Mid Essex Hospital Services NHS
NHS Trust

Job Planning Policy for Consultants and Specialty Doctors including Locums	**Type: Public** **Register No: 17023** **Status: Public on ratification**

Developed in response to:	Best Practice
Contributes to CQC Regulation number:	17

Consulted With	**Post/Committee/Group**	**Date**
	Local Negotiating Committee	December 2017
	Job Planning Committee	June 2017
Professionally Approved By	Ellen Makings, Site Medical Director and Chair JPC	October 2017

Version Number	1.0
Issuing Directorate	Corporate
Ratified by:	DRAG Chairmans Action
Ratified on:	22nd November 2017
Executive Management Board Sign-off Date	January 2018
Implementation Date	9th January 2018
Next Review Date	November 2020
Author/Contact for Information	Kay Gammage, Head of Medical Resources Rebecca Martin, Deputy Medical Director
Policy to be followed by (target staff)	All Consultants and SAS Doctors, Clinical Leads and Clinical Directors, Divisional Directors, Service Managers, ADOs and Medical Resources
Distribution Method	Intranet & website
Related Trust Policies (to be read in conjunction with)	

Document Review History

Version Number	**Authored/Reviewed by**	**Active Date**
1.0	Kay Gammage, Head of Medical Resources Rebecca Martin, Deputy Medical Director	9th January 2018

Index

1.0 Purpose

This policy is designed to:

- Ensure that all Consultants and SAS Doctors have a transparent, current, signed off, job plan with agreed objectives that is reviewed at least annually
- Bring consistency and transparency to job planning across the Trust
- Describe the circumstances when variations might be appropriate
- Provide an annual timetable for job planning

2.0 Introduction

2.1 Job Planning should:

- Identify the contracted commitments of doctors at the current time
- Ensure consistent application of relevant principles in a transparent fashion
- Support GMC revalidation procedures
- Ensure that no activity or block of time is double counted
- Reflect the Trust's commitment to part-time and flexible working, improving working lives and compliance with the European Working Time Directive (EWT)
- Ensure that service development, education, training and research are recognised and supported where appropriate and defined in a transparent, equitable way

2.2 This policy:

- Is based on the local interpretation of the Terms and Conditions of the Job Planning Agreement for Consultants (England) 2003 and SAS Doctors (2008) and the Guide to Consultant Job Planning agreed by the BMA and NHS Employers 2011
- Replaces all previous versions of the job planning policy
- Sets out the Trust principles for Job Planning and responsibilities for the process
- There is no intended derogation of the national terms and conditions of service.

3.0 Scope

This policy applies to all Consultant and SAS medical staff working at Mid Essex Hospital Services NHS Trust.

4.0 Principles

4.1 **Trust Approach**: The Trust and the Consultants or SAS Doctors will approach the Job Planning process with professionalism, honesty and transparency.

4.2 **Accountability**: As a publicly funded organisation, the Trust will exercise its statutory responsibility for probity therefore Job Plans must be based upon fact and evidence.

4.3 **Equity**: The essence of the Consultant and SAS contract is to remunerate individuals on the basis of the activities they undertake. The Trust's intention is to remunerate doctors for the work undertaken in the agreed and signed off Job Plan.

4.4 **Consistency**: The Trust will adopt a consistent and fair approach based on the principles set out in this policy.

4.5 **Collaboration**: The Trust considers the approach to Job Planning to be as important as the output. The Trust will work in partnership with Consultants and SAS Doctors to agree Job Plans. Discussions, including the job planning meeting, regarding individual doctor's job plans will normally involve the doctor, the service manager, clinical lead and clinical director with or without the divisional director and ADO, with Medical Resource support. Where proposed changes to a Consultant or SAS Doctor Job Plan may affect activity or income, the changes must be agreed with the relevant ADO prior to the Job Plan being agreed.

5.0 Duties and Responsibilities

Job Planning within the Trust is fundamental to the delivery of clinical services, training and research.

5.1 **The Trust's Executive and Divisional Team** have responsibility for ensuring that all Consultants and SAS Doctors have agreed Job Plans that are reviewed at least annually.

5.2 **The Trust's Job Planning Committee** has responsibility for overseeing the principles, purpose, scope, duties and responsibilities for job planning on behalf of the Trust. The terms of reference are included in appendix 1.

5.3 **Chief Executive** has overall responsibility for ensuring Job Planning is conducted annually across the Trust and is in line with Department of Health requirements.

5.4 **Site Medical Director (MD)** chairs the Job Planning Committee and thereby sets out principles and standards for job planning across the Trust. Where there is failure to agree a Job Plan at specialty level the MD is responsible for the mediation and appeals process in accordance with appendix 2.

5.5 **HR Director** will ensure the Job Planning policy is followed, will assume responsibility with software interfaces and will report on progress with these matters to the Job Planning Committee on a regular basis. The HR Director works with the Medical Director and Chief Executive to ensure any mediation or appeals are appropriately constituted.

5.6 **Chief Operating Officer (COO)** will contribute to the Job Planning Committee, will have oversight of the total PA activity and will ensure that the PA activity aligns to team job planning objectives across the Trust.

5.7 **Chief Finance Officer (CFO)** will contribute to the Job Planning Committee, will comment, challenge and advise on all finance issues relating to PAs and will be responsible for updating the relevant budget statements.

5.8 **Divisional Directors** have responsibility for ensuring Job Planning takes place within their divisions and they are responsible for the 2nd sign-off for agreed Job Plans for their divisions.

5.9 **The Consultant or SAS Doctor** must take part in Team and Individual Job Planning on an annual basis with their clinical lead or clinical director, and ensure that job planning rules and principles are adhered to and the necessary information is present for the 1st sign-off with the help of service managers.

5.10 **Head of Medical Resources** will work with doctors to convert any paper based job plans into electronic format; will support divisions to address sign-off conflicts; will administer the Job Planning Committee; will attend and support team job planning**.**

5.11 **Service managers** work with consultants and SAS doctors to ensure that job planning rules and principles are adhered to, and that the necessary information is present for the 1st sign-off.

5.12 **Relevant committees** are also responsible for 1st sign-off of certain job plans e.g. Research and Development Committee for research activities. Relevant committees and Board also have defined roles and contributions to job planning (see appendix 3).

5.13 **Assistant Director of Operations (ADOs)** work with the Divisional Directors to provide the 2nd sign-off and sign off SWB change of pay forms

6.0 Equality and Diversity

6.1 Mid Essex Hospitals Services NHS Trust (the Trust) is committed to providing equality of opportunity for all present and potential members of staff, and aims to ensure that no existing or potential employee receives less favourable treatment on the grounds of sex, sexual orientation, race, colour, nationality, ethnic origin, religion, marital status, carer status, socio economic background, employment status, political affiliation and trade union

membership, age or disability, or is disadvantaged by conditions or requirements which cannot be shown to be justifiable.

6.2 The principles of equality and diversity should be applied within the Job Planning process so all members of staff are treated fairly and equally.

7.0 Team Job Planning

7.1 Team job planning should ensure that similar job plans among doctors within a team carry similar PAs and that the sum total of PAs of all the doctors in the team matches the service requirements.

7.2 The work commissioned from the Trust and how that is allocated amongst doctors in a speciality should be discussed at speciality level with the whole team before individual job plan meetings. The service managers, supported by the divisional team, will make this information available. Team job planning will identify any shortfalls in the ability to deliver commissioned work and this can be addressed through business planning.

7.3 Team job planning should occur at least annually, and may occur additionally when the needs for the service delivery change during the course of the year.

7.4 The definition of “speciality level” to agree team job planning will depend on the sub-specialty teams within a given clinical service. Where a group of doctors share a rota or pattern of work unique to them, in addition to a wider specialty rota, this will define the level where team job planning should occur.

7.5 A specialty level Job Planning session should be scheduled for all Consultants and SAS Doctors, the clinical leads, clinical directors, service managers to discuss and agree a “Core Team Job Plan template” which will be used by every Consultant and SAS Doctor. The ADOs and divisional directors may be involved at the request of the service manager or doctors or where agreement cannot be reached.

7.6 Team job planning will also be attended by a member from Medical Resource department who will facilitate the creation of the Core Team Job Plan template.

7.7 Key team objectives should be agreed by the clinical team to inform the team job planning process and demonstrate how the team will meet the wider Divisional and Trust objectives. These agreed team objectives can be used to support individuals in their own job planning to describe their role in supporting the delivery of the team objectives.

7.8 Individual job plans will be reviewed as a group at JPC prior to 3rd sign off.

8.0 Individual Job planning

8.1 A job plan is an agreement between the individual Consultant or SAS Doctor and the Trust. Most doctors work as an integral part of a clinical team but the

job plan itself remains an agreement between the individual and the Trust as the employer. There should be evidence of a current, signed-off job plan prior to appraisal.

8.2 All job plans will be based on agreed Trust job plan principles set by the Medical Director via the Job Planning Committee. The doctor can request a job plan review at any time. All activities should map to the Trust's approved activities (see appendix 6) and if activities are not already recognised as approved, they should escalate through the sign-off processes described below.

8.3 The job plan must include any times that have been agreed with managers in the Trust when the doctor is not expected to be available to work for the Trust e.g. regular commitments for other employers, family responsibilities, and private time.

