

A guide to consultant job planning

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A guide to consultant job planning

Foreword

As some of the most highly skilled medical practitioners, consultants are fundamental in delivering quality and safety in medical care for patients. Working as part of a coordinated team in the NHS is more important than ever – the NHS is facing a series of unprecedented challenges. NHS organisations have to meet demands for high quality care at the same time as managing the transition to a radically different health system and delivering significant efficiency savings. Tackling any one of these individually would require a major effort; to do so simultaneously will need NHS consultants and managers to work together collaboratively and innovatively.

The consultant job plan has been in place since 1991 and is at the heart of the 2003 consultant contract. The challenges currently facing the NHS underline the importance of consultant job planning as a means of organising resources effectively and efficiently in a way which brings mutual benefits to organisations, patients and doctors in the planning and delivery of high quality patient care.

That is why we have put together this new job planning guidance based on principles that we believe can be used to provide the framework for a collaborative approach, which enables consultants and managers to meet their shared responsibility for providing the best possible patient care.

We are particularly grateful to members of the NHS Employers working group and to members of the Central Consultants and Specialists Committee of the British Medical Association (BMA) for their work in developing this guidance.

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Defining a consultant

Consultants should work as some of the most senior doctors in the NHS, and job planning should support and enable this. Consultants accept ultimate responsibility for and delivery of expert clinical care, usually within a team. This includes diagnosis and management of complex cases and spending time and effort reflecting on and reviewing patient care activities so that quality and safety improve continuously. Consultants should also be involved in teaching, training, researching, managerial decisions, running departments and developing local services. It would not be expected that all consultants are involved in all of these activities at the same time, but rather that they are undertaken across a team of consultants at specialty/directorate level. The NHS depends on consultants to be involved in the wider management and leadership of the organisations they work in, and the NHS generally.

Executive summary

The NHS is undergoing a period of unprecedented structural change against a backdrop of significant financial pressure. At the same time it is striving to meet demands for higher standards of care and improved outcomes for patients.

Managers and consultants will need to work even more closely together to ensure that NHS organisations are able to meet these diverse challenges. Effective job planning is one key mechanism through which consultants and managers can agree, monitor and deliver this shared responsibility.

This guidance has been prepared jointly by the BMA and NHS Employers and reflects a shared understanding of the key principles which should characterise a collaborative approach to the job planning process. Job planning should be:

- 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 enhancing outcomes for patients whilst maintaining service efficiency.

Job planning should not be carried out in isolation. It should form part of a dynamic, patient-focused process which incorporates organisational, team and individual objectives and in the case of consultant clinical academics is always undertaken jointly with the university employer.

The guidance highlights the benefits of effective preparation for both managers and consultants and covers objective setting, information gathering and some of the supporting resources which may be required, as well as covering some of the current contractual provisions relevant to component parts of the job plan.

A job plan, which is based on the principles set out in this guidance, is more likely to be an effective and mutually beneficial means of meeting the challenges that consultants and managers currently face in delivering high quality patient care in the face of testing financial circumstances and complex organisational change.

1. Introduction

- 1.1 Healthcare across the world is under the most intense scrutiny for value obtained; that is, the outcomes it delivers for the investment made in it. The NHS in England is undergoing one of the most wide-ranging reorganisations in its history aimed at enhancing quality whilst reducing costs. Although the landscape of healthcare is likely to change significantly, the aim of achieving continuous improvements in quality and outcomes for patients is a necessity for doctors, managers, healthcare staff and the public.
 - 1.2 The distinction between the management of care and the management of resources is becoming increasingly narrow. Now, more than ever before, consultants and managers (medical and general) have a joint responsibility to work closely together to provide the best possible care within the resources available to them. The consultant job plan, the central plank of the consultant contract, is a key mechanism through which this shared responsibility can be agreed, monitored and delivered.
 - 1.3 A job plan can be described in simple terms as a prospective, professional agreement that sets out the duties, responsibilities, accountabilities and objectives of the consultant and the support and resources provided by the employer for the coming year. However, in order to drive measurable and sustainable improvements in quality, an effective job plan needs to be more than a high level timetable which sets out in general terms the range of a consultant's activity. It is vital that it articulates the relationship between the organisation and the consultant and the desired impact on patient care. The key to this is the use of SMART objectives (see Section 3).
 - 1.4 The job planning process should align the objectives of the NHS, the organisation, clinical teams (and in the case of clinical academics, their higher education institution) and individuals in order to allow, consultants, clinical academics, managers and the wider NHS team to plan and deliver innovative, safe, responsive, efficient and high-quality care. At the same time the job plan should provide opportunities to develop both personally and professionally to help drive quality improvement in line with the present and future needs of patients.
 - 1.5 Consultants are crucial to the success of the NHS. The move towards the majority of care being delivered by fully-trained doctors requires consultants to deliver more hands-on care than might have been the case before. This requires a more innovative approach to the working life of today's consultant.
 - 1.6 The prospect of revalidation will drive a greater transparency with consultants demonstrating that they remain fit to practise, bringing a renewed focus on professional development and demonstrating improved outcomes for patients.
 - 1.7 All consultants work as part of a team of consultants, whether this is to provide emergency cover as part of a rota, or, as is increasingly seen, working as part of a multi-consultant team sharing the day-to-day responsibility for patients. A team-based approach to job planning, where these responsibilities are shared by all the consultants is being increasingly used to deliver more efficient and effective healthcare. Matching workforce availability to activity will bring greater efficiencies and quality to patient care, as well as making allowances for a better work-life balance for consultants.
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- 1.8 To make job planning a better instrument for consultants and managers to provide high quality care, the process should be:
- 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
 - clear about the supporting resources the trust will provide to ensure that objectives can be met
 - transparent, fair and honest
 - flexible and responsive to changing service needs during each job plan year
 - fully agreed and not imposed
 - focused on enhancing outcomes for patients whilst maintaining service efficiency
 - consistent with the principles set out in the Follett review, in the case of clinical academics,¹ ([see annex 3](#))
- 1.9 Employers should agree an explicit job planning policy with the Local Negotiating Committee (LNC) which should make the 'sign-off' process for finalising job plans clear.
- 1.10 While software can be helpful in collating information relevant to job planning, it is no substitute for proper preparation and engagement in job planning by both parties.
- 1.11 We cannot meet the demands for a high quality service unless consultants and managers combine forces with the wider NHS team to find new and innovative ways to work. This requires effort, patience and compromise but the rewards will be significant for all involved. That is why we have put together this new job planning guidance. It is based on principles that we believe can be used to enable job planning to provide the framework for a collaborative approach, which enables consultants and managers to meet their shared responsibility for providing the best possible patient care within the resources available to them.

¹ *A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties*. A report to the Secretary of State for Education and Skills by Professor Sir Brian Follett and Michael Paulson-Ellis, September 2001.

2. The job plan in context

- 2.1 Although consultants have been asked to agree job plans with their employers since 1991, job planning only really became a central part of consultants' working lives with the agreement of the 2003 consultant contract and terms and conditions of service. This made explicit the link between job planning and a successful relationship between the consultant and their employer(s).
- 2.2 So what are job plans? Simply, they are an annual prospective agreement between employers and consultants setting out:
- what work the consultant does for the NHS organisation and in the case of clinical academic consultants, what work they also do for the university
 - the objectives to be achieved by the consultant and supported by the employer(s)
 - when that work is done
 - where it is done
 - how much time the consultant is expected to be available for work
 - what this work (quantified) will deliver for the employer(s), employee and patients
 - what resources are necessary for the work to be achieved
 - what flexibility there is around the above
 - the working relationships and interactions, if any, that the consultant may have outside his primary role for the employer.
- 2.3 Since the contract was introduced, workload diaries have been seen as an important tool in job planning because they form the basis of an agreed timetable of work and the allocation of sufficient time. It was essential to establish this in order to implement the contract and they still have a role in monitoring changes in workload.
- 2.4 But job planning is not just about agreeing a weekly timetable. Now that both consultants and managers have had time to get used to the contract, there is a great opportunity to look again at how job planning can be used to drive improvements and quality of patient care. Some trusts are looking at new IT tools, some at annualisation, and others at team or departmental job planning amongst other initiatives. All these have the potential to improve the process and should be explored, but the best way to ensure sound job planning is to focus on objectives.

