
- 16.4 Travelling time to and from the usual place of work is not included. However, travel between sites and for on-call duties is included within the PA for which the travel is necessary. Travelling time for emergencies is also included. In allowing for travel time employers and consultants should clarify and agree what constitutes the normal place of work. This could include any location within the trust rather than a specific location. Where sites are spread out and there is regular travel between them employers should consider agreeing standard travel times applicable to all staff.
- 16.5 The main base will be defined in the original contract of employment. Any change in working practices which implies that the main base will change will involve a renegotiation of the contract in a mutually agreed way outside of the job planning process.

17 Private Practice

- 17.1 Within the contracts clinicians have a right to undertake private practice. The individual is responsible for ensuring that the provision of Private Professional Services or Fee Paying Services for other organisations does not:
- result in detriment to NHS patients or services
 - diminish the public resources that are available for the NHS.
- 17.2 The clinician will inform their Clinical Director of any regular commitments to Private Professional Services or Fee Paying Services as part of the job planning process. This information will include the location, timing and work involved. Regular private commitments must be noted in the job plan. This includes any payments made in relation to section 9, 10 and 11 of the Terms and Conditions for Consultants 2003 and 10, 11 and 12 of the Terms and Conditions for Associate Specialists and Specialty Doctors (2008).
- 17.3 Where there would be a conflict or potential conflict of interest, NHS commitments must take precedence over private work. The clinician is responsible for ensuring that private commitments do not conflict with PAs. Clinicians undertaking private practice, which is predominately individual patient care, are unlikely to create a conflict of interest, but undertaking roles in strategic management for companies competing with the Trust may not be covered by the right to undertake private practice. To avoid any doubt, clinicians should declare their interests to the Trust and seek advice on their personal position from their trade union, professional association or other advisor. It is recognised that individuals with medico-legal practices may be called for a significant number court appearances for medico-legal work, which may interfere with NHS activity. Arrangements with regard to reallocating PA time will need to be by written agreement with the Chief Executive in these circumstances. Histopathologists undertaking coroner's work locally are excluded from this requirement: such work should be addressed within the job planning process. All Consultants are required to make a declaration of interest (including a null declaration) in line with Trust policy on managing conflicts of interest in the NHS. This includes clinical private practice, relevant

shareholdings, patents, and loyalty issues. Any gifts, hospitality and sponsorship must also be declared in line with this policy.

- 17.4 The clinician should ensure that there are arrangements in place to avoid significant risk of private work disrupting NHS commitments, e.g. by causing NHS activities to begin late or to be cancelled. In particular, where a clinician is providing private services that are likely to result in the occurrence of emergency work, he or she should ensure that there is sufficient time before the scheduled start of PAs for such emergency work to be carried out.
- 17.5 Subject to the following provisions, a clinician will not undertake Private Professional Services or Fee Paying Services when on on-call duty. The exceptions to this rule are where:
- the clinician's rota frequency is 1 in 4 or more frequent, his or her on-call duties have been assessed as falling within the category B described in Schedule 16, and the employing organisation has given prior approval for undertaking specified Private Professional Services or Fee Paying Services
 - the clinician has to provide emergency treatment or essential continuing treatment for a private patient. If this work regularly impacts on his or her NHS commitments, he or she will make alternative arrangements to provide emergency cover for private patients.

Private on-call commitments must not run concurrently with NHS duties.

- 17.6 As a general principle, work undertaken during PAs will not attract additional fees to the individual unless the work involves minimal disruption. For more guidance in this area Consultants should refer to the Trust's Private Practice Policy. Where the employing organisation agrees that the work can be done in NHS time without the employer collecting the fee the arrangement needs to be agreed by the Care Group Medical Director. The undertaking of such work, covered by additional fees, is voluntary for clinicians in line with schedule 9, 10 and 11 of the Consultant Terms and Conditions of service (2003) and schedule 10, 11 and 12 of the Terms and Conditions for Associate Specialists and Specialty Doctors (2008).
- 17.7 Where a consultant wishes to undertake private practice (s)he must discuss this with their Clinical Director. If the Clinical Director considers that there is a requirement for further APAs in the department then he/she must offer it equally to all relevant members of the department. If the offer is not taken up by any other members of the team then the consultant must offer an APA (unless already providing one).

18 Additional Clinical Activity

- 18.1 Any additional clinical activity (previously know as waiting list initiative, WLI) must be recorded and included in job planning discussions.
- 18.2 Additional clinical activity should not be undertaken when clinicians are on call.
- 18.3 Any SPA work displaced by additional clinical activity must be re-provided and this includes teaching and training.

19 Job Plan Reviews

- 19.1 A job plan review should take place annually. (see appendices 2 and 3). The review should normally take place as soon as possible after the annual appraisal meeting. Either the clinician or the Clinical Director may propose an interim job plan review, for instance where duties, responsibilities or objectives have changed or need to change significantly within the year.