8.4 An individual job plan should set out everything a doctor does in a 'typical' working week, including private practice, ensuring that no activity is double counted.

8.5 The job plan should:

- Reflect the Trust's commitment to part-time and flexible working, improving working lives and compliance with the Working Time Regulations.
- Ensure that service development, education, training and research are recognised and supported where appropriate and allocated equitably.

8.6 To facilitate an informed discussion at the job planning meeting, those involved should bring all the relevant data needed to plan the activities for the coming period including such things as:

- A working time diary
- Appraisal summary and agreed PDP
- Agreed team objectives
- Objectives for additional Trust approved SPA s or APAs
- Service business plan and performance over the past 12 months covering the whole practice of the Consultant or SAS Doctor
- Individual performance over the past 12 months
- Evidence of activities undertaken in MEHT-approved SPA time
- Relevant specialty advice, e.g. Royal College and Specialty Association guidelines
- Evidence of the benefits of External Duties for outside organisations to the Trust and local patients

8.7 All activities, although time based, will also have minimum standards for performance. The standards for each activity will include evidenced attendance and expectations for alignment to the needs of the Trust for that activity (for example, during a clinical DCC it may be necessary to attend an urgent board round when the hospital status is critical). Expectations for outputs for activities in lead roles such as clinical director or appraiser will be

standardised.

8.8 Newly appointed Consultants or SAS will attend their first Job Plan review after 3 months in post.

8.9 All consultants should be provided with sufficient facilities, administrative, clerical or secretarial support and IT resources to deliver the job plan commitments and to help achieve the job plan objectives.

9.0 Work Commitment

9.1 The 2003 Consultant contract is based upon a full time work commitment of 10 Programmed Activities (PAs) per week.

9.2 The Trust's job planning system is built around the basis that each senior clinician is available for duties for at least 42 weeks per year. However, many doctors will work 42 to 46 weeks per year, and all doctors should adhere to their leave entitlements, and this should be particularly mentioned in the 1st sign-off. Please refer to the Leave Policy.

9.3 Each 4 hours of work has a value of one PA, unless it has been mutually agreed between the Consultant or SAS Doctor and the Trust to undertake the work in premium time, in which case each PA equates to 3 hours. Premium time is classified as any time that falls outside of the hours 07:00 to 19:00 Monday to Friday and any time on a Saturday or Sunday, or public holiday. Programmed activities may be programmed as blocks of 4 hours or in smaller units where approved as appropriate.

9.4 If Consultants or SAS Doctors choose to undertake a PA in premium time rather than core working hours for personal convenience and this is agreed with Trust managers, the time for the PA will be calculated as 4 hours. This does not apply to weekend and evening DCCs where there is an identified service need.

9.5 PAs above 10 per week are temporary, Additional Programmed Activities (APAs). The review of APAs is a key part of the Job Planning process (see section 16).

9.6 The work commitments of Consultants employed on the pre 2003 Contract will be discussed and agreed on an individual basis at least once a year, with reference to pre-2003 terms and conditions of service.

9.7 Where a Consultant or SAS Doctor works across more than one Specialty or organisation, it is the responsibility of the Consultant or SAS Doctor and their service managers, clinical leads, clinical directors, ADOs and divisional directors to ensure that all the relevant departments and organisations that form part of the Consultant or SAS Doctor's work are involved in the Job Planning process.

10.0 Direct Clinical Care (DCC)

10.1 Only activity which has been commissioned from the Trust will be included in the allocation of Direct Clinical Care (DCC) to individual team members.

10.2 There will be minimum standards for activity expected by individuals within the particular specialty e.g. number of new and follow up out patients to be seen in outpatient clinics, number of operations to be completed in a theatre session etc. These will be agreed with the doctors at team job planning.

10.3 The number of Programmed Activities (PAs) will be allocated for the predictable and unpredictable work performed whilst on call. The frequency and categorisation of on-call will be aligned to job planning. The amount of time which should be included in individual Consultant or SAS Doctor Job Plans for compensatory rest to comply with legal requirements will be factored in (see section 11).

10.4 The amount of time Consultants or SAS Doctors within each specialty or sub-specialty need to perform their clinical administration will be linked to DCC activities and will be agreed in each Division. Clinical administration time is DCC.

10.5 Standardised terminology of direct clinical care activities performed will be used, so that the Job Plan software language is accurate. DCC activity relates directly to the prevention, diagnosis or treatment of illnesses for individual patients. This includes:

- Operating sessions including pre-operative and post-operative care
- Outpatient Activities including outpatient clinics or virtual clinics
- Ward Rounds
- Clinical diagnostic work
- Emergency duties (including emergency work carried out during or arising from on-call)
- Other patient treatment or relative consultation
- Telephone advice to hospital
- Public health duties
- Other administration activity directly related to patient care
- On Call duties
- Travelling time between sites (see 10.9)
- Time spent teaching in clinical settings, for example ward rounds and clinics
- Meetings which relate directly to the care or treatment of individual patients such as Multi-disciplinary Team meetings (MDT) or Safeguarding meetings.
- Preparation of materials for consideration at the MDT (for example diagnostics).

10.6 Clinical administration time DCC for outpatient activities should be calculated for each outpatient activity, and should be standardised for each outpatient activity.

10.7 There will be meetings which can also be counted as DCC time. MDTs may have PAs relevant to DCC and ANR and SPA and this should be reflected in the job plan

10.8 Where Consultants or SAS Doctors spend time on more than one site during the course of a day, time spent travelling between sites will be counted in PA time. All travel associated with clinical activity should be recorded as DCC time and travel associated with non-clinical activity should be recorded as either Supporting Professional Activities (SPA) or Additional NHS Responsibilities as appropriate. Appendix 4 outlines the standard agreed travel time for common journeys.

10.9 Travel to and from work for NHS emergencies and “excess travel”. “Excess travel” is defined as time spent travelling between home and a working site other than the Consultant or SAS Doctor’s main place of work, after deducting the time normally spent travelling between home and main place of work. Travelling time between a Consultant or SAS Doctor’s main place of work and home or private practice premises is not to be regarded as working time.

11.0 Consultant On-Call activities

11.1 The nationally agreed BMA/NHS Employers “A practical guide to calculating on-call work” will be used to calculate on call for all Consultants This methodology includes prospective cover and will enable the Trust to have a fair, transparent and consistent approach for managing on call across the Trust.

11.2 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 frequency of the rota and the typical nature of the response when called, known as either category A or category B as tabled below:

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.

Availability for immediate recall to work shall normally mean 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.

	Value of supplement as % of full-time basic salary	
	Category A	**Category B**
<u>High frequency:</u> 1 – 4 Consultants *1:4.5 or more frequent*	8%	3%
<u>Medium frequency:</u> 5 – 8 Consultants *Less frequent than 1:4.5 and no more frequent than 1:8.5*	*5%*	*2%*
<u>Low frequency:</u> 9 or more Consultants *Less frequent than 1:8.5*	*3%*	*1%*
The BMA and NHS Employers have agreed that, where the frequency falls between two of the frequency groups, it should be rounded up where the frequency is, in this example, 1 in 4.5 or higher (i.e. to 1 in 4) and rounded down when it is less frequent that than 1 in 4.5 (i.e. to 1 in 5). (Guide to Consultant Job Planning (BMA & NHS Employers 2011)		

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

Details of on call availability arrangements will be determined and agreed for each specialty grouping an on call rota.

11.3 If the consultant covers colleagues' 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.

11.4 Part time Consultants, whose contribution when on call is the same as that of full-time Consultants on the same rota, will receive the appropriate percentage of the equivalent full time salary.

11.5 There is also a requirement for a PA allocation in recognition of the work actually undertaken whilst on call. This work is divided into predictable (takes place at regular and planned times) and unpredictable (purely unplanned clinical activity whilst on call). The number of PAs allocated for predictable and unpredictable work performed whilst on-call will be the same for all Consultants on a rota and will be agreed at specialty level. This allocation is calculated using the BMA/NHS Employers nationally agreed "A practical guide to calculating on-call work".

11.6 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 on an annual or equivalent basis. See Appendix 9 for an example of how this may be calculated.

11.7 In some cases a frequency will fall between the three frequency groups set out in schedule 16 of the terms and conditions of service. For example, a consultant might be on a 1 in 4.5. This does not fall neatly into either the high

frequency category (1 in 1 to 1in 4) or the medium frequency category (1 in 5 to 1 in 8). For the purpose of clarity, the BMA and NHS Employers have agreed that, where the frequency falls between two of the frequency groups, it should be rounded up where the frequency is, in this example, 1 in 4.5 or higher (i.e. to 1 in 4) and rounded down when it is lessfrequent that than 1 in 4.5 (i.e. to 1 in 5).

11.8 In some cases the doctor will participate in two on call rotas that fall in different categories (A or B). These are uncommon and the contract does not specify how to manage these. The Trust approach will be to review recommendations made by the Divisional Directors with the final sign off at Job Planning Committee. An example of how this may be calculated is in Appendix 9.

11.9 In some specialties there is a frequent requirement for compensatory rest due to the amount of work performed whilst on-call. Where this is the case the amount of time required will be agreed at the specialty level Team Job Plan discussion and will be incorporated into the Consultants' job plans.

