

Consultant and SAS Doctors Job Planning Policy

V5.0

August 2019

Summary

All Trust consultant staff and SAS doctors are required to have a current job plan.

The policy and guidelines set out how job planning will be completed across the Trust for the current year.

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Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We cannot rely on opt out, it must be opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the *Information Use Framework Policy* or contact the Information Governance Team rch-tr.infogov@nhs.net

1. Introduction

1.1. This policy is based on the local interpretation of the Terms and Conditions of the Job Planning Agreement for Consultants (England) 2003 and SAS Doctors (2008) and the Guide to Consultant Job Planning agreed by the BMA and NHS Employers 2011.

1.2. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

All Trust consultant staff and SAS doctors are required to have a current job plan. The policy and guidelines set out how job planning will be completed across the Trust for the current year.

3. Scope

The policy applies to all senior medical staff working at the Royal Cornwall Hospitals Trust.

4. Definitions / Glossary

- **Direct Clinical Care (DCC)** – all activity related to individual patient care.
- **SAS doctors** - include speciality doctors, associate specialists, staff grades and a number of other career grades.
- **Supporting Professional Activity (SPA)** – time agreed as part of the job plan for activities other than DCC.

5. Ownership and Responsibilities

5.1. Role of Medical Director

The Medical Director is the lead executive responsible for the implementation of this policy.

5.2. Role of Care Group Management Team

Care Group Clinical Directors, Specialty Leads and General Managers are responsible for ensuring that annual job planning review takes place within their Care Group and that the agreed policy is fully applied.

5.3. Role of individual staff

Consultants and SAS doctors must engage in the job planning process to ensure that an agreed job plan is in place for the current year.

6. Standards and Practice

6.1. The Job Plan

6.1.1. Job planning should:

- clarify the commitment expected of doctors
- ensure consistent application of relevant principles in a transparent fashion

- support GMC revalidation procedures
- ensure that no activity or block of time is double-counted
- reflect the Trust's commitment to part-time and flexible working, improving working lives and compliance with the European Working Time Directive (EWTD)
- ensure that service development, education, training and research are recognised and supported where appropriate and defined in a transparent, equitable way.

6.1.2. Every consultant and SAS doctor must have a current job plan and is expected to deliver the job plan as agreed in their individual job plan review unless there are factors outside their control. All senior medical staff will be reminded by the Trust of their obligation for ensuring their job plan is current and to raise promptly any concerns if this cannot be achieved.

6.1.3. All consultant and SAS doctors must have a current job plan to inform their appraisal and provide a Declaration of Interest to be eligible for future threshold incremental progression.

6.1.4. A job plan consists of:

- direct clinical care (DCC) which may include both fixed NHS sessions (eg clinics/lists/ward rounds) and flexible NHS time to deliver other direct clinical care (DCC) as defined in job planning
- travel time
- on-call NHS duties as defined by prospective diary keeping and service requirements
- supporting professional activity (SPA) time divided between core activity and additional SPA
- external and academic duties
- additional responsibilities
- PMS responsibilities
- clinical admin, MDT attendances and travel should all be clearly accounted for.

6.1.5. When possible some, or all, of the job plan will be delivered by flexible or annualised working. Guidance on how to achieve this is given in Appendix 5, *Guidance on Annualisation and Flexible Working*.

6.1.6. A job plan is an agreement between the individual consultant/SAS doctor and the Care Group Clinical Director, General Manager and their specialty lead. Most doctors work as an integral part of a clinical team but the job plan itself remains an agreement between the individual and the Trust as the employer.

6.1.7. Any other time outside these agreed sessions is uncommitted, unpaid for by the NHS, and is free to be used in whatever way the doctor wishes (eg free time, private practice, family commitments). However,

account must be made of the Trust's *Conflicts of Interest Policy* and declaration of relevant activities.

6.1.8. The job plan must include the times when the doctor is never available to work for the Trust (eg regular commitments for other employers, family responsibilities, private time).

6.1.9. The Trust acknowledges that there should be no conflict of interest between working as a doctor in the NHS and delivering healthcare elsewhere (reference – *Study of Restrictions on Consultants in Relation to NHS Work during Non-Contracted Hours*).

6.1.10. Where private practice is undertaken, the principles set out in the *Private Practice Code of Conduct* and the *Study of Restrictions on Consultants in Relation to NHS Work during Non-Contracted Hours* should be adhered to.

6.1.11. The Medical Director, through Care Group Clinical Directors and General Managers, and on behalf of the Chief Executive, is responsible for ensuring agreement of annual job plans. The job plan must be agreed by the individual doctor and signed off, on behalf of the Trust, by the Specialty Lead, Clinical Director and the General Manager. An electronic job plan is essential for sign-off.

6.1.12. The consultant and Care Group General Manager may conduct an interim review of the job plan where duties, responsibilities, accountability arrangements or objectives have changed or need to change significantly within the year. If this results in a change of total PAs, three months' notice will be given unless mutual agreement is reached for a shorter time period.

6.2. Job planning time-table for current year

<u>Date</u>	<u>Action</u>
December	<i>Consultant and SAS Doctors Job Planning Policy</i> agreed at JLNC.
December	Job planning for all consultant and SAS doctors commences.
February	Job planning completed, ratification panels held.

6.3. Schedule of sessions

6.3.1. Job plans aim to define an indicative time-table but both managers and doctors are expected to recognise professionalism within that time-table. This means that doctors are not expected to 'clock on and off' and that flexibility is inevitable and encouraged.

6.3.2. In planning capacity, the working year is defined as 43 working weeks. This could be more or less dependent on annual and study leave apportioned over the three-year period. It is acknowledged that the average year constitutes 42 working weeks if full leave is taken. 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 is taken than anticipated, then the total should be reviewed and adjusted.

6.3.3. Any work in excess of 12 PAs and not funded should be identified and included as part of the job plans for the current year so that future alteration in service delivery is correctly costed and recorded. Care Groups must ensure, wherever possible, the amount of unfunded/unpaid work is minimised. The Trust will monitor actions in relation to the reduction of unfunded activity on a regular basis.

6.3.4. It is recognised that senior medical staff do not take formal, unpaid meal or rest breaks. They are, however, responsible for ensuring that they take appropriate breaks (minimum 20 minutes) to comply with the European Working Time Directive (EWTD) when they are working continuously for six hours or more.

6.3.5. Any fraction of a PA can be used for calculation purposes but PAs are payable in multiples of 0.1 PA only.

6.3.6. All PAs should show the location where the activity is scheduled. Some activities can be time-tabled off site or be provided flexibly by time-shifting but evidence should be available to confirm that such PAs are productive.

