Liverpool University Hospitals
NHS Foundation Trust

Consultant Job Planning- Policy

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Version:	1		
Ratified by:	Local Negotiation Committee		
Ratification Date:	February 2023	**Review Date:**	February 2025
Consultation	HR Policy Group	**Applicable to:**	All staff All Sites
Equality, Diversity And Human Right Statement	The Trust is committed to an environment that promotes equality and embraces diversity in its performance both as a service provider and employer. It will adhere to legal and performance requirements and will mainstream Equality, Diversity and Human Rights principles through its policies, procedures, service development and engagement processes. This procedure should be implemented with due regard to this commitment.		
To be read In conjunction with / Associated Documents:		**Information Classification Label**	☐ **Unclassified**
Access to Information	To access this document in another language or format please contact the policy author.		

Document Change History (changes from previous issues of policy (if appropriate):

Version number	Page	Changes made with rationale and impact on practice	Date

Contents

1. Purpose

1.1 Consultant job plans should support the well-being of individual consultants and promote the delivery of timely quality patient care in a sustainable working pattern whilst also providing adequate time for continuous professional development and revalidation.

1.2 This policy provides a framework for the professionalisation of non-patient facing roles that support the professional activities required to manage our services and meet our educational and research goals, whilst acknowledging the substantial discretionary effort that consultants at LUHFT (Liverpool University Hospitals NHS Foundation Trust) deliver.

1.3 The aim of this policy is to describe the job planning processes and requirements for all Consultant doctors and dentists employed across LUHFT.

1.4 It sets out the key principles for professional job planning, details roles, responsibilities and time frames for the job planning process and sets out details of how time should be recorded within the electronic Job Planning system (Allocate codes).

1.5 The policy is consistent with the Consultant Contract (2003) and is informed by the BMA (British Medical Association) guidance and NHS Employers “Guide to Consultant Job Planning (2017)”.

1.6 The policy replaces all previous LUHFT job planning policy and guidance and has been coproduced with the LNC (Local Negotiating Committee).

1.7 This document is designed to be a comprehensive guide for both the consultant whose job- plan is being discussed, and their clinical lead with whom they are discussing it. This means, for example, that there is additional information about Trust processes for the oversight of the job planning process across the whole organisation, which is not directly relevant to individual consultants.

1.8 We hope, by being comprehensive, it will improve the understanding of job planning for all involved. All Trust policies are living documents. Please feedback on anything which you feel could be clearer or any gaps of information or process we should fill.

2. Scope

- To provide each consultant with an accurate job plan that sets out the agreed number of programmed activities and on-call commitments they will undertake. This will also include a clear and detailed understanding of the duties agreed to be performed within that time and the location of where the activity will take place.

- To recognise and acknowledge the work that consultants undertake and provide assurance that this is aligned with the Trust improvement plan and clinical strategy.

- To agree how the Trust will support consultants in delivering their responsibilities.

- To effectively prioritise the work of consultants and reduce excessive workload, whilst improving well-being and ensuring value for public money.

- To provide the consultant with evidence for appraisal and revalidation.

What is new in this version?

- This is a renewed policy merging the previous Consultant Job planning policy and the supplementary operational guidance for implementation.

- It describes the process of departmental and individual job planning with agreed DCC (Direct Clinical Care) and SPA (Supporting Professional Activity) tariffs for professional non-patient facing roles within clinical teams and our site-specific structures e.g., Clinical Director, Governance lead, Mortality lead, SAIL (Specialty Audit and Improvement Lead), and other locally defined roles.

- It provides a framework to align departmental SPA activity and individual SMART (Specific, Measurable, Achievable, Realistic, Time-limited) objectives with our Improvement plan and clinical strategy.

3. Policy Content

3.1 Accuracy

3.1.1 For a job plan to have value for the individual and the Trust, it should accurately reflect the work provided by the consultant. There are no artificial limits or restrictions to the contents of a consultant's job plan. Care and service provided can be complex. Creating a functional job plan requires both an understanding of the job and an understanding of the most appropriate way that it can be recorded on the job-planning software.

3.1.2 Accurate recording of the contributions made to undergraduate teaching is an essential element of the relationship between the Trust and the University of Liverpool. At present almost all consultants have 0.25 within their SPAs to reflect this work.

3.1.3 In addition to work provided for the Trust, the job plan may include external duties essential for the delivery and organisation of medical care and education. The Trust recognises that this 'non-clinical work' is essential and should not just be supported but actively encouraged.

https://www.england.nhs.uk/mids-east/wp-content/uploads/sites/7/2014/11/non-standard- clinical-work-revalidation.pdf
https://www.england.nhs.uk/publication/appropriate-release-of-medical-colleagues-for-the- purposes-for-carrying-out-work-for-the-wider-health-system/

3.1 Dialogue

The job planning process should be a dialogue between the consultant and their clinical manager. Whilst it might sometimes be helpful to have other inputs to the process, these contributions are best made outside the job-planning meeting. To have an asymmetrical job- planning meeting with more than two participants can make discussions unbalanced, which is contrary to the principles of good job-planning practice.

3.2 Consensus

After accuracy, the next most important principle of the job planning process is that the final sign-off of the job plan is by mutual agreement. The route to consensus is usually straight- forward. If problems arise there are clear pathways in the policy to resolve any disagreements.

3.3 Consistency and Fairness

Recognising that every consultant's job plan is different, the principles of fairness and consistency should apply across specialties, sites and roles. Training of those involved

in the job-planning process and the nature of job-planning software will promote fairness and consistency.

3.4 Efficiency and Optimal Use of Knowledge, skills and experience

The Trust recognises that the pressures placed on the NHS, along with expediency and pragmatism, can result in consultants undertaking work which may be more efficiently and economically delivered by other clinical staff. Where this can be identified in the job-planning process, it may aid those developing business cases for a more efficient service.

3.5 Work Life Balance

The Trust recognises that even 10 session job-plans can place pressures on work-life balance. We encourage all those involved in the job-planning process to recognise the risks of burn-out and to keep the long-term interests of the consultant (and therefore the Trust) at the forefront of the planning process. It is not just the total hours of work but also the content of the work which should be sustainable and satisfying.

3.6 Responsive

When a substantive change happens to the content of a consultant's job plan, the process should be flexible and responsive to these changes to maintain the accuracy of the job plan.

3.7 Collaboration

The approach to Job Planning is as important as the output. LUHFT is committed to working in partnership with its consultant workforce to agree mutually acceptable job plans. Consultants across specialties, divisions, sites, and the Trust will work together collaboratively to agree shared objectives and outcomes aligned to the clinical strategy and our improvement plans.

3.8 Equality

A consistent and fair approach to job planning will be adopted between individuals, specialties, and sites. This is based upon a consistent, logical, and transparent framework that applies equally to everyone.

3.9 Transparency

Job plans are not confidential and will be freely available to appropriate members of the Trust management and the clinical teams. They will be reviewed annually by a Standards and Consistency Panel.

3.10 Professionalism

As a publicly funded organisation, LUHFT has a statutory responsibility for probity and integrity. Job Plans must be evidence based. Job plans should describe all elements of an individual's professional service and support excellence by defining their appropriate responsibility and accountability.

3.11 Prospective

The job planning process is prospective; therefore, decisions made will affect future work, future workload, and future remuneration.

3.12 Outputs

Both parties should agree on the outputs and outcomes expected from activity defined in the job plan and how they will be measured and reported. It is acknowledged that at times not all outcomes are achievable. However, if measurable work has been completed this will be recognised.

4. Departmental Job Planning

4.1 Departmental DCC time

4.1.1 The clinical manager (Clinical Director or Site-Specific Clinical lead), in conjunction with their operational manager, should maintain a contemporaneous understanding of the departmental DCC demand to provide appropriate timely quality patient care and flow for 52 weeks of the year.