12.0 SAS On-Call Activities

12.1 The nationally agreed BMA/NHS Employers "A practical guide to calculating on-call work" will be used to calculate on call for all SAS doctors. This methodology includes prospective cover and will enable the Trust to have a fair, transparent and consistent approach for managing on call across the Trust.

12.2 An SAS doctor's job plan should clearly set out their on-call commitments. Under the 2008 contract it is recognised in three ways:

12.3 An availability supplement (see table below) based on the commitment to the rota. There is no prospective cover allowance here. If a doctor works on more then 1 rota the frequency will be calculated as per section 11 and Appendix 9.

	Value of supplement as % of full-time 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%*

12.4 PA allocation for predictable emergency work arising from on-call duties (ward rounds, administration etc) should also be prospectively built into timetables as DCC PAs. There is no limit on the amount of predictable on-call work that

can be allocated to DCC PAs and prospective cover (providing this is compliant with the Working Time Regulations). If an SAS doctor covers colleagues' on-call duties when they are away on annual or study leave, this should be factored into the calculation.

12.5 The expected average amount of time that a doctor is likely to spend on unpredictable emergency work each week whilst on-call and directly associated with on-call duties will be treated as counting towards the number of Direct Clinical Care Programmed Activities that the doctor is regarded as undertaking. This will normally be up to a maximum of two Programmed Activities per week. This should usually be assessed using diary evidence and included first within the allocation of DCC PAs in the job plan. The allocation can be adjusted at job plan review. Once again, prospective cover should be recognised here.

12.6 Where the unpredictable emergency work arising from a doctor's on-call duties exceeds the equivalent of two Programmed Activities per week the clinical manager and the doctor will review the position. The employing organisation shall ensure additional arrangements to recognise work in excess of this limit, either by remuneration or time off, are in place. The doctor and the clinical manager should also consider whether some of the work is sufficiently regular and predictable to be programmed into the Working Week on a prospective basis. If no arrangements are made the default position is to trigger a Job Plan review.

13.0 Supporting Professional Activities (SPAs)

13.1 Supporting Professional Activities (SPA) form a core part of a Consultant or SAS Doctor's work and are essential to ensure that a Consultant or SAS Doctor keeps up to date, maintains training requirements and revalidates. SPAs are not optional and are a required part of the job plan.

13.2 SPA should be specified in the Job Plan and should normally take place on site during working hours unless agreed otherwise by the doctor with their Clinical Lead or Clinical Director and reflected in their job plan.

13.3 There should be objectives for SPA – Specific, Measurable, Achievable, Realistic, and Timed (SMART).

13.4 It is expected that SPA time should predominately consist of:

13.4.1 Core SPAs, which are self-directed activities associated to one's own practice. These activities include those required for:

- CPD
- job planning
- mandatory or other training,
- participation in mandatory audits
- mortality review
- appraisal preparation and appraisal meetings to support revalidation

- attendance at departmental, directorate, division and Trust governance-associated meetings
- responding to complaints, incidents and general queries about one's own actions.

Failure to deliver on these will lead to performance management from the Division or Job Planning Committee.

13.4.2 Formal local teaching and training approved by the Trust's department of Medical Education or other recognised education bodies. The budget for this SPA needs to have been approved by the Job Planning Committee. If this is not the case, the Divisional Director will need to recommend approval by the Job Planning Committee. Regional or national educational roles are covered by Additional NHS Responsibilities (ANR).

13.4.3 Research, where this is approved by the Research and Development department, or other recognised research bodies. The budget for this SPA needs to have been approved by the Job Planning Committee. If this is not the case, the Divisional Director will need to recommend approval by the Job Planning Committee

13.4.5 Other (non-core) SPAs will be tailored to individuals and will need to be approved by the Job Planning Committee

13.5 Any SPA time above the core SPA allowance which is allocated for specific activities will need to map to activities already approved by the Job Planning Committee. For activities not already approved by the Job Planning Committee, the relevant Divisional Director will need to make a recommendation to the Job Planning Committee for approval. The Trust will not expect any doctor to commence work of this nature prior to gaining approval from the Job Planning Committee. Payment for this activity will not be made until Job Planning Committee approval has occurred.

13.6 The Consultant contract and BMA guidance state that a full time Consultant will typically undertake 2.5 SPAs per week. Therefore 2.5 is neither a minimum nor a maximum; neither is it an allowance. Therefore, if an individual receives 2.5 SPA, this will consist of 1.5 core SPA and Job Planning Committee-approved 1 non-core SPA.

13.7 Core SPA will be a defined entity on the electronic job plan and will reflect all the activities in 13.4.1. To ensure value of this time for both the doctor and the Trust it must be allocated in blocks of time not less then 1 hour (0.25 PA).

13.8 The core SPA allocation above will be included in job plans for all Consultants, irrespective of their working hours. There is an absolute minimum of 0.5 core SPA's for any doctor.

For job plans less than 10 PA the core SPA allocation will be:

5.1 -9.9 PA DCC in Job Plan	1.5 Core SPA
3- 5 PA DCC or less in Job Plan	1 Core SPA
< 3 PA DCC in Job Plan	0.5 Core SPA

For job plans more than 10 PA the core SPA allocation will remain at 1.5.

13.9 To ensure fairness the doctor should detail all practice – both private and NHS within the job plan, and the Trust will provide a pro-rated core SPA allowance based on the percentage of all time worked within the Trust against the total work undertaken i.e. a consultant works 5 PA's at MEHT and the equivalent of 5 PA's with another employer, the Trust will provide 0.75 PA's (50% of full time allowance) for core PA activity.

13.10 The core SPA allocation above will be included in job plans for all SAS doctors and national terms and conditions guaranteed a core SPA allocation of 1 PA.

13.11 If administrative time beyond that included within DCC is required for non-patient related administration, the nature of these tasks should be agreed as part of the Job Planning process through an 'evidence based' approach regarding SPA time. The principles of divisional agreement and divisional recommendation to the Job Planning Committee apply.

14.0 General Teaching Commitments

14.1 Clinicians are expected to participate in education as part of their employment; it is considered part of both core DCC and core SPA.
It is important to recognise that time spent teaching in clinics and ward rounds already described in job plan is not additional.

14.2 Undergraduate teaching relates to specific undergraduate teaching in SPA time and is separate from contact time during fixed activities such as clinics. The amount of SPA time for this activity will be individually agreed as part of the job planning process with the involvement of the division and the undergraduate department for education through an evidenced based approach.

14.3 Consultants appointed as Educational Supervisors will be allocated 0.25 SPA per week for the first trainee and 0.125 per additional trainee. It is anticipated that where there is more than 1 trainee in the department each educational supervisor would take on more than 1 trainee. Educational supervision should be planned as part of teams job planning process to meet agreed training slots available and reviewed yearly based on fill rates. This role applies to deanery funded trainees and MTI trainees only.

14.4 Consultants appointed as Named Clinical Supervisors will be allocated 0.25 SPA per week for the first trainee and 0.125 for each additional trainee (this is a specific role for GP trainees only). Consultants will be required to demonstrate relevant knowledge and skills as a key part of fulfilling their role. Only one Consultant within a team should take named Clinical Supervisor

responsibility for each trainee at any one time. Where there are multiple Consultants within a team and only one trainee, it should be agreed who will take Clinical Supervisor responsibility. This role applies to deanery funded trainees only.

14.5 Individuals that undertake the role of Clinical or Educational Supervisor should have undergone the appropriate training for each role and should be able to demonstrate the required GMC standards for trainers (April 2010). Individuals that cannot evidence appropriate training and demonstrate that they have had an educational supervisor / clinical supervisor appraisal will not be permitted to undertake the role.

15.0 Job Plan Objectives

15.1 Job planning should be focused on measurable outcomes that benefit patients and are consistent with the objectives of the NHS, the Trust, teams and individuals.

15.2 The Job Plan will include objectives that have been agreed between the doctor and his or her Clinical Lead or Clinical Director. These objectives, which map to job-planned activities, are distinct from personal development plans arising from the appraisal process. The objectives will:

- Be SMART – Specific, Measurable, Achievable, Realistic and Timed
- Reflect different, developing phases in the doctor's career
- Be informed by team job planning and team objectives
- Be agreed on the understanding that delivery of objectives may be affected by changes in circumstances or factors outside the doctor's control, which will be considered at the Job Plan review
- Take account of any objectives agreed with other employers where relevant
- Where a doctor has additional trust-approved SPAs or ANR PAs, e.g. Educational Supervisor, Appraiser, Clinical Lead, these PAs will carry separate agreed objectives for the role

15.3 The objectives will include:

- Reflecting the current Trust, Divisional and Local service objectives based on team objectives and team working
- Key Quality and Performance indicators
- Management of resources, including efficient use of NHS and Trust resources
- Service development
- Additional responsibilities

16.0 Additional Programmed Activities

16.1 Additional Programmed Activities (APAs) are all PAs beyond 10. APAs are temporary and will be formally reviewed as part of the annual job plan review and may be introduced or reduced subject to no fewer than three months in

advance of the start of the proposed extra Programmed Activities, or six months in advance where the work would mean the consultant has to re-schedule external commitments (which can be waived by mutual agreement). APAs may consist of DCC, SPAs, additional NHS responsibilities and/or any other external duties.