6.3.7. A full-time contract is 10 PAs. Extra PAs can be offered to a maximum of 48 contracted hours (normally 12 PAs). These additional PAs would normally be DCC sessions.

6.3.8. Where more than 10 PAs are described in a job plan, there should be a clear distinction between the baseline DCC PAs (ie those included in the 10 PA total) and additional DCC PAs.

6.3.9. No doctor will be required to work more than an average total of 48 hours in order that RCHT fulfils its responsibilities regarding standards set out in *Improving Working Lives* and the EWTD. Where there is a request to waive this right, the process outlined in *Appendix 6, European Working Time Directive* will be followed.

6.3.10. Non-RCHT sessions: the times of any non-RCHT sessions need to be detailed on the job plan. A maximum of two sessions per week can be identified on the job plan of a consultant on a fixed 12 PA contract when they are not available for RCHT NHS work.

6.4. Direct clinical care (DCC)

6.4.1. DCC refers to all activity related to direct individual patient care. 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
- MDT meetings
- outpatient and clinic activities

- clinical diagnostic work
- other patient treatment
- public health duties
- multi-disciplinary meeting about direct patient care
- administration directly related to the above (including but not limited to referrals and notes). Clinical administrative time must be time-tabled if it exceeds more than two hours in total per week in aliquots
- travel between sites for delivery of DCC activity
- providing clinical advice by e-mail, telephone and tele-conference.

6.4.2. The Care Group General Manager and Clinical Director will focus on identifying capacity in job plans on an annualised basis with an aim of triangulating as much information in relation to demand and capacity to gain a full and clear picture of job planning assumptions. Standardisation of PA allocation for clinical activity across the consultant body and among SAS doctors is the goal. To simplify staffing and to improve efficiency of regular clinics, theatres, etc, fixed clinical episodes will not include patient related administration. This DCC work must appear separately in the job plan.

6.4.3. Sessions (theatre lists, outpatients, cardiac catheter, endoscopy, etc) will be expected to provide clinical activity for their scheduled time which is normally four hours. This time will not include associated activity arising from the session such as additional anaesthetic time, letter signing, travel, etc – all this work will appear separately within the job plan. Additionally, Peninsula Medical School (PMS) DCC PA will be shown as agreed through the PMS service level agreement.

6.4.4. An annualised job plan should deliver a predictable number of clinical episodes each year based upon agreed annual leave, study leave and professional leave allocations. There will be some individual variation, particularly for individuals with specifically agreed responsibilities. Further guidance is given in *Appendix 5, Guidance on annualisation and flexible working*.

6.4.5. Where annualisation of sessions is agreed among a clinical team, it should be noted that each job plan agreement is still between an individual and the Trust. Therefore, if any member of that team changes their work pattern (eg by taking on external duties) then this may necessitate a job plan review for the other members of that team.

6.4.6. **Productivity**

6.4.6.1. For outpatient clinics and operating theatre sessions, a clear estimate of the number of patients per session should be included in the job plan. Justification will be from agreed levels of service for clinic and theatre capacity or from retrospective data including new/follow-up ratio. An individual or team's capacity should be agreed with clinical teams and specialty leads with sign off by the Care Group management team. Issues which are outside the control of the doctor must be discussed and recorded at appraisal and thence job planning. This should include the

impact of planned or unplanned absence and the impact of any significant deficiencies in supporting infrastructure.

6.4.6.2. Week-day elective work can be programmed at normal rates into contracts between 07.00 and 19.00. Other definitions of 'normal working hours' can be agreed between an individual and their specialty or Care Group Clinical Director, eg 08:00 to 20:00. Elective work programmed outside these agreed times must be at a rate approved by the doctor and their clinical manager and authorised by an Executive Director or the Ratification Group as part of the annual job planning round.

6.4.6.3. Some DCC PA work can be allocated flexibly but this must be clearly defined in the job plan. These flexible allocations could include the following if they are not easily incorporated in the fixed time-table:

- clinical administration – for example writing letters, vetting referrals, reviewing clinical notes, responding to GP or patient enquiries. If this category occupies more than one PA, the doctor should work with the Trust to reduce this workload by provision of appropriate support services
- pre and post-operative care
- early starts and late finishes not offset by flexible working elsewhere
- patient review outside defined ward rounds or 'hot' weeks (eg ad hoc patient reviews, cross-specialty referrals)
- clinical management meetings and MDTs.

6.4.6.4. Flexible DCC sessions would normally be provided within Trust premises. However, where adequate resources are not available or where flexible working is beneficial they may, if applicable, be time-shifted or re-provided at any suitable location.

6.4.6.5. If it is agreed that more than one PA of administration time is flexibly allocated, at the annual job planning review it should be agreed when this would normally be delivered (eg in otherwise unallocated time between fixed sessions, after work, as part of a backfill arrangement for cross-cover or annualisation of clinical sessions). This could be recorded in the 'comments' section of the individual's job plan or clarified in a specialty-level agreement.

6.5. Supporting Professional Activities (SPA)

6.5.1. The Academy of Medical Royal Colleges recommends that:

- new consultant posts should continue to be advertised with a job plan which typically includes 2.5 PAs with an expectation of annual review and agreement of an additional SPA above the core 1.5 SPAs
- if a consultant is employed with two or fewer SPAs, any problems with revalidation should lead to an urgent review of the SPA allocation.

6.5.2. The requirements for revalidation remain uncertain and are subject to on-going review.

6.5.3. **Consultant contracts**

A minimum of 1.5 PAs of core SPA will be allocated to all consultant contracts. Where individuals are working for more than one employer and for less than 10 PAs at RCHT, there must be clear agreement in the job plan as to what proportion each employer provides for core SPA. If SPA accounts for >30% of total PAs in a part-time contract, the job plan and allocation of PAs should be assessed on a case-by-case basis by the individual and their clinical manager to ensure that there is a proper balance between the needs for revalidation and service development and the need to deliver clinical services and to maintain adequate clinical experience. A minimum of one SPA must be fixed and specified in the job plan.

6.5.4. **New consultants**

New consultants will be appointed with an initial allocation of up to 2.5 SPA during their first year. This will be reviewed after 12 months at the annual job plan review. This constitutes best practice (Professor Sir Bruce Keogh, 2009) and should enable a new consultant to settle into their post, be given recognised time to develop their clinical service and provide adequate opportunities for mentoring. It should also ensure that the Trust can comply with any Royal College requirement of 2.5 SPA for College recognition of the new post and that new posts remain attractive to potential applicants. At annual job plan review any additional SPA time above core will be agreed.

