Leeds Community Healthcare NHS Trust

Job Planning Policy for Consultants, SAS Doctors, Salaried GPs and Salaried Dentists	
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Executive summary

The policy adheres to the principle that all qualified medical and dental staff will undertake annual job planning in keeping with the process agreed at the time by the GMC, BMA and Department of Health under the Consultant Contract 2003, the Salaried GP contract 2006 the Salaried Dental Contract 2007 and the SAS contract 2008.

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1.0 Introduction

Job Planning for doctors and dentists is an annual process in which the doctor/dentist being job planned has a formal structured meeting with their Associate Medical Director/Medical Lead (AMD/ML) and General Manager (GM) to agree individual programmes of work that contribute to the overall delivery of services. This policy applies to all consultants, SAS doctors, salaried GPs, employed Forensic Medical Examiners (FMEs) and salaried dentists employed by Leeds Community Healthcare (LCH) NHS Trust. This policy will be overseen by the Joint Negotiating Committee (JNC) and ratified by the Remuneration Committee.

2.0 Policy Scope

The purpose of job planning is to value and reward the full range of work activities that doctors/dentists do for the NHS. It is an annual process to successfully marry the aspirations of the organisation with those of the doctor/dentist but the Department of Health explicitly links participation in job planning with eligibility for pay progression for consultants/SAS doctors Salaried GPs and dentists.

3.0 Aims

The aim of this document is to:

- Provide guidance to support job planning.
- Standardise practice
- Bring greater clarity, focus and consistency to the process.
- Ensure work patterns are fully aligned with the organisation's priorities and specifically the Business plans of the relevant services.

The Associate Medical Directors (AMD)and Medical Leads (ML) structure is designed to enable and enhance engagement within services and so improve the process of business planning, providing a clearer and better informed context for job planning, which will be led by these AMD/ML working in partnership with GM.

Due to fluctuations in patient demand and available capacity, the organisation requires a workforce that is able to work with a degree of flexibility to meet patient needs and thereby deliver the accepted measures of high quality care. Job planning needs to recognise the complexities of the current environment we work in, and needs to reconcile individual aspiration with the requirement to improve productivity and deliver a consistent standard of high quality patient care across the organisation.

Our organisation recognises and supports the need for medical/dental staff to participate actively in research and teaching at local, national and international level. The new national rules for funding for these major elements of our role as an organisation means that job plans must

identify and measure the output from these activities.
The organisation through the JNC is committed to reviewing the effectiveness of these arrangements. Although these principles and standards are very comprehensive, out of necessity to cover most eventualities, it is anticipated that Job Planning for most medical/dental staff will be a simple and straightforward process to the benefit of both the organisation and the doctor/dentist.

4.0 Principle for Job Planning

The following principles are developed with reference to the Terms and Conditions of the Consultant Contract (2003), Salaried GP Contract (2006), Salaried Dental Contract 2007 and SAS Contract (2008). This guidance will not be prejudicial to, or take precedence over, the agreed national terms and conditions of these contracts.

Job Planning should be:

For Consultants:

- Undertaken in a spirit of collaboration and cooperation
- Completed in good time
- Reflective of the professionalism of being a doctor
- Focused on measurable outcomes that benefit patients
- Consistent with the objectives of the NHS, the organisation teams and individuals
- Transparent fair and honest
- Flexible and responsive to changing service needs during each job plan year
- Fully agreed and not imposed
- Focused on enhanced outcomes for patients whilst maintaining service efficiency.

(ref. NHS Employers – key principles to job planning)

For SAS Doctors:

- Undertaken in a spirit of collaboration and cooperation
- Mutually agreed and not imposed
- completed in good time with at least annual review
- reflective of the professionalism of being a doctor
- agreed taking account of the career development and aspirations of the doctor
- focused on maintaining high-quality care
- transparent, fair and honest
- agreed taking into account the individual doctor's area(s) of expertise
- agreed with adequate provision for any activities mandated by regulating agencies
- responsive to appraisal discussion

(ref. The UK guide to Job Planning for Specialty Doctors and Associate Specialists)

For Salaried Dentists:

- it should be developed in the spirit of partnership
- it is an agreement that sets out objectives (both professional and
- personal), duties and responsibilities for the coming year
- resources and support should be identified and agreed
- it should cover all aspects of a dentist's professional practice
- it should cover the requirements of the organisation/employer
- it may be built onto the previous year's plan
- the plan may include team activities
- the process is separate from, but linked to, appraisal.

(ref. Job Planning Guidance BDA and NHS Employers)

Alignment with organisational business plans and objectives

4.1 The job plan must align to the delivery of the Service Business Plan and objectives.

4.2 The job plan must be aligned with any mandatory organisational objectives.

4.3 All job plans should include an agreed annual amount of clinical activity and supporting professional activity. This will be calculated against a typical working year of 42 weeks. The agreed activity will form part of objective setting within the job planning process.

4.4 Activity delivered over the agreed annual amount will be locally negotiated between the AMD/ML and GM and with reference to the 'Cover for Absent Colleagues' guidance.

4.5 Objective setting (personal and organisational) are key elements of the consultant job plan.

Lead responsibility for Job Planning

4.6 The AMD/ML or delegated lead clinician will be responsible for annual job planning. Job Planning is to be carried out by the AMD/ML or delegated lead clinician and doctors will be encouraged, but not obliged, to involve the appropriate senior Operations/General Managers at this meeting.

The AMD/ML or delegated lead clinician will, in general, work closely with their General Manager counterpart in delivering the service business plan and, between them, they will have the necessary

knowledge of the relevant clinical service to bring clarity, transparency and consistency to the job planning process. Involvement of the General Manager in the job planning process helps the clinical team's understanding of the wider business and organisational context, resulting in the setting of objectives that are more meaningful to patient needs.

Associate Medical Directors will undertake their job planning with the Executive Medical Director.

Programmed Activities (PAs) Consultants/SAS doctors

4.7 All Programmed Activities* (PA's) must be evidenced. This is to ensure that the process is transparent, with an appropriate audit trail.

(* Detailed Definitions of Direct Clinical Care (DCC), Supporting Professional Activities (SPA), Additional NHS Responsibilities (AR), External Duties (ED) and Emergency work are shown in **Appendix A**.

4.8 The organisation, in line with EWTD 2009 regulations, has set an upper limit for paid PAs of 12 for all consultants/SAS doctors. In addition the following will apply;

4.8.1 Full-time substantive contracts will be advertised and paid at a maximum of 10 PA's.

4.8.2 Part-time substantive contracts will be advertised and paid at a;

- Maximum of 9 PA's for those not undertaking private practice
- Maximum 8 PA's for those undertaking private practice

4.8.3 Additional Programme Activities (APAs) up to a maximum of 2 (and maximum total of 12 PAs) can be offered. Importantly;

- Any doctor wishing to undertake private practice must offer to undertake up to 1 APA. The service will decide if it wishes to take up this time.
- They are an effective mechanism for increasing DCC activity
- They can be agreed and paid for a time-limited period (to meet demand pressures) rather than part of the annual contract agreement
- Where an additional PA is agreed an addendum job plan would be issued, agreed and signed. A contract for additional PAs should be issued which should clearly set out the additional activity. (applied as defined within National Terms and Conditions of Service for Consultants and SAS contracts)

- If any additional PAs are to be withdrawn, 3 months' notice will be given (this would not be below the substantive number of PAs) by either party.

4.8.4. The proportions of DCC, SPA, AR and ED will be determined by the activities agreed at the job plan. These proportions can be supported by a job plan diary completed by the clinician in preparation for the job planning meeting.

4.8.5 Supporting professional activities (SPA) are an essential part of the work of a doctor and the organisation is fully committed to supporting and paying for this work. Effective Job planning will define the detail of what activities are to be delivered and how much time is to be given to undertake these activities[*]. The general principles of SPA activities and the time to be allocated are;

4.8.5.1: A typical consultant/associate specialist is likely to require a minimum of 1.5 PA's for SPA, unless otherwise agreed, to cover Continuing Professional Development (CPD), General SPA, appraisal preparation and education and training.

(**Appendix B**) and for specialty doctors 1.0 PA's for SPA. Evidence of activities beyond the minimum must be included within the Job Plan

4.8.5.2. The actual amount of SPA time (and the outputs expected) will be discussed and agreed through the job planning process. The SPA time agreed for individuals may be more or less than the typical PA level outlined above. All agreed outcomes over a clear time period to be included in the objectives of the Job Plan.

4.8.5.3. For work undertaken by individuals in important <u>defined areas of responsibility</u> such as clinical governance, appraiser, service development, additional Education & Training and Research (**Appendices B & C**) further SPA time would be allocated.

4.8.5.4. It is envisaged that within the organisation a typical doctor will undertake their full CPD, General SPA, Education and Training role and many individuals will have a role(s) in other areas of responsibility. Therefore it would be anticipated that individuals who undertake

[*] National guidance recommends a typical consultant will require a split of 7.5 DCC to 2.5 SPA, with proportionally more time for SPA for part time contracts.

these activities will require more than the minimum level described in section 4.9.5.1 above.

4.8.6 For the substantive element of an individual contract, where it is evident that the non-DCC activities are to be reduced for example SPA time, and the individual does not wish to alter the level of his/her substantive contract, the AMD/ML is expected to replace this time with DCC activity up to the level of the substantive contract.

4.8.7 For individuals receiving additional programmed activities, the organisation will continue to apply the 3 month notice rules, for either party, as defined under the national terms and conditions of the consultant/SAS contract.