4.1.2 The starting point is the DCC required to provide departmental emergency activity (e.g., SDEC (Same Day Emergency Care), ward rounds, hot clinics, NCEPOD (National Confidential Enquiry into Patient Outcome and Death) lists). When defining this activity, reference can be made to the appropriate Royal College or National

Specialty guidance, where this exists, and the 7-day standards for NHS service provision:

- Safe medical staffing | RCP London
- B1230-seven-day-services-clinical-standards-08-feb-2022.pdf (england.nhs.uk)

4.1.3 The DCC demand that is needed to support elective activity should then be added to this. Elective DCC demand should be informed by data from the previous year's activity and the contemporaneous specialty PTL (Patient Tracking List).
Clinical managers are expected to clearly identify through this process whether the Trust's activity targets can be met. They should then be able to identify and commission any appropriate additional activity needed or identify how to replace direct clinical care that is no longer required. Divisional clinical leaders are available to support this.

4.1.4 Clinical managers should try to allow for unforeseen events during the year when planning how to meet their service delivery requirements e.g., appropriate departmental DCC demand uplift to provide prospective cover for sickness.

4.1.5 If a gap exists between demand and capacity, it could then be used in a departmental business case for consultant, SAS, or other autonomous Nursing or AHP (Allied Health Professional) expansion.

4.1.6 The overall calculated Departmental DCC demand will then be used to inform the departmental job planning discussion meeting.

4.2 Departmental SPA time

4.2.1 Each department also has a requirement for non-patient facing activity that can support the delivery of departmental objectives aligned with our Trust improvement plan and clinical strategy.

4.2.2 This SPA activity is core to the effective operational management of a department. Each role is defined by a job description and carries a departmentally specific and divisionally agreed tariff of allocated SPA time (dependent on the size and activity of the department). Expected roles may include:

- Governance lead
- Specialty Audit and Improvement Lead (SAIL)
- Mortality lead
- Infection Prevention lead
- Education Lead

- Safety lead

Other locally agreed roles with a definable cycle of business that can be evidenced by:

- Demand/workload for the role across the clinical area(s) covered
- Evidence of output from the role
- Evidence of effective management of clinical standards and risk within the role
- Requirements to meet national standards or service specifications

4.3 Departmental Job Planning Meeting Conduct

4.3.1 At the start of each job planning cycle, there should be a departmental job planning discussion 1-2 weeks prior to any individual job planning meetings taking place.

4.3.2 This is a principle in ensuring transparency and equality in remuneration for DCC and SPA work across the department.

4.3.3 Colleagues should collaboratively discuss:

- The departmental objectives for the next year and alignment with the improvement plan and clinical strategy.
- The calculated departmental DCC demand and capacity.
- The plan for unforeseen events (uplift in DCC activity for prospective cover or no uplift to be calculated and TOIL (time off in-lieu) or extracontractual provision for service deficits related to sickness).
- The number of PAs allocated for predictable and unpredictable work performed whilst on call.
- The number of PAs allocated for patient administration work.
- Which consultants are going to undertake the expected departmental SPA roles. Other locally defined roles and tariffs should also be agreed e.g., departmental well- being lead, departmental research lead, service lead for a subspecialty that requires a definable cycle of business.
- Which consultants are going to fulfil the undergraduate or postgraduate educational lead roles.
- Which consultants will act as educational or clinical supervisors and that adequate SPA time will be allocated to their individual job plans.
- How the department will provide any additional undergraduate educational activity as set out in their departmental educational Service Line Agreement.
- Departmental annual leave planning should be considered. Agreed plans must be in place to maintain essential services. This includes emergency cover, management of in-patients and the management of cancer and elective waiting lists.
- External roles of those working in the department and the impact these could have on the delivery of care. The Trust recognises that external roles are essential for the future of the NHS and asks departments to be supportive of those individuals who undertake this important work.

Where departmental agreement cannot be reached through discussion, divisional or hospital site leadership, further support should be sought.

5. Individual Job Planning

5.1.1 The job planning process should take place annually following the cycle set out within this policy, unless requested earlier by either the consultant or Department. A review is indicated following a notable change in activity or service within the year and can be initiated by the Trust or the consultant.
Individual discussions will follow on from departmental level job plan discussions.
Individual Job Plan discussions will involve:

- The consultant
- The clinical manager (Clinical Director or Clinical Site Lead)

5.1.2 Ideally, involvement of the relevant senior manager (e.g., Directorate Manager) should be outside the job-planning meeting. The Job-planning meeting should be a dialogue. Written contributions from the relevant senior manager can be useful additions to the process. Only in exceptional circumstances should a senior manager be part of a job-planning meeting. Involvement of a senior manager should only be when this has been agreed in advance with the consultant and the consultant should be offered the opportunity to have support from a colleague or BMA representative to maintain balance if considered necessary.

5.1.3 Discussions may be face to face, by email or telephone, but always centred around the job plan which is viewable and shared on the electronic job planning system.
Generic Codes for DCC and SPA (with the detailed description in the comment section beneath the codes) should be used to allow more meaningful reporting of collated activity statistics while maintaining granularity at specialty level, e.g., DCC- Critical care, DCC- Emergency Department.

5.1.4 However, it is recognised that some Divisions will
have some specialist activity which cannot be expressed sufficiently well through the Generic Codes to allow meaningful analysis – as such a limited number of Specialty DCC codes have been agreed.

5.1.5 The agreed job plans should then be submitted on the Trust's electronic system (Allocate) and signed off by the consultant and the clinical lead. This agreed job plan will then be signed off by divisional leaders and subsequently reviewed at the Standards and Consistency Panel (SCP).

5.2 Full time Contracts

5.2.1 A full-time contract is based upon a work commitment of 10 programmed activities per week.

5.2.2 Each job plan will start from the assumption of there being a minimum of 42 contracted working weeks normally available for each full-time Consultant unless otherwise agreed (exclusive of professional, study and annual leave –which accounts for the other 10 weeks within a calendar year).

Services must be provided collectively by the department for 52 weeks of the year.

5.2.3 A leave policy is in place at LUHFT and any leave taken must include SPA time, not solely DCC activity.

5.3 Annualised Work

5.3.1 Annualisation is a flexible working agreement which should meet both the needs of the individual and the employer. Within their job plan, consultants can agree to the annualisation of their Programmed Activities across an agreed number of weeks (42 weeks for full-time contracts).

5.3.2 In such a case, the consultant and their clinical manager will agree the annual number of programmed activities and set out mutually acceptable variations in the level and distribution of programmed activities within the overall annual total e.g., +/- 2.5%. Accurate data provided by the clinical business manager is essential for this agreement to comply with the principles outlined at the start of this job-planning policy. Accurate recording of the actual DCCs worked is important to ensure that the activity matches the plan.

Worked example: Consultant works 8.5 PA DCC per week x 42 contracted weeks equalling 357 PA (+/- 9 PA) contracted DCC target per annum

5.3.3. Where the recorded activity deviates from the plan, efforts should be made to ensure the variation is corrected. If correction is not possible, an excess should be addressed with additional payment at the agreed extracontractual rate or TOIL, i.e., the additional PAs- worked should be subtracted from the following year's expected DCC target number. Under- delivery of an annualised plan would be added to the following year's plan in a similar way. It is important that any consistent over or under delivery should result in a change in the job plan to maintain accuracy of the plan.

5.4 Consultants with Less Than Full Time (LTFT) Job Plans

The division of programmed activities between direct clinical care and other activities for less than full-time staff will be seen broadly as pro-rata of those for full-time staff. However, the Trust recognises that a minimum of SPA time is necessary for revalidation, which is the 1.5 Core specified elsewhere in this policy. The core SPA time allocation within an LTFT individual's job plan must not fall below 1.25 PA.

5.5 Additional Programmed Activity (APA) above the full time 10 PA consultant contract

5.5.1 A review of APA is a key part of the job planning process. As with all programmed activities, the activities undertaken within all APA will be explicitly agreed and recorded in the job plan. Following review, either party can initiate the reduction of APA, with a 3-month notice period. They will be supported with an additional APA letter detailing the start and end date.