6.5.5. **SAS doctors**

Under the terms of the national contract SAS doctors are deemed less likely to need core allocations for service management and are guaranteed a minimum SPA allocation of one PA. More senior SAS doctors are likely to need more than one SPA to meet the requirements for incremental and threshold progression. Where individuals are working for more than one employer, there must be clear agreement in the job plan as to what proportion each employer provides for core SPA. The mechanism for job planning for SAS doctors is detailed in *A UK guide to job planning for specialty doctors and associate specialists (November 2012)*.

6.5.6. **General**

6.5.6.1. All SPAs should be based on SMART objectives and measurable outcomes; allocation will require evidence of full participation in essential training programmes, evidenced at appraisal. Evidence of CPD must also be presented at appraisal.

6.5.6.2. The core SPA can be worked flexibly but it is expected that at least 0.5 of the 1.5 PA allocated to consultants will be specified and time-tabled.

6.5.6.3. Core SPA includes, for example:

- core requirements for revalidation

- participation in essential training
- appraisal and job planning
- attendance at Care Group and management meetings, if required
- rolling divisional audit/governance programmes
- clinical audit and mortality review
- general non-patient related administration, eg correspondence, e-mail
- CPD outside study leave
- informal teaching
- research not supported by external funding
- clinical management
- local governance activities and meetings.

6.5.6.4. SPA time for education and supervision must be appropriately identified and allocated to protect future potential reduction in training numbers.

6.5.6.5. Clinical work that is lost owing to activity already included in core SPA (eg the rolling governance programme) should either be re-provided flexibly at a time agreed by the doctor and clinical manager (see Appendix 5, Guidance on Annualisation and Flexible Working) or, if predictable, a correction factor applied to the DCC allocation to ensure that there is no double-payment of sessions.

6.5.6.6. Any additional SPA allocation over the core allocation must be specified in the job plan and agreed in consultation with the Specialty and Care Group clinical director. The additional SPA should be clearly defined and will be to enable the doctor to deliver the Trust's objectives or to enable the Trust to fulfil its wider responsibilities to the NHS. Each full-time consultant or senior SAS doctor will be encouraged to contribute in these other roles up to 2.5 PAs of SPA on average as per the national consultant contract. SPA time is vital to support clinical leadership and recognises the importance of clinical engagement in delivering service improvements.

6.5.6.7. The additional SPA time resource for each speciality will be agreed and performance managed by each Care Group management team following job plan ratification. All SPA should be evidenced in appraisal documentation. Much of the allocation will be for roles which are mandatory for each Care Group. Examples include:

- time-tabled educational meetings
- time-tabled clinical governance or management meetings if not included in other allocations
- PMS activity agreed with Sub Dean
- specialty clinical leadership roles
- service development

- representative role or requirement of regulatory body
- college tutor
- educational supervisor
- specialty governance role
- research
- designated NICE audits
- informatics project work.

6.5.6.8. SPA sessions should be provided wherever is most appropriate either within Trust premises or elsewhere. Typically no more than one SPA should be off-site unless the Trust is unable to provide suitable facilities (eg adequate facilities for uninterrupted working). Where adequate resources are not available at a specific time, or where flexible working is beneficial, they may, if applicable, be time-shifted or re-provided at any suitable location by agreement at job planning ratification.

6.5.6.9. Royal College and ‘Deanery’ (Health Education England Peninsula Postgraduate Medical Education) guidance should be followed for relevant PA allocations to allow postgraduate education roles.
www.peninsuladeanery.nhs.uk

6.5.6.10. All additional SPA activity over 1.5 PA will be reviewed annually by the Ratification Group (RG).

6.5.6.11. Exceptionally, a job plan may have more than 2.5 SPAs. This will require the agreement of the Medical Director and be reviewed annually.

6.6. **Additional NHS activities**

6.6.1. These are special responsibilities which are agreed between the consultant or SAS doctor and the Trust and which cannot be absorbed within the time that would normally be set aside for SPA. They must be time-tabled in the job plan. All additional responsibilities must be recorded in the job plan.

6.6.2. Current agreements, with associated responsibility payments where applicable, include:

	<u>PAs</u>	
▪ Medical Director	8	
▪ Deputy Medical Director	3	
▪ Assistant Medical Director	2	Deputy GMC Responsible Officer
▪ Medical DIPC	0.5	
▪ Care Group Clinical Director	2/4	
▪ Specialty Director	Up to 1	
▪ Director of Medical Education	3	

▪ Clinical Tutors	1	Three consultant posts and two SAS doctor posts
▪ PMS Sub Dean	2	
▪ Research & Development Lead	2	
▪ Children's Lead	1	
▪ Named Doctor (Safeguarding)	3	
▪ Director of Cancer Services	1	
▪ Organ Donation Champion	1	
▪ Clinical Data (Coding)	1	
▪ SMADEC and LNC Chair	1	Shared
▪ SAS Tutor	1.5	
▪ Quality and Safety (Serious Incidents)	0.5	
▪ Quality and Safety (Complaints)	0.5	

6.7. External NHS duties

6.7.1. All external NHS duties should be within the job plan with a clear time allocation if regular, or summative where irregular, recognising adequate time for the role that should support the NHS both locally, regionally or nationally.

6.7.2. Some external roles are remunerated by the employer, e.g. PMS. Where this is the case, this must also be made clear in the Job Plan and agreed with the Clinical Director in order for funding to be tracked to the correct budget.

6.7.3. Examples:

- PMS roles – additional to core teaching with clinical placements being shown as 2/3 NHS and 1/3 PMS. Additional activities such as feedback sessions, academic tutors should be detailed in addition to clinical placements. The SLA with the PMS should correlate with the job planning SLA and be included in the job plan sign off process
- training programme directors (payment as funded by 'Deanery')
- trade union duties
- reasonable quantities of work for the Royal Colleges in the interests of the wider NHS
- clinical network leads.

6.7.4. All additional roles must be explicit in the individual job plan and reviewed annually by the Ratification Group. The Care Group and the individual consultant/SAS doctor need to ensure that the impact on delivery of service is minimised.

6.7.5. Research and Development – activity for which funding is received from the R&D department should be included.

6.8. **On-call duties**

6.8.1. The job plan should clearly set out on-call commitments and is recognised in three ways:

- PA allocation (DCC) for work actually done, defined as predictable and unpredictable on-call
- on-call supplement to reflect frequency of on-call
- on-call availability supplement to reflect how disruptive the working pattern is.