4.8.8 The organisation will provide the appropriate resources to allow delivery of the agreed programmed activities.

Salaried Dentists

4.9 The hours of work for a full time employee are 37.5 hours per week and will be set out in a weekly job schedule.

4.10 All hours must be evidenced. This is to ensure that the process is transparent, with an appropriate audit trail.

4.11 Full-time substantive contracts will be advertised and paid at a maximum of 37.5 hours.

4.12 The proportion of clinical activity (DCC), supporting professional activity (SPA), or additional responsibility activity will be determined by the activities agreed at the job plan to be undertaken.

4.13 Supporting Professional Activities (SPA) to include CPD, audit, teaching/training, service meetings, quality framework activity, are an essential part of the work of a dentist and the organisation is fully committed to supporting and paying for this work. Effective Job planning will define the detail of what activities are to be delivered and how much time is to be given to undertake these activities. The general principles of governance activities and the time to be allocated are;

4.13.1 A typical Senior Dental Officer (SDO) is likely to require a minimum of 5.6 hours for SPA, unless otherwise agreed and for Dental Officers (DOs) 3.75 hours

4.13.2 The actual hours (and the outputs expected) will be discussed and agreed through the job planning process. The hours agreed for individuals may be more or less than the minimum level outlined above.

4.13.3 For work undertaken by individuals in important defined areas of responsibility such as clinical governance, service development, additional Education & Training and Research further hours would be allocated.

Salaried GPs

4.14 The hours of work in the salaried GP contract is 37.5 hours per week or 9 sessions full time. The length of a session is therefore 4 hours and 10 minutes.

4.15 Scheduling in job plan (Appendix G) should include:

4.15.1 Clinical duties (DCC): appointments, dealing with telephone queries from patients or other health care professionals and administration/paperwork: whether arising directly from this caseload (referrals, investigations, results) and indirectly (reports, medicals, etc).

4.15.2 Supporting Professional Activity (SPA) defined as: team meetings: formal or informal, essential to the delivery of team based care, discussing clinical practice standards, developing practice protocols, mutual professional support for the individual practitioners, audit, significant event analysis, meetings with colleagues in the locality, and Personal CPD (continuing professional development) time: to include a mix of in-house meetings and events, time away from the practice, attending educational events or time in lieu of attending educational events outside of normal working hours.

4.15.3 Specific specialist roles in the team: e.g. medical student or registrar teaching or training, responsibility for particular areas of practice development, Quality and Outcomes Framework (QOF) areas of responsibility.

4.16 Workload should be:

4.16.1 Defined in amount (number of patients) and type (clinical, paperwork, team meetings), with provisions for fluctuations in exceptional circumstances.

4.16.2 Realistically match contracted hours as defined in the contract of employment

4.16.3 Balanced, recognising both clinical and non-clinical work (including meetings, both formal and informal and administration). A typical full time Salaried GP is likely to require 4-6 hours for SPA type activity per week.

4.17 Session length: although a session is defined as 4 hours and 10 minutes, periods of duty do not need to be exact multiples of sessions. For example, short days are permissible as long as the hours are all counted.

4.18 European Working Time Directive (EWTD): breaks should be granted within worked hours in keeping with the European Working Time Directive.

4.19 Improving working lives: start and finish times should consider the employee's need to meet childcare or other care commitments.

Flexibility to meet patient demand

4.20 A degree of flexibility in the time and place for programmed activities is an essential part of a professional contract. Therefore to meet the patient demand and capacity of services the following will apply:

4.20.1 If requested, SPA time that is appropriate to move may be undertaken outside of the agreed time set in the weekly timetable as long as the output of such work is evidenced, and it does not impact on attendance at mandatory SPA activities (such as clinical governance meetings) and it is agreed in advance with the HOS/ML/AMD/GM.

4.20.2 It would be expected that the majority of the agreed amount of DCC/SPA would be delivered at the time and place as indicated in the working week timetable. By agreement some of the agreed annual amount of DCC activity may have to be delivered at times other than routinely indicated in the weekly timetable. This can be achieved by providing greater flexibility to move activities in time and place.

4.20.3 The agreed amount of activity is dependant on the organisation providing the appropriate resource to deliver this agreed amount.

4.20.4 The agreed amount of DCC activity must equally meet the needs of the patients, the practitioner and the performance of the organisation.

General

4.21 An agreed job plan is a prospective agreement on the activities to be undertaken for a maximum of the next 12 months. To align with the business plans for services, the preference is for job plans to be undertaken between September and March in each financial year. If necessary agreement can be reached on the job plan to begin from April of the next financial year.

4.22 The organisation recognises that doctors/dentists will go through different phases during their career in the relative proportions of the activities within their job plan. For example many new practitioners will require greater time delivering DCC activities to develop their skills and experience, whilst the more mature practitioners may devote relatively more time to non-DCC activities such as education/training and the wider NHS.

4.23 The organisation endeavours to support its practitioners' changing career needs when wishing to develop external roles. To aid transparency and consistency any practitioner who is asked to or has a wish to undertake additional roles outside the organisation (AR and/or ED) must obtain approval from their respective Operational Director/Medical Director, via the AMD/GM before agreeing to apply/accept to do this work. A review against the individual's agreed annual amount of activity will take place to seek to ensure that this

activity can still be undertaken either by the individual (by being flexible in delivering this work) or backfill of this work through team based job planning or expansion in resource (where the external work comes with external PA funding). This will ensure that any impact to service delivery is understood before any approval is given.

4.24 The Job Plan must be agreed in accordance with the Terms and Conditions of the Medical/Dental contracts and adhere to all relevant organisational Policies and Procedures.

4.25 Practitioners must demonstrate that they are acting in accordance with the code on private practice.

4.26 For LCH medical staff, where they have a prescribed connection to LCH as a designated Body, the Job planning process during 2015/16 will move to an electronic system which will be fully operational during 2016/17. For dental practitioners and all other medical staff this must be completed using the current approved version of the Job Plan template (Appendix F). All sections must be completed prior to sign off.

4.27 Job planning is an open process, agreed between the practitioner and their AMD/ML or delegated lead clinician. Once agreed, job plans will be available for other members of the clinical team to use to help plan the delivery of services and will be available, if appropriate, to other practitioners within the team. Job plans are public documents therefore if a member of the public requested a copy the Trust would be obliged to provide it. The individual would be consulted and involved in identifying elements considered to be of a sensitive personal nature to be removed before this was released either to other practitioners or in response to the public request. Request will be addressed to the Business Unit AMD and monitored by the Responsible Officer Support team.

4.28 Where it is not possible to reach agreement on the job plan, the process of Mediation and Appeal is an important part of the process (please see Section 9).

4.29 Whilst the primary function of job planning is successfully to marry the aspirations of the practitioner with those of the organisation/NHS, the Department of Health explicitly links participation in job planning with eligibility for pay progression.

4.30 Practitioners who fail to participate in annual job planning will be considered in breach of their contract of employment, thereby potentially adversely affecting their;

- Annual pay progression
- Application for new and/or renewal of clinical excellence awards (consultants)
- Employment status

4.31 Extra contractual duties: there must be clear agreement on arrangements regarding how and when extra-contractual duties (where

agreed to) will be recognised, or when additional payments are to be made. There should be clear agreement if Time in Lieu is to be granted before the activity is undertaken and with reference to the LCH Cover for Absent Colleagues framework and guidelines. (amended wording – ref Dr AT).

5.0 Standard for Job planning

5.1 The following are the mandatory standard for job planning.

5.1.1 All job plans to be undertaken by the AMD/ML or delegated lead clinician and the practitioner.

5.1.2 Where the delegated Lead clinician undertakes the job plan with the practitioner, the AMD/ML will ratify the agreed job plan.

5.1.3 For medical staff who have LCH as their designated body during 2015/16 existing job plans will be uploaded into the electronic system and accessible to the Executive Medical Director via the electronic system. For dental practitioners and salaried GP's all completed job plans to be completed electronically on the approved template (**Appendix F and G**) and sent electronically to the Responsible Officer support team.

5.1.4 The default is that all activities should be identified in the 7 day job-plan timetable. Flexibility (time and place shifting) in the delivery of the weekly activities may be required to meet the agreed amount of activity in the interests of patients, the individual and the organisation. These changes will be by **prospective** agreement between the individual and AMD/ML or delegated lead clinician. Activities undertaken on a less than weekly basis are to be indicated on the weekly timetable using the prefix 1 in 3/4/5 weeks/months as required

5.1.5 All activities must state the start and finish times, the place where undertaken and the activity to be delivered.

5.1.6 All job plans must be aligned to the relevant service business plan.

5.1.7 The job plan will record (in the objectives section) an agreed annual amount of activity over a typical 42 week[†] working year calculated from the weekly timetable. It is expected that the

[†] The typical 42 week working year is based on 6 weeks annual leave, 10 days bank-holidays and average 10 days Study/professional leave. For consultants in post for over 7 years and long service to the NHS, additional days of leave will apply and therefore the annual amount adjusted accordingly. Individual consultant's working year will be agreed as part of the job plan process and the amount of agreed annual activity determined with reference to the individuals leave entitlement.

majority of this work will be undertaken at the time and place indicated in the weekly timetable.

5.1.8 This amount of measurable activity is linked to the description of the work to be done each week. For example if a practitioner undertakes 2 clinics per week (whether full or part time) the amount will be 84 clinics per year. (**Appendix D**)

5.1.9 The job plan will record an agreed number of weeks the activity will be delivered across. For example if the individual has no agreed additional responsibilities/external duties and is likely to only take the allotted annual leave and study/professional allocation this would mean a typical 42 weeks of specialty specific DCC & SPA activities

5.1.10 For individuals who have agreed additional responsibilities/external duties or have purchased additional annual leave, in accordance with the terms contained within the LCH Annual Leave policy, the amount will be based around a lower number of working weeks but will be agreed at the annual job plan review or within the year if appropriate. (ref. Annual Leave Policy)

5.1.11 It is recognised that there can be a level of flexibility for both individuals and the organisation in the delivery of this however the ability of the supporting service to respond to flexibility and non-organisational commitments of individuals mean that negotiation will be required and that these should always occur with at least 6 weeks notice.