5.5.2 To comply with the principles at the start of this policy, in particular aiming for a sustainable work-life balance, consultants should normally not work more than 12 PAs

in their working week. There is some acceptable variation in this standard if there are high numbers of premium PAs within a job plan e.g., weekend resident shift pattern working.

5.5.3 Some variation from this standard may be accepted to support service provision and continuity of care in specialties in which recruitment is difficult and in which the DCC and SPA demand outstrips the departmental capacity.
Job plans containing more than 12 PAs will be presented at the Standards and Consistency Panel by the Clinical Director.

5.5.4 ***A red or amber rating will be applied to job plans of 12 PA or more to highlight the need for changes to ensure safe and sustainable working practices, together with a clear plan to reduce them over a reasonable period that is mutually agreed (typically 3-12 months). Focus should be given to providing support to transfer administrative and clinical tasks which could be undertaken by other clinicians allowing the consultant to maximise the use of their professional skills and knowledge***.

5.5.6 Consultants must sign an EWTD "opt out" if their contract amounts to more than 12 PAs.

5.5.7 To highlight the desire of this policy to generate sustainable job-plans with optimal work-life balances, any PAs undertaken above 10 per week will be marked as temporary Additional Programmed Activities (APA). APA should be assigned in Allocate to the activity they refer to e.g., DCC or SPA.

5.5.8 When a consultant ceases activity in a substantive role with internal responsibilities e.g., management or education, the job plan should usually return to a 10 PA contract where the consultant held a full-time post before taking up the clinical leadership role.

5.5.9 There is no obligation for the consultant to offer, or accept the offer of, an additional DCC PA from the Trust except when they wish to perform private practice.
Where the Trust or consultant decides to withdraw an APA (Additional Programmed Activity) without mutual agreement, they must give the other party three months' notice.

5.6 DCC's (Direct Clinical Care)

5.6.1 Direct clinical care is work directly relating to the prevention, diagnosis, or treatment of illness, i.e., clinical, and clinically related activity.
The job plan should clearly describe the type of direct clinical care activity, as well as when and where it is undertaken.

5.6.2 It should include scheduled and unscheduled emergency work; Theatre/Endoscopy, including pre- and post-op follow-up/review; out-patient sessions; formal ward rounds; board rounds (which will be typically less than the duration of a formal ward round); unplanned consultations/telephone advice, consent taking, clinical diagnostic work (Radiology and Laboratories); preparation time for direct "MDT work" namely that work which requires pre-meeting preparation (Radiology, Histopathology,

MDT leader); clinical administration (dictation, reviewing results/requests/referrals), request investigations referral on. This list is illustrative not comprehensive.

5.6.3 Meetings which relate directly to the care or treatment of individual patients such as Multi-Disciplinary Team meetings (MDTs), are counted as DCC time. There may be other similar meetings which can also be counted as DCC time, e.g., long-stay review meetings.

A list of DCC codes for the e-Job Plan system Allocate is included.

5.6.4 The use of the Allocate 'Other' codes is discouraged as these codes do not support appropriate summative statistics for external validity with partners and regulatory bodies e.g., University of Liverpool or NHSE/I. Their use will be phased out by the 24/25 job planning cycle, through appropriate challenge at the SCP (Standards and Consistency Panel).

5.6.5 As well as supporting work/life balance goals, LUHFT recognises that some DCC activity can be undertaken off site and that this can contribute to efficiency, productivity, and safety.

5.6.6 Working from home (including DCC such as telemedicine, virtual wards, specialty telephone advice for General Practitioners or MDT meetings via conferencing software, will be supported, providing patient confidentiality is not compromised.

5.6.7 Consultant doctors must remain contactable and be available should a recall to site become necessary (e.g., in emergency situations or major incidents).
A full-time consultant at LUHFT (undertaking 10 PAs per week) will typically undertake 8.5 DCC and 1.5 SPA per week (inclusive of the roles clearly identified within the 1.5 Core SPA allowance as set out below).

5.6.8 Each 4 hours of work, undertaken between 0700 and 1900 Monday to Friday, has a value of one PA.

5.6.9 Activities may be programmed as blocks of 4 hours or in smaller units (rounded up to the nearest 0.25 PA), as appropriate.

5.6.10 If it has been mutually agreed between the consultant and the Trust to undertake work in premium time, the value of a PA will be 3 hours. Premium time is classified as any time that falls outside of the hours 07.00 to 19.00 Monday to Friday. Public holidays are also premium time.

5.6.11 If a consultant chooses to undertake a PA in premium time rather than core working hours for personal convenience, and this is agreed in the job plan review, the time allocation for the PA will be 4 hours.

5.6.12 Where a consultant's role necessitates resident overnight shifts e.g., Trauma Team Leader, an additional tariff for this extracontractual work e.g., 2 hours per PA between the hours of 2300-0700 may be agreed.

5.7 Administration Time

5.7.1 It is expected that all consultant job plans include some non-patient facing DCC directly related to the administration necessary to deliver effective patient care. The PA allocation will vary according to the administrative requirements of a particular role and may vary between specialties and activities. The allocated time for a clinic is dependent on the proportion of new vs. follow-up patients (with new patients potentially requiring more admin time).

5.7.2 Clinical administration time also includes time to action and file results, answer complaints and time needed to prepare coroner's reports.
An average of DCC administrative time should be calculated over a reasonable period to determine how much time is required and considered a reasonable allocation, based upon agreed specialty variation in the number of patients seen per activity and their duration.

5.7.3 A frustration for consultants is when the burden of administration displaces clinical activity. Often time is spent on activities which would be better undertaken by support staff if they were available. The target for Clinical Administration PA is a maximum of 1 Clinical Administration PA. Where an individual job plan includes administration time which exceeds 1 PA per week, this will be flagged as an outlier (red or amber). The clinical lead and the SCP will review the administrative support available to the consultant and consider the best way to reduce the administrative burden within the job plan.

5.8 Tariffs for DCC activity

5.8.1 Clinical Directors have a responsibility to objectively review activity data and ensure that individual workloads during PAs lie within an acceptable spectrum of variability that delivers equity across all consultants and clinical services.

5.8.2 Royal College guidance (Safe medical staffing | RCP London) exists to support the expected time taken for generic and acute medical specialty ward round activity. Variation around this guidance should be based on evidence and agreed.

5.8.3 Tariffs for other specialty activities should be evidence based and linked to their specialty service specification or appropriate professional body guidance.

5.8.4 Maintaining the principle of equity through transparent and evidence based constructive challenge is at the core of the implementation of the policy and is supported by the SCP as described below.

5.9 Travel and DCC

5.9.1 Where Consultants are expected to spend time on more than one site during a day, time spent travelling between sites will be included as DCC.

5.9.2 Travel to and from work for on-call duties and NHS emergencies is to be included within the PA for which travel is necessary. ‘NHS Emergencies’ are defined as unexpected work that requires the consultant to return to the hospital site.

5.9.3 'Excess Travel' is defined as time spent travelling between home and a working site other than the consultant's main place of work, after deducting the time normally spent travelling between home and main place of work, this excess travel time is to be included in the PA for which travel is necessary.

5.9.4 Travelling time between a consultant's main place of work and home or private practice premises will not be regarded as part of working time.

5.9.5 A small number of consultants have, with agreement by the Trust, chosen to reside more than 10 miles/30 minutes from the hospital. Should this be the case, the allocated time for travel within the PA will be limited to 30 minutes.

5.10 Supporting Professional Activities (SPAs)

5.10.1 Supporting Professional Activities (SPAs) are activities that underpin and improve DCC. It is acknowledged that some SPA will be planned well in advance with other elements occurring on a week-by-week basis.

5.10.2 SPAs underpin clinical care and contribute to ongoing professional development as a clinician. This includes activities like:

- teaching and training
- medical education
- continuing professional development
- clinical governance
- appraisal and revalidation.

5.10.3 SPA time allocation should be evidence based and the detail of SPA activities should be explicitly agreed at the job plan review meeting. A list of SPA codes for the e-Job Plan system Allocate is included.

5.10.4 This list is not exhaustive but is intended to provide guidance on key activities which are likely to constitute SPA time in the Consultant job plan.