6.8.2. Work actually done whilst on-call is paid through DCC PAs as “predictable” and “unpredictable” on-call.

6.8.3. “Predictable” on-call includes, for example, scheduled ward rounds, lists, handovers.

6.8.4. “Unpredictable” on-call includes all other emergency work, including telephone calls, unscheduled return to work, travel from home to work.

6.8.5. Routine patient administration, audit, etc that happens to be performed whilst on-call would normally be recorded within other DCC or SPA categories. The expectations for predictable on-call (eg handover arrangements, scheduled ward rounds) should be defined for each speciality.

6.8.6. The allocations for predictable and unpredictable on-call should be evidenced by diary data and averaged across the whole speciality group for a minimum of one complete rota cycle. The median value is applied to all individuals within that group.

6.8.7. The supplement is defined in the National Terms and Conditions and is based on the actual frequency of on-call work. The bands are:

- low frequency one in nine and less frequent
- medium frequency between one in five and one in nine
- high frequency more frequent than one in five.

6.8.8. This should be calculated across a typical rota cycle or calculated from an average taken over a suitably representative time (eg six months). The frequency of on-call worked will be at a higher rate than that calculated from the actual number of doctors on the rota if there is prospective cover or if a member of the rota provides a limited contribution (eg part-time or job share).

6.8.9. Interim internal cover to cover longer term vacancies or absences can be negotiated where fully supported by those on the rota (eg agreement to cover a sabbatical or maternity leave); in other circumstances the *Remuneration for Unpredictable Work Policy* will apply.

6.8.10. There are two categories to reflect the inconvenience of being on a rota and the duty to participate in it:

- category A applies to a consultant who needs to attend a place of work immediately when called or to undertake analogous interventions (eg telemedicine or complex telephone consultations)
- category B applies to a consultant who can attend a place of work later or respond by non-complex telephone consultations later. It is possible for a consultant on category B availability supplement to agree with their employer not to be contactable immediately for short intervals provided that there are arrangements for any messages to be taken and for the consultant to be able to respond immediately after the interval in question.

6.8.11. When determining which category is appropriate, reference should be made as to how disruptive the rota is to the consultant when on-call.

6.8.12. It is likely to be category A if, for example:

- the consultant needs to be available for immediate recall
- could not be out of contact with the hospital
- could not be more than 30 minutes' travel time away from the hospital
- could not be solely responsible for childcare when on-call
- they could not undertake private work whilst on-call.

6.8.13. It is likely to be category B if, for example, whilst on-call:

- the consultant could have a return time to the hospital of a maximum of two hours
- could undertake limited private practice, or
- be temporarily out of contract.

6.8.14. When determining whether category A is appropriate, owing to the need to undertake interventions with a similar level of complexity to those that would normally be carried out on site, such as tele-medicine or complex telephone consultations, assessment will need to include whether the detail of the telephone-based consultation is equivalent to that given on site and whether these consultations have a similar level of complexity to those that do require return to site. Ultimately the underlying principle of the availability supplement, that it is to compensate for disruption whilst on-call, should be paramount.

6.9. Leave

6.9.1. Leave requested and taken by individuals must be in accordance with the leave policy. When annual leave is taken for part of a week, the individual must be able to respond to the needs of the Care Group during the rest of the week.

6.9.2. Study and professional leave is provided up to a maximum allocation as defined in the *Consultant and SAS Doctors Leave Policy*, a copy of which is available from the Human Resources (Medical Staffing) folder on the document library.

6.9.3. The following principles apply to all additional study or professional leave that is granted above the normal allocation:

- a clear case must be made to the Ratification Group and will be reviewed annually
- clear benefit must be demonstrated to the Trust, local specialty, or greater NHS
- backfill arrangements and/or workload annualisation for the individual must be clear.

6.10. *Travel time*

6.10.1. Job plans should be designed to minimise disruption of fixed clinical episodes by time spent travelling between sites.

6.10.2. Travel time should appear in the job plan clearly as a DCC allocation and not be included in SPA allocations as per the national contract and will only be paid when it exceeds normal travel time of home to base hospital.

6.10.3. A consultant's base may be changed according to where the majority of the working week is conducted (eg WCH or SMH) by mutual agreement of the doctor and their clinical manager.

6.11. *Academic and research*

Job planning for academic and research activity will follow a modified process. Academic activity will map into job plans with clearly demonstrated benefit and identified funding.

6.12. *Sabbatical leave*

Proposals for sabbatical leave should be made before the annual appraisal and considered in the annual job plan review.

6.13. *Job plan agreement and publication*

6.13.1. All job plans must be agreed and signed by the individual consultant or SAS doctor concerned, the specialty lead, Care Group Clinical Director and General Manager.

6.13.2. The Trust will hold one spreadsheet that lists all job plans. The spreadsheet will be transferred to a shared drive so that Care Group teams can readily access the job plan information. Access to the shared folder is available to all consultants and SAS doctors, specialty directors, Care Group Heads of Nursing and General Managers on a read-only basis.

6.13.3. A record of any amendments made to a job plan by the Care Group during the year should be notified to the Medical Director's office so that the spreadsheet can be updated.

6.13.4. The job plan spreadsheet will be explicit as to the amount of time spent on Supporting Professional Activities (SPA) in comparison with Direct Clinical Care (DCC). This will enable consultants and SAS doctors to be benchmarked against each other or between different specialties.

6.13.5. All job plans that are not signed off by February of the current year will be requested and chased for completion.

6.14. *Probity and private practice*

6.14.1. All consultant and SAS doctors will be required to complete an electronic *Declaration of Interest* which will detail and include other activities or interests that could potentially be viewed as a conflict of interest with the Trust corporate objectives. Individuals must ensure that any changes during the year are updated and recorded to reflect any changes in role as they occur. Any potential conflict of interest and any paid work from any employer other than RCHT will be declared using the revalidation documentation at the annual appraisal. This declaration will be published in a shared job planning folder.

6.14.2. The time spent delivering this activity will be identified in the job plan but, where this is worked variably, a covering statement describing the employer, the nature of the work and the average weekly time commitment will be included.

6.14.3. Sessions within the normal working week during which it is agreed that the doctor will not normally be available for NHS work should be included in the job plan using the 'private' allocation. Other sessions that are not timetabled may be used for private activities but it may be necessary to provide diary evidence as to when displaced flexible activity is being undertaken and attendance will be expected for some activities (eg rolling audit meetings, mandatory training and other agreed SPA activity). Separate fee paying work (previously known as Cat 2) should be included using the 'private' allocation.