5.1.12 Where there is evidence that organisational problems created the inability to deliver the agreed number of activities at less than 6 weeks notice both parties would negotiate to see if this DCC activity could be re-provided, for example by flexible use of SPA time. If both parties can agree to replace the lost DCC activity at a different time then the total agreed amount will not be changed until this activity has been delivered.

5.1.13 Where agreement has not been possible, for example with last minute cancellation of a clinic, then the agreed activity will count as delivered and appropriate adjustment made to the running amount of annual activity. As the practitioner is being paid for NHS work it is expected that he/she will undertake other NHS work be it DCC or SPA in this time, unless otherwise agreed.

5.1.14 Annual and Study/Professional Leave is included in the typical 42 weeks per annum. (ref. Annual Leave Policy).

5.2 Programmed Activities/Hours/Sessions

The following describe the specific standard for the job plan relating to DCC, SPA, AR and ED activities

5.2.1 Direct Clinical Care (DCC) Activities

These are activities directly relating to the prevention, diagnosis or treatment of illness that forms part of the services provided by the Trust under section 3 (1) or section 5 (1) (b) of the National Health Service Act 1977. This includes emergency duties, (including emergency work carried out during or arising from on call), operating sessions including pre-operative and post-operative care, ward rounds, outpatient activities, clinical diagnostic work, other patient treatment, public health duties, multi-disciplinary meetings about direct patient care and administration directly related to the above (including but not limited to referrals and notes)

As a minimum level, where applicable, the annual number of the following DCC activities to be delivered by the practitioner (or group of practitioners as part of an agreed "team job plan") will be set in the Job plan(s).

- Outpatient clinics
- Surgeries
- MDT assessments
- Ward rounds
- Acute service days/weeks
- Telephone advice
- Clinical administration

This list is not exhaustive and will be developed within each specialty

5.2.2 **Non-DCC Activities (SPA, AR, ED)**

5.2.2.1 **Supporting Professional activities (SPA):**

These are activities that underpin DCC. This includes, participation in training, medical education, continuing CPD, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.

The organisation is committed to paying for reasonable amounts of SPA activities which are as defined in the contracts (See **Appendix A**). It is not expected that all practitioners will undertake all of the SPA activities defined in the contracts. It is likely, therefore, that the

SPA time within practitioner job plans will vary across the medical and dental staff body. It is also likely that SPA time will change as the activities change throughout the course of a practitioner's career. Within the contracts SPA is defined as including CPD. The majority of practitioners will fulfil all their CPD, deliver their general SPA to the level defined. As a minimum, unless otherwise agreed, for this level of activity 1.5 PA's/week for Consultants/Associate Specialists, 5.6 hours Senior Dental Officers and 1 PA for Specialty Doctors, 3.75 hours Dental officers, 4-6 hours Salaried GPs would apply. This can be adjusted on an individual basis to more or less than this depending on the agreed level of additional activities to be undertaken.

5.2.2.2 **Continuing Professional Development (CPD)**

As defined by the Relevant Royal College, includes

- Clinical CPD
- Professional CPD
- Academic CPD
- In addition different colleges recognise personal/self accredited

5.2.2.3. **General SPA**

- Formal teaching activities outside clinical (generally defined as DCC) and education supervisory roles (**Appendix B**)
- Attendance at operational/staff meetings
- Annual Appraisal and Job planning leading to revalidation.
- Dealing with non-patient administration, for example organisational communications
- Clinical Governance activities including Quality Improvement.

Practitioners working part-time may require proportionally more SPA (with respect to DCC) than full time practitioners.

5.2.2.4 **SPA time for activity in defined areas of responsibility**

SPA time will be given for those practitioners who are undertaking work in specific areas of responsibility directly linked with the business of the organisation, examples include:

(a) Lead roles in Clinical Governance activities
- Audit/Guideline
- Service development (in addition to Lead Clinician/CD)

- Risk Management
- Research (**Appendix C**)

(b) Education and Training Roles
- Post-Graduate (see Appendix B)
- Undergraduate

(c) Appraiser roles

5.2.3 **Additional NHS responsibilities (AR):**

To be granted for clearly defined roles. These include
- Associate Medical Director
- Lead clinician
- Executive Medical Director

This list may not be exhaustive

5.2.4 **External Duties (ED)**

These are duties not included in any of the three foregoing definition and not included within the definition of fee-paying services or private professional services, but undertaken as part of the job plan by agreement between the practitioner and the Trust.

This can include:

- Trade union duties
- Undertaking inspections for the CQC
- External member of the AAC
- Undertaking assessment for NCAS
- Work for royal colleges in the interest of the wider NHS
- Work for a government department
- Specified work for the GMC.

If external duties are undertaken and recognised as part of the Job Plan and the clinician is in receipt of remuneration in respect of these duties the clinician will be expected to advise the Trust accordingly and ensure appropriate payments are made to the Trust.

If the organisation agrees to support an individual wishing to undertake external roles this will include an assessment of the balance between the needs of patients and the organisation's performance with that of a contribution to the wider NHS. If

agreed the standard in job planning is dependent on whether or not external funding is available for ED.

(a) Not Externally funded

- Must be identified in the job plan
- Must not materially impact on agreed annual amount of DCC or SPA activity
- The individual must be able to meet the requirements for CPD and mandatory SPA activities

(b) Externally Funded

- Must be identified within the Job plan
- The specialty must be able to backfill the activities given up by the individual undertaking this role.
- The individual must be able to meet the requirements for CPD and mandatory SPA activities
- If role(s) cease(s), the organisation cannot guarantee to return the individual to the activities given up, although it will maintain the agreed substantive contract level (ie excluding Additional Responsibilities PA's) prior to the role being undertaken.

6.0 Methods to assist effective job planning

6.1 Team job planning

- Where appropriate the development of team job planning[‡] within services can be developed.
- Aims to deliver the activity across a team of practitioners over 52 weeks per year.
- If circumstances within a team job plan change in-year, for example one of the practitioners leaving and delay in replacement, then the job planning process for the team will be undertaken at the point of change and a revised amount of measurable activity will be agreed with reference to the cover for absent colleague guidance.

6.2 Practitioner rostering system

- Rostering systems will be used to maximise the use of available capacity and manage the leave for practitioners.

7.0 The process in outline

7.1 The AMD/ML or delegated clinician will need to prepare for the first meeting with the practitioner by conferring with their GM/HOS about

[‡] Team job planning is defined as agreements between the consultants in that specialty to deliver the clinical activity. This would normally be over 52 weeks per annum.

the shape and size of service that needs to be delivered and by having a 'mind map' of what doctors/dentists currently do.

7.2 If it is a first job plan meeting, the practitioner can complete the job plan timetable template (**Appendix E, F, and G**), and consider any objectives that would support the service

7.3 Where necessary, the practitioner will need to produce a record of their activity which relates to their average activity using a diary in preparation for their first job plan meeting (templates are available from the BMA/BDA).

7.3.1 At subsequent annual job planning practitioners should bring or refer to their online PReP job plan, their existing job plan with any proposed changes for discussion and information of completion of previous job plan objectives. Further diary records can be useful if there are significant changes to discuss.

7.3.2 Before formal agreement and sign off can take place, the AMD (or delegated clinician) and GM/HOS will need to match the proposed Job Plan, along with those of all other practitioners in their clinical area to the Directorate/ Business Unit business plans. Clear measurable objectives linked to the business plan and Quality Improvement Activities will be defined in the agreed job plan.

7.4 During the meeting the practitioner should complete their job plan template and submit electronically for approval to the AMD/ML. If the job plan is agreed this should be downloaded signed and dated by those present at the meeting. An electronic copy should be sent by the AMD/ML to Responsible Officer, Support Team with a copy to the Medical Director's PA who will keep this electronically and record the date in the database. Any paper copies will be retained in the practitioner's personnel file. Where this function is within PReP system, the Responsible Officer Support Team will maintain storage.

7.5 Medical Director support/input is available where clarification is needed.

7.6 Job Plans for newly appointed substantive posts should reflect the Job Plan agreed in the job description. A job plan review needs to occur within 6 months of taking up the post and annually thereafter.

7.7 For Locum posts the job plan should reflect the job plan agreed in the job description. A job plan review is required for any locum post longer than 6 months.

7.8 If either party is unable to agree the job plan within a reasonable time-frame (defined as 3 months from initial job plan meeting), then the job planning process must be referred for mediation (see Section 9).