5.10.5 Leave applications must include any SPA time during which the doctor will be on leave.

5.10.6 When SPA activities are being undertaken off-site, consultants must be contactable. The consultant should agree to a request to return to the Trust in case of unforeseen emergencies/situations to maintain business continuity (e.g., Full capacity Protocol or a Major Incident).

5.10.7 SPA time should be tariffed as core working hours (4 hours per PA), unless it is evidenced the consultant is fully engaged by the Trust throughout the normal working week.

5.10.8 Short-term locum posts may have very specific roles and could fall outside this policy. Where a locum post will last 3 months or more, in common with all consultant posts, the job plan of long-term agency locum/fixed-term contract consultants should

reflect their activity. Where a temporary post has no other SPA roles, they should receive the 1.5 core SPAs to maintain their revalidation and appraisal. Locum posts

should not normally be longer than 12 months without consideration of appointing a substantive consultant.

5.11 Core SPA

5.11.1 The contract and BMA guidance states that a full-time Consultant (undertaking 10 PAs per week) will typically undertake up to 2.5 SPAs per week. Of the total SPA allocation, all Consultants starting in employment with the Trust will be allocated 1.5 core SPA per week for CPD (Continuing Professional Development), personal job planning, personal appraisal, attendance at regular team meetings which will have a clinical governance aspect and participating in audit.

Participating in audit means:

- Registered attendance at 80% of departmental audit meetings
- Contributing data to and participation in GIRFT (Getting It Right First Time) review of practice.
- Implementing agreed audit recommendations in the consultant's own area of practice

Participating in governance means:

- Registered participation in 80% of departmental governance meetings
- Providing clinical expertise into the governance processes including incidents and complaints.

5.12 Job plan objectives and additional SPA

5.12.1 Additional SPA time above the 1.5 Core SPA should be agreed between the consultant and their clinical lead during the job plan review session. This further allocation should be provided within the standard 10 PA contract. It must be evidence based and linked with SMART objectives to provide oversight and governance:

- Specific
- Measurable
- Achievable
- Realistic
- Time-limited

5.12.2 These SMART objectives should be aligned to departmental roles, (e.g., Governance, SAIL, IPC, or mortality lead), with the LUHFT clinical strategy and Improvement Plan and may also support the achievement of the personal development plan agreed at the individual's Medical Appraisal for Revalidation.
They may include objectives relating to:

- Trust Goals and the Improvement Plan
- Local service objectives
- Quality Improvement activity
- Patient safety

- Clinical effectiveness
- Clinical standards
- Service development
- Multi-disciplinary teamwork.
- Research
- External roles

5.12.3 Personal 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. They should be agreed upon, following discussion, as part of the job plan alongside an agreement on the resources required to achieve them.

5.12.4 Where a doctor works for more than one NHS employer, where LUHFT is the substantive employer, the job plan will take account of any objectives agreed with other employers.

5.12.5 Progress against agreed job plan objectives will be reviewed at the following annual job plan meeting, or earlier if necessary. Failure of the Trust to provide the resources agreed should be highlighted by the consultant if achievement of agreed objectives has been affected. The consultant should also inform their clinical manager if the nature of the agreed activity changes.

5.12.6 Like all elements of a job plan, SPA time can be evidenced in two ways:

- A work diary, which may be suggested by either party. The BMA has a work diary app https://www.bma.org.uk/pay-and-contracts/job-planning/dr-diary/dr- diary-app which has proven useful. Other similar apps are available.
- Evidence of the output from this SPA time (research, articles, teaching, SMART goals etc.).

This evidence can then be reviewed and discussed at the job planning session.

5.13 Research Elements of Job Plans

5.13.1 A key strategic priority of the Trust is to deliver great research and innovation. This includes building a team of high-quality research active clinicians who can widen access to research opportunities across our local communities and embed a culture of research into standard practice.

5.13.2 The funding for Research PAs may be external and clearly recorded within the job planning process e.g., University or NIHR (National Institute of Health Research) funded.

5.13.3 Our LUHFT Clinical Investigator Programme has been designed to encourage, value and support the local development and expansion of a critical mass of Chief and Primary Investigators. Consultants will be supported to undertake this programme and as such it should be recognised within the SMART objectives in individual job plans. Consultants who are primary investigators for NIHR portfolio trials with evidence of contemporaneous recruitment who do not already have university or NIHR supported research PA activity, should consider claiming an additional 0.25 SPA, above the expected 1.5 Core SPA, for the duration of the trial through the set-up and to closure.

5.14 Educational SPA time - Core Education SPA

5.14.1 LUHFT is a university teaching hospital and the largest local provider of postgraduate education, as such, there is an expectation that all consultants will participate in opportunistic and formal undergraduate and postgraduate education as part of their employment.

5.14.2 This commitment to medical education is recognised through the specific allocation of 0.25 PA (of the total of 1.5 Core SPA allocated to consultants) for the delivery of 'formal' educational activity.

5.14.3 How this allocation is utilised should be agreed in the job planning process with consideration paid to the consultant's own interests, development plans and the service demand for the provision of specific undergraduate, postgraduate, and allied professional educational activities.

5.14.4 The agreed objectives for this educational delivery Core SPA time should be documented in the job plan.

5.14.5 For clarity, this 0.25 PAs of Core SPA is to be considered separate to undergraduate and postgraduate educational supervisor provision which is coded for and remunerated separately. It should not be used to allow reduction of/absorption of educational activity contained elsewhere in job plans into Core SPA time and is supplementary to other job planned educational PAs.

5.14.6 It is important to recognise that time spent teaching in clinical settings (e.g., clinics and ward rounds) is not additional, it is a key part of the PA tariff for any DCC. It is recognised that workplace-based teaching may affect the volume of activity which can be undertaken within a clinical session. Variations in teaching activity should be identified, discussed, and agreed on as part of the job planning process.

5.15 Educational SPA time - Undergraduate Education SPA

5.15.1 Specific undergraduate teaching in SPA time is separate from contact time during a fixed clinical activity such as a clinic or theatre list.

5.15.2 The amount of SPA time for this activity will be agreed as part of the job planning process with the involvement of the Clinical Director through an evidenced based approach. This approach should be focused on time input, quantitative output, and where possible, qualitative output.

5.15.3 'Formal' Educational activity is activity that happens when the teacher has taken specific time to be away from clinical service to deliver the activity, e.g., a scheduled classroom teaching session such as a CBL, a formal timetabled undergraduate teaching session at the 'bed side', preparation and delivery of a lecture or tutorial, acting as an undergraduate clinical examiner, acting as a research supervisor for students/trainees, or the delivery of undergraduate departmental induction.

5.15.4 For clarity, an undergraduate 'bedside teaching' session is a separately timetabled activity that is focused only on teaching. It is not teaching as part of a ward

round, which would be regarded as opportunistic teaching within clinical service delivery, and therefore as 'opportunistic' educational activity.

15.15.5 The amount of SPA time for this activity will be agreed as part of the job planning process with the involvement of the Clinical Director through an evidenced based approach. This approach should be focused on undergraduate teaching demand and expectations within the specialty, time input, quantitative output, and where possible, qualitative output.

15.15.6 For clarity, such 'opportunistic' teaching is not teaching that requires the teacher to be timetabled to be away from clinical service to deliver the teaching, e.g., it is not a 'formal bedside teaching' session, CBL or UG/PG educational supervision meeting.

15.15.7 Oversight of medical education provision will be undertaken during the Standards and Consistency Panel by a Director of Medical Education who will address issues of demand and capacity and ensure that adequate job planned time across the department has been identified to support the educational service line agreement held by the department of Medical Education.

15.16 Educational SPA time - Postgraduate Education and Training

15.16.1 Each department should allocate 0.25 SPAs per trainee to cover combined clinical and educational supervision. Educational supervision describes the provision of consistent supervision of a trainee over a period of up to one year and mandates a schedule of meetings to assess and support educational progress. It is expected that Educational Supervisors should ideally supervise no more than 4 trainees.