16.2 There is no obligation on Consultants or SAS doctors to offer, or accept the offer of, additional PAs.

16.3 Consultants or SAS doctors who wish to undertake Private Practice may choose not to offer, or accept the offer of, an additional PA. If a consultant declines the opportunity to take up additional Programmed Activities that are offered in line with the provisions above, and the consultant subsequently undertakes remunerated clinical work as defined above, this will constitute one of the grounds for deferring a pay threshold in respect of the year in question. If another consultant in the group accepts the work, there will be no impact on pay progression for any consultant in the group. Guidance relevant to private practice may be found in "Department of Health, A Code of Conduct for Private Practice, Recommendations and Standards of Practice for NHS Consultants".

16.4 Where a consultant works for more than one NHS employer, the employers concerned may each offer additional Programmed Activities, but the consultant will not be expected to undertake on average any more than one Programmed Activity per week to meet the relevant criterion for pay thresholds. The job planning process should be used to agree for which employing organisation any additional Programmed Activities should be undertaken.

16.5 Consultants with existing extra-contractual commitments (such as private practice commitments) will be entitled to six months' notice to commence an additional PA.

16.6 Where more than 10PAs are included in a job plan there will be a clear distinction between the baseline PAs (those included in the 10 PA total which forms the permanent part of the doctors job) and APAs.

17.0 Additional NHS Responsibilities (ANR)

17.1 There are a range of additional NHS responsibilities that Consultants undertake both within the Trust and externally which the Trust recognises and supports. These responsibilities relate to specific roles filled by clinicians for a defined period, and these activities will have allocated ANR PAs.

17.2 Consultants who wish to perform ANR PAs must seek formal agreement from their divisional director and ADO prior to applying to the role, and if this is not forthcoming, may appeal to the Job Planning Committee. The nature of the additional responsibility and the time required to fulfil it should be discussed and agreed. Upon agreement, the appropriate ANR PAs are recommended by the Divisional Director to the Job Planning Committee. The Trust will not

expect any doctor to commence work of this nature prior to gaining approval from the Job Planning Committee. Payment will only occur after agreement from the Job Planning Committee.

17.3 When the Consultant is paid ANR PAs by an external organisation, there is no requirement to allocate PAs to discharge this responsibility however the nature of the additional responsibility should be noted in the Job Plan and adequate time identified.

17.4 Examples of Additional NHS Responsibilities include:

- Medical managerial leadership: Medical Director, Divisional director, clinical director or lead clinician
- Director of Public Health
- Caldicott Guardian
- Governance: clinical audit lead or other governance activity
- Regional or national educational roles: Undergraduate Dean, Postgraduate Dean, clinical tutor, regional education advisor and others
- Responsible Officer
- Appraiser or appraisal lead role

17.5 Clinical Leads are management roles that normally attract 0.5 PA / week but remuneration can be flexed according to department workload in agreement with Clinical Director (if one) / Divisional Director and recommended for approval at JPC.

17.6 Specialty Leads, whose role is focussed on a particular service/ specialty but does not include managerial responsibilities e.g. job planning, line management, will normally be remunerated at 0.25PA/ week but can be flexed according to department workload in agreement with Clinical Director/ Divisional Director and recommended for approval at JPC. This will be SPA above core SPA not ANR.

18. External Duties (END)

18.1 Some clinicians undertake additional duties for organisations which are associated with the NHS but not formally part of it. Some examples include college work and examinations, national representation on committees and teaching or external lectures.

18.2 Consultants who wish to perform external duties must seek formal agreement from their Divisional Director and ADO prior to applying for the role. The Trust will take a pragmatic approach to this decision on an individual basis and in principle agree to support external duties so long as:

- There is demonstrable benefit to the individual, the Trust or the wider NHS
- The clinical lead, clinical director, divisional director and ADO support the request and support will not be unreasonably withheld
- There is no significant loss of service delivery within the specialty/department unless replacement of this loss is agreed by the divisional director and ADO

18.3 Where Consultants are already performing external duties, the nature of these and the time commitment associated with the duties will be reviewed as part of the annual Job Plan review.

18.4 Examples of External Duties include:

- Trade union duties
- Undertaking inspections for the Care Quality Commission
- Acting as a 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
- Specified work for the General Medical Council

19.0 Flexible Working

Negotiating for flexible working will be agreed according to the flexible working policy between the doctor, the division and human resources. This will be noted by the Job Planning Committee.

20.0 Private Practice and Fee Paying Services

20.1 Clinicians and managers should consult "Department of Health, A Code of Conduct for Private Practice, Recommendations and Standards of Practice for NHS Consultants".

20.2 Consultants who are responsible for ensuring the provision of Private Professional Services or Fee Paying Services for other organisations should ensure that there is no:

- Detriment to NHS patients or services
- Diminishing of public resources that are available for the NHS.

20.3 Regular commitments in respect of Private Professional Services or Fee Paying Services must be documented in the Job Plan. This information will include the planned location, timing, and broad type of work. If time spent undertaking Private Professional Services results in an individual working in excess of 48 hours per week, the decision and the responsibility to undertake that work will lie with the individual.

20.4 Scheduling of NHS work should take priority over the scheduling of non-NHS work, subject to the Trust providing sufficient notice, as per national terms and conditions, of any proposed change to the agreed Job Plan.

20.5 Individual Consultants are responsible for ensuring that private commitments do not conflict with Programmed Activities.

20.6 Individuals who undertake private medico-legal work i.e. work which is not performed in their capacity as a Trust employee, may be called in court from time to time, a requirement which may interfere with NHS activity. Where this

is the case, arrangements will need to be agreed in writing with the relevant divisional director.

20.7 Subject to the following provisions, Consultants will not undertake Private Professional Services or Fee Paying Services when on-call. The exceptions to this rule are where:

- The Consultant'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 of the Consultants Terms and Conditions of Service (2003)
- The Trust has given prior approval for undertaking specified Private Professional Services or Fee Paying Services.
- The Consultant has to provide emergency treatment or essential continuing treatment for a private patient.

If the Consultant finds that such work regularly impacts his or her NHS commitments, he or she will make alternative arrangements to provide emergency cover for private patients.

20.8 Private work or fee paying services should normally be conducted outside of contracted work which includes SPAs and on-call duties (unless the on-call duties fall under the exception rules described previously). Any secretarial work required for these activities should be performed out of hours and Consultants should pay for this work to be undertaken.

20.9 In cases where private work or fee paying services are undertaken during contracted programmed activities times, the individual is expected not to collect a fee unless the work involves minimal disruption to NHS work. Where the Trust agrees for the work to be done within NHS time without collecting the fee, the arrangement needs to be agreed by the ADO. 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).

20.10 Where private cases are included in operating lists, clinic schedules etc., the time taken to treat/see such cases must be accumulated up to the equivalent of 1 PA and the time offered back to the Trust at a mutually agreed time.

20.11 All Consultants and SAS Doctors must provide a 'Declaration of Interest' of private practice worked to be eligible for future threshold incremental progression. Where private practice is undertaken, the principles set out in the Private Practice Code of Conduct and the Study of Restrictions on Consultants in Relation to NHS Work during Non-Contracted Hours should be adhered to.

20.12 All Consultants and SAS Doctors must adhere to the "Conflict of Interest Policy" and declare any such activities. The Trust acknowledges that there should be no conflict of interest between working as a doctor in the NHS and delivering healthcare elsewhere (reference - Study of Restrictions on Consultants in Relation to NHS Work during Non-Contracted Hours).

21.0 Capacity Lists and other Capacity work

21.1 Consultants are often asked to perform additional lists, clinics, investigations or reports in order to reduce or maintain patient waiting times. One of the important principles of the 2003 Consultant Contract is that Consultants cannot be paid twice for the same period of time. For this reason, Consultants must not, under any circumstances, undertake 'waiting list (time) initiative' lists or other capacity work whilst on-call. The Trust will not, under any circumstances, ask Consultants to undertake lists or other related work whilst on-call.

21.2 The Trust will not normally ask Consultants to perform non job planned activities work during their SPA time. When this is necessary, the displaced SPA should be allocated at another time and there should be explicit written agreement regarding the time and location of this. Where it is agreed that the displaced SPA will be performed in lieu of a clinical session, the Consultant will not be entitled to any additional remuneration for the additional sessional work undertaken. In contrast, where it has been agreed that the displaced SPA will be performed at a time when the Consultant is not contracted to work for the Trust the Consultant will be entitled to payment for the non- job planned activity work at rates at least equivalent to the rates of standard time as defined by the national terms and conditions.

21.3 If a doctor offers to cover DCC in SPA time for non-capacity work but to cover unexpected unplanned emergencies e.g. sick leave of a colleague the SPA time will be repaid back at a mutually agreed time. This will not normally attract enhanced payment.

22.0 Leave

Annual/professional/study leave must be booked at least 6 weeks in advance and is subject to approval by the Consultant or SAS Doctor's clinical lead, clinical director or divisional director. Please refer to the Leave Policy.

23.0 Work Diary

23.1 Whilst not a requirement of the contract, Consultants or SAS Doctors should keep or be advised to keep a work diary to inform the Job Plan meeting of the range of activities and the time spent on these.

