Model job plan <u>Ms Mandy Bull</u> – Consultant OMFS who works on three sites – The Queen Camilla Hospital (QC)- a large forward-thinking DGH with aspirations towards Foundation status - ,The Milburn Memorial Hospital (MM) - a smaller hospital protected by 'Keeping the NHS Local' - , and St. Coughups (St.Cs) - a local private hospital.

1. Job content

Day	Time	Location	Work	Categorisation	No. of PAs
Monday	0800-1000	QC	Ward Round	C4 DCC	0.5
	1000-1400	QC	Patient Admin.	C11 DCC	1.0
	1400-1800	QC	Clinic	C2 DCC	1.0
Tuesday	0800-1800	QC	Major Op List	C3 DCC	2.5
Wednesday	0800-1000	QC	Ward	C4 DCC	0.5
	1000-1300	QC	Supporting	S1-S7 SPA	0.75
	1300-1330,1630-1700		Travel (QC to MM and back)	C10 DCC	0.25
	1330-1630	MM	Clinic	C2 DCC	0.75
Thursday	0800-1200	QC	Clinic	C2 DCC	1.00
	1200-1400	QC	Supporting	S1-S7 SPA	0.5
	1430-	St.Cs	Private Pts	P1,P2	
Friday	0800-1300	Variable	Supporting	S1-S7 SPA	1.25
	1330-1730	QC	Operating	C3 DCC	1.00
Saturday	1000-1200	Variable	Other Duties	D1-D5	0.5
Sunday					
Additional agreed activity to be worked flexibly	Variable		Management, Regional and national Meetings	ADD	0.5
Predictable emergency on-call work				Direct clinical care	

Unpredictable emergency on-call work	Variable	On-site, at home on the telephone and travelling to and from site		Direct clinical care	
TOTAL PAs					

Programmed activity	**Number**
Direct clinical care (including unpredictable on-call)	**8.5**
Supporting professional activities	**2.5**
Other NHS responsibilities	**0.5**
External duties	**0.5**
TOTAL PROGRAMMED ACTIVITIES	**12**

Notes

(a) There are four time blocks set out for each day. Not all blocks need to be filled in. It is feasible that consultants will have 1,2, 3 or even more PAs on any one day.

(b) Under 'additional agreed activity' the consultant might agree, for example, with the employer that they will undertake a certain proportion of regular patient administration equating to x PAs, at an unspecified time and location during the week. This section might also be used to set out the number of PAs for any unpredictable external duties.

(c) Predictable on-call work: where this work follows a regular pattern each week, consultants should identify within the weekly schedule when and where this takes place. Where such work does not follow a regular pattern, for example due to the variability of the on-call rota, consultants should assess an average level of activity per week and identify it in the predictable activity box at the bottom of the form.

(d) The location and timing of unpredictable emergency work cannot be completed, therefore only the categorisation and number of PAs should be completed.

(e) Location can be the principal place of work or any other agreed location e.g. the consultant's home for some duties.

(f) In the 'work' column, a description of the duty should be completed, e.g. outpatient clinic, ward round, operating list.

(g) The 'categorisation' column should define whether the work is direct clinical care, supporting professional activity, additional NHS responsibility or external duty.

(h) The number of PAs should specify the number of PAs allocated to the duty. This can be a full PA or broken down into smaller units. If the work is in premium time after 1 April 2004, 3 hours of work is one programmed activity.

(i) *Regular* private practice commitments should be identified broadly in terms of timing, location and type of work.

(j) In addition to regular duties and commitments, the consultant might have certain ad-hoc responsibilities. These would normally but not exclusively fall into the 'additional NHS responsibilities' or 'external duties' categories of work, for example member of an Advisory Appointments Committee or work for a Royal College. Such duties could be scheduled or agreement could be reached to deal with such work flexibly (see section 5 below).

2. On-call availability supplement

Agreed on-call rota e.g. 1 in 5:	No. of colleagues on published rota
Agreed category (delete):	**A / B**
On-call supplement e.g. 5%:	

3. Objectives

Objectives and how they will be met
1. **Continue to provide high quality emergency services (with the necessary support available).** 2. **Sustain local Trust Objectives where adequately resourced.** 3. **Continue teamworking (MDT, networking etc)** 4. **Participate in audit and clinical governance at local and other levels.** 5. **Work with management to sustain local activity in the light of other pressures.**

4. Supporting resources

Facilities and resources required for delivery of duties and objectives	**Continued availability of access to ITU, Ward, and Ambulatory care beds. Some degree of agreed flexibility to maintain a balanced service to all aspects of NHS needs.**
1. Staffing support	**Recruit additional ward staff. Ensure where possible continued recruitment to OMFS with expansion of SpR grade.**
2. Accommodation	**Ensure out-patient and ambulatory care facilities are appropriately funded with sufficient clinic and office accommodation. Improve staff residencies.**
3. Equipment	**Ensure adequate funding to maintain/update essential operating dept. items.**
4. Any other required resources	**Increase secretarial support in the light of continued and expanding need (Clin. Governance, Audit, Protocols etc.)**

6. Additional NHS responsibilities and/or external duties

Specify how any responsibilities or duties not scheduled within the normal timetable will be dealt with Following local agreement to ensure that service is maintained and other colleagues not unduly burdened.