15.16.2 Consultants may also be Clinical Supervisors (i.e., have trainees within their team that they supervise on a day-to-day basis in clinical settings) or educational supervisors or both, the associated SPA allocation will be a maximum of 0.25 SPA. This provision includes the time required for workplace supervision and the completion of workplace-based assessments.

15.16.3 Consultants appointed as Trust Specialty Tutor, College Tutor or Training Programme Director should be allocated adequate time to perform the role. The time required should be agreed on a case-by-case basis and should be based on the objectives the individual is required to achieve. Where this role exists within specialties, 0.05 PA per trainee per week, this is one twentieth of a PA. It is 12 minutes but rounded up to a minimum of one half of a PA per week (2 hours).
1-10 trainees = 0.5 PAs per week

15.16.4 Non-training grade Trust doctors and FY3/Clinical Fellow Posts should also be allocated an Educational Supervisor with 0.25 SPAs per post.

15.16.5 A compelling case can be made to support an increase in the educational and clinical supervision of Trust grade doctors, new to working in the NHS or UK healthcare

setting (0.5 PAs per post). This should be agreed departmentally, and the additional PA funding budgeted for in the approval process of a non-training grade job.

15.16.6 Roles that extend outside the organisation will be dealt with as outlined below. External agencies such as HEENW (Health Education England North West) or a university may commission Additional Programmed Activities which should be recorded within the job plan.

15.17 Internal responsibilities

15.17.1 There are a range of additional internal NHS responsibilities which are recognised, supported and promoted by the trust. These roles may only be recognised for a set tenure, examples include Divisional Medical Director, Deputy Divisional Medical Director, Clinical Director, Lead Clinician, LNC Chair, LNC deputy chair and Educational Advisor.

15.17.2 The nature of the additional responsibility and the time required to fulfil it should be explicitly discussed and the consequences for other members of the clinical/specialty team be understood before agreement is made.
When an additional role is agreed, the time commitment required to undertake it and/or additional remuneration in the form of a responsibility payment should be recorded in the job plan.

15.17.3 When a consultant ceases activity in a substantive role with internal responsibilities e.g., management or education, the job plan will return to, at least, a 10 PA contract, where the consultant held a full-time post before taking up the role.

A table of the internal PA tariffs for roles is included

15.18 External responsibilities

5.18.1 There are a range of additional NHS or university responsibilities that extend outside of the Trust which may be encouraged, recognised and supported on the basis that these roles will promote and enhance our position as a leader in clinical, research and educational excellence. The Trust will consider such requests on an individual basis upon understanding that:
External roles undertaken should not compromise safe and sustainable working practices for the individual concerned or departmental service delivery and patient care.

15.18.2 These responsibilities are seen as entirely discretionary and must be subject to an annual review as part of the job planning process. When an external role is agreed, the time commitment required to undertake it and/or additional remuneration must be recorded in the job plan.
Consultants who wish to perform additional external NHS responsibilities must seek formal agreement from their Clinical Manager and Clinical Business Manager prior to applying for the role.
Some examples include:

- Clinical Academics, Regional Education Advisor, Royal/Specialty College work and examinations, National representative on committees e.g., NICE (National

Institute of Clinical Excellence), NCEPOD (National Confidential Enquiry into Patient Outcome and Death), External Trade Union activity.

15.18.3 External role activity must be undertaken outside of the agreed job planned DCC and core SPA time. If this is not possible, as a result of short-term notice, then any activity displaced by an external role should be re-provided on a flexible basis by the consultant.

15.18.4 Consultants with substantial external roles could consider annualisation of the internal elements of their Trust job plan.

15.18.5 External roles may attract additional remuneration paid directly to the individual by the relevant external agency. In this situation there is no requirement to allocate additional PA remuneration to discharge the contracted external responsibility by the Trust, although the nature of the additional responsibility should be recorded. The principle of safe and sustainable working practices must be maintained and then recorded in the job plan.

15.18.6 The Trust may request formal confirmation of all external duties. Only in extreme circumstances should an agreement to undertake an external role need to be removed if patient care and service delivery has been affected and remedial actions cannot be agreed.

15.19 On-call

15.19.1 Consultants on an on-call rota are paid an on-call availability supplement in addition to basic salary. The level of supplement depends upon the frequency of the rota and the typical nature of response when called.

Frequency of rota commitment	Value of supplement as % of full-time basic salary	
	Category A	Category B
High Frequency 1 in 1 to 1 in 4	8.0%	3.0%
Medium Frequency 1 in 5 to 1 in 8	5.0%	2.0%
Low Frequency 1 in 9 or less frequent	3.0%	1.0%

15.19.2 Less than full-time consultants, whose contribution when on-call is the same as that of full-time consultants on the same rota, will receive the appropriate percentage of the equivalent full-time salary. Less than full-time consultants who participate on the rota on a different basis will receive the same supplement as a full-time consultant on an equivalent rota.

15.19.3 Category A: this applies where the consultant is required to return immediately to site when called or must 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.

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

15.19.5 There is also a requirement for a PA allocation in recognition of the clinical work whilst on-call. This work is divided into:

- Predictable: which takes place at regular and planned time e.g., consultant ward rounds at weekends in line with the 7-day standards for the NHS.
- Unpredictable: purely unplanned clinical activity whilst on-call.

15.19.6 The number of PAs allocated for predictable and unpredictable work performed whilst on-call will be the same for all consultants on a rota and will be agreed at specialty level during the departmental job planning discussion. This allocation is calculated by analysing the amount of time consultants spend on on-call related clinical activity to produce an average weekly amount.

15.19.7 To achieve this, individual consultants need to record their workload over a representative period and share the results with their Clinical Manager and Clinical Business Manager so that an average can be agreed for the specialty or rota concerned. The length of the representative period should be agreed at specialty level; in most cases 10 weeks will suffice.

15.19.8 Some consultants take part in more than one on call rota. For these individuals, the combined frequency (within the parameters) of the rotas in which they participate should be used to determine the nature of their on-call commitment. This should happen rarely and where it does the two rotas should not coincide, unless specifically agreed. Consultants cannot be paid twice for the same time period.

15.19.9 The service requirement for continued on-call provision and any changes in the frequency and intensity rates will be revisited each year as part of the job planning process.

15.20 Private practice and free-paying services

15.20.1 Where a consultant intends to undertake remunerated clinical work that falls under the definition of Private Professional Services other than such work specified in his or her job plan, whether for the NHS, for the independent sector, or for another party, the provisions of Schedule 6 of the Terms and Conditions will apply.
It is essential that the undertaking of private practice services do not:

- **Result in detriment to NHS patients or services, and/or**
- **Diminish the public resources that are available to the NHS.**
- **Take place when scheduled to be on-call for the Trust.**

15.20.2 Regular commitments in respect of Private Practice or Fee-Paying Services must be agreed and identified within the job plan. This information will include the planned location, timing and the broad type of work involved. If time spent undertaking Private Practice results in an individual working more than an average of 48 hours per

week, the decision, and the responsibility to undertake that work will lie with the individual.

15.20.3 Where there would be a conflict or potential conflict of interest, NHS commitments must take precedence over private work. Individual consultants are responsible for ensuring that private commitments do not conflict with their NHS job plan.

15.20.4 Where DCC activity takes place within premium time for consultants' own convenience (i.e., Clinical admin displaced to allow private practice in standard hours), this activity will not attract premium time rates.

15.20.5 Individuals who undertake private medico-legal work (i.e., work which is not performed in their capacity as a Trust employee) may be called to appear in court from time to time, a requirement which may interfere with NHS activity. Where this is the case, this should be taken as annual leave. If the consultant is subpoenaed or requested to appear as a result of their Trust duties, e.g., coroner's court, then they will be given time to attend. Histopathologists undertaking coroner's work locally will be excluded from this requirement.

15.20.6 Where the consultant has a GMC (General Medical Council) obligation to provide emergency treatment for a private patient, they must make alternative arrangements to cover their NHS patients and job planned activity.