23.2 The diary is not to dictate the Job Plan but it will assist in the Job Planning process where the Consultant or SAS Doctor or Manager feels that there are discrepancies between the current Job Plan and actual workload.

24.0 Locums

24.1 The Trust will agree job plans with locums as per this policy and will take into account their familiarity with Trust systems and processes and the extent to which their contribution may differ from their colleagues.

24.2 The job plan may differ from the Consultant they are replacing and they may deliver more direct clinical care. The Trust standard core SPA allocation will apply to locum doctors to enable them to meet college and other external requirements.

25.0 Job Plan System and Template

25.1 The Trust will from time to time commit to certain software packages to help deliver job plan templates and systems. The software system used at present is 'Allocate'. Links to user guides can be found in the references section.

25.2 New consultants and SAS doctors will need to have their job plans on Allocate within 2 weeks of commencement. This is part of the local induction process. The responsibility lies between the doctor, the Clinical lead/CD and Medical Resources. Doctors must fully co-operate with Trust job planning processes but it is recognised sign off of the job plan falls outside of the consultant's control.

26.0 Job Plan Sign-off Process

26.1 First sign-off

26.1.1 The draft Job Plan will be reviewed and agreed by the Consultant or SAS Doctor and their clinical lead and service manager using e-job planning. Once agreed the doctor will submit their job plan and this will lead to provisional 1st sign-off. This applies to all doctors, including clinical leads, clinical directors and divisional directors. If there is no clinical lead (or if the doctor is the clinical lead), the clinical director should provide the 1st sign-off. If there is no clinical director (or if the doctor is the clinical director) or clinical lead, an alternative clinical director from another clinical area should be used for 1st sign-off.

26.1.2 There will be demonstration of adherence to budget and job planning principles, including the following list:

- Confirm budget approval
- Confirm DCCs are consistent with service needs. The sum total of individual DCCs for consultant and SAS doctors should not exceed the sum total of service DCCs. For example, the sum total of theatre anaesthesia DCCs should equate to the sum total of DCCs for anaesthetists taking into account the 42-week plan and services delivered by non-consultant-non-SAS doctors
- Confirm SPAs are already approved by Job Planning Committee
- Explain clearly any discrepancies in points 2 and 3

26.1.3 The Divisional Director or delegate will return the job plan unsigned to the first signers if these principles have not been adhered to.

26.2 **Second sign-off:**

The clinical director and will review and agree the Job Plan on the electronic system for 2nd sign-off. This stage should still be regarded as provisional and represents a recommendation to JPC.

26.3 **Third sign-off:**

The Job Planning Committee will review and approve team job plans as a group prior the third sign-off by the Divisional Director.

26.4 It is expected that the sign-off processes described in this policy will be performed on an annual basis. However, the Job Planning Committee will be the monthly forum to review signed-off job plans which need modifying. This matter will be brought to the Committee's attention by the Divisional Director.

26.5 All staff involved in job planning process have a responsibility for ensuring sign off process is managed in a timely manner. Doctors must fully co-operate with Trust job planning processes but it is recognised sign off of the job plan falls outside of the consultant's control.

27.0 Job Planning and the link to Pay Progression

27.1 Consultants

27.1.1 The Consultant Contract makes provisions for Consultants' remuneration to rise through a series of thresholds subject to certain conditions and it is recognised that this progression is not automatic. The criteria to be referred to annually for pay progression purposes are that the Consultant has:

- Made every reasonable effort to meet the time and service commitments in the Job Plan, including participating fully in the job planning process
- Participated satisfactorily in the appraisal process
- Adhered to Trust and personal objectives linked to the job plan, or where this is not achieved, made every reasonable effort to do so
- Taken up any offer to undertake Additional Programmed Activities that the Trust has made to the Consultant or SAS Doctor in accordance with Schedule 6 of the Terms and Conditions
- Met the standards of conduct governing the relationship between private practice and NHS commitments set out in Schedule 9 of the Terms and Conditions
- Undertaken the appropriate Mandatory Training

27.1.2 The clinical lead or clinical director who has conducted the Job Plan review, in conjunction with the service manager and ADO will report the outcome to the Job Planning Committee who will in turn make a recommendation to the Chief Executive on whether the Consultant has met the criteria for pay progression.

In turn the Chief Executive will decide whether the consultant has met the criteria for pay progression.

27.1.3 Where one or more of the criteria are not achieved, evidence for this decision will be provided to the consultant. Consultants who wish to appeal against the decision made by the Chief Executive should do so in accordance with Schedule 4 of the Terms and Conditions which can be found on the NHS Employers website.

27.1.4 If the Chief Executive decides that a Consultant has not met the necessary criteria for pay progression, the Trust will defer the award of the appropriate pay progression and this will be reviewed one year hence. Pay progression will only be paid on designated pay progression dates and there will be no back-dating.

27.1.5 The consultant is entitled to appeal, and the process is described in appendix 1. If the appeal is upheld, the pay progression will be paid and backdated to the relevant pay progression date.

27.2 SAS Doctors

27.2.1 The Specialty Doctor Contract makes provisions for SAS Doctor remuneration to rise through a series of thresholds subject to certain conditions and it is recognised that this progression is not automatic. The criteria to be referred to annually for pay progression purposes are that the SAS Doctor has:

- Made every reasonable effort to meet the time and service commitments in the Job Plan, including participating fully in the job planning process
- Participated satisfactorily in the appraisal process
- Adhered to Trust objectives linked to the job plan
- Taken up any offer to undertake Additional Programmed Activities that the Trust has made to the SAS Doctor in accordance with Schedule 7 of the Terms and Conditions
- Met the standards of conduct governing the relationship between private practice and NHS commitments set out in Schedule 11 of the Terms and Conditions
- Undertaken the appropriate Mandatory Training

27.2.2 The clinical lead or clinical director who has conducted the Job Plan review, in conjunction with the service manager and ADO will report the outcome to the Job Planning Committee who will in turn make a recommendation to the Chief Executive on whether the SAS Doctor has met the criteria for pay progression. In turn the Chief Executive will decide whether the consultant has met the criteria for pay progression.

27.2.3 Where one or more of the criteria are not achieved, evidence for this decision will be provided to the consultant. SAS Doctors who wish to appeal against the decision made by the Chief Executive should do so in accordance with Schedule 5 of the Terms and Conditions which can be found on the NHS Employers website.

27.2.4 If the Chief Executive decides that a SAS Doctor has not met the necessary criteria for pay progression, the Trust will defer the award of the appropriate pay progression and this will be reviewed one year hence. Pay progression will only be paid on designated pay progression dates and there will be no back-dating.

27.1.5 The SAS doctor is entitled to appeal, and the process is described in appendix 1. If the appeal is upheld, the pay progression will be paid and backdated to the relevant pay progression date.

28.0 Annual Job Planning Timetable

Annual job planning will take place on a yearly cycle for each doctor.

29.0. Job Plan Reviews

29.1 A Job Plan will usually be reviewed on an annual basis as part of the Trust wide job planning round.

29.2 However there may be times during the year when changes occur and a Consultant or SAS Doctor's Job Plan will need to be reviewed, either due to external influences having an impact on the service which the Consultant or SAS Doctor provides or because a Consultant or SAS Doctor circumstances have changed. For example where activity in a department has continuously reduced, or the local Clinical Commissioning Group no longer contracts for particular services, Job Plans will need to be reviewed and amended accordingly to meet the needs of the service.

30.0 Job Planning and the link to Clinical Excellence Awards

It has been determined nationally that adherence to the National Standards of Best Practice for Job Planning will form part of the eligibility criteria for clinical excellence awards. The Trust expects all Consultants who apply for a Clinical Excellence Award to have participated fully in job planning for the relevant year. The sign off process is outside of the consultants control as such there should be no detriment to any consultant who has co-operated fully with the job planning process.

31.0. Job Plan Appeals Process

31.1 Where it has not been possible to agree a Job Plan or a Consultant or SAS Doctor disputes a decision that he or she has not met the criteria required for pay progression in a given year, a mediation process and appeal procedure is available, and this will be escalated to the Job Planning Committee.

31.2 Full details of the mediation process and appeal procedure is outlined in Schedule 4 of the Terms and Conditions which can be found on the NHS Employers website. The link can be found in the references section.

32.0 Audit of Job Planning Process

In the spirit of openness and transparency the Trust will make available to the Trust Board, LNC, MAC and Management Team, data regarding the outcome of the Job Planning process on an annual basis.