19.2 The review should be designed to:

- consider what factors have affected the carrying out of the duties and responsibilities set out in the job plan
- consider progress against the personal objectives in the job plan
- consider current levels of workload
- agree any changes to the Consultant's duties and responsibilities, taking into account opportunities in relation to staffing, skill mix and ways of working and, if the Consultant wishes, the scope for more flexible ways of working
- agree a plan for achieving a Consultant's personal objectives
- agree what support the Consultant will need from the organisation and from colleagues to help achieve these objectives.

19.3 The job plan review should also be the occasion for reviewing the relationship between NHS duties and any private practice (in line with the Code of Conduct for Private Practice).

19.4 To support a more planned and phased approach to Consultant careers, it is good practice to hold a broader career review from time to time, possibly linked to the revalidation process.

Where agreement cannot be reached on a job plan

19.5 Clinicians and reviewers will make every possible effort to agree job plans. In the rare circumstances where a doctor cannot reach agreement on their job plan with their Clinical Director, then the process of mediation and appeal is available. Full details of this process are set out in the relevant national terms and conditions of service:

- Schedule 4 of the new Consultant contract
- Schedule 5 of the new Associate Specialist contract
- Schedule 5 of the new Specialty doctor contract Copies of the national terms and conditions are available on the Trust intranet.

19.6 The first step in this process is an appeal by the clinician to the Medical Director within 10 working days of the disagreement arising. The Medical Director may seek a review by the Medical Job Planning Consistency Committee before making a decision on an appeal. A mediation meeting will be held to seek to resolve the matter and, if the clinician remains dissatisfied, he or she may lodge a formal appeal to the Chief Executive as set out in Schedule 4 of the Consultant Contract Terms & Conditions.

20 Records

20.1 Job planning must be recorded within the Trust's electronic job planning system.

20.2 Where a job plan review results in a change to existing commitments, an effective date for the change should be agreed. In the absence of an agreement, three months' notice of the change will be given.

20.3 Where the job plan review is to increase the number of PAs to be paid requires the prior approval/authorisation from the Care Group Boards (where PAs are to be exchanged between team members at the same grade without a net increase then this may be approved by the Clinical Director). Reductions in PAs may be approved by the Clinical Director, subject to the development of a job plan that meets service needs. Where a reduction is agreed to below 10 PAs there should be a balanced reduction in DCC and SPAs.

20.4 Where a change in contracted PAs or the on-call availability supplement is approved, a Change of Circumstances form must be sent to ESR by the Clinical Director.

21 Medical Job Planning Consistency Committee

- 21.1 A Medical Job Planning Consistency Committee (MJPCC) has been set up in the Trust, with the purpose of agreeing and overseeing the process of job planning across the specialties, to ensure consistency and to provide assurance that job planning is in line with Trust guidance.
- 21.2 Membership of the MJPCC comprises the Deputy Medical Director (chair), Deputy Chief Operating Officer, 3 Care Group Medical Directors, a Workforce Business Partner, a Trust LNC representative and the Revalidation Programme Manager.
- 21.3 The scope of the MJPCC is to:
- review new job plans for permanent medical and dental staff
 - review a representative sample of job plans across the Trust specialties and ensure that they achieve the required standards
 - support the Care Groups in the process of job planning across the Trust
 - review job planning policy and procedures across the Trust
 - report compliance and submit progress reports to the Executive Medical Director and Workforce Committee.

22 Training

- 22.1 There is no mandatory training associated with this guidance.

23 Equality Impact Assessment

- 23.1 This document has been subject to an Equality Impact Assessment and is anticipated to have a positive impact by ensuring a fair and equitable process for all consultants.

24 Process for monitoring compliance with the effectiveness of this policy

| Aspect of compliance or effectiveness being monitored | Monitoring method | Responsibility for monitoring (job title) | Frequency of monitoring | Group or Committee that will review the findings and monitor completion of any resulting action plan |
|---|-------------------|---|-------------------------|--|
| Review of consistency of job plans | Job plan review | Deputy Medical Director via MJPCC | Six monthly | Workforce Committee |

25 Review arrangements

- 25.1 This document will be reviewed in 5 years of approval date, or sooner if required. The document will be reviewed in light of feedback. In order that this document remains current, any of the appendices to the policy can be amended and approved during the lifetime of the policy without the document having to return to the ratifying committee.