“A consultant job plan should be a prospective agreement that sets out a consultant's duties, responsibilities and objectives for the coming year.”

“...consultant job plans should set out agreed personal objectives and their relationship with the employing organisation's wider service objectives.”

Job planning: standards of best practice, Department of Health, April 2003

- 2.5 Objectives, used properly, can help consultants and managers work together to lead improvements to the service, for example through innovation and development of new ways of working, or audit and improvement of existing ways of working.
- 2.6 Improving the quality and safety of patient care and the overall patient experience is vital, not only as this is increasingly expected by patients, but also for the beneficial effects on the efficiency and future stability of the trust and on the wider health economy.

3. From objectives to the job plan

- 3.1 When the consultant contract was introduced in 2003, the BMA and the NHS Modernisation Agency (part of the Department of Health) published several pieces of guidance explaining different aspects of the contract alongside the terms and conditions of service and the model contract. It was also issued for clinical academics with the Consultant Clinical Academic Contract in 2004.

What the terms and conditions of service says about objectives

- The Job Plan will include appropriate and identified personal objectives that have been agreed between the consultant and his or her clinical manager and will set out the relationship between these personal objectives and local service objectives. Where a consultant works for more than one NHS employer, the lead employer will take account of any objectives agreed with other employers.
- The nature of a consultant's personal objectives will depend in part on his or her specialty, but they may include objectives relating to:
 - quality;
 - activity and efficiency;
 - clinical outcomes;
 - clinical standards;
 - local service objectives;
 - management of resources, including efficient use of NHS resources;
 - service development;
 - multi-disciplinary team working.
- Objectives may refer to protocols, policies, procedures and work patterns to be followed. Where objectives are set in terms of output and outcome measures, these must be reasonable and agreement should be reached.
- The objectives will set out a mutual understanding of what the consultant will be seeking to achieve over the annual period that they cover and how this will contribute to the objectives of the employing organisation. They will:
 - be based on past experience and on reasonable expectations of what might be achievable over the next period;
 - reflect different, developing phases in the consultant's career;
 - be agreed on the understanding that delivery of objectives may be affected by changes in circumstances or factors outside the consultant's control, which will be considered at the Job Plan review.

Source: *Terms and conditions of service – consultants (England) 2003*. Schedule 3, paragraphs 3.10: 3.13

- 3.2 Objectives should be set for most of the activities the consultant has in their job plan. This can be explicit – in a stated objective, or implicit in the agreed job schedule and annually agreed Programmed Activities (PAs) delivered. They should set out a mutual understanding of what the trust and consultant will be seeking to achieve over the year and how this will contribute to team, service and organisational objectives.
- 3.3 Clear objectives provide focus for consultants and managers and will help with both service provision and quality improvements. Objectives may be ‘hard’, relating to quantifiable achievements, or ‘soft’, where they may be more descriptive about how someone goes about their job.
- 3.4 The process should follow the SMART formula:
- specific
 - measurable
 - achievable and agreed
 - realistic
 - timed and tracked

Applying this method to objective setting will make the agreed objectives purpose clear and agreement on each aspect should avoid problems arising later.

- 3.5 Objectives should cover all aspects of a consultant’s role; direct clinical care (DCC), supporting professional activities (SPAs) including personal development and those which are more professionally oriented and academic sessions, where appropriate. However, all objectives should ultimately focus on the benefits to patients, although in some instances, for example education and training, the impact may be less direct or immediate. All objectives need to be clear in the way that they define the individual consultant’s specific and personal objectives. It is only through personalising objectives that meaningful progress can be made and measured.
- 3.6 A key role of medical managers is to take their organisation’s objectives and translate them into meaningful objectives for consultant colleagues. They should devise and seek to agree personalised service objectives.
- 3.7 Objectives should remain focused on key strategic and service aims. More general contractual requirements, such as the need to retain professional registration, participation in mandatory training or adherence to trust policies and procedures do not necessarily need to be included as separate objectives as they are the expectations of being an employee and are covered by employment law and guidance. In some trusts there may be some benefits in having mandatory training and other general requirements under one objective to ensure that it is reviewed at job planning and receives necessary additional focus.
- 3.8 Managers share the responsibility for making the process work as intended; the clinical director or lead clinician will have a fundamental role in setting and agreeing the objectives of all the consultants in the directorate/specialty, and should guide and direct the consultants in pursuing their objectives. In many instances this should link to the trust’s annual plan and strategic objectives to maintain continuity and business focus.

3.9 In most instances, this is initially best achieved through the team of consultants meeting and looking at the team's objectives for all. Individual consultant objectives should therefore link to the team objectives and individual job plans should be considered collectively to see how they fit together and work as a whole towards meeting the needs of patients.

The clinical director's aims should be to:

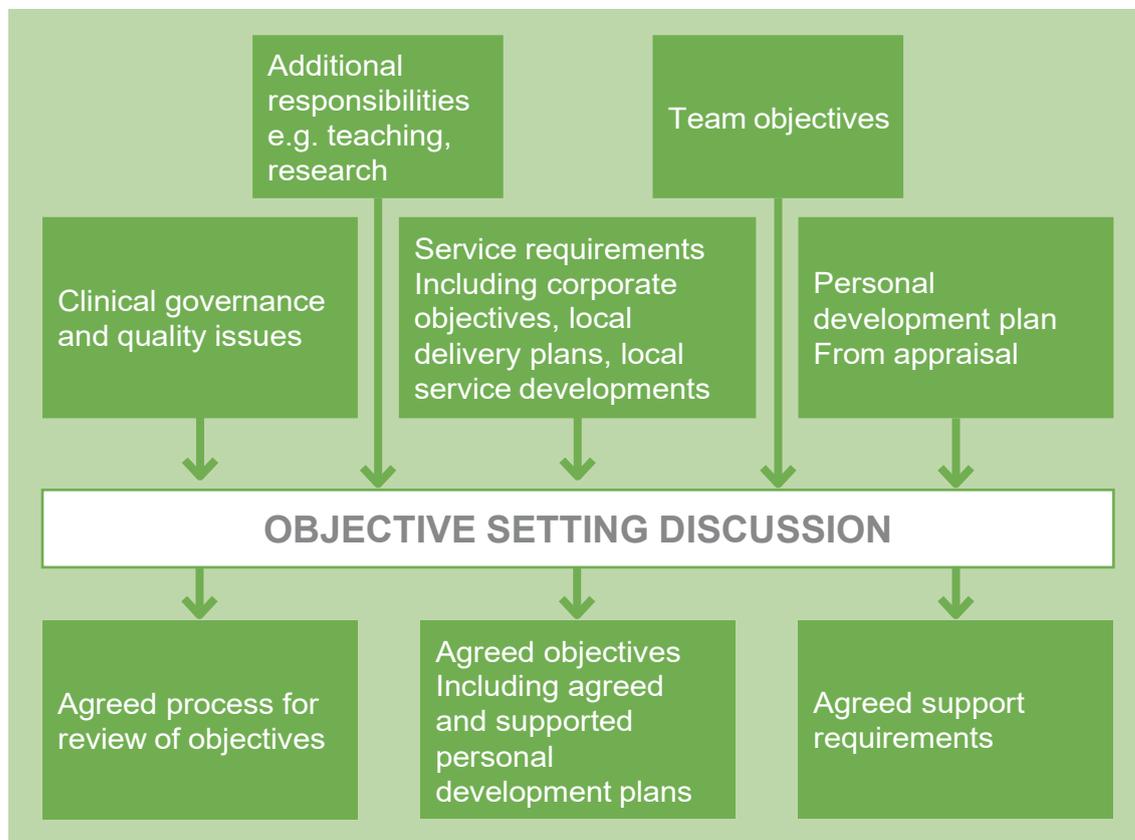
- enhance the quality and efficiency of patient care
- remove unnecessary duplication of effort amongst the consultant and wider medical team
- achieve comprehensive coverage of the SPA and other non-clinical work needing to be done. Examples would be the contribution of the consultants to deliver the education and training of junior doctors and other staff and involvement in quality improvement processes
- assure that responsibility for this work is shared and does not rest with one individual consultant
- provide the supporting resources needed for this work
- regularly monitor progress.