33.0 Monitoring compliance

In order to ensure compliance with this policy, the Trust will undertake the following monitoring

Aspect of compliance	Method	Responsible Officer	Frequency	Report to	Responsible for action
Signed off job plans to meet requirements of commissioners and the Trust	Interim audits	Medical Director	Annual	Executive Team and Trust Board	Clinical leads, clinical directors, divisional directors, service managers, ADOs

34.0 References

British Medical Association & NHS Employers - A guide to Consultant Job Planning (July 2011)

Department of Health – Consultant Job Planning: Standards of Best Practice (January 2004)
http://www.nhsemployers.org/SiteCollectionDocuments/Appendix_1_Job_planningstandard_of_best_practice.pdf

NHS Modernisation Agency – Effective Job Planning: A concise guide for consultants (February 2005)
http://www.nhsemployers.org/SiteCollectionDocuments/Effective_job_planning.pdf

Terms and Conditions – Consultants and SAS (England) 2003
Consultant
http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/consultants-and-dental-consultants/consultant-contract-(2003)

SAS
http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/specialty-and-associate-specialist-doctors

Terms and conditions of service NHS Medical and Dental Staff (England) 2002
http://www.nhsemployers.org/SiteCollectionDocuments/Hospital_Medical_and_Dental_Staff_TCS_March_08_cd_160209.pdf

General Medical Council – Recognition and approval of trainers http://www.gmc-uk.org/education/10264.asp

Department of Health, A Code of Conduct for Private Practice, Recommendations and Standards of Practice for NHS Consultants
BMA/NHS Employers nationally agreed 'A practical guide to calculating on-call work

Allocate Consultant and SAS Guide:
https://products.zircadian.com/ConsultantsUI/Documents/Doctor_guide_for_eJobPlan_England.pdf

Allocate Management Guide:
https://products.zircadian.com/ConsultantsUI/Documents/Manager_guide_for_eJobPlan_England.pdf

Appendix 1: Job Planning Committee

Stakeholders

Medical Director
Director of Human Resources
Chief Operating Officer
Deputy Medical Director
Head of Medical Resources
Divisional Director (for each division),
Chief Financial Officer
LNC representative
Any relevant external company dealing with activity efficiency

Terms of Reference

1. To identify, describe and delegate job planning principles
2. To approve and review the Job Planning Policy
3. To recognise and agree on all PAs approved by MEHT
4. To handle and assess PAs hitherto not approved by MEHT
5. Performance queries for any PAs
6. Evidence method of approval of role and PA allocation by management team
7. Make a decision to approve or reject these PAs
8. To reference planned activity to financial pressures
9. To handle appeal cases
10. To agree 3rd sign-off for job plans
11. To receive any progress reports on the software used for Job Planning

The JPC will be accountable to the Senior Management Group (SMG)

Agenda

1. TOR discussion and agreement (first meeting only)
2. Job planning policy discussion and agreement (first meeting only)
3. MEHT-approved PAs – discussion and agreement (first meeting only)
4. Handling newly uncovered PAs – discussion and agreement (first meeting only)
5. Divisional concerns with job plans including newly uncovered PAs (recurring)
6. Financial implications (recurring)
7. 3rd sign-off for job plans
8. Job planning appeals (recurring)
9. Updates on job planning software (by exception)

Appendix 2: Mediation and Appeals Process

Consultants

This section should be read in conjunction with Schedule 4 of the Terms and Conditions – Consultants (England) 2003.

Where it has not been possible to agree a Job Plan or a Consultant disputes a decision that he or she has not met the required criteria for a pay threshold in respect of a given year, the following mediation and appeals procedure will be available.

Mediation – Step 1

The Consultant or (in the case of a disputed Job Plan) the Clinical Lead or Clinical Director should refer the matter via the Divisional Director to the Medical Director via the Job Planning Committee, where a designated person will be found if the Medical Director is one of the parties involved with the initial decision.

Where a Consultant is employed by more than one NHS organisation, the prime employer will take the lead. The purpose of the referral will be to reach an agreement.

The referral in writing to the Job Planning Committee is made within two weeks of the disagreement arising.

The referral will set out the nature of the disagreement and his or her position or view on the matter.

Where the referral is made by the Consultant, the Clinical Lead responsible for the service will review the Job Plan, or (as the case may be) for making the recommendation as to whether the criteria for pay threshold have been met, will set out the position or view on the matter.

The position and perspective of the Consultant is set out, as is the position and perspective of the Clinical Lead, Clinical Director and Divisional Director

The mediation hearing will be heard within 4 weeks at the next available Job Planning Committee or at a Special Mediation Meeting, whichever occurs sooner.

The Medical Director or delegate will chair the Special Mediation Meeting. The Consultant and Clinical Lead or Clinical Director or Divisional Director would be expected to attend this meeting.

Formal Appeal – Step 2

A formal appeal panel will be convened only where it has not been possible to resolve the disagreement using the mediation process. A formal appeal will be heard by a panel under the procedure set out below. An appeal shall be lodged in writing

to the Chief Executive as soon as possible and in any event within two weeks, after the outcome of the mediation process. The appeal should set out the points in dispute and the reasons for the appeal.

The Chief Executive will, on receipt of a written appeal, convene an appeal panel to meet within four weeks.

The membership of this panel will be:

- A chairman nominated by the Trust
- A representative nominated by the Consultant
- The JPC will choose a third member who will be external to the organisation: selected from NHS Midlands and East Medical Directors Network or a suitable member of the BMA/ BDA. MEHT will continue to monitor the way in which individuals are allocated to appeal panels to avoid particular individuals being routinely called upon. If there is an objection raised by either the Consultant or the employing organisation to the first representative, one alternative representative will be allocated. A list of selected individuals will be regularly reviewed.

No member of the panel should have been previously been involved in the dispute.

The parties to the dispute will submit their written statements of case to the appeal panel and to the other party one week before the appeal hearing. The appeal panel will hear oral submissions on the day of the hearing. Management will present its case first explaining the position on the Job Plan, or the reasons for deciding that the criteria for a pay threshold have not been met.

The Consultant may present his or her own case in person, or be assisted by a work colleague or trade union /other professional organisation representative, but legal representatives acting in a professional capacity are not permitted.

Where the Consultant, the employer or the panel requires it, the appeals panel may hear expert advice on matters specific to a specialty.

It is expected that the appeal hearing will last no more than one day.

The appeal panel will make a recommendation on the matter in dispute in writing to the Board of the employing organisation, normally within two weeks of the appeal having been heard and this will normally be accepted. The Consultant should see a copy of the recommendation when it is sent to the Board. The Board will make the final decision and inform the parties in writing,

No disputed element of the Job Plan will be implemented until confirmed by the outcome of the appeals process. Any decision that affects the salary or pay of the consultant will have effect from the date on which the consultant referred the matter to mediation or from the time that he or she would otherwise have received a change in salary, if earlier.

SAS Doctors

This section should be read in conjunction with Terms and conditions of service for specialty doctors – England (2008) Schedule 5 Mediation and Appeals**.**

Where it has not been possible to agree a Job Plan (including Job Plan reviews and interim reviews) or a doctor disputes a decision that he or she has not met the required criteria for a pay increment or threshold in respect of a given year, a mediation procedure and an appeal procedure are available.

Where a doctor is employed by more than one NHS organisation, mediation and appeals will be undertaken by the organisation where the issue arises.

Mediation – Step 1

The doctor may refer the matter to the to the Medical Director via the Job Planning Committee, where a designated person will be found if the Medical Director is one of the parties involved with the initial decision. The purpose of the referral will be to reach agreement if at all possible. The process will be that:

• The doctor makes the referral in writing within 10 working days of the disagreement arising.

• The doctor will set out the nature of the disagreement and his or her position or view on the matter; this should be provided in writing and normally within 15 working days of the referral being submitted.

• The clinical manager responsible for the Job Plan review, or (as the case may be) for making the recommendation as to whether the criteria for pay increments or thresholds have been met, will set out the employing organisation's position or view on the matter. This should be provided in writing and normally within 15 working days of the referral being received.

• The mediation hearing will be heard within 20 working days at the next available Job Planning Committee or at a Special Mediation Meeting, whichever occurs sooner. This will include meeting with the doctor and the responsible clinical manager to discuss the disagreement and to hear their views.

• If agreement is not reached at this meeting, then within 10 working days the Medical Director or designated other person will decide the matter and shall notify the doctor and the responsible clinical manager of that decision or recommendation in writing.

If the doctor is not satisfied with the outcome, he or she may lodge a formal appeal to the Chief Executive within 10 working days..

Formal Appeal – Step 2

A formal appeal panel will be convened only where it has not been possible to resolve the disagreement using the mediation process. A formal appeal will be heard by a panel under the procedure set out below.

An appeal shall be lodged by the doctor in writing to the Chief Executive as soon as possible and in any event within 10 working days of receipt by the doctor of the decision. The appeal should set out the points in dispute and the reasons for the appeal.

The Chief Executive will, on receipt of a written appeal, convene an appeal panel to meet within 20 working days.

The membership of the panel will be**:**

- A Chair, being a Non-executive Director of the appellants employing organisation
- A second panel member nominated by the appellant doctor, preferably from within the same grade
- An Executive Director from the appellant's employing organisation

No member of the panel should have previously been involved in the dispute.

The parties to the dispute will submit their written statements of case to the appeal panel and to the other party no less than 5 working days before the appeal hearing. The appeal panel will hear oral submissions on the day of the hearing. Following the provision of the written statements neither party shall introduce new (previously undisclosed) written information to the panel. A representative from the employing organisation will present its case first.

The doctor may present his or her own case in person, or be assisted by a work colleague or trade union or professional organisation representative, but legal representatives acting in a professional capacity are not permitted.

Where the doctor, the employer or the panel requires it, the appeals panel may hear expert advice on matters specific to a specialty or to the subject of the appeal.

It is expected that the appeal hearing will last no more than one day.

The decision of the panel will be binding on both the doctor and the employing organisation. The decision shall be recorded in writing and provided to both parties no later than 15 working days from the date of the appeal hearing.