6.14.4. A declaration of interest statement will be included in the revalidation documentation for those undertaking private practice: "I hereby inform Royal Cornwall Hospitals Trust that, in addition to my NHS work, I also undertake private practice. This practice takes place in non-designated NHS periods and I will deliver my agreed job plan in totality. It is understood that both I and the Trust abide by the Code of Conduct for Private Practice and the Study of restrictions on consultants in relation to NHS work during non-contracted hours."

6.14.5. Where a consultant wishes to undertake private work and is not already committed to at least 11 PAs in their job plan (or, for part-time consultants, one additional PA over their base contract), the Trust may offer one extra DCC PA to the whole group of consultants within that specialty. If the extra PA is declined by the group and the consultant undertakes private work, that individual will not be entitled to receive pay progression during the year in question. If the Trust requires a consultant to reduce to 10 PAs (or equivalent pro rata for part-time doctors) this will not prejudice the consultant's right to pay progression.

6.14.6. Time shifting is the process whereby one activity (eg SPA, private practice, waiting list initiative) is carried out during the time scheduled for another (eg DCC work, clinical administration). The equivalent amount of missed activity is then re-provided during time allocated for the other activity (eg

SPA or private practice) without additional payment. This can provide flexibility and encourage professional working practices but, if it is required regularly (eg more than once per month) then a job plan review should be considered to incorporate the change in programmed activities.

6.15. Ratification process

Each Care Group will present its draft job plans for the current year for scrutiny and challenge to the Trust Ratification Group (RG) comprising representatives from another Care Group or clinical cabinet (eg General Manager, Clinical Director, specialty directors), the Medical Director and Director of Operations or their deputies and the Director of People and Organisational Development. The aim is to ensure that job planning principles are applied in a fair, equitable and transparent process across the whole Trust and to propagate best practice. A summary of the outcomes of these meetings will be used to define principles which are listed in Appendix 3, *Trust-wide Principles for Job Plans*.

6.16. Annual review, mediation and appeals

6.16.1. If there is a disagreement regarding a job plan, the next step is mediation.

6.16.2. Mediation is an informal process led by the Deputy Medical Director or Associate Medical Director for resolving disagreements. The “mediator” will initially meet with the consultant or SAS doctor and Clinical Director or specialty lead separately; all three will meet together subsequently to address the areas where agreement cannot be reached.

6.16.3. A formal appeal panel will be held if it is not possible to resolve the disagreement using the mediation process described in the national terms and conditions. This step is final.

7. Dissemination and Implementation

The policy and guidelines will be circulated to all Care Group General Managers and Clinical Directors, specialty leads, consultant staff, SAS and Trust doctors by the Medical Director.

8. Monitoring compliance and effectiveness

Element to be monitored	Development and delivery of job plans to meet agreed local delivery plans.
Lead	Medical Director
Tool	Ratification meetings to be held in February (as per page 7) of the current year. Key Performance Indicators to be agreed in each Care Group to monitor productivity and job plan delivery to meet service and agreed local delivery plans.
Frequency	The job planning process for the current year will be monitored and reviewed by the Care Group leads.
Reporting arrangements	Care Group leads to report progress to Executive team.
Acting on	Audit Committee.

recommendations and Lead(s)	
Change in practice and lessons to be shared	Identified through analysis by internal audit and implementation of agreed actions. Change in practice will be shared with all the relevant stakeholders.

9. Updating and Review

The RCHT Consultant and SAS Doctors Job Planning Agreement will be reviewed no less than every three years subject to any legislative changes, national policy instruction or Trust Board decision.

10. Equality and Diversity

10.1. The Royal Cornwall Hospitals NHS Trust is committed to a Policy of Equal Opportunities in employment. The aim of this policy is to ensure that no job applicant or employee receives less favourable treatment because of their race, colour, nationality, ethnic or national origin, or on the grounds of their age, gender, gender reassignment, marital status, domestic circumstances, disability, HIV status, sexual orientation, religion, belief, political affiliation or trade union membership, social or employment status or is disadvantaged by conditions or requirements which are not justified by the job to be done. This policy concerns all aspects of employment for existing staff and potential employees.

10.2. The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Document Title	Consultant and SAS Doctors Job Planning Policy V5.0		
Date Issued/Approved:	July 2019		
Date Valid From:	August 2019		
Date Valid To:	August 2022		
Directorate / Department responsible (author/owner):	Medical Director		
Contact details:	01872 252223		
Brief summary of contents	Local interpretation of national Terms and Conditions of Job Planning Agreement for Consultants (England) 2003 and SAS Doctors 2008		
Suggested Keywords:	Job planning, time-table, direct clinical care, job plan agreement, private practice, on-call		
Target Audience	RCHT ✓	CFT	KCCG
Executive Director responsible for Policy:	Medical Director		
Date revised:	July 2019		
This document replaces (exact title of previous version):	RCHT Consultant and SAS Doctors' Job Planning Agreement for Current Year V4.0		
Approval route (names of committees)/consultation:	JLNC, PRG		
Signature of Jonathan Lord Chair of JLNC	{Original copy signed}		
Signature of Executive Director giving approval	{Original copy signed}		
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only
Document Library Folder/Sub Folder	Human Resources/Medical Staffing		
Links to key external standards	CQC Regulation 18		
Related Documents:	<ul style="list-style-type: none"> ▪ Consultant and SAS Doctors Leave Policy ▪ Additional Employment Policy ▪ Conflict of Interests Policy for Royal Cornwall Hospitals NHS Trust 		
Training Need Identified?	No		

Version Control Table

Date	Version No	Summary of Changes	Changes Made by (Name and Job Title)
	V1.0	Initial version	
Nov 2011	V2.0	Full review and consultation.	Sophie Scott Deputy Director of HR
Dec 2012	V3.0	Full review and consultation	Jo Gibbs Chief Operating Officer
Dec 2013	V4.0	Full review and consultation	Duncan Browne Interim Medical Director
July 2019	V5.0	<ul style="list-style-type: none"> ▪ Reformatted to comply with reviewed Trust Policy template. ▪ Very minor changes only to reflect current organisational structure etc pending a full review following the implementation of e-job planning. 	Helen Strickland HR Business Partner

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Initial Equality Impact Assessment Form