Note: In addition to regular duties and commitments, the consultant might have certain ad-hoc responsibilities. These would normally but not exclusively fall into the 'additional NHS responsibilities' or 'external duties' categories of work, for example member of an Advisory Appointments Committee or work for a Royal College. Such duties could be scheduled or agreement could be reached to deal with such work flexibly. The method of dealing with such commitments should be set out in the box above.

6. Other comments or agreements

Detail any other specific agreements reached about how the job plan will operate. For example, with regard to category 2 fees, domiciliary consultations and location flexibility.

7. Additional programmed activities

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

If yes to (e) please describe:
……
……

8. Signed off and agreed

Consultant name ……..

Signed (consultant) ……..

Date ……..

Clinical manager ……..

Signed (clinical manager) ……..

Date ……..

ADDITIONAL NOTES TO HELP OMFS COLLEAGUES WHEN COMPLETING JOB PLANS

1. The attached draft job plan is certainly not meant to be exclusive and is merely an attempt to represent a reasonable spread of activity for an OMFS colleague. It is accepted that there will be wide individual variation but an attempt should be made to ensure that the proportions of 7.5 for clinical care to 2.5 of supporting activity is broadly maintained.

2. Although that the enclosed draft shows the working day starting at 0800 hours it is accepted that this may well not be the norm, but a later start will of course generally mean a later finish in order to make up the hours.

3. OMFS colleagues are also reminded that on completion of the job plan they will need to agree seniority (i.e., years in post) and time taken for a second primary degree can now be included (if this has not already been assessed on appointment) see page 30, para 6.

4. Care should be taken when choosing the incremental date. This will normally be 1st April 2003, but as seniority is reckoned in whole years it may be beneficial to agree a later incremental date (foregoing any additional remuneration in the intervening months) as this may mean that the next pay threshold more quickly (see the Ready Reckoner on the BMA website).

5. Although PAs in excess of 10 are not pensionable the draft new contract does say "Pensionable pay… and any other pay expressly agreed to be pensionable". Colleagues may wish to bear this in mind when negotiating and certainly if previously they have been paying superannuation on additional remunerated sessions (e.g., managerial commitments).

6. The inclusion of lunchtime in the assessment of PAs is a matter for local and personal judgement. Certainly on days where it is not possible to have a short break this time should be counted.

7. On-call availability supplements will vary with frequency and intensity.

8. Assessment of predictable and unpredictable will vary between Units but if, for instance, you routinely have a Saturday morning ward round following a night on-take this can be assessed as the number of hours spent at premium time divided by the rota frequency to give a weekly assessment of PAs. Remember that as from 1st April 2004 premium time is assessed as 3 hours.

9. Remember, you are not obliged to undertake more than 10 PAs, unless you wish to do so, and some would suggest that you would be in a strong position to negotiate an enhanced rate for PAs in excess of 11. This will no doubt be a matter for local LNCs.

10. Under the European Working Time Directive (EWTD) employees are not meant to work for more than 6 hours without a 20 min break. If say 20 or 30 mins are taken for lunch, then it should be made clear that you are not available to do any NHS activity apart from dealing with clinical emergencies and may be off the premises. Alternatively, many of us are available for management meetings, give advice to trainees, take phone calls in relation to NHS work at the same time as eating a sandwich. Under these circumstances, lunch should be included within the working day. However, management cannot have it both ways i.e. expect consultants to be available for meetings or other NHS activity within unpaid lunch breaks.

11. Under the new contract the maximum part-time option is gone (for those that switch across) and therefore there is no travelling time into the base hospital. Travelling time can be claimed for travelling to peripheral centres from base and also the excess travelling time (i.e. travel time less time to base) when travelling from home to a peripheral centre. This comes out of the Direct Patient Care PAs.

12. Many consultants will work more than 11 PAs and some less. Some management has said they will not pay more than 12 PAs, as this is the maximum under the EWTD. This is not true – they can pay more than 12 provided consultants opt out on an annual basis of the protection of the EWTD. This facility may not last much longer, as the EWTD is meant to be health and safety legislation for employees. Consultants can also work more than 12 PAs and still be compliant with the 48-hour weekly limit provided some of the PAs are undertaken in premium time and are only 3 hours long.

13. The EWTD does not apply to self-employment. You cannot therefore be told that if you offer 11 PAs to the Trust that means that you can only work 4 hours in private practice. In other words, if you want to kill yourself doing additional work in private practice that is up to you but you must turn up for work able to do the job you are paid for.

14. Do not agree to less than 2.5 PAs for supporting activities –for many in our specialty 3 PAs will be reasonable provided they can be justified on the job plan.

Remember all the administration related to patient care must now come out of the Direct Patient Care PAs. This includes planning for surgery, discussing joint management of cases with colleagues, reporting radiographs, as well as dictating letters etc.