3.10 Effective job planning will require the clinical director to have an overview of objectives, to seek the views of individual consultants, (and potentially other) colleagues and to achieve a consensus. It will also be important to bring knowledge of trust objectives and service requirements into the objective-setting discussions.

“Translating the objectives of the trust into meaningful, measurable objectives in consultant or specialty job plans allows consultants to identify the required changes to support growth and efficiency in their particular service area and ensure their service remains attractive to commissioners”

Large Scale Workforce Change (LSWC) consultant contract programme

3.11 The following diagram gives a useful summary of the inputs and outputs that consultants and managers should consider as part of an objective setting discussion for individual and consultant teams:



Source: 'Effective job planning – a concise guide for consultants', BMA 2005.

3.12 Objectives must be appropriate, identified and agreed. A consultant should take part in the objective setting process and must make reasonable efforts to achieve the agreed objectives. This is not only a general expectation in the contract but is laid out in two of the (seven) criteria for pay progression:

- participated satisfactorily in reviewing the job plan and setting personal objectives
- met the personal objectives in the job plan, or where this is not achieved for reasons beyond the consultant's control, made every reasonable effort to do so. (*Terms and conditions of service*, schedule 15, paragraph 1.)

3.13 It is the norm for consultants to achieve pay progression, but progression is not automatic. Consultants should not be penalised for failing to meet objectives for reasons beyond their control, such as illness, whether this is due to a lack of agreed supporting resources or another reason. However, both employers and consultants have a responsibility to identify potential problems with achieving objectives as they emerge rather than waiting for an annual job plan review meeting.

3.14 There is also a link between the themes underpinning both the job planning process and the Clinical Excellence Awards (CEA) scheme as it currently stands.² At the moment consultants are not eligible for an award unless the employer confirms that they have:

- participated successfully in the appraisal process (or in the case of clinical academics, a joint appraisal process)
- participated in job planning
- met their contractual obligations
- complied with the Private Practice Code of Conduct.

It is likely that any new scheme will be closely linked to job plans and this guidance will be updated to reflect future arrangements.

² The Doctors and Dentists Pay Review Body is currently undertaking a review of the CEA scheme and is expected to report in July 2011

4. Supporting resources

- 4.1 The job plan review should identify and agree the resources that are necessary if the objectives are to be met. There is no point in agreeing objectives if they cannot be realistically achieved.
- 4.2 Not completing an objective may be because of a lack of necessary resources or the existence of organisational barriers to progress. If this happens the consultant and manager should meet to discuss how such barriers could be overcome at the earliest possible opportunity, so that the agreed objectives can be achieved or new achievable objectives agreed.

| Example of supporting resources | |
|---------------------------------|-----------------------------------|
| Generic | Specific |
| Time (SPAs) | Time – leave or external duties |
| Workspace and computer | Access to database |
| Medical staff team | Audit/governance support |
| Secretarial/PA | Off site remote access to servers |
| Mandatory training opportunity | Theatre access |

5. The link with consultant appraisal

- 5.1 Although objectives should be discussed and agreed at the job plan meeting, the appraisal process is an important source for agreeing and monitoring personal development objectives. Making sure that job plans reflect personal development objectives is a good way of making sure that the necessary supporting resources have been allocated. For this reason, it is important that the clinical director, or manager, has a discussion with the appraiser prior to the appraisal to embed the link to job planning. For clinical academics it is important that the university appraiser/line manager is also involved in this process. Like the appraisal process, job planning should be the subject of continuing dialogue and discussion throughout the year in the spirit of the 'no surprises' approach which underpins effective appraisal.

6. Preparing for the job plan

- 6.1 Preparation is the key to effective job planning. The teams (consultants and general managers in the NHS and fellow academics in the higher education sector) should meet beforehand so that job planning flows naturally from organisational and team objectives and that job plans are not drawn up in isolation. Some of the areas the team should explore include:
- mapping the current commissioning and contracting environment, including expectations for the coming year and beyond
 - reviewing the previous year and identifying what went well and where there might be areas for improvement across the organisation/directorate
 - identifying the actions and resources needed to improve quality
 - reviewing areas of strength and weakness and methods to maximise the opportunities and minimise the possible threats
 - identifying the priorities the organisation(s) and the team(s) want to deliver and the shared objectives which might influence job plans
 - setting out what will be needed to meet clinical governance requirements, including education, training and research
 - improving the use of data in setting objectives and the job plan. [The BMA's consultant job planning diary](#) can help to provide information on work load
 - linking to personal objectives around appraisal
 - determine any known or likely significant demands on consultant time away from the trust (for example, senior college roles) that will impact on service delivery.
- 6.2 Organisations can take practical steps to ease the assimilation of job and business planning by harmonising the job planning and appraisal cycles and strengthening the link between personal development plans and business plans where appropriate. Induction programmes can provide an opportunity to emphasise the importance of the job planning process as a means of linking the aims and objectives of the service to individual activity.
- 6.3 Teams could also consider benchmarking their job planning framework with those of others within the organisation, or even in different organisations, to secure consistency and benefit from good practice. Transparency of the outcome of job planning allows consultants to have confidence in the process. For example, integrating job planning across teams in different specialties can lead to improved theatre use and reduce delays. Teams should reflect upon what they want to achieve over the year, their shared objectives and link the outcome to individual job plans.

- 6.4 Many medical managers work closely with their general manager counterpart in delivering the service business plan. For many trusts involvement of the general manager in the job planning process has invariably helped the consultant team's understanding of the wider business and organisational context. This has made the setting of objectives more meaningful to patient needs. Academic managers may need to work together with other staff in the higher education institution/medical school in order to arrive at an understanding of the wider business context for the Higher Education Institution (HEI).

7. Background information the clinical manager should consider

- 7.1 The NHS is moving away from a target driven approach to one which improves outcomes and quality of care for patients. The NHS Quality, Innovation, Productivity and Prevention (QIPP) challenge and CQUIN (Commissioning for Quality and Innovation) are encouraging NHS organisations to think critically about how they can continue to improve the quality of the care they provide and to do so more efficiently. It follows that job planning should also focus on outcomes and the patient experience. All data should be discussed and shared in good time.
- 7.2 The job plan diary has the potential to provide the most immediate piece of data on activities undertaken by consultants, which can then be supplemented by other sources of information, for example Finished Consultant Episodes (FCE) spells linked to service level agreements. Focusing the job plan diary on the collective elements of the job plan (for example, direct clinical care, supporting professional activities) and how these have changed over time is likely to be more productive for job plan discussions than detailed accounts of timed activity.
- 7.3 Indicators of health, performance, quality and efficiency can offer a valuable insight into how care is being delivered. The Department of Health's work on developing an NHS Outcomes Framework should provide a useful reference point. [The NHS Information Centre](#) has identified an evolving set of indicators to describe the quality of a broad range of services, the Indicators for Quality Improvement (IQI) are:
- a set of robust indicators to help clinical teams select indicators for local quality improvement
 - a source of indicators for benchmarking
 - assured by clinicians for use by clinicians
 - published with full metadata for transparency.
- 7.4 IQIs bring assured indicators into one place, allow clinicians to benchmark and measure quality and encourage local clinical teams to work together to improve services within the three dimensions of quality care – safety, effectiveness and patient experience.
- 7.5 The NHS Information Centre also provides some additional services. [NHS Comparators](#) can help benchmark and compare clinical activity, outcomes and costs at a local, regional and national level. [NHS Comparators](#) contain around 200 comparators, benchmark data against peers and breakdown data by 30 consultant
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- 7.6 The quality and productivity section of NHS Evidence acts as the national evidence base demonstrating how to improve quality whilst making efficiencies. Better Care, Better Value indicators developed by the NHS Institute, are based around 15 high level indicators of efficiency which identify potential areas for improvement in efficiency. These indicators can be used locally to inform job planning.
- 7.7 The Department of Health has issued a tool for trusts to enable them to compare activity rates of the consultants they employ with national benchmarking data. This is currently limited to five surgical and five medical specialties but is likely to expand to cover other specialties in time.
- 7.8 Some of the data being used to assess the productivity of consultants can be limited in scope, and can fail to measure quality of care or reflect the intricacies of patient care and how consultants contribute to that care. For this reason, it is essential that both consultants and managers are aware of how the data is collected and agree upon how it is interpreted and used to drive improvements in future. It may also be useful to consider whether consultants can spend SPA time helping to develop and improve data used for these purposes.
- 7.9 To facilitate an informed discussion at the job planning meeting, those involved should bring all the relevant data needed to plan the activities for the coming year. For example this could include:
- a working time diary
 - appraisal and agreed personal objectives
 - any academic objectives
 - service business plan and performance over past 12 months covering the 'whole practice' of the consultant
 - individual performance over past 12 months
 - information on activities undertaken in supporting professional activity (SPA) time including:
 - audits
 - teaching
 - clinical management
 - continuous professional development (CPD)
 - administration
 - research
 - views on future objectives
 - evidence to support any new resources required to meet the work and objectives within the contract.
 - relevant specialty advice, for example, royal college and specialty association guidelines
 - evidence of the benefits of external duties/work for outside organisations to the trust and local patients.
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8. The job planning process