The decision of the panel will be implemented in full as soon as is practicable and normally within 20 working days.

No disputed element of the Job Plan will be implemented unless and until it is confirmed by the outcome of the appeals process and where appropriate a revised Job Plan is issued.

A decision which increases the salary or pay which the appellant doctor will receive will have effect from the date on which the doctor referred the matter to mediation. A decision which reduces salary or pay will have effect from a date after that which the revised job plan was offered (giving a locally agreed period of notice) following the decision of the panel.

Appendix 3: Role of Board and Committees

Where	Responsible author for agenda	What reported
Departmental meetings	Lead Clinician	Job planning issues
Directorate meetings	Clinical Director	Job planning issues
Divisional meetings	Divisional Director	Job planning issues
Corporate committees e.g. Research and Development	Relevant Lead	Relevance of PAs
Job Planning Committee	MD and Divisional Directors	Issues (MD) and reports (DD)
Divisional Accountability Meeting	MD and Divisional Directors	Issues (MD) and reports (DD)
SMG	MD and Divisional Directors	Issues (MD) and reports (DD)
Assurance: Patient Safety and Quality	MD	Assurance paper
Trust Board	MD	Assurance paper

Appendix 4: Trust Approved activities

1st block: Other than the Medical Director, PAs for all the roles below will be agreed by the JPC
2nd block: divisions will make a case for the PA allocation. For the roles below CD and CL – the divisions will make a case for PAs to JPC.

Block 1	**Medical Director**
	Chair Job Planning Committee
	Chair Clinical Governance Group
	Chair Mortality Review Group
	Caldicott Guardian
	Divisional Directors
	Deputy Medical Director
	Clinical Lead Organ Donation
	Medical Examiners
	Appraisers
	Serious Incident investigators
	Case Investigators
	Responsible Officer
	Appraisal Lead
	Effectiveness Lead
	Guardian Safe Working Hours
	Clinical Communications
	7 day working/H@N
	VTE Lead
	Chair APC and MOSG (medicines)
	Chief Clinical Information Officer
	Chair Informatics Steering Group
	Clinical Safety Officer
	Sepsis Lead
	Trauma Lead
	End of Life
	Cognition & dementia
	POCT and Medical Devices
	Director of Medical Education
	College Tutor
	Educational Supervisors
	Chair Deteriorating Patient Group
	Research
Block 2	**Clinical Directors**
	Clinical Leads
	Governance Lead
	Mortality Lead
	Audit Lead

Appendix 5: Agreed standard Trust travel times

The table below sets out the agreed standard Trust travel times for common journeys made by Consultants or SAS Doctors employed by the Trust. These times have been verified. For any frequent journeys not included in this table please use the time from Google Maps.

Travel times should be monitored and reviewed with the participation of Consultants and SAS doctors. All travel time should include the time taken to travel from one site to another “door to door” this would take account of normal levels of traffic including variations in traffic at different times of day, the time to park and any journey necessary on foot rounded up to the nearest 15 minutes. All travel time between clinics is working time and should be accounted for fully in the job plan.

E-Job planning will not allow for specific times to be entered as it counts in 15 minute multiples.

Single Journey **From/To:** Broomfield Hospital CM1 7ET:

Hospital	**Travel Time (Car)**
Southend Hospital	45 Minutes
Basildon Hospital	45 Minutes
Colchester Hospital	45 Minutes
South Woodham Ferrers Hospital	30 Minutes
Halstead Hospital	40 Minutes
St Peters (Maldon) Hospital	30 Minutes
Braintree Community Hospital	30 Minutes
Epping Hospital	45 Minutes
Princess Alexandra Hospital	45 Minutes
Harold Wood Hospital	45 Minutes

Appendix 6: BMA/NHS Employers nationally agreed 'Practical guide to calculating on-call'

A practical guide to calculating on-call work

Introduction

One of the elements of the new contract that Trusts and consultants may find challenging is calculating the amount of work that is done on call and how to translate this into Programmed Activities. The purpose of this brief guide is to provide a possible mechanism and two methods for working this out.

It should be stressed that in 2003/04, all PAs have an average timetable value of 4 hours. However, since the average timetable value of PAs undertaken in premium time i.e. outside 7am to 7pm Monday to Friday, will be three hours from 1st April 2004 onwards, the examples shown have three hours as their average time content.

It is also important to remember that up to one PA per week on average can be allocated to unpredictable work until 31st March 2005, rising to an average of two PAs a week after this date.

Step 1

All consultants should undertake a diary exercise and note how much work is undertaken as a result of being on call. This should be divided into predictable and unpredictable emergency work. From this, an average amount of work for each weekday (Monday to Friday) and weekend (Saturday and Sunday) can be calculated. The total amounts for the whole team should be calculated at this stage, not allocated to individuals.

Step 2

The number of days consultants are available for on call work should be calculated. Normally this would be 52 weeks 1 day minus 6 weeks (plus one day in 2004/05 and 2 days in subsequent years) annual leave plus 10 bank holidays and lieu days, and 2 weeks study leave per year, unless a local variation has been agreed. This gives a total of 211 weekdays and 44 weekends reducing to 210 weekdays in 2004/05 and 209 in subsequent years.

Step 3

There are two suggested methods of showing how the average amount of work undertaken by each consultant per week could be calculated. The second method is not a different calculation, but an arguably simpler way of showing the calculation.

Method 1

1. Calculate the number of PAs per year by multiplying the average number of PAs per weekday by 261 (52 X 5 + 1) – **Figure 1.**
2. Multiply the number of PAs per weekend by 52 – **Figure 2.**
3. Divide the number of PAs per year undertaken on weekdays (**Figure 1**) by 210, multiply by 5 (there are 5 weekdays in each week) and divide by the number of consultants on the rota.
4. Divide the number of PAs undertaken at weekends (**Figure 2**) by 44 and divide the result by the number of consultants on the rota.
5. Add these two figures together to give the average number of PAs per week of on call work done by each consultant.

The following examples show how this calculation works. For simplicity, the annual leave entitlement for 2004/05 is used.

Example 1

Five consultants are on a rota. They have undertaken a diary exercise for three months and this shows that on average, each weekday night on call generates 1 _ hours work, i.e. half a PA. In addition, each weekend they undertake ward rounds on both Saturday and Sunday mornings. Each ward round takes an average of 2 hours. In addition, there is a further 5 hours unpredictable emergency work over each weekend, giving a total of 9 hours or 3 PAs. In terms of predictable and unpredictable work, each week on call generates 12 _ hours or just over 4 PAs of unpredictable work and 4 hours or 1 1/3 PAs of predictable work.

- Over the whole year, this equates to 130 PAs on weekdays and 156 PAs at weekends.
- Weekdays – 130 divided by 210, multiplied by 5 and divided by 5 (number of consultants on the rota is 0.6)
- Weekends – 156 divided by 44 and divided again by 5 is 0.7.
- On average, the consultants undertake 1.33 PAs per week of on call generated work.

Example 2

A team of 10 consultants are on a rota. They have undertaken a diary exercise for 4 months. This shows that on average, a weekday on call generates 6 hours work, or 2 PAs in total, with the time being split roughly 3 hours of ward rounds and 3 hours of unpredictable work. They undertake ward rounds and theatre lists each Saturday and Sunday which last 4_ hours each day on average and in addition, each weekend generates 9 hours of unpredictable work, giving a total of 18 hours or 6 PAs of work. In total, therefore, each week on call generates 8 PAs of unpredictable work and 8 PAs of predictable work.

- Over the whole year, this is a total of 522 PAs during weekdays and 312 PAs at weekends.
- Weekdays – 522 divided by 210 multiplied by 5 and divided by 10 gives an average of 1.25 PAs per week.
- Weekends – 312 divided by 44 and divided again by 10 gives just under 0.75 PAs.
- On average, the consultants undertake 2 PAs per week of on call generated work.

Method 2

Multiply the average number of PAs per year for weekdays by 124.29% (261/210) and weekend PAs by 118.18% (52/44).

Example 1

Each week of on call generates 7.5 hours or 2.5 PAs of work during weekdays and each weekend generates 9 hours or 3 PAs of work. As there are 5 consultants on the rota, this equates to 0.5 PAs for weekday work and 0.6 PAs for weekend work.

0.5 x 1.2429 = 0.62

0.6 x 1.1818 = 0.71

Total PAs per week arising from on call = 1.33 PAs

Example 2

Each week of on call generates 30 hours or 10 PAs of work during weekdays and each weekend generates 18 hours or 6 PAs of work. As there are 10 consultants, this equates to 1 PA for weekday work and 0.6 PAs for weekend work.