<i>Name of the strategy / policy / proposal / service function to be assessed</i> Consultant and SAS Doctors Job Planning Policy V5.0					
Directorate and service area: Human Resources/Medical Staffing			New or existing document: Existing		
Name of individual completing assessment: Helen Strickland			Telephone: 01872 25 2649		
1. <i>Policy Aim*</i> <i>Who is the strategy / policy / proposal / service function aimed at?</i>	Job planning for senior staff.				
2. <i>Policy Objectives*</i>	To set out clear job planning principles for the Trust.				
3. <i>Policy – intended Outcomes*</i>	Equality across the organisation in its job planning process.				
4. <i>*How will you measure the outcome?</i>	Ratification Group. Analysis of data held on the central job plan database.				
5. <i>Who is intended to benefit from the policy?</i>	Executive team, Care Group leads, Trust and senior medical staff.				
6a <i>Who did you consult with</i>	Workforce	Patients	Local groups	External organisations	Other
	✓				
b). <i>Please identify the groups who have been consulted about this procedure.</i>	The JLNC was consulted on the original procedure. This updated policy has only been reformatted and updated for currency so further consultation is not required at this stage, pending a full review.				
What was the outcome of the consultation?	Please see above.				

7. The Impact

Please complete the following table. **If you are unsure/don't know if there is a negative impact you need to repeat the consultation step.**

Are there concerns that the policy could have differential impact on:				
Equality Strands:	Yes	No	Unsure	Rationale for Assessment / Existing Evidence
Age		✓		
Sex (male, female, trans-gender / gender reassignment)		✓		
Race / Ethnic communities /groups		✓		
Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.		✓		
Religion / other beliefs		✓		
Marriage and Civil partnership		✓		
Pregnancy and maternity		✓		
Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian		✓		
<p>You will need to continue to a full Equality Impact Assessment if the following have been highlighted:</p> <ul style="list-style-type: none"> You have ticked “Yes” in any column above and No consultation or evidence of there being consultation- this <u>excludes</u> any <i>policies</i> which have been identified as not requiring consultation. or Major this relates to service redesign or development 				
8. Please indicate if a full equality analysis is recommended.			Yes	No ✓
9. If you are not recommending a Full Impact assessment please explain why.				
Not indicated.				
Date of completion and submission	July 2019	Members approving screening assessment		Policy Review Group (PRG) APPROVED

A summary of the results will be published on the Trust’s web site.

Appendix 3. Trust-wide principles for job plans

The following principles have been agreed for the current year job planning process.

- Theatre operating lists are 1.25 PAs which include Anaesthetic and Surgical pre and post operating rounds or 2.5 PAs if a full day session.
- The timing of theatre lists is from the patient entering the theatre anaesthetised to leaving for recovery. Job planning should be used to encourage safety briefing meetings at the beginning of each list. Usually lists will be 09.00 to 13.00 in the morning and either 13.30 to 17.30 or 14.00 to 18.00 in the afternoon. All day operating lists are scheduled 09.00 to 17.30 in theatre.
- Pre and post time should be consistently allocated – usually 0.25 PA per session/list for both surgeons and anaesthetists.
- Outpatient sessions usually last four hours with a full, agreed templated new to follow up ratio but should be timetabled for less when it is not possible to run them for the full four hours.
- Outpatient templates should be consistent in a specialty and college guidance viewed as an absolute minimum as many specialties have templates that substantially exceed college guidance.
- Admin time is complex as the work is created in a variety of ways. Care Groups have different approaches eg an allocation per four hour outpatient session or a fixed amount pro rata for the number of DCCs in a job plan.
- MDTs – these consume a large amount of consultant time but generally seem to be efficiently run with the appropriate attendance; MDT work must be identified on the job plan.
- Educational supervision – RCHT needs to be able to demonstrate appropriate time in consultant job plans as funding changes mean that we will not be paid the usual amount of the trainee's salary if we do not. Most Care Groups have included 0.125 PA per trainee with some having paid college tutor time on top taking it close to the required 0.25 PA per trainee.

Appendix 4. Checklist for job plan sign-off

Specialty Sign-Off

Executive Sign-Off

1. **Clinical DCC**
Full clinics of four hours with an agreed templated new to follow up ratio and one PA for four hours decreasing if the clinic is of three-hour duration
2. **Operating Lists**
1.25 PAs to include Anaesthetic and Surgical pre and post op rounds.
2.5 PAs for an all-day list
3. **Core SPAs**
1.5 PA for consultants.
1.0 PA for other senior medical staff.

This includes Care Group/management meetings and Governance meetings.
4. **Clinical Admin**
 - 4.1 For specialties with clinics, operating lists, MDTs and on-going continuity of care, this is likely to be approximately six hours or 1.5 PAs usually relating to a 12 PA job plan. This should be pro-rata'd down on the number of clinical DCC activities that are undertaken. This is clinical admin, not admin associated with day to day Trust management and revalidation which is core SPA.
 - 4.2 Non face to face clinical advice should be explicitly recorded as part of clinical admin time, eg avoidance of outpatient attendance. This is in order to support being paid for it.
5. **Ward rounds**
These need to be pro-rata and reflect the on-going case load of inpatients related to either emergency or planned care. Examples would be General Surgery with two hours per week and Trauma and Orthopaedics with one hour per week.

6. **MDT**
MDTs should be identified on job plans for those who are required to attend. The time actually spent at the meeting should be identified if the whole meeting is not always attended.
7. **Travel**
This is as per the agreed schedule minus any time saved by a consultant living closer to the outlying hospital than RCHT.
8. **Correction factors**
Correction factors for prospective cover need to be explained as this is a complex area and consistency across Care Groups is required.
9. **Peninsula Medical School (PMS)**
Time to be included in job plans with clinical placements being recognised as 2/3 NHS; 1/3 PMS. Additional activities, such as feedback sessions, should be recorded in addition to clinical placements. The service level agreement (SLA) with PMS should correlate with the job planning SLA and included in the sign-off process.
10. **Additional responsibilities**
Clinical directors' and specialty leads' time should be recorded in this section. Care Groups have approximately two PAs of governance time which is distributed differently within the Care Groups. This needs clearly identifying in the job plans.
11. **Cancer leads**
Where a specialty has a significant focus on cancer care, a cancer lead may be identified in job plans. This, however, must be accompanied with an agreed description of the role.
12. **Education**
Educational supervisors receive 0.125 PA per trainee and the rotation being supervised needs to be specified on the individual job plan.

Additional educational activities such as college tutors and training leads should be identified. Only externally funded additional roles will be recognised.