- 8.1 **Training:** Employers should ensure that those involved in job planning receive appropriate training – not just on the contractual aspects, but also on the shared organisational aims, quality improvement and objective setting which underpin the whole job planning process. This will help to support consistency across teams and promote fairness to individuals. Training should be included in the objectives of clinical directors and other staff central to the job planning process. Employers should consider setting up a local review panel or quality assurance group to provide a forum to discuss key principles and to undertake benchmarking work.
- 8.2 **Scope of the meeting:** It is important that at the outset there is a common understanding of the purpose and scope of the meeting. As suggested earlier, in many instances there may have been ‘team’ job planning of some elements of the timetable, for example, on-call, emergency cover, departmental SPA and it is inadvisable for this to be revisited on an individual basis. While the meeting can sometimes throw up other issues that are outside the scope of job planning, these are best noted to be dealt with at another time as otherwise the meeting can be distracted from its core purpose.
- 8.3 **Format of the meeting:** At least an hour should be set aside for the meeting at a time when all parties are free of other commitments. Avoiding interruptions, such as pagers and mobile phones, as far as possible is conducive to a productive meeting. The job planning meeting will generally take place between the individual consultant and their clinical manager (who will usually be the clinical director) and academic manager for clinical academics. In many trusts the presence of the relevant general manager is seen as significantly improving the job planning process and has been supported by the relevant Local Negotiating Committee (LNC). It will often be helpful for the discussion to be held between clinicians because they will understand some of the technical issues and requirements. All of those involved in the process should be clear about the level of sign-off required at each stage.
- 8.4 **Where to start:** As objectives are at the heart of the consultant job plan it is best to start by reviewing the objectives from the previous job planning round. If any have not been achieved then the reasons for this should be explored in a non-critical fashion. If any change in overall direction of the consultant’s job plan is anticipated this should be discussed at this point. The next step is to consider what objectives are appropriate for the new job plan. It may be helpful to consider the organisation’s objectives and ask the consultant how they think they can contribute to them through their own objectives. This should lead to the agreement of a new set of objectives for the coming year. It can be entirely appropriate for some of these to be identical to the previous year’s objectives but, in general, to have a completely unchanged set suggests poorly chosen objectives.

- 8.5 Progressing to a job plan: Once the objectives are agreed, the resources required to achieve them should then be considered. These could, for example, include clinic or operating theatre time, support from other staff, SPA time, or secretarial and IT support. This is an aspect of the job plan that may need to be revisited at an interim review if it appears that objectives may not be achieved because either agreed resources are not being provided or some resources are required that were not anticipated.
- 8.6 Finalising the timetable: The consultant and their manager(s) then need to review the agreed resources and any elements that have already been agreed through team job planning, so that they can be mapped to the timetable. This is an opportune point to consider whether there are advantages to the consultant, the organisation or both in creating an annualised job plan. There should also be consideration of whether any external duties will be undertaken and whether professional leave will be required for these. Any private practice should be reviewed to ensure compliance with the Code of Conduct on Private Practice.
- 8.7 What if there is a disagreement? The job plan is so central to the work of consultants that it is worth taking the time to get it right. If an element of the job plan cannot be agreed then it may be best to leave that issue for further discussion at another time. Both parties should consider if they can meet half way for example, where there is an activity that the consultant wants to continue but there seems little room within the overall PA envelope for it, alternating this activity with another on a weekly basis may satisfy both parties. An alternative strategy may be to suggest a trial of a particular job plan and schedule a review within six months. While there is an agreed process for mediation and appeal, it is best if the parties can arrive at an agreed job plan by themselves.
- 8.8 Sign-off: What is agreed at the job planning meeting should be put in writing but it should not be put into effect until this has been reviewed and signed off by all parties. There may be a need to discuss some aspects of the agreement with other parties before a revised job plan can take effect. There should be an agreement as to when the job plan will be reviewed and whether there is any specific data that may be required at that time. Once the job plan has been verbally agreed both parties must complete formal sign off within a reasonable period of time.

9. The job plan detail

- 9.1 The job plan will outline the consultant's commitments to the NHS and, for clinical academics and NHS consultants with academic components to their job, to the university. It should include:
- a timetable of activities
 - a summary of the total number of PAs of each type in the timetable
 - on-call arrangements i.e. supplement category and rota
 - a list of agreed SMART objectives
 - a list of supporting resources necessary to achieve objectives
 - a description of additional responsibilities to the wider NHS and profession (including external duties)
 - any arrangements for additional PAs
 - any details of regular private work
 - any agreed arrangements for carrying out regular fee-paying services
 - any special agreements or arrangements regarding the operation/interpretation of the job plan
 - accountability arrangements
 - any agreed annualised activity.

The main components of the job plan are covered in [annex 1](#).

10. Annualisation

- 10.1 Increasingly, consultants and employers are finding that it is not easy or desirable to agree fixed weekly job plans. Sometimes working patterns simply change too regularly to effectively accommodate or represent their work in any single week. Others want to arrange their work so that they can spend the maximum amount of time at home with their families and would like, for example, to have as much leave during school holidays as possible.
- 10.2 Equally, employers may find that work varies in its intensity and efficient employment of staff at the right times can save time and money. Annualisation of all or part of job plans or agreed annual numbers of certain activities (quanta), for example clinics can enable employers and consultants to match variations in demand with the available resources.
- 10.3 Annualisation is an approach to job planning in which a consultant contracts with their employer to undertake a particular number of PAs or activities on an annual, rather than a weekly, basis. Most consultants are used to carrying out at least part of their work on an annualised basis where the on-call commitment varies from week to week.
- 10.4 As with all aspects of job planning the decision whether to annualise a job plan or not must be by mutual agreement. At the outset, employers and consultants should agree that activity relates to measureable outputs and that arrangements reflect the professional nature of the consultant contract and consultants' continuing responsibility for care as described in [the GMC's Good Medical Practice](#). At the same time employers should clarify a consultant's responsibilities when they are not scheduled to work and not undertaking any other planned activity, on-call or when they are on leave, for example whether they are required to return to work in the event of an emergency.

Key principles of annualisation

- Annualisation is a flexible working arrangement which needs to meet both the needs of the individual and employer. It is a method which both parties to this guidance are seeking to promote widely. Consultants work an agreed annual total of programmed activities instead of the same number each week.
- An alternative approach is for there to be an agreement as to the number of specific activities, for example out-patient clinics, to be delivered over the year.

From the 2003 model contract (7.2):

You and your clinical manager may agree, as part of your Job Plan, arrangements for the annualisation of Programmed Activities. In such a case, you and your clinical manager will agree an annual number of Programmed Activities and your Job Plan will set out variations in the level and distribution of Programmed Activities within the overall annual total.

You and your clinical manager may agree, as part of your Job Plan, other arrangements for flexible scheduling of commitments over an agreed period of time.