8.0 Roles and Responsibilities

8.1 AMD/ML or delegated clinician

- Agree with management basic issues such as:

    - Shape of the current service
    - Aspirations of the service (business plan)
    - Must do's (e.g. Clinical Governance, Local Delivery Plans, Access, Finance)
    - Possible areas of confusion or difficulty
- Conduct effective job planning meetings
- Collate information resulting from job planning meetings and assess gaps between aspirations and commitments
- Infer issues that arise and discuss with management and clinical colleagues
- Agree 'final' job plan with individual practitioners for the year
- Where necessary, take part in appeals process
- AMD/ML will provide job planning information/activity within the Medical Director's annual report to the Board

8.2 General Managers/Head of Service

Before Job Planning Meetings to facilitate effective preparation:

- Ensure that adequate administrative support arrangements are in place
- Meet with the AMD/ML or delegated clinician
- Provide information –
    - Current Activity
    - Targets
    - Needs for Development
    - The Business Plan
- Make links with other departments / services
- Discuss the service 'map':
    - Shape
    - Pressure points
- Prepare and discuss
    - Financial issues (e.g. affordability of Job Plans)
    - Workforce Issues
    - Existing known gaps
    - Quality Improvement Activities

During Job Planning Meetings – if required and by invitation of the AMD/ML or delegated clinical lead and the practitioner

- Witness / record agreement
- Answer 'technical' management questions regarding
    - employment
    - support / resources available
- Work with the AMD/ML/Delegated Clinician in putting it all together (e.g. speciality matrix)
- Feed into planning 'round'
- Check against proposed business plan (including 3 year rolling plan)
- Link to other services

8.3 Practitioner

Practitioners should take the opportunity of the job planning process to see that they are neither over nor under committed in delivering local or wider objectives of the NHS. To get the best out of the processes Practitioners will wish to:

- Decide beforehand what they want to get out of job planning
- Decide what their objectives for personal service development and Quality Improvement activities will be over the coming year
- Have a view on how changes can reasonably be achieved
- Be ready to share all the facets of their practice within and outside the organisation, so that realistic agreements can be struck
- Be aware of their colleagues' aspirations so that any agreement over the job plan is in a sensible context
- Take broader clinical governance issues into consideration.

9.0 Mediation and Appeals

If at all possible, disagreements should be settled informally. If there is a dispute over a job plan or a decision relating to pay progression, there is a process of mediation and appeal written within the Terms and conditions of service which illustrate how matters should be progressed..

9.1 Mediation

In the first instance, the practitioner or the AMD/ML/Delegated clinician should refer the dispute to the Executive Medical Director (or the Head of Workforce if the Executive Medical Director is one of the parties to the initial decision) in writing within two weeks of the disagreement arising, setting out the nature of the dispute. The other party should then set out their position on the matter. There will then be a meeting, usually set up within four weeks of the referral, involving the medical job plan lead, the practitioner and the Executive Medical Director. If agreement is not reached at the meeting, the Executive Medical Director will take a decision or make a recommendation to the Chief Executive of the employing organisation. The Executive Medical Director must inform the practitioner and medical job plan lead of the decision or recommendation in writing. Where the dispute is over pay progression, the Chief Executive should write with his/her decision to the practitioner, Executive Medical Director and medical job plan lead.

If the practitioner is not satisfied with the outcome, a formal appeal can be lodged.

9.2 **Appeal**

The practitioner must lodge the appeal in writing to the Chief Executive within two weeks and the Chief Executive will then convene an appeal panel. The membership of the panel is a chairman nominated by the

employer, a representative nominated by the practitioner and a third independent member from a list approved by the BMA/BDA. . The practitioner can object on one occasion to the independent member who would then be replaced with an alternative representative. No member of the Panel should previously have had any prior involvement in the dispute, should this be the case then an alternative panel member will need to be sought.

The parties to the dispute will submit written statements of case to the appeal panel one week before the hearing. The practitioner can either present his or her own case at the hearing or he or she can be assisted by a representative, who may be a member of BMA/BDA regional services, but may not be someone acting in a professional legal capacity. The panel will then make a recommendation to the Trust Board of the employing organisation, usually within two weeks of the hearing, with a copy to the practitioner. The recommendation will normally be accepted by the Board.

10.0 References

Consultant contract accessed via:
http://www.nhsemployers.org/~/media/Employers/Documents/Pay%20and%20reward/Consultant_Contract_V9_Revised_Terms_and_Conditions_300813_bt.pdf

NHS Employers; accessed via www.nhsemployers.org

SAS contract 2008 accessed via:

http://bma.org.uk/-/media/files/pdfs/practical%20advice%20at%20work/contracts/sasengmodelcontract.pdf

Salaried Dental contract 2007 – unable to open link but not sure if this has changed recently

Salaried GP contract 2006 – unable to find exact document

www.doh.gov.uk/consultantframework - unable to find

Effective Job planning for consultants accessed via:
http://www.wsh.nhs.uk/AboutUs/MedicalDirectorsDocs/Effective%20Job%20Planning%20-%20guide%20for%20consultants.pdf

Appendix A

Definitions of Programmed Activities adapted from the Consultant Contract 2003

Direct Clinical Care (DCC): work directly relating to the prevention, diagnosis or treatment of illness that forms part of the services provided by the employing organisation under section 3(1) or section 5(1)(b) of the National Health Service Act 1977. This includes emergency duties (including emergency work carried out during or arising from on-call), operating sessions including pre-operative and post-operative care, ward rounds, outpatient activities, clinical diagnostic work, other patient treatment (including telephone consultations, public health duties, multi-disciplinary meetings about direct patient care and administration directly related to the above (including but not limited to referrals and notes).

Supporting Professional Activities (SPA): activities that underpin Direct Clinical Care. This may include participation in training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities to include Quality Improvement Activities.

Additional NHS Responsibilities (AR): special responsibilities – not undertaken by the generality of practitioners in the employing organisation – which are agreed between a practitioner and the employing organisation and which cannot be absorbed within the time that would normally be set aside for Supporting Professional Activities. These include being a Medical Director, Director of Public Health, AMD, Clinical Director or lead clinician, or acting as a Caldicott guardian, clinical audit lead, clinical governance lead, undergraduate dean, postgraduate dean, clinical tutor or regional education adviser. This is not an exhaustive list.

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

Emergency Work:
Predictable emergency work: this is emergency work that takes place at regular and predictable times, often as a consequence of a period of on-call

work (e.g. post-take ward rounds). This should be programmed into the working week as scheduled Programmed Activity.

On-call duties

Reference should be made to nationally agreed Terms and Conditions of Service.

Travelling time

Reference should be made to nationally agreed Terms and Conditions of Service

Appendix B

Education Roles and Job Planning

1. Key principles

1.1. Excellence in education and training ensures patient safety. Well assessed, trained and competent doctors/dentists are critical to LCH being a success. Many practitioners also teach wider professional groups although this paper will focus mainly on Undergraduate and Postgraduate Medical training.

1.2. Educational Governance is the systematic approach to maintaining and improving the quality of education provision and these were outlined by the DH in 2003, PMETB in 2008 and have brought into sharper focus by the new Yorkshire and Humber Deanery and Health Education Yorkshire and the Humber.

1.3. Educational activities must be clearly identified in the job plan and agreed with the AMD/ML, or delegated clinician, specifically "SPA for teaching" will be an inadequate way of recording matters. Where teaching/training is a welcome and significant part of a Job Plan, there is an expectation of mention of it, both in the individual's Personal Development Plan and in the Objective setting associated with job planning.

1.4. Formal educational roles must have job descriptions, clear responsibilities, transparent appointment processes, regular appraisals and objective setting. Roles that do not have such descriptors will be considered part of the normal DCC and SPA work of an LCH practitioner.

1.5. The development of a common "tariff of time" for the various educational roles within the organisation is important. Clear identification of the allocated time and output expected must be recorded in the job plan. When an individual relinquishes this role then the time allotted to it within the job plan will be removed.

1.6. If specific teaching roles are undertaken it will be over and above the typical 1 PA for CPD and General SPA.

1.8 Educational work should have measurable outcomes which could include:

- definite objectives if in a formal educational role
- attendance at timetabled teaching sessions
- numbers of students and trainees taught and supervised
- current timetables and programmes of work
- feedback from students and trainees/ end of placement feedback evaluations

- e-portfolio evidence of use and numbers of Work Place Based Assessments carried out
- audit/research output with trainees and undergraduates

Such evidence must be discussed at annual job planning and appraisal.

2. Educational roles undertaken by most practitioners

2.1. Teaching

2.1.1 Some allowance for educational preparation should be given to include teaching of other health professionals and multi-agency professionals – if this is documented and quantified it can count towards SPA time. This should be evidenced in appraisal with copies of lectures, tutorials, student feedback

2.2. Undergraduate

2.2.1 When identified teaching SPA time is represented in job plans it should be subject to the normal scrutiny of SPAs. This scrutiny should include documented teaching commitments, involvement in the organisation of teaching, contributing to interviewing, personal tutor, supervision of special study components, development of e-learning materials, and participation in examinations. Where student teaching is for a limited period during the year the job plan should reflect the time period involved.

2.2.2 Objective setting around such SPA time could include preparation of teaching materials usable by others, utilisation of student feedback, planning/managing teaching courses.

2.2.3 Undergraduate teaching activities can be validated against student timetables and SIFT allocation.

2.3. Postgraduate training of junior doctors

2.3.1 All practitioners who work with junior doctors/dentists will increasingly be drawn into spending much greater defined time with them, making assessments and giving more supervision. These assessments can form part of SPA time but are more likely to be part of clinical supervision (see 3.2) and be part of Direct Clinical Care (DCC) activities.

2.4 Defined Educational roles undertaken by some practitioners

2.4.1 Educational supervisors

2.4.1.1 Educational supervisors are responsible for overseeing training to ensure that trainees are making the necessary clinical and educational progress.

2.4.1.2 This is an important role as ideally trainees will have the same educational supervisor for the whole or discrete periods of their training e.g. core and advanced. This is determined by the Training Programme Director/Tutor. Often practitioners who are Educational Supervisors oversee more than one trainee.

2.4.1.3 This role encompasses responsibility for all aspects of personal development, planning, appraisal, attending faculty meetings (Trust and Specialty), completing reports and helping the trainee complete Workplace Based Assessments (WBAs) and helping with career guidance.