Appendix 1 Examples of Corporate Activities for SPA

- Educational Supervision
- Principal and chief investigators
- Human Tissue Authority Lead
- Pandemic Flu
- Appraisal Lead
- Safeguarding
- Training Leads
- VTE Lead
- Clinical Leads
- Governance Leads
- Service Leads
- Educational Leads
- Committee work with external/internal partners
- Audit
- Medical Education
- Research
- Systematic Quality Improvement
- Continuing Professional Development (CPD)
- Clinical management: this does not include formal clinical management roles such as Clinical Director, which are encompassed in the Additional NHS Responsibilities section (8). All Consultants are expected to contribute to the management of their service
- Teaching: (see General Teaching Commitments, Section 7)
- Job Planning – as a job planner
- Appraisal – as an appraiser
- Non patient-related administration

This is not an exhaustive list and will be updated as necessary.

Appendix 2 Content of a Job Plan Review

1. The front page should be completed and signed by the clinician undergoing a job plan review and the reviewer to confirm mutual agreement of the job plan.
2. The previous agreed timetable should be completed in full.
3. The new revised timetable should be completed in full including:
 - a. Start and finish times of elective sessions
 - b. Time that the clinician will be expected to be on-site when on-call (including weekends)
 - c. The PA allocation unpredictable on-call
 - d. Times of any business-related travel
 - e. Timings and location of SPA activity
 - f. Teaching or university sessions should be displayed separately.
4. Job plan objectives

Each clinician should agree a minimum of 5 objectives to achieve by the time of the next job plan review. Two of these will be corporate objectives supplied by the Medical Director, and the remaining objectives will be related to work carried out for the benefit of the clinician's team in support of the organisation's strategy.

The job plan review should include evidence supporting the achievement of objectives agreed at the previous review or provide an explanation as to why this was not possible.

Appendix 3 The Annual Job Planning Cycle

1. Group Job Planning Meetings

The Clinical Director and Business Manager meet each group of clinicians to agree the following:

- a. Clinic templates
- b. Start and finish times of elective sessions
- c. Allocation of PAs for on-call and their distribution
- d. On-call supplement
- e. Allocation of SPA activities within the group
- f. Group job planning objectives
- g. Template for the group job planning review.

These meetings should be completed by 31 December.

2. Individual Job Plan Reviews

Each clinician meets with the Clinical Director to discuss their individual job plan and agree any changes. The Business Manager for the specialty should be involved either at this meeting or with the output from this meeting in order to inform the demand and capacity model for the specialty.

This meeting should include review of the following:

- a. Clinic templates
- b. Start and finish times of elective sessions
- c. Allocation of PAs for on-call and their distribution
- d. On-call supplement
- e. Review of allocated SPAs
- f. Review of the outputs of SPA activity for the previous year
- g. Assessment of achievement of previous job plan objectives
- h. The listing of new job plan objectives for the next financial year.

This may take a series of face-to-face or virtual meetings before a job plan is agreed and signed off.

Individual job planning meetings should be completed by 28 February.

3. Medical Job Planning Consistency Committee

A Medical Job Planning Consistency Committee (MJPCC) meets to review a sample of job plans to ensure consistency and to provide assurance that job planning is in line with Trust guidance.

Medical Staff Job Planning

Equality Impact Assessment Form - Stage 1 – Initial Assessment

| | | | |
|---|--|---|---|
| Managers Name | Sam Hooper | Division | Medical Directorate |
| Function, Policy, Practices, Service | Medical Job Planning Policy | Purpose and Outcomes – intended and differential | To provide a clear outline of the requirements of job planning and to provide consistency and transparency of both the job plan and the process |
| Implementation Date | 01.07.2018 | Who does it affect? | Consultants and SAS doctors |
| Consultation Process | Via LNC and PAG and distributed to all relevant stakeholders | Communication and awareness | Notification will be communicated to all relevant staff members. |

For completion of the following table please see point 7 in the guidance notes.

| Equality Target Group | (a) Positive Impact | (b) Negative Impact | Reason/Comment |
|--|---------------------|---------------------|---|
| Men | Yes | None | Positive impact by showing a transparent and equitable process for all Senior Medical Staff, Consultants and SAS doctors. |
| Women | Yes | None | |
| Black/Black British | Yes | None | |
| Asian/Asian British | Yes | None | |
| Chinese | Yes | None | |
| White (including Irish) | Yes | None | |
| Other racial/ethnic group (please specify) | Yes | None | |
| Mixed race | Yes | None | |
| Disabled | Yes | None | |
| Gay/Lesbian/Bi-sexual | Yes | None | |
| Transgender | Yes | None | |
| Younger People (17-25) and | Yes | | |

Medical Staff Job Planning

| | | | |
|--|-----|------|--|
| children | | | |
| Older People (50+) | Yes | None | |
| Faith groups (please specify) | Yes | None | |

Following completion of the Stage 1 assessment, is Stage 2 (Full Assessment)

necessary? ☐ **Yes** x ☒ **No**

Date Completed: 19.6.2018.

Signed by Manager completing the assessment:

S M Hooper