15.20.7 If the consultant finds that such work regularly impacts on their NHS commitments, they must make alternative arrangements to provide emergency cover for private patients. The frequency of such impact should be reviewed on a continuous basis by the consultant and the Trust.

15.21 Extra-contractual work and Waiting List Initiatives

15.21.1 Consultants are often asked to carry out additional operating lists, clinics, investigations, or reports in order to reduce or maintain patient waiting times. There is no obligation for consultants to undertake this extra-contractual work. To be consistent with the Trust's view on the importance of work-life balance, where there is frequent need for extra-contractual work, consideration should be given to increasing the workforce so that this additional work can be delivered within contracted time.

15.21.2 One of the more important principles of the 2003 Consultant Contract is that consultants cannot be paid twice for the same period of time. For this reason, the Trust will not ask consultants to do extra-contractual work whilst on call. If this happens by accident, alternative arrangements should be made.

15.21.3 The Trust should not ask consultants to do extra-contractual work during their SPA time, other than in exceptional circumstances. In the rare occasions where this is necessary the displaced SPA must be undertaken at another time and there should be an explicit written agreement regarding the time and location of this.

15.21.4 Where it is agreed that the displaced SPA will be performed in lieu of a clinical session the consultant will not be entitled to any additional remuneration for the work undertaken. In contrast, where it is agreed that the displaced SPA will be performed

at a time when the consultant is not contracted to work for the Trust (such as an evening) the consultant will be entitled to payment for the extracontractual work at the agreed Trust rate.

15.21.5 In exceptional circumstances, consultants may be required to 'act down' to cover unavoidable gaps in junior rotas. A specific policy to cover this activity has been agreed with the LNC.

15.22 Failure to Agree a Job-Plan- Mediation and Appeal Process

15.22.1 Where it has not been possible to agree a job plan, including where a consultant disputes a decision that they have not met the required criteria for a pay threshold, the first step is to attempt to resolve the issues through mediation in accordance with Schedule 4 of the new Consultant contract terms & conditions of service. Where possible, this will be completed within 3 months of the dispute being raised.

15.22.2 Where there is a dispute about the job plan that cannot be resolved through discussion with the Clinical Director, the CMO will appoint a Divisional Medical Director who has not been involved in the job planning process to mediate. A meeting will take place between the Divisional Medical Director, the Clinical Director and the consultant. In preparation for the mediation meeting, the following information should be shared and 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
- Specialty/college 'best practice' advice
- NICE guidance.

15.22.3 If attempts at mediation are unsuccessful a formal appeal procedure, which is also in accordance with Schedule 4 of the Terms and Conditions, will be instigated. An appeal panel will be convened to consider a formal review of the job plan. The panel will consist of the CMO, or deputy, a consultant nominated by the appellant consultant and a consultant chosen from a list of individuals approved by NHS Employers, BMA, and BDA (British Dental Association). The appeal shall proceed in accordance with Schedule 4 of the Consultant Contract Terms and Conditions of Service 2003.

The decision of the appeal panel will be final.

15.22 Failure to engage with the job planning process

15.22.4 Accurate job plans provide a stable environment within which consultants can work. The Trust has a responsibility to ensure that job plans are accurate, just as it has a responsibility to the medical regulator to ensure that doctors fulfil the requirements of appraisal and revalidation.

15.22.5 Failure of consultants to complete appraisal is a standard against which the Trust is judged and similarly failure to maintain accurate job plans represents a reputational risk to the Trust.

15.22.6 As an essential element of the job-planning process is consensus, there can be instances where agreement may take time. Where a consultant is actively engaged in the job planning process, any delay in agreement should not negatively impact on the consultant.

15.22.7 In the exceptionally rare instance where a consultant does not engage in job planning the Trust may initiate actions defined in the 'Raising Concerns' policy.

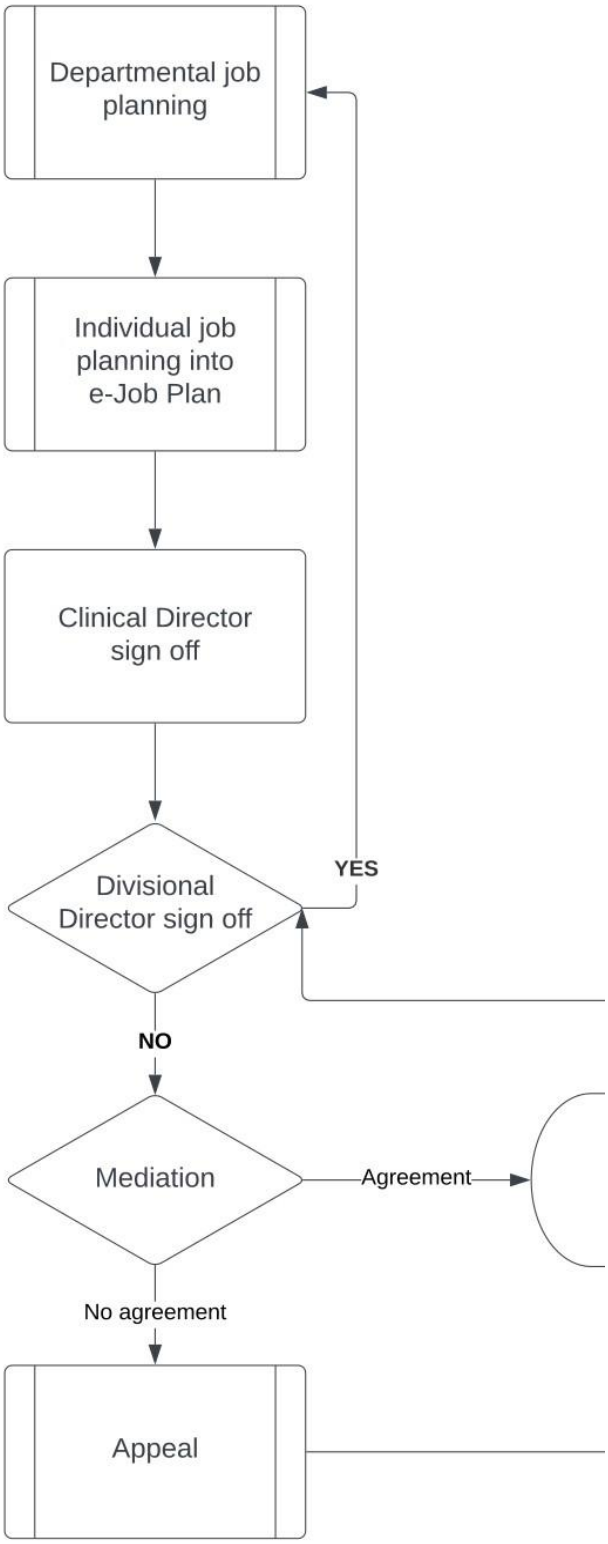
6. Job Planning Cycle

NHS Improvement published their national Best Practice Guidance for Job Planning in 2017.

This Guidance stressed the importance of aligning consultant job planning with business development to ensure that job plans are set up to deliver the annual plan. The table below sets out the time frame recommended and which LUHFT will adopt as best practice from 23/24:

Annual job Planning cycle	
July to September	Workforce makes last year's job plans available as new forward year job plans on the Allocate system and informs CDs Workforce commences the timetabling of SCP meetings to be completed The Clinical director sends out preparation for and invitation to departmental job plan review with preparation guidelines, giving six weeks' notice. Clinical director prepares Demand/Capacity tables to inform departmental meeting
October to December	Meeting of the consultant clinical team to discuss and agree departmental roles, service objectives, SPA activities, rota participation, leadership role agreement. Job plans are amended on the electronic system by the consultant and their CD jointly at a meeting. Job plans are submitted by the consultant and approved by the CD. Standards and Consistency Panel commence the review of summarised departmental job plan information
January to March	Mediation and appeals completed as soon as possible. Registration of job plan completion to feed into pay progression and Clinical Excellence Award process
April to June	Job plan effective (In reality, the job plan may already be in effect)

6.1 Summary Flowsheet



7. Standards and Consistency Panel

In accordance with NHSI Guidance on Job Planning 2017, LUHFT will appoint a Standards and Consistency Panel. The Standards and Consistency Panel will meet as required to review and make recommendations where necessary regarding all new and revised job plans once the service managers and CDs have reached service level agreement.