2.4.1.4 This typically accounts for an average of 0.25 PA per week per trainee and should be recognised in the job plan.

2.4.1.6 From time to time some Educational Supervisors will be involved in significant remedial work with trainees who are in difficulty. This will mean periods of time where a significant increase over the 0.25 PA will be required.

2.4.1.7 Educational Supervisors support regional and national processes of recruitment. This is essential work for the organisation.

2.4.1.8 Educational supervisors will be trained and appraised for this role as part of the learning and development agreement with the SHA.

2.4.2 Clinical Supervisors

2.4.2.1 Clinical supervisors are responsible for providing safe clinical oversight of trainees during all clinical sessions within the clinical placement in the organisation.

2.4.2.2 They will undertake a small number of WBAs, contribute to 360° feedback and report to the educational supervisor. It is expected that clinical supervisors will be trained and appraised for this role

2.4.2.3 It is anticipated that this supervision takes place during routine clinical time and is therefore included in the DCC within the job plan

Appendix C

Recording of Research Programmed Activities in the Job Plan

1. Approved Research Categories

1.1 The Organisation recognises and values a spectrum of research activity, to be recorded as "research programmed activities (RPAs)" in the job plan, described below in 5 categories:

1.1.1 NIHR Portfolio studies (including those where the contribution to the study is recruitment of patients to clinical trials, whether done as part of a team or on an individual basis). This category also includes industry-sponsored Portfolio studies.

1.1.2 Research funded by recognised charitable organisations

1.1.3 Small-scale pilot studies with collaborators in the University of Leeds or University of York, which are aimed at providing a basis for an application for research funding to NIHR partners.

1.1.4 Non-portfolio commercial research that has genuine scientific merit and properly funded is of considerable value.

1.1.5 Research that forms part of a recognised training or development programme for junior staff leading to MSc, MMed-Sci, MD, PhD etc. This type of research must include a proper mentoring programme and be linked to a major research group.

2. Recording of "Research PAs" (RPAs) within the job Plan

2.1 One of the principles of the contracts is that all programmed activity (PAs)/time is identifiable in terms of time, location, and output. In addition the output from the job plan must be subjected to an audit trail through the job planning/appraisal process. Therefore in order to achieve these principles the following apply

2.1.1 Research PAs" (RPAs) may be deemed either as DCC (where patient contact is involved, for example, clinical trials recruitment) or SPA (for example, experimental medicine projects, review of progress, mentoring of research staff, writing papers (linked to the approved research) etc).

2.1.2 Only research in categories 1.1.1 - 5 above are to be recorded as RPAs in the job plan

2.1.3 As part of the funding arrangements for the research identified above, the RPAs will need to be clearly identified for categories

1-5. Therefore the job plan must clearly indicate the RPAs within the working week.

2.1.4 For practitioners with RPA's who undertake clinical work, flexibility in the timing of the RPA's may be required to meet the needs of patients, the individual and the organisation.

2.1.5 Where there is pre-existing identified RPA's within the Job Plan and the new funding received equals this amount, eg 1PA, then no changes are required to the job plan as this is now clearly recorded and funded for this time. This assumes that the output from existing RPA's has diminished/stopped and that the new funding provides the opportunity to replace it.

2.2 Where the research output from these pre-existing RPA's has diminished/stopped and where no further approved research funding is available, then the PAs need to be either replaced with other activities or discontinued.

2.2.1 Where there is no pre-existing RPA's or the time funded exceeds (or is in addition to) pre-existing, agreement has to be reached to either

2.2.1.1 Increase the PA's within the job plan (to Trust maximum of 12) or

2.2.1.2 Replace non-research PA's with the RPA's to the level of the funding received. This requires approval from the relevant AMD/ML and GM/HOS who needs to be assured that the clinical activity given up can still be delivered, for example through other practitioners taking up the work.

2.2.2 Where mentoring /supervision of trainee researchers undertaking a specific research project is part of a practitioner's role, firstly the funding for the PAs for this role must be part of the funding arrangements for the study and secondly must be identified as dedicated RPA's in the job plan for the duration of the supervision.

2.2.3 "Own account", or commercial studies that are not approved will not be supported by dedicated RPA's in the job plan (see below).

2.2.4 Not all practitioners will either want to or be able to be involved in any of these categories of valued research for the recording of RPA time in the job plan. The sensible approach is to have discussions within a team as to the strategy for research and the relative commitments of the practitioners. This policy recognises that those that are not involved with the approved categories are not expected to identify time in their job plan.

3. Recognition of “own research” and/or research support to trainees

3.1 For many practitioners the examination of best evidence as part of guideline development and/or patient management, refereeing papers for colleges, writing review articles and supporting trainees in preparation of posters and papers for publication (outside of research category’s 1.1.1 - 5) have been commonly recorded as “Research” PAs in the job plan.

3.2 Reasonable levels of these activities are an important part of the work for many practitioners. However, it is expected if these activities are deemed necessary to continue that the time required to undertake these activities are assigned to CPD PAs and/or Teaching Pas (SPA) within the job plan.

Appendix D

Rules for Managing the Annual Amount of Measurable Activity

1. Measurable activities include

   1.1 DCC

   1.1.1 Ward rounds

   1.1.2 Outpatient clinics

   1.1.3 Theatre work

   1.1.4 MDT assessments/meetings.

   This list is not exhaustive

   1.2 SPA

   1.2.1 College standards for **internal** CPD credits, (minimum of 25 credits (hours) per year, 20 credits RCPsych). 1 hour (0.25 PA) per week is delivered by most practitioners per year (~41-42 credits per year). The four areas for CPD are

      1. Clinical
      2. Professional
      3. Academic
      4. In addition different colleges recognise personal/self accredited

   1.2.2 Agreed number of operational/team meetings to attend each year

   1.2.3 Lead roles in, Education/training, Research, Risk management, Audit.

2. The job plan will record an agreed number of weeks the activity will be delivered across. For example if the individual has no agreed additional responsibilities/external duties and is likely to only take the allotted annual leave and study/professional allocation this would mean a typical 42 weeks of specialty specific DCC & SPA activities

3. For individuals who have agreed additional responsibilities/external duties or more annual leave[§] the amount will be based around a lower number of working weeks but will be agreed with the individual at the annual job plan review.

[§] The typical 42 week working year is based on 6 weeks annual leave, 10 days bank-holidays and average 10 days Study/professional leave. For consultants in post for over 7 years and long service to the NHS, additional days of leave will apply. Individual consultant' working year will be agreed as part of the job plan process and the amount of agreed annual activity determined with reference to the individuals leave entitlement.

4. It is recognised that there can be a level of flexibility for both individuals and the organisation in the delivery of this however the ability of the supporting service to respond to flexibility and non-organisation commitments of individuals mean that negotiation will be required and that these should always occur with at least 6 weeks notice.
5. The weekly job plan timetable will allow determination of the amount of measurable activity that needs to be delivered over a typical 42 week working year basis for individuals or 52 week working year for teams.
6. This amount of measurable activities must be delivered as equally as possible over the course of the 12 months of the job plan, excluding times of approved annual/study/professional leave, to avoid risk of breaching accepted quality standards, for example 18 weeks.
7. Where a practitioner receives notice of cancellation of a measurable activity from the organisation the following will apply:

    7.1 If outside 6 weeks, this activity will still count as part of the agreed annual amount of measurable activity and negotiation will be undertaken as to how this can be re-provided

    7.2 If less than 6 weeks, negotiation will occur as to how this time lost could be replaced. This could entail either replacing the lost time as SPA or losing the time and thereby the activity (with appropriate subtraction from the agreed annual amount). If replaced as SPA it would be expected that SPA time on another occasion (to limit impact on breaches) would be used to contribute to the agreed annual measurable activity. Negotiation will involve the AMD/ML and GM/HOS.

    7.3 Where there is evidence that inability to deliver the agreed number of activities was following organisational problems at less than 6 weeks notice and the activity could not be re-provided after negotiation then the activity will count as delivered, for example last minute cancellation of a theatre session. The time will be replaced with either other DCC or SPA work.

8. Where the practitioner gives appropriate notice of cancellation, for example for annual/study/professional leave, and within the time frames agreed, the measurable activity for that time will be lost (as in general it is not part of the annual amount). The caveat, however is:

    8.1 If measurable activities are being disproportionately lost on a particular day of the week, for example taking leave on proportionally more DCC days than SPA, then it is likely that quality standards will be affected and equally likely that the individual would not be able to meet the agreed amount of measurable activity. As such discussion must take place with the AMD/ML and GM/HOS as to how this time is re provided. If this would impact on the quality standards the practitioner will be expected to re-provide this activity at an appropriate time.

9. Where the practitioner does not give sufficient notice of cancellation and it primarily affects an agreed DCC measurable activity the AMD/ML and GM/HOS will be likely to decline the request. Occasionally agreement will be reached allowing the time off. However the practitioner will agree to re-provide the DCC measurable activity within a time-frame determined by the AMD/ML and GM/HOS to deliver the needs of the patients and the Trust.
10. Rolling Audit programmes, which may displace DCC work, will be re-allocated as SPA time in the practitioner's job plan. The practitioner whose DCC activity is lost by the Audit time is assumed as having provided the DCC activity and the annual amount adjusted accordingly. However the expectation is that the practitioner will be in attendance at the audit meeting at this time. It would also be expected that this attendance would be part of the agreed annual amount of SPA activities.