- Either arrangement must be compatible with the consultant contract and job planning best practice. This provides for working time measured in programmable activities and also for paid leave.
- The arrangement must be agreed. As for job plans, this agreement is between the consultant and their clinical manager.
- Agreement must be reached on how many programmed activities or specific activities (quanta) are to be done in a year.
- For programmed activities this is usually expressed as a mean number per week multiplied by the number of weeks in the working year. For example, on a ten-PA fully annualised contract, this would be the number of weeks in the working year multiplied by ten.
- For individual components (e.g. clinics, lists) this is usually expressed as the number normally undertaken in a week multiplied by the number of weeks in the working year.
- The number of weeks in the working year is not a fixed number. It is equal to 52 less the number of weeks granted as leave (annual, study, professional). This number will vary for individuals and cannot be assumed to be 42 or any other fixed number. Using the previous year as a guide, it should be possible to estimate prospectively the number of weeks leave that will be taken. If during the year it becomes apparent that significantly more or less leave than anticipated will be taken then the annualised total should be reviewed and adjusted as appropriate.
- Both parties should agree on the outputs and outcomes expected from activity in the job plan, and the means by which they will be measured and reported.
- Employers and consultants should agree the arrangements by which consultants notify them when objectives or agreed levels of activity are not being met. These arrangements may form part of a wider system of review which tracks progress against objectives; is able to take into account changing circumstances and other external factors and allows for agreed modifications in the job plan where necessary.
- Programmed activities do not always run to exactly the scheduled time and a professional approach should be taken to this. In the short term such variances will often balance out but if an activity consistently lasts longer or for less time than the PA time allowed then an interim job plan review should be held.
- Both consultant and employer should keep an idea of where they are against their annualised total. In some circumstances, a minimum number of PAs per week or month may need to be agreed for annualised plans so that activity can be delivered in a predictable manner. There should also be agreement on the frequency and nature of reporting arrangements so that any issues arising can be dealt with within a timeframe that allows reasonable changes to be made.
- It is important that the delivery of annualised clinical activities aligns to patient demand/ waiting times and the capacity of the service to deliver. It is important, therefore, that agreement is reached on when the annualised activities will be delivered to meet these.

There is no one agreed or recommended way of annualising a job plan. Different methods will work for different situations. The following are examples of how job plans can be annualised. What they share is an adherence to the principles set out above.

Example A: Term time working

Consultant A wishes to spend as much time during the school holidays at home. He or she then arranges their job plan on an annualised basis so that all their elective direct clinical care (DCC) and emergency work is carried out during term time. Supporting professional activities (SPAs) are worked partly during term time and partly during the school holiday periods. This is how the job plan is worked out:

Assumptions

- Consultant A does 1 PA of unpredictable on call work per week and 6.5 elective direct clinical care work.
- There are 35 weeks of term time per year and 17 weeks of school holiday time.
- All annual leave (6 weeks plus 2 weeks of bank holidays and extra days = 8 weeks) will be taken during the school holidays.
- A week of professional leave will be taken to teach on a postgraduate course.
- That leaves 43 weeks during which Consultant A must work – 430 PAs per year (based on a 10 PA contract).
- Consultant A will work all their DCC programmed activities (PAs) in the 35 weeks of term time. SPAs will be worked over both term time and school holiday time.
- Study leave will be handled on an ad-hoc basis.
- On-call duties falling during school holidays will be swapped as they would be for annual leave.

The detail

| | Weekly equivalent (52 weeks) | School holidays (18 weeks) (PA per week) | Term time (34 weeks) (PA per week) |
|--|---------------------------------|--|--|
| Direct clinical care (DCC) | 7.5 | 0 | 9.45 |
| Supporting professional activities (SPAs) | 2.5 | 3.5 | 1.4 |
| Total programmed activities (PAs) per week | 10 | 3.5 | 11.9 |
| Total programmed activities (PAs) per year | | 63 | 369 |

- During term time consultant A will work on average an 11.9 PA week consisting of 9.45 DCC and 1.4 SPAs.
- During the school holidays and during leave consultant A will do just 3.5 PA per week of SPAs only.
- These proportions can be adjusted according to the needs of both consultant A and the trust.
- Over the year, consultant A will deliver a total of 432 PAs.

Example B

- Consultant B works 5 DCC PAs per week but would like to work this out on an annualised basis.
- Consultant B takes a total of eleven weeks (55 days; 110 half-days) of approved leave (for bank holidays, annual leave, study leave, professional leave and sick leave).
- This leaves 41 weeks so that means that 205 PAs should be carried out during the rest of the year.
- SPAs can be worked out in a similar way.

Example C

- The consultants and the trust agree that workload for acute medicine is greater during the winter months and therefore, on average three months are spent working a 12 PA week.
- During the summer months, workload is eased and thus the consultant works three months at 10 PAs per week.
- The consultant's salary is maintained at 11 PAs across the year. This is a simple form of annualisation which may be useful for specialties with a seasonal variation in workload.

Example D

- An agreement is reached that a consultant who nominally undertakes two out-patient clinics per week and has a working year of 42 weeks, to deliver 84 clinics per year.
- Flexibility is provided by the employer that this can at times be delivered at different times in the week than may have been nominally indicated on the weekly timetable.
- Without this flexibility, this annualisation would not have led to a different outcome than a rigid weekly job plan.

11. Locums

- 11.1 Employers should agree job plans with locums which take into account their familiarity with local systems and processes and the extent to which their potential contribution may differ from that of their established colleagues. The job plan may be different to that of the consultant they are replacing, and they may deliver proportionately more direct clinical care. Employers should allocate a standard level of SPA time to allow locum doctors to meet college and other external requirements. Many trusts have determined this to be between 1 and 1.5 PAs.

12. Clinical academics

- 12.1 For clinical academic staff and NHS staff with a substantial academic component to their job, there should be an established mechanism for the university and the NHS employer to agree both general and specific arrangements for employment on a regular basis and, in particular, in advance of individual consultant job planning sessions.
- 12.2 Areas which have caused difficulty for individual consultants in the past include:
- arrangements for annual leave
 - support for continuing medical education (CME)/continuing professional development (CPD), including study leave
 - SPA time
 - special leave including maternity leave
 - contracted private practice
 - annualisation
 - additional programmed activities
 - pensions
 - continuity of service
 - division of teaching time, both undergraduate and postgraduate
 - research for the NHS
 - the contribution of the individual versus that of the team.

It is expected that there is a functioning LNC process with academic representation to which some of these issues may be referred for local resolution.

- 12.3 The employment of clinical academics is determined by the principles of the Follett review. Duties of a clinical academic should be set out in a single integrated job plan which covers the whole of the clinical academic's professional duties for both the substantive and honorary employer. A nominated representative of both the substantive employer and honorary employer should be present with the clinical academic at the job planning meeting. The job plan must be jointly agreed by all parties and must include the clinical academic's management and accountability arrangements to both employers.
- 12.4 Clinical academic contracts vary both between and within the nations of the UK. The typical types of contract are an integrated contract, an A+B contract and a secondment. There is also a variation on the balance of work between the academic and clinical components. Clinical academics may also be employed by organisations other than universities, such as the Medical Research Council, pharmaceutical companies or by the NHS and funded by the National Institute for Health Research. The special nature of the clinical academic consultant's job derives from its two major components, academic and clinical, which are of equal importance and together make up the integrated workload. It is expected that the separate components of a clinical academics job plan fit together as an

integrated job rather than as separate jobs. It is expected that all the major criteria for employment and progression would be discussed at the job planning meeting rather than be subject to separate discussions with each employer.

- 12.5 The NHS and university employers should, therefore, make themselves aware of their respective expectations of the employee. It is expected that, in advance of the job planning meeting, there is an established mechanism for the two employers to meet and discuss both the general arrangements under the contract (such as, leave, continuity of service and continuing professional development) and to prepare for the job planning meeting itself. Job planning should take account of the likelihood of medical or clinical responsibilities resulting in emergency care that may impact on other scheduled responsibilities.
- 12.6 Those involved in the job planning must be aware of the importance of giving appropriate priority to NHS and university work, with clear delineations as to when a consultant is undertaking work for which employer. Whilst the substantive employer is responsible for determining and approving leave arrangements on a practical level this can mean ensuring that the proposed leave arrangements are approved by both the trust and university requirements and appropriately recorded.
- 12.7 The university and NHS should define and agree the allocation of time needed to deliver the continuing professional development for and revalidation of the consultant.
- 12.8 In the case of NHS consultants who undertake academic activity for a university, such as undergraduate teaching or research activities away from their principal place of employment, job plans should take full account of both university and NHS commitments and should be agreed jointly. For such consultants all SPA time is regarded as NHS.
- 12.9 Employers should ensure that the whole team understands the relationship of clinical academic staff to the team and the benefits that they bring to the organisation. They should make it clear that the clinical work of clinical academics is subject to the same clinical governance arrangements as NHS consultants.