13. **Consultant appraisers**
0.25 PAs should be included where possible for the appraisal of 10 colleagues per year.
14. **On-call activity**
Predictable and unpredictable on-call hours should be recorded in the job plan as per the schedule.
15. **On-call category**
This needs to be clearly documented and include the frequency. This is to reflect the availability and speed of response of the consultant. The actual work conducted is recorded in the predictable and unpredictable on-call.
16. **Specialty leave policy**
This must be submitted with the specialty job plans.
17. **Research and development**
Activity for which funding is received from the R&D department should be included.
18. **Private sessions**
The times of any fixed sessions need to be detailed on the job plan. A maximum of two sessions per week can be identified on the job plan of a consultant on 12 PAs when they are not available for RCHT NHS work.

A summary sheet for each specialty must be completed.

Once job plans are agreed and signed off, they will be uploaded to *R:\RCH Job Plans* and stored in the folder for the appropriate year.

Appendix 5. Guidance on annualisation and flexible working

1. Definition

- 1.1. Annualisation is an approach to job planning in which a doctor contracts with their employer to undertake a particular number of PAs on an annual, rather than a weekly, basis.
- 1.2. Annualisation can be used to increase flexibility for both doctor and employer: for example, predictable peaks and troughs of activity can be proactively managed or cross-cover for sessions built in so that they are not cancelled during one doctor's leave. For the employee sessions could, for example, be worked predominantly in term-time with increased time off during school holidays or flexibly used to facilitate other duties like academic work or external duties.
- 1.3. Most doctors already carry out part of their work on an annualised basis: for example, on-call is normally prospectively covered and varies from week to week.
- 1.4. Although true annualisation refers to calculations made over a calendar year, the principles apply to all forms of flexible working. The terms "flexible" and "annualised" are therefore largely interchangeable in the context of this document.

2. Scope

- 2.1. There are numerous different models of flexible working that can be followed:
 - limited, eg annualised on-call arrangements
 - agreements for cross-cover within a team so that sessions are not cancelled during leave
 - allocation of flexible PAs that can be translated into fixed clinical sessions within a weekly departmental roster
 - service week working to cover specific areas of activity (eg an acute admissions unit)
 - full, eg agreement of a whole team to staff an entire service (eg ITU).
- 2.2. Advantages are likely to be greatest where there are benefits to both employer and employee where flexibility permits more productive working that improves patient care and where the agreement is transparent and clearly defined.
- 2.3. Although there are many different models that could be used, there are some common principles and each agreement should adhere to the principles outlined in section 3 and define the key parameters and limits of flexibility as outlined in section 4.

3. Principles

3.1. Annualisation is a flexible working arrangement.

Doctors work an agreed total of programmed activities instead of the same number each week.

3.2. The arrangement must be compatible with the consultant and SAS contract and job planning best practice.

3.3. The arrangement must be agreed.

This agreement is between the individual doctor and their clinical manager although often doctors will agree to annualisation within a clinical team. If there are changes to the team (eg absences or change in duties) then the agreement with each individual may have to be revised.

3.4. A robust agreement needs to define three key parameters.

The number of clinical sessions that need to be covered, the number of weeks in the working year and the scope and limits of the flexibility.

3.5. Agreement must be reached on how many PAs are to be done in a year.

This is normally expressed as a mean number per week multiplied by the number of weeks in the working year.

3.6. In calculations, leave must be able to be taken during a normal working week.

If, in practice, leave cannot be taken during certain phases (eg in a service week, during a nightshift or whilst on-call) then compensation for this prospective cover must be built in. It is usually easiest to account for prospective cover by annualising over a working year as described below. However, this is not always practical and, in junior doctors' rotas for example, it is normal practice to calculate prospective cover separately. If it really is necessary to calculate prospective cover in job plans, it is normally more convenient to account for it either through monitoring via a diary exercise (eg to determine the actual time working in a rolling "average" period) or by annualising over an adjusted working year as described below.

3.7. The number of weeks in the working year is not fixed.

It is 52 minus leave, including absence from external duties, vacancies, maternity leave, etc. The normal working week is usually assumed to be 42 weeks (52 weeks minus six weeks' annual leave, 10 days' public holiday and statutory days, up to 11 annualised days' study and professional leave) but this may be less (eg consultants with more than seven years' service have an additional two days' annual leave; there may be additional external duties) ie 41.5 weeks. It should be possible to calculate prospectively the number of weeks of leave that will be taken but, if there is doubt, then a check every six months can be made and the annualised total adjusted. If calculations are made prior to study leave and professional leave being taken, then 44 and 43.5 weeks should be used.

3.8. The number of clinical sessions that need to be worked must account for variations in the whole team and are not necessarily distributed evenly.

If there are team members with external duties, absent colleagues through sickness or vacancies, or a high proportion of consultants with more than seven years' service, then the total number of annualised sessions may be different for each team member. The total number of sessions needs to account for unproductive time (eg service closures during holidays, scheduled down-time owing to maintenance). It is unreasonable to ask doctors to pay back sessions that arise either from extra leave or from cancellations that are beyond their control.

3.9. The balance between DCC and other work must be fair, balanced and facilitate safe practice.

3.10. Annualisation represents a professional contract and does not call for clocking on and off.

Doctors deliver continuity of care and are not shift workers but, conversely, any arrangement must not exploit this professionalism with persistent over-running.

3.11. Annualised PAs should be spaced out reasonably.

An arrangement will fail if sessions are, for example, disproportionately needed at one time of the year or if it results in a working week being overloaded with clinical activity. Where sessions are predictably cancelled (eg for rolling audit) it is usually preferable to adjust the annualised total to prevent double counting rather than expecting this sessions to be repaid (eg where a theatre is cancelled owing to audit, it is unlikely another would be available and it is better simply to calculate the number of theatres that will be lost over the year and reduce this from the total DCC if the audit is already accounted for in the SPA allocation). Sessions that the doctor expected to work but are cancelled for reasons beyond their control do not have to be repaid.

3.12. Study leave and professional leave.

The number of sessions to be delivered each year can be calculated with no study leave and professional leave included and then decreased as leave is taken. Alternatively, all the study leave and professional leave can be included and, if not taken, additional sessions added.

4. Practicalities

Although there are many variations as to how agreements could be drawn up, most will need to define at least some of the following parameters in order to provide clarity and transparency.