Appendix E

Non-Designated body Consultant/SAS Job Plan Template

JOB PLAN FOR Dr ……

1. Job Content

Day	Time	Location	Work	Categorisation	No. Of PA's
Monday					
				Total	
Tuesday					
				Total	
Wednesday					
				Total	
Thursday					
				Total	
Friday					
				Total	
Saturday					
Sunday					
Additional agreed activity to be worked					

flexibly					
Predictable emergency on-call work				Direct Clinical Care	
Unpredictable emergency on-call work	Variable	On-site, at home on the telephone / travelling to and from site		Direct Clinical Care	
TOTAL PAs					

Programmed activity	Number
Direct clinical care (including unpredictable on-call)	
Supporting Professional activities	
Other NHS responsibilities	
External duties	
TOTAL PROGRAMMED ACTIVITIES	

2. On-call Availability Supplement

Agreed on-call rota (e.g. 1 in 5):

Agreed Category (delete):

On-Call supplement (e.g. 5%):

3. Objectives

Objectives and how they will be met

4. Supporting Resources

Facilities and resources required for delivery of duties and objectives	
1. Staffing Support	
2. Accommodation	
3. Equipment	
4. Any other required resources	

5. Additional NHS Responsibilities and/or External Duties

Specify how any responsibilities or duties not scheduled within the normal timetable will be dealt with

6. Other Comments or Agreements

Detail any other specific agreements reached about how the job plan will operate. For example, with regard to fee paying services and location flexibility.

7. Additional Programmed Activities

a) Are you undertaking private medical practice as defined in the terms of the service?	**Yes/No**
b) If yes, are you already working an additional programmed activity above your main commitment?	**Yes/No**
c) If yes, has this been taken up?	**Yes/No**
d) If no, have the Trust offered an additional programmed activity this year?	**Yes/No**
e) If no, have other acceptable arrangements been made (e.g. taken up by a colleague)?	**Yes/No**

If yes to (e) please describe:
……
……
……
……..

8. SIGNED OFF AND AGREED

Practitioner Name:……..

Signed (Practitioner):……..

Date: ……...

AMD/Medical Lead:……..

Signed (AMD/ML):……...

Date: ……..

General Manager/Deputy:…….

Signed (General Manager/Deputy):…….

Date: ……..

Appendix F

Salaried Dentist Job Plan Template

Name:_____

Job title:_____Date:_____

Weekly schedule

Day	Time	Location	Work- nominal allocation	Category	Hours
Total hours					

Objectives

Organisational objectives	Team or directorate objectives	Personal objectives

Supporting resource

Role (staff)	Comments

Accommodation

Organisation	Comments

Equipment

Type	Comments

External duties

Organisation	Comments

Other comments or agreements

Additional

	Yes/no
1. Are you undertaking: a. any other NHS work? b. any other professional non-NHS work? c. any other paid employment (Working Time Directive)?	
2. If yes, how many sessions and at what times?	

Signed off and agreed

Dentist name:_____

Signed (dentist):_____

Date: _____

AMD/Dental Lead :_____

Signed (AMD/Dental Lead):_____

Date:_____

General Manager /Deputy _____

Signed (General Manager/Deputy) _____

Date:_____

Appendix G

Salaried GP/FME Job Plan Template

JOB PLAN FOR ……

1. Job Content

Day	Time	Location	Work	Categorisation	No. of sessions/ Hours
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					
Additional agreed activity to be worked flexibly					

Predictable emergency on-call work				Direct Clinical Care	
Unpredictable emergency on-call work	Variable	On-site, at home on the telephone / travelling to and from site		Direct Clinical Care	
TOTAL Sessions					

Programmed sessions/Hours	Number
Direct clinical care (including unpredictable on-call)	
Supporting Professional activities	
Other NHS responsibilities	
External duties	
TOTAL PROGRAMMED SESSIONS	

2. On-call Availability Supplement

Agreed on-call rota (e.g. 1 in 5):

Agreed Category (delete):

On-Call supplement (e.g. 5%):

3. Objectives

Objectives and how they will be met

4. Supporting Resources

Facilities and resources required for delivery of duties and objectives	
9. Staffing Support	
10. Accommodation	
11. Equipment	
12. Any other required resources	

5. Additional NHS Responsibilities and/or External Duties

Specify how any responsibilities or duties not scheduled within the normal timetable will be dealt with

6. Other Comments or Agreements

Detail any other specific agreements reached about how the job plan will operate. For example, with regard to fee paying services and location flexibility.

SIGNED OFF AND AGREED

Doctor Name: ……..

Signed ……..

Date: ……..

AMD /Medical Lead: ……..

Signed (AMD/ML):……

Date: ……..

General Manager/Deputy……

Signed (General Manager/Deputy)……..

Date: ……..

APPENDIX H

Appendix Equality Analysis (EA) - Relevance Screening Form

1. Name of the document	Job Planning policy for Consultants, SAS Doctors, salaried GP's and salaried dentists, Leeds Community Healthcare NHS Trust			
2. What are the main aims and objectives of the document	The overall aim of this policy adhere to the principle that all qualified medical and dental staff will undertake an annual job plan			
3. Is this a key strategic document?	**Yes**		**No**	
			X	
4. What impact will this document have on the public or staff?	**High**	**Medium**	**Low**	**Don't know**
		X		
Explain: This policy relates to				
5. Is there any evidence, or reasons that different groups have different needs, experiences, issues and priorities in respect of this particular document?	**Yes**	**No**	**Don't know**	
		X		
Explain: This policy is applicable to all Consultants, SAS doctors and dentists in LCH and provides explanation of the annual job planning process.				

If you have answered **Yes** to question 3, you should move straight onto EA.
If, for question 4 you have answered **Low**, there is no need to continue to conduct an EA.
If for question 4 you have answered **Medium** and **No** for question 5, there is no need to conduct an EA.
If, for question 4 you have answered **Medium** or **Don't Know**, and have answered **Yes** or **Don't Know** for question 5 you should move on to a **Stage One** EA.
If, for question 4 you have answered **High**, you need to conduct an EA.

	Equality Analysis	**None**
6. Based on the result of the screening, is an EA required?		No

Linda Dobrzanska: Research & Responsible Officer Manager
Dr. Amanda Thomas: Executive Medical Director

Workforce Policy dissemination and implementation plan - Tick boxes that apply and add comments

Name of author who is leading with disseminating the document **Linda Dobrzanska**	**Title of Document** Job Planning policy for Consultants, SAS Doctors, salaried GP's and salaried dentists, Leeds Community Healthcare NHS Trust

	Actions	**Dates**	**Comments**
	Induction Sessions required - provide dates:	Monthly induction	
	Launch Event required - provide dates:	As part of induction checklist on commencement of employment	
	Raising at meetings, provide dates/which meetings:	AMD/ML meetings	
	Specific Instructions for disseminating the document	Via intranet and email	
	Lead for audit and monitoring		

The following will be actioned by the Workforce Lead who uploads documents onto the Intranet:

- Email business units and departments requesting dissemination of document to applicable services
- Document uploaded on the LCH intranet
- Superseded documents removed from the Intranet
- Article submitted for to the next Community talk

Policy Consultation Responses

Complete this template when receiving comments at various draft stages of the Policy.

Responder (including job titles and organisation)	Version, Comment and Date	Response from Author
Version 2: Draft 3		
Linda Dobrzanska Research & Responsible Officer Manager	v.2.0 draft 3:	Changed Clinical Director to Associate Medical Directors (AMD) throughout the document
	v.2.0 draft 3 –	re- formatted to take into account changing policy templates
	v.2.0 draft 3 –	removed Quality, Risk and governance Committee and replaced with Joint Negotiating Committee and ratified by Remuneration Committee
	v.2.0 draft 3 p10 section 4.28 To change to take into account new IT system for medical staff	
	v.2.0 draft 3 p10 section 4.29 FmD queried this section and asked how e monitor who has access to HR folders.	AT response: Request will be made to the Business Unit and AMD and monitored by the RO support Team
	v.2.0 draft 3 p11 section 5.1.3 This will have to change to reflect the new IT system	
	v.2.0 draft 3 p10 section 5.1.6 To change 'demonstrate' to 'must be aligned'.	changed
	v.2.0 draft 3 p17 section 8.1 'After job planning meeting FmD wondered if this needs to be kept in?	Changed to AMD/ML /delegated clinician
	v.2.0 draft 3 Appendix E FmD wondered if we just need the weekly plan only for new staff – all the rest will be in the new IT system.	AT – this will be for non-designated body Drs not in the PReP system
Dr Amanda Thomas Executive Medical Director	v.2: draft 3 page 4 Introduction: to include 'Currently employed Forensic Medical Examiners'	changed
	v.2: draft 3: Page 5: 4.4 include reference to the cover for absent colleagues guidance	included
	v.2: draft 3: Page 5: 4.7 instead of relevant speciality it should read 'in their service'	changed

Responder (including job titles and organisation)	Version, Comment and Date	Response from Author
	v.2: draft 3: Page 7: 4.9.5.3 include appraiser after clinical governance	included
	v.2: draft 3: Page 8: Salaried GPs add FMEs	included
	v.2: draft 3: Page 9: 4.18 to remove sentence 'when time in lieu will be taken' time in lieu has to follow the LCH Policy month by month	removed
	v.2: draft 3: Page 9: 4.22.1 to remove HOS/ML and to include AMD/GM	changed
	v.2: draft 3: Page 10: 4.25 change ML/CD to AMD/GM	changed
	v.2: draft 3: Page 10: 4.28 For LCH medical staff …to include 'where they have a prescribed connection to LCH as a designated Body' and for dental practitioner and all other medical staff	Changed and included
	v.2: draft 3: Page 11: 4.29 Request will be made to the Business Unit and AMD and monitored by the RO support Team	included
	v.2: draft 3: Page 11: 5 /5.1.3 included HOS to include 'For medical staff who have LCH as their designated body'	included
	v.2: draft 3: Page 12: 5.1.10 please include reference to the buying of additional annual leave	Referenced policy
	v.2: draft 3: Page 13: 5.2.2.1 include stat and mandatory training	included
	v.2: draft 3: Page 14: 5.2.2.3 include clinical governance activities including Quality Improvements	included
	v.2: draft 3: Page 14: 5.2.2.4 include appraiser roles	included
	v.2: draft 3: Page 15: 5.2.3 Add designated or named roles	included
	v.2: draft 3: Page 15: 5.2.4 APA was in previous Policy – need some clarification	AT – should read Additional Responsibilities Pas - changed