Annex 1: Job plan components

This section looks at the component parts of the job plan and in some cases suggests ways in which the flexibilities contained within the consultant contract can be used to support the job planning process.

The basic timetable

The full time commitment is for 10 programmed activities (PAs) of 4 hours each (3 hours in premium time). These may be divided into any of the following categories as defined in the terms and conditions of service:

- direct clinical care
- supporting professional activities
- additional responsibilities
- external duties
- academic activities.

Direct clinical care

Direct clinical care (DCC) is work that directly relates to the prevention, diagnosis or treatment of illness that forms part of the services provided by the employing organisation under section 3(1) or section 5(1)(b) of the National Health Service Act 1977. This includes:

- emergency duties (including emergency work carried out during or arising from on-call)
- operating sessions including pre-operative and post-operative care
- ward rounds
- outpatient activities
- clinical diagnostic work
- other patient treatment
- public health duties
- multi-disciplinary meetings about direct patient care
- administration directly related to the above (including but not limited to referrals and notes).

On-call duties

A consultant's 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) should also be prospectively built into timetables as direct clinical care PAs. There is no limit on the amount of predictable on-call work that can be allocated to DCC PAs 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 PAs in the job plan. The allocation can be adjusted at 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 consultant's on-call duties, for example recall to hospital to operate on an emergency basis.

Box 1. On-call categories

Availability supplement

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

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

| | Category A | Category B |
|--------------------------------------|------------|------------|
| High frequency: 1–4 consultants | 8.0% | 3.0% |
| Medium frequency: 5–8 consultants | 5.0% | 2.0% |
| Low frequency: 9 or more consultants | 3.0% | 1.0% |

Prospective cover

If the consultant covers colleagues' on-call duties when they are away on study leave and annual leave, this prospective cover should be taken into account when assessing the workload for both types of emergency work. With six weeks annual leave, on average two weeks study leave and statutory days, it is likely that this could mean another ten weeks of each colleague's duties. This could mean an average out of hours workload 24 per cent greater in the week and 18 per cent greater at weekends than that measured when nobody is on leave. Prospective cover is not taken into account when calculating the on-call supplement.

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

Example: A consultant works on two different on call rotas; 1 in 14 and 1 in 8, over a 112 week period he will be on call.

- 8 times on the 1:14 rota
- 14 times on the 1:8 rota

This is equivalent to 22 times in 112 weeks or 1 in 5.09.

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.

Additional/extra programmed activities

The ability to agree extra programmed activities is a useful means for dealing with peaks of activity and other short term pressures, but should be regarded as a temporary and short term measure. In some cases this may be a more effective solution than appointing extra staff.

Provision is made within the terms and conditions for two types of extra-contractual PAs (for practical purposes these can be used interchangeably):

- 1 Extra PAs are referred to in Schedule 6 of the terms and conditions as those that are linked to spare professional capacity. Consultants wishing to undertake private practice as defined, and who wish to remain eligible for pay progression, are required to offer up the first portion of any spare professional capacity (up to a maximum of one PA per week).

Where a consultant intends to undertake such work, the employing organisation may, but is not obliged to, offer the consultant the opportunity to carry out up to one extra PA per week on top of the standard commitment set out in their contract of employment. Schedule 6.2 of the terms and conditions sets out the provisions regarding putting offers to consultants and the periods of notice required. There is flexibility to agree a fixed number of extra PAs to be undertaken as required over the course of the year and NHS organisations may find this provision particularly helpful in that arrangements can be tailored to reflect varying service needs. One approach, for example, is to assess on a departmental basis how many extra PAs are likely to be required during the course of a year to increase capacity temporarily, for example for waiting list work; to cover clinics and lists; or to cover a vacancy. The employer can then contract for an agreed number of extra PAs with those consultants willing to work them.

- 2 Additional PAs are not linked to spare professional capacity but may be used to reflect regular, additional duties or activities (whether scheduled or unscheduled) that cannot be contained within a standard ten PA contract. They can be used, for example, to recognise an unusually high routine workload, or to recognise additional responsibilities. In this context “regular” is not intended to necessarily imply “at the same time each week or month”.

The terms and conditions provide flexibility for employers and consultants to agree to contract for additional PAs for a variety of purposes, although no consultant can be compelled to agree to a contract containing more than 10 PAs.

Supporting professional activities

These are activities that underpin direct clinical care. They may include:

- participation in training
- medical education
- continuing professional development
- formal teaching
- audit
- job planning
- appraisal
- research
- clinical management
- local clinical governance activities.

Used effectively, supporting professional activities will benefit the individual, the organisation and the wider NHS as consultants take time to enhance skills, extend knowledge, work on quality improvement initiatives, undertake academic research and lead and develop others in pursuit of the common aim of improving the patient experience. However, like any other resource, SPAs should be deployed to support the individual consultant in achieving their own agreed objectives and those of the team and organisation in which they work.

The consultant contract currently provides for a typical weekly split of 7.5 Programmed Activities to 2.5 SPAs. However this is not a universal allowance and the job planning process should develop a range of SPA activities for individuals linked to personal continuing professional development (CPD) requirements and the agreed needs of the team of consultants and the service. Therefore, there may be variation in the number of SPAs, and in the range of activity, within individual job plans.

The Academy of Medical Royal Colleges estimates that 1 to 1.5 SPAs per week is the minimum time required for a consultant to meet the needs for CPD for revalidation purposes. CPD activities encompass clinical, personal, professional and academic activities. Additional SPA time should be linked to organisational objectives, such as, research, clinical management or medical education roles.

Like direct clinical care, all SPAs should be based on SMART objectives and measurable outcomes. There should be clarity on the core content and expectations around activity, such as, audit, CPD, revalidation. There may be flexibility on timing and location of activity

but this must be agreed between the employer and the consultant in order to help service planning. It should be clear that time set aside for SPA activity should only be spent on those elements identified within the job plan and not on any other activity.

Where an activity for a clinical academic is funded from or, is part of an NHS requirement this should also be included in the allocation of SPAs. At present, only the NHS employers are required to support SPA activity. This will almost certainly change with the introduction of revalidation. Examples of NHS activity carried out in the clinical workplace and which require an SPA allocation may include clinical undergraduate teaching funded by Service Increment for Teaching (SIFT) and NHS research and development activity funded by an NHS organisation.

External duties and additional NHS responsibilities

In addition to direct clinical care and supporting professional activities, consultants often have extra responsibilities to undertake, such as being a clinical director or working from time to time for a royal college. Where the work is regular, it should be set out and scheduled. Where it is irregular, an allocation of PAs can be agreed or there could be a substitution for other activities.

It is just as important to discuss potential commitment to external duties as part of the preliminary team discussion so that:

- the impact on service can be assessed and managed
- any potential benefits to the organisation can be identified
- there is fairness and transparency between team members at the outset.

The opportunities to contribute in this way arise during the course of a career and both the timing and relevance of the proposed external activity may be a subject for discussion within the team on the understanding that individuals may wish to take up additional responsibilities at different stages in their careers. Consultants and employers should agree outcomes for this activity and arrangements for reporting back to the employer.

An alternative way of recognising management and other additional duties is through a responsibility allowance payable under Schedule 16 paragraph 15 of the terms and conditions. The Department of Health endorses the importance to the wider NHS of work beyond local healthcare delivery.

Additional NHS responsibilities

These are special responsibilities, which are agreed between a consultant and the employing organisation and which cannot be absorbed within the time that would normally be set aside for supporting professional activities. Some examples include:

- medical director
- a director of public health
- clinical director or lead clinician
- acting as a Caldicott guardian
- clinical audit lead
- clinical governance lead

- undergraduate dean
- postgraduate dean
- clinical tutor
- regional education adviser.