Standards and Consistency Panel	
Members	CMO (Chief Medical Officer) office representative Hospital site representative (DMD (Divisional Medical Directors) medicine/surgery) Workforce/People Officer representative (familiar with Policy and Terms and Conditions of service) Member of Allocate team CFO or deputy Educational Advisor DME (able to advise on general educational, undergraduate, and postgraduate commitments) Clinical Director and Senior Manager attending to present data from specialty
Purpose	To ensure a consistent and fair approach across hospital sites and specialties within LUHFT To ensure compliance with contract, Job planning policy and National Guidance Provision of advice as necessary Not mediation Not an appeal
Outcomes	Make suggestions to achieve consistency or standardisation Return job plans to relevant clinical area with RAG rating Advise as requested on national terms and conditions, this policy and provide guidance
Frequency of meetings	As required annually after a clinical group has completed their annual job planning round.

7.1 Information to be supplied to meetings by the workforce team:

- Summary table of total PAs (Programmed Activities) in electronic system by individual at least by DCC, SPA, other. The table must also include on-call availability payments, PAs applicable to on-call working, private practice etc.

- Comparison by individual showing total PAs paid through ESR (Electronic Staff Record) as well as on call availability supplement currently paid in ESR.
- Electronic copies of each job plan.
- Copies of departmental consultant rotas.

7.2 SCP meeting conduct and agenda

The meetings should use the information provided to scrutinise as follows:

- Ensure all consultants are treated fairly and consistently across specialty and Trust
- Compare the total PAs in system to total PAs in ESR to note any discrepancies (under or overpayments and ensure reconciliation)
- Compare on call availability supplements with consultant rotas to ensure correct payments are being made
- Compare PAs related to on-call or resident working to ensure correct across all consultants
- Ensure private practice recorded and if so that an 11th PA has been offered
- Ensure DCC PAs do not present an onerous job plan but also enough DCC to support practice
- Ensure sufficient SPAs are present. Ensure appropriate allocation of non-core SPAs.
- Ensure appropriate allocation of educational and teaching Pas
- Ensure appropriate allocation of admin Pas
- Ensure that the information aligns with job planning policy and contractual requirements
- Ensure that external/non-clinical work is appropriately funded and remunerated.
- Assurance should be provided by clinical managers that SMART objectives have been set.

Outcomes of the Standards and Consistency panels should be RAG rated to support documentation and inform tracking of progress:

Consistent with job planning guidance and policy Matches with contracted PAs SMART objectives defined Minor queries addressed Variation explained by evidence	Green-no further action or alterations necessary
Outstanding queries at first look Clarification provided has not given assurance Job Plan significantly over-contracted PAs Clinical Admin > 1PA Job plans >12 PA SPAs not described appropriately or without objectives On-call commitment queries requiring diary exercise or rota frequency changes	Amber- queries, clarification and amendments required for consistency
No job plan provided Job plan totals under-contracted PAs Outstanding queries after review at SCP meeting or clarification given to panel has not provided assurance Excessive time commitment >14 PA	Red- immediate remedial action required to comply with contractual obligations and ensure overpayments or underpayments are not being made

Documentary evidence of meetings must be kept for reference purposes and to track actions resulting from meetings. The SCP will report into the Executive People and Organisational Development Group at the conclusion of each cycle in April.

A job planning outcome report will be provided to the LNC each year in April. This will report completion levels, number of mediations and outcome, number of appeals and outcome.

8. Role Tariff Table

SPA and Other Non-Clinical Activity	Illustrative PA Envelope
SPA – Core	1.5 (total)
SPA – Core	1.25
SPA Core - Delivering Educational Activity - Undergraduate	0.25
SPA Core - Delivering Educational Activity – Postgraduate	
SPA Core – By exception It is recognised that a minority of consultants will not be able to deliver Educational Activity. By exception, this code should be used to ensure that these individuals receive the agreed 1.5 Core SPA which is recognised as essential for revalidation activities	0.25
Teaching/Educational Activity	
Undergraduate Formal Educational Activity	
Postgraduate Teaching / Educational Activity - Trust Funded	
Postgraduate Teaching / Educational Activity - Externally funded	Must list funding source
Research Activity	
Research Activity - Trust Funded	
Research Activity - Externally Funded	Must list funding source
CMO Office Roles	
Deputy CMO Role	5-8 PA
AMD (Associate Medical Director) Role	2-3 PA
Responsible Officer	3 PA
Appraiser	0.25 PA for an average of 4 to 6 – Appraisals/yr.) (Representing a range of 6.7-10 hours per appraisal) For those appraising >6 colleagues PA allocation is for agreement on an individual basis
CCIO - Research and Innovation	3 PA
Associate CCIO	2 PA

Trust Clinical Lead - CMO Office Post	1-2
Trust Clinical Lead – Other	
Guardian of Safe Working	2 PA
Deputy Guardian of Safe Working	1 PA
Medical Education Roles	
Director of Medical Education	3 PA
College Tutor	
Clinical Sub dean	
UG Year Lead	
UG Trust Specialty Teaching Lead	
Clinical supervisor	0.25 per trainee (to max 1 PA)
Educational supervisor – Undergraduate	0.25 per student (to max 1 PA)
Educational supervisor – Postgraduate	0.25 per trainee (to max 1 PA)
Training Program Director	PA as described above/HEENW
ME Office Roles	
Lead Medical Examiner	0.5 PA
Medical Examiner	1-2 PA
Operational Roles	
Hospital Medical Director	8
Divisional Medical Director Role	4-6 by agreement with HLT (Hospital Leadership Teams)
Deputy Divisional Medical Director	1-4 by agreement with DMD
Specialty Clinical Director or Site-Specific Clinical Lead	1-3 by agreement with DMD
SPA – Departmental Specialty Roles	
Clinical Governance Lead	0.5-1
Post graduate education lead	0.25-1
Undergraduate education lead	0.25-1
Safety lead	0.25-1
IPC lead	0.25-1
SAIL	1
Mortality Lead	0.25-1

External NHS Duties *****	
External Duties - externally funded	Must list funding source
External Duties - Trust funded	

8.1 E-Job Plan Allocate Codes for specialist activity

Ward Rounds / Ward Based Care
Ward round / Ward Based Care- Acute assessment area
Ward round / Ward Based Care - Post take ward round
Ward round /Ward Based Care – Ward
Ward round / Ward Based Care- Virtual
Clinics
Outpatient clinic
Outpatient clinic – virtual
Outpatient Clinic - Rapid access
Advice and Guidance
Theatre / Interventions
Theatre - Emergency/Non elective
Theatre - Elective
Clinical Diagnostics Work
CDW – Endoscopy
CDW – Cardiac
CDW – Respiratory
CDW – Other
Admin
Clinical admin
On Call
Predictable on call clinical activity
Unpredictable on call clinical activity
MDT
Multidisciplinary Team Meeting

Referrals and In reach
Acute area in reach
Ward referrals
Private Practice
Private practice / Fee paying services
DCC – External Organisation
DCC – Liverpool Heart and Chest Hospital
DCC – Liverpool Women's Hospital
DCC – Walton Centre
DCC – Clatterbridge Cancer Centre
DCC – External Acute Trust
DCC – Other External NHS Organisation
DCC Other
DCC Other

LCL DCC
CDW Microbiology
CDW - Telephone Advice
CDW - Infection control
CDW - Medical authorisation
CDW - Clinical Authorisation
CDW - Clinical Liaison
CDW - Consults service
CDW Pathology
Post-mortem examination
Pathology - Specimen Cut up
Pathology - Microscopy
Pathology - Tertiary Referrals
Pathology - Other

Radiology Specific DCC
Plain film reporting
Ultrasound
Outpatient cross-sectional imaging (CSI)
Inpatient cross-sectional imaging (CSI)