Responder (including job titles and organisation)	Version, Comment and Date	Response from Author
	v.2: draft 3: Page 16: 7 Include after AMD/ML or delegated clinician at each time	completed
	v.2: draft 3: Page 16: 7.4 include 'or refer to on-line PReP job plan'	included
	v.2: draft 3: Page 16: 7.5 & 7.6 Add Quality Improvement activities Add 'Where this function is within the PReP system, the RO team will maintain storage'.	included
	v.2: draft 3: Page 17: 8.1 Instead of medical Manager insert AMD/ML or delegated clinician 8.2 Remove Director Insert Quality Improvement Activities	Completed
	v.2: draft 3: Page 18: 8.3 Include 'and Quality Improvement'	included
	v.2: draft 3: Page 18: 9.1 instead of clinical manager insert AMD/ML or designated clinician' each time remove: (or other designated person such as Director of Operations, head of HR, Medical director from other organisation) – insert Head of Workforce 9.2 Remove SHA and insert NHS Employers	completed
	v.2: draft 3: Page 20: Appendix A include ref to stat and mandatory training and Quality Improvement Activities Remove Commission for health Improvement and insert CQC	completed
	v.2: draft 3: Page 21: Appendix B Add Health education Yorkshire and Humber remove third paragraph	completed
	v.2: draft 3: Page 24 Appendix C Include University of York	Completed

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Version 2: draft 5		
AT (L3)	P6: Section 4.6: Suggest the wording should be the following: The AMD/ML or delegated lead clinician will be responsible for the job plan and lead the process. They will undertake the process with a General Manager/Head of Service or delegated manager to ensure that there is the necessary knowledge of the relevant clinical service and bring clarity, transparency and consistency to the job planning process.	Completed
SK4	P6: section 4.7: GM are not clinicians and should not undertake the JP	
AT (L5)	P6: section 4.7 Can remove this paragraph	completed
AT (L7)	P6: section 4.7 My response to the BMA would be that this approach is in keeping with our triumvirate partnership working, roles and responsibilities. SK 6 and SK 8 comments are addressed in section 7, so remove these comments	removed
SK8	P6: section 4.7 Need a section here re annual review of JP and interim review of JP	Removed as indicated above
AT (L9)	P7: Section 4.9.3 Agree change from activity to pa	changed
AT (L10)	P7: section 4.9.3 Agree change	
SK11	P7: section 4.9.3 The practitioner can also provide 3 months' notice	
AT (L12)	P7: section 4.9.3 Suggest change to : If any additional PAs are to be withdrawn, 3 months' notice will be given (this would not be below the substantive number of PAs) by either party.	changed
AB (L13)	P7: section 4.9.4 These proportions can be supported by a job diary completed by the clinician in preparation for the job planning meeting. The BMA produce a template diary.	

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AT (L15)	P7: section 4.9.4 Agree to add ‘ These proportions can be supported by a job plan diary completed by the clinician in preparation for the job planning meeting’. SK14 comments addressed in the next section	Changed to address above points
AB (L17)	P7: section 4.9.5.1 This is a significant change from previous agreement. If the appraisal prep and S&M are now included we need additional minimum SPA time to reflect this.	
AB (L18)	P7: section 4.9.5.1 In our trust we have specialty doctors taking on significant roles in the organisation. They also require minimum of 1.5 SPAs.	
AT (L19)	P7: section 4.9.5.2 No significant change all these were in the previous Job plan policy	agreed
AB (L20)	P7: section 4.9.5.2 The SPA time above is minimum, not typical, and as a minimum surely this para should say it may be more than ie can’t be less than a minimum.	
AB (L22)	P9 Section: 4.18 Time in lieu has been removed. Not sure why. Should there be reference to the cover policy?	
AT (L23)	P9: section 4.18 Please add ‘ There should be clear agreement if Time in Lieu is to be granted before the activity and in line with LCH policy – please reference the policy – Graham can you check the wording?	added
AB (L24)	P10: section 4.22.1 Clarity would be helpful here. Does the clinician need to seek agreement to flex on every occasion, or are we happy to trust clinicians to have a flexibility statement in the job plan for the SPA delivery? Possible wording: SPA time which does not impact on attendance at mandatory SPA activities can be worked flexibility, as long as the outcomes agreed in job planning are delivered.	added

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AB (l26)	P11: section 4.28 Training please	
AT (L27)	P11: section 4.28 Remove the comment and we can offer training on request?	completed
AT (L28)	P12: section 5.1.1 Wherever we have put GM or HOS please change to GM/HOS ore delegated manager	Completed
AB (L29)	P13: section 5.1.10 Where is the footnote?	
AT (L30)	P13: section 5.1.10 I cannot find this asterix reference anywhere, can we reference the leave policy because I think this could be about purchasing additional leave etc?	Added reference
AT (L31)	P14: section 5.2.1 Happy with the addition here if it is preferable to LNC and remove from Appendix A . Graham can you check their preference	
AT (L32)	P14 Section 5.2.2.1 Happy with the addition	
AB (L33)	P15: section 5.2.2.1 Please show where this is in contracts of employment? I can't find it.It was not in previous agreed SPA activity. If it is to be included need additional minimum SPA time as noted previously.	
AT (L34)	P15: section 5.2.2.1 Remove 'and stat man training', I am not sure where it came from as it wasn't in the 2014 policy	Actioned
AB (L35)	P15: section 5.2.2.3 Not preparation though	
AT (L36)	P15: section 5.2.2.3 Could be prep time?	
AB (L37)	P15: section 5.2.2.3 Quality improvement has been added here. We are more than happy to contribute to this, but the limitation of SPA time must be recognised.	

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AT (L39)	P15: section 5.2.2.3 Is this the new revalidation terminology?	
AT (L40)	P16: section 5.2.3 Seems to duplicate above. Either these roles are identified as having additional SPA time or AR time.	removed
AT (L41)	P16: section 5.2.4 If we include these we need an additional sentence to state if any of these roles are paid then the Trust should receive the payment. Graham could you add wording?	added
AB (L42)	P17: 5.2.4 This clearly discriminates against younger clinicians just starting out on their national profiles. Established clinicians will already have had historical agreements in place. The wider role of clinicians in the NHS should not be limited if local agreement with lead is reached. EG what if a senior clinician with a national role steps down? There would be scope for another member of department to take something up. Could we remove this bullet point?	
AT (L43)	P17: section 5.2.4 I don't agree it goes back to ensuring that ED are negotiated in the job plan in advance of taking up or accepting the role	
SK44	P18 section 7.0 Need to under this section talk about interim review of JPs	
AT (L45)	P18: section 7.0 Could Shazia give us some wording to include at the end between 7.7 and 7.8	
AB (L46)	P18: section 7.4 Isn't the role to discuss the job plan which was previously drafted and brought to the meeting by management?	
AT (L47)	P18: section 7.4 I do not want to be too prescriptive about who or how the final one is completed.	
SK48	P20: section 9.0 Need to include here the relevant TCS provisions for the different grades.	
AT (L49)	P20: section 9.0 Agree with this addition	

Responder (including job titles and organisation)	Version, Comment and Date	Response from Author
AT (L51)	P20: section 9.0 There are no consultants on the pre 2003 contract so this was never included.	
AB (L52)	P20: section 9.1 Throughout mediation any prior input from EMD should mean EMD is replaced in the whole process by another.	
AT (L53)	P20: section 9.1 Remove this addition, we have already stated that the mediator will be the EMD and where there is a conflict then the Head of workforce.	Removed
SK54	P21: section 9.2 These lists are currently being updated	
SK55	P21: section 9.2 Although appreciate these are no longer in existence this is what is within the TCS.	
AT (L56)	P21: section 9.2 Can't include SHA if it no longer in exists	Removed
AT (L57)	P21: section 9.2 Agree with this addition	
AT (L58)	P21: section 9.2 Happy with these additions	
AT (L59)	P21: section 10 Happy with these additions	
AT (L60/61)	P22: Appendix A Does the LNC want this as a separate appendix or included in the sections above? Can we page break each appendix	
SK62	P22: appendix A Should include section re on-call duties	
AT (L63)	P22: Appendix A Could they give us the wording – w don't have anyone on call?	