External duties

External duties are those duties not included within the definition of fee paying services or private professional services, but undertaken as part of the job plan by agreement between the consultant and employing organisation. Some examples include:

- trade union duties
- undertaking inspections for the Care Quality Commission
- acting as an external member of an Advisory Appointments Committee
- undertaking assessments for the National Clinical Assessment Authority
- reasonable quantities of work for the royal colleges in the interests of the wider NHS
- reasonable quantities of work for a government department
- specified work for the General Medical Council.

It is accepted that undertaking external duties such as these brings benefit to the wider NHS. However, trusts and consultants need to minimise the impact on the delivery of service and the ability of consultants to deliver their agreed job plan outcomes. In some cases, external bodies reimburse individuals or trusts for such work. Even when this is the case trusts and consultants need to consider any support costs and the potential effect on workload for the wider team.

Team based job planning and agreements between the consultant and clinical director and the level of flexibility needed to deliver the trust and external needs should be discussed at the job planning meeting.

Administration

Administration relating to individual patient care (letters to colleagues, notes, triage etc) will fall into direct clinical care activities. Other administration may be categorised as supporting professional activities (SPAs).

Annual Leave

Managing annual leave consistently and fairly across the team can sometimes be difficult. A project carried out by the large scale workforce change team on the consultant contract found that reviewing, strengthening and clarifying leave policies across the consultant resource can help trusts to improve services. Electronic rostering systems are available and have been used to manage leave and align different staff groups to deliver activities. They are not a mechanism for undertaking job planning but rather a means to enable the delivery of the activities agreed in the job plan.

A week, for the purpose of annual leave entitlement, consists of whatever constitutes the consultant's normal working week. So for a consultant (whether part time or full

time) who works a three-day week, a week's leave entails three working days off. Leave cannot apply to a day when no work is scheduled to take place. Annual leave entitlement (days per annum) is based on the assumption that the normal working week is five days. Therefore, if the timetabled working week is only day days, the annual leave entitlement is based on the pro-rata calculation of $3/5 \times$ annual entitlement equals the annual leave for entitlement for that individual.

Taking an extreme example, it is possible that a consultant could deliver their contractual commitment in two days of work. If a consultant in that position took all their leave in individual days rather than weeks (on the assumption that 6 weeks = 30 days), they could spend several months away from the hospital. Although this is an extreme example, the principle that such a way of using leave is not consistent with professionalism and is unfair on his/her colleagues can be easily understood. In this case, the annual leave entitlement could be expressed as $2/5 \times 30 = 12$ days.

Consultants should aim to take their leave to impact proportionately on their DCC and SPA (and external duties) activities.

Employers and consultants should take a flexible and pragmatic approach to planning annual leave. There should be a clear policy for each rota setting out the maximum number of individuals who can be on leave at any one time in order to maintain on-call and service delivery cover. It would be helpful to discuss annual leave prospectively as a team in order to plan for seasonal fluctuations and service variation and to ensure openness and fairness in allocating annual leave. Teams should share leave policies to assist with wider service planning and to allow for business continuity.

Where it is difficult to account for leave in weeks it may be useful to consider using one of the two following approaches:

- the job plan could be annualised, describing the consultant's work commitment; what remains is leave
- recognising that the 2003 contract is based around PAs, it may be more straightforward to calculate leave on a PA basis rather than by days or weeks. For example six weeks of leave on an 11 PA contract amounts to 66 PAs of annual leave. Direct clinical care PAs and SPAs should be taken as leave in the same proportions as allocated in the job plan. Bank holidays are fixed and are in addition to the above entitlement.

Annual leave arrangements for clinical academics are determined and approved by the substantive university employer, however it is necessary for consultation to take place with the NHS employer to ensure that agreed clinical commitments can be met.

Location

The contract will state the principal place(s) of work and consultants will generally be expected to undertake programmed activities at agreed locations. However, there is the facility to agree off-site working where appropriate. A rigid approach may not be feasible where, for example, office space or resources are limited. The focus should be on what outcomes are achieved rather than on where they are achieved.

Travelling time

Travelling time to and from the usual place of work is not included. However, travel between sites and for on-call duties is included within the PA for which the travel is necessary. Travelling time for emergencies is also included. In allowing for travel time employers and consultants should clarify and agree what constitutes the normal place of work. This could include any location within the trust rather than a specific location. Where sites are spread out and there is regular travel between them employers should consider agreeing standard travel times applicable to all staff.

Lunch breaks

A proper balance of work and rest is vital to maintain a healthy workforce. It is recommended that consultants have adequate breaks from clinical work during the day. However the nature of many consultants' work means that it is rarely possible for them to absent themselves from clinical duties and have a total break. This necessary professional attitude to patient care means that during a day of clinical activity it is unlikely that many consultants will be able to free themselves from potential interruption to take an unpaid lunch break. Consultants normally exercise their judgement in taking breaks flexibly, at times chosen to minimise disruption to patient care and to promote the safety of patients.

Timing

PAs may be planned in whole or half units. Consultants may elect to use smaller units where appropriate with agreement with their employer, to provide for greater flexibility. Many trusts have agreed to pay down to levels of 0.25 PAs.

Attaching a timed value to PAs is intended to provide greater transparency. However flexible arrangements can be agreed such as averaging duties over a period of time to allow for variable childcare commitments. Annualisation can be useful for this. Such agreements should be documented in the job plan.

Premium time

Any programmed activity undertaken outside of the hours 7am to 7pm, Monday to Friday, is regarded as taking place in 'premium time'. This means that a programmed activity at these times lasts only 3 hours instead of 4 hours. Alternatively, an agreement for an enhanced rate of pay may be reached.

Non-emergency work in premium time, like all work, should only be undertaken through mutual consent. Non-emergency work for these purposes includes the regular, programmed work of consultants whose specialty by its nature involves dealing routinely with emergency cases, for example, A&E consultants. Noting the strong evidence of the benefits of consultant delivered care, teams should discuss with their managers how to cover non-emergency work in premium time as part of the objective setting discussions in advance of the job planning meeting. Consultants retain continuing professional responsibility for the care of their patients and a team based discussion should help to find fair and equitable ways for employers and consultants to meet this responsibility together to enhance the quality of patient care.

Private work

The Code of Conduct on Private Practice established the principle that the provision of services for private patients should not prejudice the interests of NHS patients or disrupt NHS services. Other than in an emergency, NHS commitments should take priority over private work.

The job plan should include details of any private work carried out. Consultants should identify any regular private commitments and provide information on the planned location, timing and the broad type of work done to ease effective planning of NHS work and any out-of-hours cover.

The code also states that effective job planning should minimise the potential for conflicts of interest between different commitments. Employers and consultants should be clear about the implications of not delivering the job plan because of the impact of private practice. Other than in the circumstances described in paragraph 5 of Schedule 8 of the terms and conditions, undertaking private work when on-call could amount to breach of contract.

Employers and consultants should recognise that the nature of NHS work may vary and at times impact upon private commitments, which may have to change as a result. Any change should take place after a reasonable period to allow consultants to rearrange sessions and fulfil binding or contractual commitments that they may have. The job plan should recognise the potential for consultants to be called in for sudden, unexpected events if they are available. Successful integration of private work and NHS commitments will depend on both parties having all the information available on the full range of activity.

Except where immediate care is justified on clinical grounds, consultants should not, in the course of their NHS duties and responsibilities, make arrangements to provide private services, nor should they ask any other NHS staff to make such arrangements on their behalf unless the patient is to be treated as a private patient of the NHS facility concerned.

Employers, consultants and other NHS staff should be clear about the need to take out professional indemnity for private practice and fee paying work. Employers are not responsible for a health care professional's private practice, even in an NHS hospital. However, where junior medical staff, nurses or members of professions supplementary to medicine are involved in the care of private patients in NHS hospitals, they would normally be doing so as part of their NHS contract, and would therefore be covered. It remains advisable that health professionals who might be involved in work outside the scope of their NHS employment should have professional liability cover.