1 x 1.2429 = 1.24

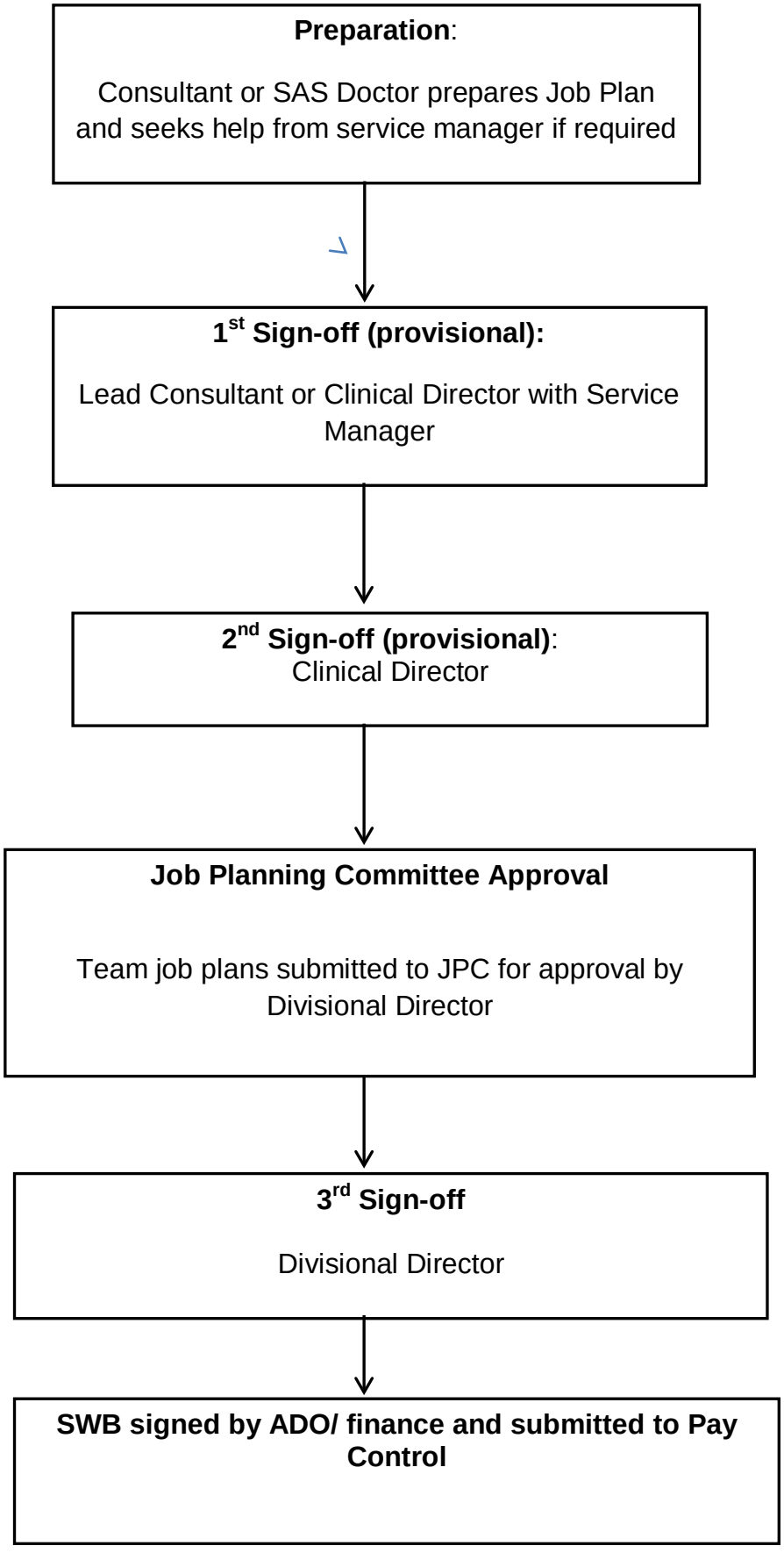
0.6 x 1.1818 = 0.71

Total PAs per week arising from on call = just under 2.

CCIT
NHS Modernisation Agency

1 March 2004

Appendix 7: Sign-off Process



Appendix 8: Calculating On Call Availability Supplement (OCAS) for Mixed Frequency or Category Rotas

This appendix outlines how these examples may be worked through and agreed but the final decision will rest with Job Planning Committee and subject to the Appeals process.

Example for mixed frequency rota for job plan:

If doctors participate in two rotas, they do not normally receive the supplement for each. Normally, the overall on-call commitment or frequency would be calculated to establish the true frequency. This is a relatively easy process **IF** the rotas are in the same category.

e.g.
1:18 Cat A = 2.89 weeks of on call per annum - 3% if only rota
1:4 Cat A = 13 weeks of on-call per annum - 8% if only rota
Total = 15.29 weeks = 1in 3.4 = 8% OCAS i.e. doctor does not receive 11% (3+8)

Examples for a mixed category rota for job plan:

If the rotas are in different categories, the TCS does not cover this and OCAS will have to be determined by local agreement.

The Trust approach will be based on the assumption that no clinician will receive more than 8% for their on-call supplement.

If a doctor participates in two rotas, one of which is in Category A High Frequency, an 8% on-call supplement will be allocated.

If a doctor participates in two rotas with different categories, and neither of the rotas are in the Category A High banding, the supplement allocated, will be the full value of the Category A rota, plus the half value of the Category B rota.

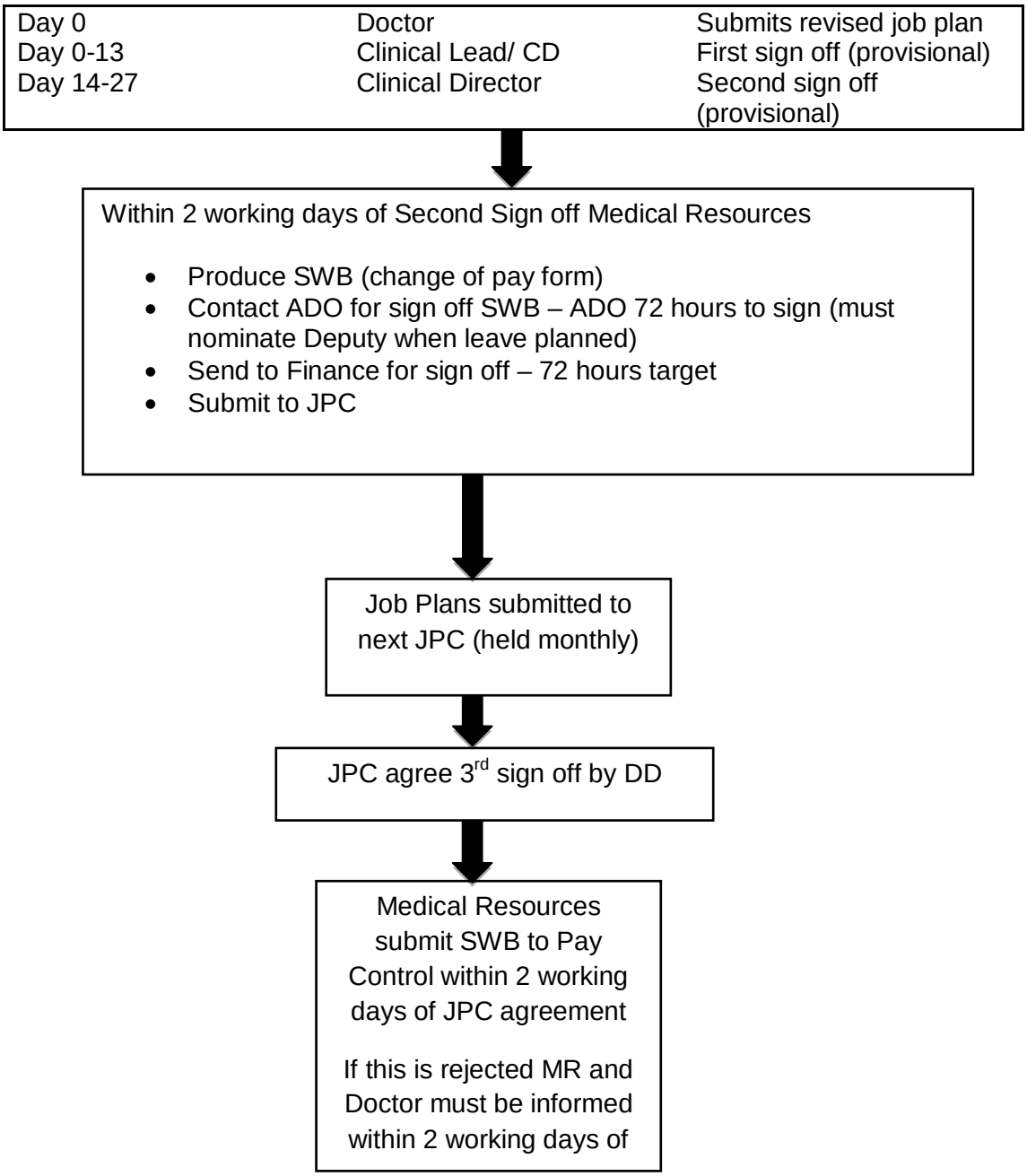
		Category B High	Category B Medium	Category B Low
		3.00%	2.00%	1.00%
Category A High	8.00%	8.00%	8.00%	8.00%
Category A Medium	5.00%	6.500%	6.000%	5.500%
Category A Low	3.00%	4.500%	4.000%	3.500%

Appendix 9: Sign Off for Job Plan Changes Outside Job Planning Cycle

MEHT recognises that job plans for Consultants and SAS doctors may need to be changed outside of the formal job planning business cycle for a number of valid reasons.

Job Planning processes will carry the following quality standards from when the doctor moves their revised job plan into the sign –off phase on Allocate.

Performance against these standards will be monitored though JPC.



Appendix 10: Job Planning Business Cycle