Responder (including job titles and organisation)	Version, Comment and Date	Response from Author
AT (L65)	P22: appendix A S&M excluded	
SK66	P23: Appendix A A section to follow here about Additional PAS, premium time, administration, location, and travelling time.	
AT (L67)	P22: Appendix A What does Shazia want included here? Can you ask her for the wording?	
Responder (including job titles and organisation)	**Version, Comment and Date**	**Response from Author**
Version 2 draft v6		
Adam Douglas (AD) Medical & Dental Directorate Team Secretary	Version 2 draft v6. Page 3, contents, paragraph 1, Introduction, annotated page (4)	(GD)(CHNT1): page numbers to check on completion of final layout.
	Page 6, For salaried Dentists	(AB2): Awaiting feedback from dental.
	Page 6, Lead Responsibility for Job Planning, Section 4.6: The AMD/ML or delegated lead clinician will prepare a draft job plan which will then be discussed and agreed with the practitioner. Leeds Community Healthcare NHS Trust will encourage and support both parties to the job planning discussion to engage with the General Manager/Head of Service or a delegated operational manager during the preparation of a draft job plan. It is envisaged that both parties will invite the General Manager/Head of Service or a delegated operational manager to attend for part of the Job Planning discussion to ensure that there is the necessary knowledge of the relevant clinical service to facilitate clarity, transparency and consistency to the job planning process	(GD)(CHNT3): Paragraph amended following JNC meeting on 8/3/16. (AB5): Still not clear that the normal situation is just head of service and clinician. See note from Marie.
	Page 8, section 4.8.5.1: A typical consultant/associate specialist is likely to require a minimum of 1.5 PA's for SPA, unless otherwise agreed, to cover Continuing Professional Development (CPD), General SPA, appraisal preparation and	(GD)(CHNT7): Now removed (professional) following the JNC meeting on 8/3/16 – agreement that Statutory Mandatory Training would be undertaken flexibly by practitioners and will not be illustrated within any particular part of the job plan.

	education and training.	(AB9): I thought we had agreed that Stat and Mand was out.
Responder (including job titles and organisation)	**Version, Comment and Date**	**Response from Author**
	Page 11, General, 4.20.1: If requested, SPA time that is appropriate to move may be undertaken outside of the agreed time set in the weekly timetable as long as the output of such work is evidenced, and it does not impact on attendance at mandatory SPA activities (such as clinical governance meetings) and it is agreed in advance with the HOS/ML/AMD/GM.	(GD)(CHNT12): This amended paragraph is adopted.
	Page 12, General, 4.26: For LCH staff, where they have a prescribed connection to LCH as a designated body, the job planning process during 2015/16 will move to an electronic system which will be fully operational during 2016/17. For dental practitioners and all other medical staff this must be completed using the current approved version of the job plan template (appendix F). All sections must be completed prior to sign off	(GD)(CHNT13): This amended paragraph is now adopted
	Page 12, General, 4.27: Job planning is an open process, agreed between the practitioner and their AMD/ML or delegated lead clinician. Once agreed, job plans will be available for the other members of the clinical team to use to help plan the delivery of services and will be available, if appropriate, to other practitioners within the team. Job plans are public documents therefore if a member of the public requested a copy the Trust would be obliged to provide it. The individual would be consulted and involved in identifying elements considered to be of a sensitive personal nature to be removed before this was released either to other practitioners or in response to the public request. Request will be addressed to the Business Unit AMD and monitored by the Responsible Officer Support team.	(GD)(CHNT14): Now amended to align with section 4.6
	Page 13, Standard for Job Planning, 5.1.1: All job plans are to be undertaken by the AMD/ML or delegated lead clinician and practitioner.	(GD)(CHNT15): Now aligned with 4.6

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	Page 13, Standard for Job Planning, 5.1.4: These changes will be by **Prospective** agreement between the individual and AMD/ML or delegated lead clinician.	(GD)(CHNT17): Now aligned with 4.6
	Page 14, Standard for Job Planning, 5.1.10: For individuals who have agreed additional responsibilities/external duties or have purchased additional annual leave, in accordance with the terms contained within the LCH Annual leave policy, the amount will be based around a lower number of working weeks but will be agreed at the annual job plan review or within the year if appropriate.	(GD)(CHNT18): Para now adopted (GD)(CHNT19R18):
	Page 15, Programmed Activities/Hours/Sessions, 5.2.1 Direct Clinical Care (DCC) Activities: These activities directly relating to the prevention, diagnosis or treatment of illness that forms part of the services provided by the Trust under section 3(1) or section 5(1)(b) of the National Health Service Act 1977. This includes emergency duties, (including emergency work carried out during or arising from on call), operating sessions including pre-operative and post-operative care, ward rounds, outpatients activities, clinical diagnostic work, other patient treatment, public health duties, multi-disciplinary meetings about direct patient care and administration directly related to the above (including but not limited to referrals and notes) (Dr AT – supports amendment here – remove from appendix A)	(GD)(CHNT20): Now adopted.
	Page 15, Non DCC Activities (SPA, AR, ED), 5.2.2.1 Supporting Professional Activities (SPA): These are activities that underpin DCC. This includes, participation in training, medical education, continuing CPD, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.	(GD)(CHNT21) Now adopted
	Page 17, External Duties, 5.2.4: If external duties are undertaken and recognised as part of the job plan and the clinician is in receipt of remuneration in respect of these duties the clinician will be expected to advise the Trust accordingly and ensure appropriate payments are made to the Trust. (Note added with reference to payment – Dr AT)	(AB22): Can we be clear whether these involve the payments for section 136 Psych assessments. We have discussed this before at JNC. (GD)(CHNT23): Not discussed at JNC 8/3/15. (S124R23): Seems fine.

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	Page 19, The process in outline, 7.4: During the meeting the practitioner should complete their job plan template and submit electronically for approval to the AMD/ML.	(GD)(CHNT25): Now aligned with 4.6
	Page 20, General Manager/Head of Service 8.2: Before Job planning meetings to facilitate effective preparation.	(GD)(CHNT26): Align to 4.6
	Page 20, General Manager/Head of Service 8.2: If required and by invitation of the AMD/ML or delegated clinical lead and the practitioner • Provide moral support • Witness/record agreement • Answer 'technical' management questions regarding - Employment - Support/resources available • Work with the AMD/ML/Delegated Clinician in putting it all together (eg speciality matrix) • Feed into planning 'round' • Check against proposed business plan (including 3 year rolling plan) • Link to other services	(GD)(CHNT27): Aligned to 4.6
	Page 21, Mediation, 9.1: Executive medical Director (or the Head of Workforce if the Executive Medical Director is one of the parties to the initial decision) in writing within two weeks of the disagreement.	(GD)(CHNT28): Adopted
	Page 24, On Call Duties: Reference should be made to Nationally agreed Terms and Conditions of Service. **This would remove the need for the narrative:** A Consultants job plan should clearly set out their on-call commitments. Under the 2003 contract it is recognised in three ways: • An availability supplement (see box 1) based on the commitment to the rota. • There is no prospective cover allowance here. • PA allocation for predictable emergency work arising from on-call duties (ward rounds, administration etc)	(GD)(CHNT29): Following JNC 8/3/16 Deleted

	should also be prospectively built into timetables as direct clinical care PA's. There is no limit on the amount of predictable on-call work that can be allocated to DCC PA's and prospective cover. When a consultant covers colleagues on-call duties when they are away on annual or study leave, this should be factored into the calculation. PA allocation for unpredictable emergency work done whilst on-call. This should usually be assessed retrospectively (using diary evidence) and included within the first allocation of DCC PA's in the job plan. The allocation can be adjusted at the job plan review. Once again, prospective cover should be recognised here. Definitions of emergency work (taken from the terms and conditions of service) • Predictable emergency work: is emergency work that takes place at regular and predictable times, often as a consequence of a period of on-call work (for example, post-take ward rounds). This should be programmed into the working week as scheduled Programmed Activity. • Unpredictable emergency work arising from on-call duties: is work done whilst on-call and associated directly with the consultants on-call duties, for example recall to hospital to operate on an emergency basis. • Calculating unpredictable on-call work can be the source of some uncertainty for both employers and consultants, as can distinguishing between category A and B work and defining a 'complex telephone call'. In drawing up on-call arrangements, employers should, wherever possible match skills, availability and patient need to maintain the provision of a high quality service. • Participation in low frequency on-call arrangements may have implications for clinical governance where individuals may not have sufficient opportunities to see or undertake a range of procedures over the course of the rota.	

	• Where the rota requires a low frequency, category B contribution this should trigger a review as to the need for the contribution in the first place. • Employers may also need to clarify the on-call arrangements for a consultant working for two employers. Where a consultant participates in an on-call rotas for different employers at different times those employers should satisfy themselves that there are no governance or risk management issues which might affect performance in any subsequent activity, such as a late finish followed by an early start. It might be the case that a consultant is on two rotas of differing frequency with the same employer. In such cases, the availability supplement can be calculated by working out their overall contribution on an annual or equivalent basis. Employers should only pay the appropriate on-call supplement for the period of time that consultants are contributing to the rota and not automatically for the whole year. • 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 1 in 4) or the medium frequency category (1 in 5 to 1 in 8). For the purposes of clarity, the BMA 7 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 (ie to 1 in 4) and rounded down when it is less frequent that than 1 in 4.5 (ie to 1.5). • Employers should recognise the ability for some consultants to work remotely, for example radiologists with remote access to images and those who are able to access telemedicine applications.	

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	Page 25, Travelling Time: Reference should be made to Nationally agreed terms and conditions of Service. Travelling time to and from the 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.	(GD)(CHNT30): Following JNC 8/3/16

Policy Consultation Process

Title of Document	Job Planning Policy for Consultants, SAS Doctors, Salaried GPs and Salaried Dentists, Leeds Community Healthcare NHS Trust
Author (s)	Dr Amanda Thomas: Executive Medical Director
Revised Document	Revised document
Lists of persons involved in developing the policy	Dr Amanda Thomas: Executive Medical Director Linda Dobrzanska: Research & Responsible Officer Manager Dr Florence McDonagh: Associate Medical Director for Appraisals and Job Planning
List of persons involved in the consultation process	JNC Committee members AMD/ML