Radiology Clinic
MSK Radiology Clinic/MSK Hot Radiologist
Reporting for an external Trust

PET-CT Reporting
Nuclear Medicine Reporting
Breast Reporting
Cardiac CT List
Cardiac MRI List
Interventional ultrasound
Fluoroscopy
Vascular Intervention
Non-Vascular Intervention
Combined IR Theatres
Vetting

9. Training resources for Clinicians

Training for Clinical directors will be provided in the operational delivery of this policy, including:
Webinars on meeting conduct

- Webinars on meeting conduct
- Allocate e-Job Plan support team

Hosted on our staff hub intranet page:

https://staffhub.liverpoolft.nhs.uk/working-with-us/medical-job-planning.htm

10. Exceptions

No exceptions

11. Monitoring of compliance

Minimum requirement to be monitored	Process for monitoring e.g. audit/ review of incidents/ performance management	Job title of individual(s) responsible for monitoring and developing action plan	Minimum frequency of monitoring	Name of committee responsible for review of results and action plan	Job title of individual/ committee responsible for monitoring implementation of action plan

Minimum requirement to be monitored	Process for monitoring e.g. audit/ review of incidents/ performance management	Job title of individual(s) responsible for monitoring and developing action plan	Minimum frequency of monitoring	Name of committee responsible for review of results and action plan	Job title of individual/ committee responsible for monitoring implementation of action plan

12 Relevant regulations, standards and references

13 Equality, diversity and human right statement

The Trust is committed to an environment that promotes equality and embraces diversity in its performance both as a service provider and employer. It will adhere to legal and performance requirements and will mainstream Equality, Diversity and Human Rights principles through its policies, procedures, service development and engagement processes. This SOP should be implemented with due regard to this commitment.

14 Legal requirements

This document meets legal and statutory requirements of the EU General Data Protection Regulation (EU 2016/679) and all subsequent and prevailing legislation. It is consistent with the requirements of the NHS Executive set out in Information Security Management: NHS Code of Practice (2007) and builds upon the general requirements published by NHS Digital/Connecting for Health (CfH).

Appendix 1: Equality impact assessment

Title	Consultant Job Planning
Strategy/Policy/Standard Operating Procedure	Policy
Service change (Inc. organisational change/QEP/ Business case/project)	Following Merger
Completed by	Alison Terry
Date Completed	14th February 2023

Description *(provide a short overview of the principle aims/objectives of what is being proposed/changed/introduced and the impact of this to the organisation)*
Alignment of site policies from pre-merger and to follow introduction of trust-wide e-job planning system.

Who will be affected *(Staff, patients, visitors, wider community including numbers?)*
Consultants

The Equality Analysis template should be completed in the following circumstances:

- **Considering developing a new policy, strategy, function/service or project(Inc. organisational change/Business case/ QEP Scheme);**

- **Reviewing or changing an existing policy, strategy, function/service or project (Inc. organisational change/Business case/ QEP Scheme):**

  - If no or minor changes are made to any of the above and an EIA has already been completed then a further EIA is not required and the EIA review date should be set at the date for the next policy review;
  - If no or minor changes are made to any of the above and an EIA has NOT previously been completed then a new EIA is required;
  - Where significant changes have been made that do affect the implementation or process then a new EIA is required.

Please note the results of this Equality Analysis will be published on the Trust website in accordance with the Equality Act 2010 duties for public sector organisations.

Section 1 should be completed to analyse whether any aspect of your paper/policy has any impact (positive, negative or neutral) on groups from any of the protected characteristics listed below.

When considering any potential impact you should use available data to inform your analysis such as PALS/Complaints data, Patient or Staff satisfaction surveys, staff numbers and demographics, local consultations or direct engagement activity. You should also consult available published research to support your analysis.

Section 1 – Initial analysis

Equality Group	Any potential impact? Positive, negative or neutral	Evidence *(For any positive or negative impact please provide a short commentary on how you have reached this conclusion)*
Age *(Consider any benefits or opportunities to advance equality as well as barriers across age ranges. This can include safeguarding consent, care of the elderly and child welfare)*	Neutral	
Disability *(Consider any benefits or opportunities to advance equality as well as impact on attitudinal, physical and social barriers)*	Neutral	
Gender Reassignment *(Consider any benefits or opportunities to advance equality as well as any impact on transgender or transsexual people. This can include issues relating to privacy of data)*	Neutral	
Marriage & Civil Partnership *(Consider any benefits or opportunities to advance equality as well as any barriers impacting on same sex couples)*	Neutral	
Pregnancy & Maternity *(Consider any benefits or opportunities to advance equality as well as impact on working arrangements, part time or flexible working)*	Neutral	
Race *(Consider any benefits or opportunities to advance equality as well as any barriers impacting on ethnic groups including language)*	Neutral	
Religion or belief *(Consider any benefits or opportunities to advance equality as well as any barriers effecting people of different religions, belief or no belief)*	Neutral	
Sex *(Consider any benefits or opportunities to advance equality as well as any barriers relating to men and women eg: same sex accommodation)*	Neutral	
Sexual Orientation	Neutral	

(Consider any benefits or opportunities to advance equality as well as barriers affecting heterosexual people as well as Lesbian, Gay or Bisexual)		

If you have identified any **positive** or **neutral** impact then no further action is required, you should submit this document with your paper/policy in accordance with the governance structure.

You should also send a copy of this document to the equality impact assessment email address.

If you have identified any **negative** impact you should consider whether you can make any changes immediately to minimise any risk. This should be clearly documented on your paper cover sheet/Project Initiation Documents/Business case/policy document detailing what the negative impact is and what changes have been or can be made.

If you have identified any negative impact that has a high risk of adversely affecting any groups defined as having a protected characteristic then please continue to section 2.

Section 2 – Full analysis

If you have identified that there are potentially detrimental effects on certain protected groups, you need to consult with staff, representative bodies, local interest groups and customers that belong to these groups to analyse the effect of this impact and how it can be negated or minimised. There may also be published information available which will help with your analysis.

Is what you are proposing subject to the requirements of the Code of Practice on Consultation?	**Y/N**
Is what you are proposing subject to the requirements of the Trust's Workforce Change Policy?	**Y/N**
Who and how have you engaged to gather evidence to complete your full analysis? (List)	
What are the main outcomes of your engagement activity?	
What is your overall analysis based on your engagement activity?	

Section 3 – Action Plan

You should detail any actions arising from your full analysis in the following table; all actions should be added to the Risk Register for monitoring.

Action required	Lead name	Target date for completion	How will you measure outcomes

Following completion of the full analysis you should submit this document with your paper/policy in accordance with the governance structure.

You should also send a copy of this document to the equality impact assessment email address

Section 4 – Organisation Sign Off

Name and Designation	Signature	Date
Individual who reviewed the Analysis	Jay Naisbitt	14th February 2023
Chair of Board/Group approving/rejecting proposal	Jim Gardner / LNC	26th January 2023
Individual recording EA on central record	Tracy Lowry	14th February 2023

Appendix 2: Roles and responsibilities

Role	Responsibility
CMO (or Deputy)	Overall responsibility for the completion of the annual job planning process and will support Clinical Directors in leading and completing the process. The Medical Director also has specific responsibilities defined in section Mediation and Appeals and Pay Progression
Chief People Officer	Is responsible for ensuring appropriate systems exist to ensure all staff to whom this Policy applies are health with fairly, equitably, consistently and that current employment legislation and good practice are considered.
Clinical Directors	Are responsible for agreeing job plans within their areas of responsibility with the assistance of their managerial colleagues and ensuring consultants within their responsibility have up to date job plans
Consultants	Are responsible for complying with their contractual responsibilities and agreeing and completing a job plan annually using the Trust electronic job planning system (Allocate).
Workforce Department	Will provide general support during the mediation and appeals process and a representative will assist the medical management in the presentation of the management case to the Appeals panel.
Workforce	Will administrate and support the electronic Job Planning system and co-ordinate Scrutiny Panels.