- **Define the number of fixed sessions and any times that can never be worked.**

Most job plans will have some sessions that need to be fixed on a weekly timetable (eg elective theatres, scheduled clinics) which the doctor and Trust would expect to be worked on a regular, predictable basis. There may also be sessions when doctors are not available for work and these are listed as

“Private” in the job plan. These sessions will never be available for annualised work and must be defined in the job plan. Not all doctors will need to fix all these sessions – for many, a flexible approach may be better for some or all of these. However, fixing predictable private sessions is important for some groups (eg part-time workers; those with outside commitments; portfolio workers or those with more than one employer; predictable private practice). All other sessions can be assumed to be available for work up to the total number of contracted PAs.

The number of fixed private sessions that can be included should be agreed at the job plan review but, as a guide, would usually be no more than the number of PAs remaining when all those that are worked flexibly or out of hours (eg agreed non-timetabled SPA, travel time, on call, other agreed non-timetabled sessions such as some administration – hereafter referred to collectively as “floating PAs”) are subtracted from the total contracted PAs and this subtracted from a nominal 40-hour week in which the annualised sessions would be worked:

guide number of available private sessions = (10-session working week in which flexible sessions could be worked – total contracted PAs) + floating PAs

Part-timers use the same calculation (deducting their contracted PAs from a nominal 10-session availability in the week).

If there is agreement that weekend or evening sessions should be included in the annualisation then, instead of using 10 sessions as the assumption for the working week, this is increased and a correspondingly higher number of private sessions would become available. It should be noted that out of hour sessions are the equivalent of 1.3 PA each four-hour block and that it is entirely voluntary as to whether an individual agrees to work out of hours for elective activity.

- **Define any fixed sessions that can be displaced by clinical activity.**
Some fixed sessions can be displaced into other times and therefore could be used to provide annualised sessions. For example, a team of two surgeons may have an agreement to cross cover for leave and schedule a fixed admin session at the same time as a theatre session. When one is on leave, the admin is re-provided at another time. Such an arrangement provides both transparency (it is clear what each doctor is contracted to do during these sessions) and flexibility but can only be used when the displaced session can be readily provided in a flexible way.
- **Define the minimum notice period for which a doctor can be asked to work a flexible session.**
This will be two weeks less than the notice period needed for leave and would normally be fixed on a rolling rota published as soon as possible after leave can no longer be taken (eg if the minimum notice time for leave is eight weeks, flexible sessions would be rostered with a minimum of six weeks’ notice). Doctors are not expected to repay sessions that are cancelled for reasons beyond their control unless two weeks’ notice given.

- **Define the maximum notice period for which a doctor can be asked to repay a flexible session.**

This will normally be the same as the minimum notice period – the “balance sheet” is kept even over an agreed rolling cycle of the same duration as minimum notice for leave. However, it may be advantageous to have more flexibility and agree a degree of carryover but it should be exceptional not to wipe the slate clean each year at the job plan review and the presumption is that any sessions that have not been worked will be written off at the review. This number should be used to inform the number of annualised sessions agreed for the following year.

- **Calculate the length of the working year.**

As described in paragraph 3.7.

- **Calculate the total number of sessions that need to be annualised.**

As described in paragraph 3.8.

This should be adjusted to account for double counting (eg cancellations for audit) and scheduled cancellations (eg service closure over Christmas/New Year, maintenance).

- **Annualised sessions are total number of sessions divided by length of working year.**

- **Other factors that are fundamental to the operation of a flexible working roster should also be recorded.**

For example, agreements that leave is co-ordinated so that all members of a team are not absent at the same time; agreements to cross-cover displaced admin or other sessions.

- **Each department should have a named individual responsible for rota co-ordination.**

This individual has responsibility for tracking the flexible sessions and for alerting both the doctor and the clinical manager if sessions are being under or over used over the agreed rolling period.

- **In the event of any disputes, in the first instance resolution between the doctor and clinical manager is encouraged.**

If this does not resolve the issue, an informal group consisting of representatives from SMADEC, LNC, Medical Staffing and the Medical Director’s office will attempt to arbitrate. If this fails to resolve the problem, the Trust’s processes for job plan appeals and grievance procedures will apply.

5. Examples of best practice of flexible working in RCHT

ITU – full annualisation

The Critical Care consultants share a generic job plan. The workload (PAs) for each component of the job (ICU cover, outreach, on-call, PMS activities, etc) is calculated and divided equally between the eight consultants who then have an equal commitment to cover those elements of the service in a fully flexible rota. The generic components of the job plan total 9.5 PAs each, leaving up to a further

2.5 PAs (within the constraints of a maximum 12 PAs) for individual aspects of the job. These may be additional activities (such as Specialty Director, Trust roles, etc) or clinical roles such as anaesthetic lists. The consultants undertake to fulfil all components of the job plan, managing leave internally to ensure that sufficient consultants are present to cover all duties.

Appendix 6. European Working Time Directive

1. A waiver of the EWTD is only possible as a voluntary offer by the consultant and no individual can be required to waive their right to the EWTD provisions.
2. The consultant must request, in writing, to the specialty director their wish to be able to waive the EWTD, indicating the start and finish date of such an agreement. This would normally be for a short term and not longer than the timeframe of the job plan and for a maximum period of 12 months.
3. Where a job plan describes more than 12 PAs the consultant and specialty lead should draw up an agreement recording:
 - the reasons for needing the consultant to work in excess of 48 hours
 - the time period of the agreement (no more than one year)
 - a set of actions that will return the workload to within 48 hours.
4. A copy of the agreement should be provided to the Care Group General Manager and Clinical Director who will sign the agreement reached by the consultant and Specialty Director.
5. For the duration of the period of work in excess of 48 hours the consultant or rota co-ordinator must, if requested by the speciality or clinical director, complete a workload diary and submit this on a four-weekly basis to the speciality lead. For each four-week period the speciality lead will confirm that the level of funded additional activity is being delivered and, if necessary, adjust the agreed PA allocation. In each 26-week period the specialty lead must report to the Clinical Director on the total hours of actual work completed by the consultant.
6. The Trust may decide not to contract consultants for additional clinical work, despite a voluntary request, beyond the EWTD in circumstances where there is too high a clinical risk (eg obstetrics, cardiac surgery, neurosurgery)
7. The consultant should provide a minimum one month's notice if they choose to reduce their hours to their original contract.
8. If the Trust terminates the agreement the specialty director will write to the consultant giving one month's notice and reasons for doing so.
9. All waiver agreements from the previous year, and any proposed for the following year, will be reviewed and scrutinised at the annual job planning review process that includes representation from an external Care Group, the Medical Director's office and Staff-Side representatives.