Category 2 work is by definition not undertaken for the employing NHS body and is therefore not covered by NHS indemnity. Unless the work is carried out on behalf of the employing NHS body, professional liability cover would be needed.

In establishing any limits on the extent to which consultants may undertake private practice, employers should take account of the recommendations contained in the report of the Co-operation and Competition Panel (CCP). The report concluded that patients and taxpayers could only be expected to benefit overall from a restriction on a consultant's ability to work for other providers in two limited situations:

1. Restrictions imposed on an individual consultant to address legitimate patient safety concerns arising from the specific performance of that consultant.
2. Restrictions that prevent a consultant from:
 - holding strategic management positions (at clinical director and above) in more than one organisation
 - holding a strategic management position in one organisation while assisting another organisation to tender for NHS funded services
 - assisting more than one organisation to respond to the same tender for NHS-funded services.

Paragraph 25 of Schedule 9 of the Terms and Conditions reaffirms the guidance contained within the Code of Conduct on Private Practice that consultants should make all reasonable efforts to support initiatives to increase NHS capacity. This is consistent with the overarching aim of the job planning process which is to improve the quality of services and the patient experience.

Category 2 work/fee-paying services

There is a basic principle within the contract that consultants should not be paid twice for the same work and that any extra-contractual work should not conflict with and only cause minimal disruption to NHS duties. However a consultant and his/her employer can agree for category 2 and fee-paying work to continue with the consultant retaining the fee if:

- the work causes minimal disruption to NHS work
- the work is undertaken in the consultant's own time (i.e. on leave or out of NHS hours or by 'time-shifting', where this is appropriate, ie without cancelling or curtailing clinics).

It may be that the employer and the local negotiating committee (LNC) can agree a protocol for how fee-paying work will be treated within the trust. Many services, such as work for the coroner, depend upon a flexible approach being adopted in this area by both sides, and this is ultimately in the best interests of patients and the wider NHS. It is essential that consultants ensure that there is no conflict between such work and their NHS work. Flexibility in job planning is the best way to achieve this.

Private practice and fee-paid work by clinical academics

In some cases fee-paid work undertaken by clinical academics forms part of their work for the university with the fees remitted back to the university. The consultant does not, therefore, benefit directly from this work.

Annex 2: Annual review, mediation and appeals

Job plans must be reviewed annually. Information arising from annual appraisal could inform this process, and so it is sensible to link the timing of the job plan review to some time after appraisal. The review should consider:

- factors affecting the achievement of objectives
- adequacy of resources
- potential changes to duties or responsibilities
- ways to improve workload management
- planning of careers.

This will be a significant meeting and will play an important part in determining pay progression. It will be a chance to clarify any changes to workload and any issues around supporting resources.

It is good practice for clinical directors to keep a regular review of progress against objectives for all consultants. This may be informal, or should it become necessary, more formally through an interim review.

Interim review

Either party may request an interim review where duties or needs have changed during the year or where there is a substantial risk of failure to meet an objective.

Mediation

If there is disagreement about a job plan, the next step is mediation. Mediation is an informal process normally led by the medical director (unless he or she has already been involved in the disputed plan) for resolving disagreements. The mediator will first meet the consultant and the clinical manager separately; all three meet together subsequently. This will normally be within four weeks of referral.

As soon as there is formal disagreement the consultant should request mediation by writing to the medical director and consider copying the letter to the director of human resources and LNC chairman. This request must be made within two weeks of the failure to agree.

In preparation for the mediation meeting the following should be considered by both sides:

- the nature of the disagreement
- the reasons for their position
- the evidence for their point of view

- the consequences of alternative job plans
- their ideas for reducing hours worked if the number of PAs is the cause of the disagreement.

Evidence brought to the mediation meeting will depend on the nature of the disagreement, but may include:

- work diaries
- workload or activity statistics
- corroborating letters from external organisations
- comparison with agreed job plans of other consultants in the same or different organisations
- speciality/college 'best practice' advice
- Care Quality Commission (CQC) visit information
- NICE guidance.

The mediation meetings involve only the mediator, the consultant and the clinical manager. If agreement is reached, the job plan should be signed off within five working days. If mediation does not resolve the differences, a formal appeal should be lodged.

Appeals

A formal appeal panel will be convened when it has not been possible to resolve the disagreement using the mediation process. An appeal is lodged according to Schedule 4 of the terms and conditions. The panel will consider the dispute, taking into account the consultant and the trust management's views, and will make a formal recommendation to the trust board within two weeks of the appeal being heard. It is expected that the trust board will normally accept the recommendation.

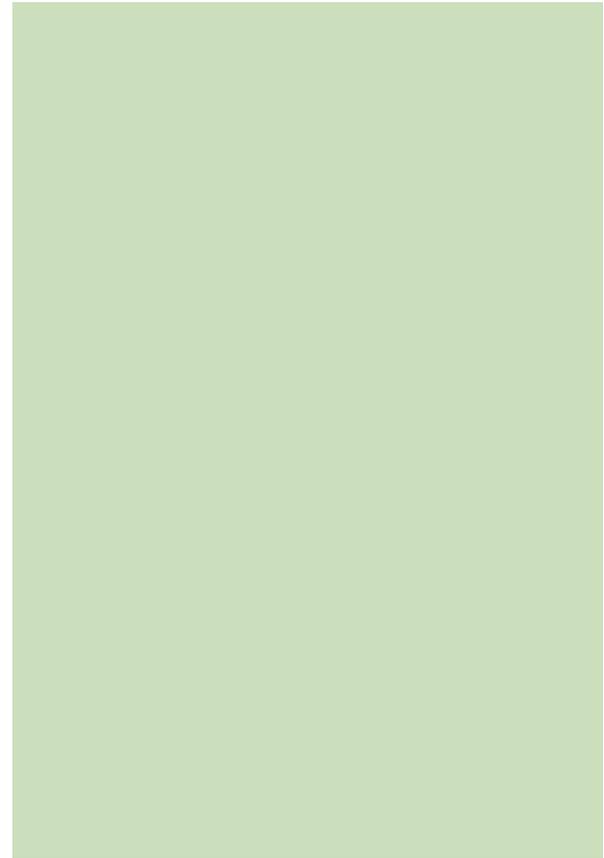
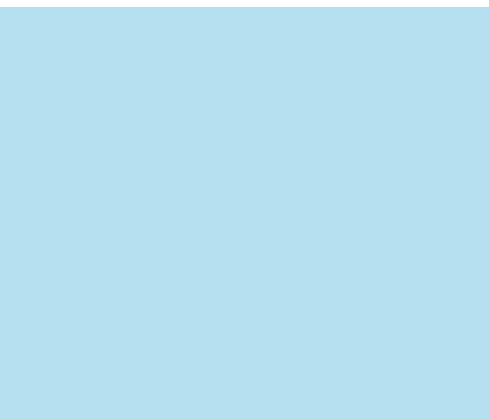
Clinical academics

A similar mediation and appeals process exists in the academic sector, but involves both employers. Please refer to the [honorary consultant contract \(England\)](#) for further information.

Annex 3: The Follett review

Below are some of key recommendations of the Follett review of appraisal, disciplinary and reporting arrangements for senior NHS and university staff with academic and clinical duties:

- The key principle for NHS and university organisations involved in medical education and research should be 'joint working to integrate separate responsibilities'.
- University and NHS partnerships responsible for medical education and research should establish joint strategic planning bodies, with joint subsidiary bodies responsible for staff management policies and procedures for staff with academic and clinical duties.
- Universities and NHS bodies should formally make all senior NHS and university staff with academic and clinical duties fully aware to whom they are accountable for the separate facets of their job.
- The key principle of joint working to integrate separate responsibilities should be applied to the management of senior NHS and university staff with academic and clinical duties.
- The job descriptions for new and replacement senior NHS and university staff posts with academic and clinical duties should be jointly prepared and formally agreed by both partners prior to advertisement.
- Substantive and honorary contracts for senior NHS and university staff posts with academic and clinical duties should be explicit about separate lines of responsibility, reporting arrangements and staff management procedures, and should be consistent, cross-referred and issued as a single package.
- The substantive university contract and the honorary NHS contract for clinical academics should be interdependent.



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