GPC

General Practitioners Committee

Job Planning

Guidance for GPs

July 2014

BMA

Job planning

The job plan is the document that translates expectations of employee and employer into a working schedule. It ensures that the post delivers its aims and the requirements of the contract of employment are met, including provision for CPD.

Contents

Principles of a good job plan

(1) Job Plans: should be developed collaboratively between the employer and employee reviewed regularly by mutual agreement. This should be done at a minimum of 8-12 weeks after initial appointment, and then annually, or when there are any significant changes to the work pattern suggested by either party.

(2) Scheduling in job plan should include:

- (a) Clinical duties: appointments, visits, dealing with telephone queries from patients or other health care professionals
- (b) Administration/paperwork: whether arising directly from this caseload (referrals, investigations, results) and indirectly (reports, medicals, etc).
- (c) Primary care team meetings: formal or informal, essential to the delivery of team based care, discussing clinical practice standards, developing practice protocols, mutual professional support for the individual practitioners, audit, significant event analysis, meetings with colleagues in the locality, care trust etc. Where these occur on an *ad hoc* basis, adjustments to clinical workload may be required.
- (d) Personal CPD (continuing professional development) time: This may include a mix of in-house meetings and events, time away from the practice, either in private study, attending educational events or *time in lieu* of attending educational events outside of normal working hours.
- (e) Time for personal mentoring
- (f) Specific specialist roles in the practice: e.g. medical student or registrar teaching or training, responsibility for particular areas of practice development, QoF areas of responsibility, 'Practitioner with Special Interest' etc.

(3) Workload should be:

- (a) Broadly Defined in amount (number of patients) and type (clinical, paperwork, team meetings), with provisions for fluctuations in exceptional circumstances.
- (b) Reflect the individual employee's particular abilities and developmental priorities, such as those relating to experience, return after a career break, disability, or knowledge of a second language.

(c) Realistically match contracted hours as defined in the contract of employment

(d) Balanced, recognising both clinical and non-clinical work (including meetings, both formal and informal and administration). It is estimated that the ratio of clinical work to administrative work is usually in the region of 3:1 for salaried doctors without any practice development role and this excludes meetings. This ratio may vary greatly from practice to practice. Where the post-holder works effectively like a salaried partner or performer/provider, this ratio is likely to include significantly more time needed for practice development.

(4) Extra contractual duties: there must be clear agreement on arrangements regarding how and when extra-contractual duties (where agreed to) will be recognised, when time in lieu will be taken (e.g. monthly or added to annual leave), or when additional payments are made. This is of particular relevance where there are significant fluctuations in workload and hours of the employed doctor if she or he is helping to cover another doctors' absence, for example, sickness or maternity leave.

(5) Session length: although a session is defined as 4 hours and 10 minutes, periods of duty do not need to be exact multiples of sessions. For example, short days are permissible as long as the hours are all counted. An example would be where childcare commitments mean that an employee may prefer to work short days – perhaps two days from 9 am to 3 pm and one day from 9 am to 1.40 pm = 4 sessions (16 hours 40 minutes).

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

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

(8) Paperwork: it is helpful to specify whether this includes correspondence/prescriptions addressed only to the doctor or whether it includes a share of the day's workload. Reports – whether time is allocated within the general admin time, and reports are shared, or whether time is blocked-off during surgery and whether the fee is retained by the doctor.

(9) On-call: commitment should be specified in terms of frequency but also maximum number in a month or year as on call duties can often extend contracted hours for that day or week. e.g. 12 mornings a year, and the hours covered. On call frequency should be based and **not exceed** the pro-rata share of clinical work for that doctor. So for example a doctor works 4 sessions in a practice where there are 40 sessions provided by doctors. The doctor should not be required to work more than 1:10 of the on calls (assuming all are present and not off on maternity and long term sick). On calls in a year (52x5)-8= 252. Share for this doctor is 252/10=25 per year or around 2.5/month.

(10) Clinical workload: it is not appropriate to base clinical workload on that of partners. This is because partners (defined as performers/providers under the new contract) define their role and workload as a reflection of their profit share rather than in hours. As profits can fall and rise so can the workload of partners in a way which should not be expected to affect salaried doctors on an hour's based contract. Employed doctors are contracted and paid on the basis of time worked. There is a risk of breach of contract if employed doctors' commitments increase due to,

for example, a colleagues' leave, unless these additional duties are entered into by mutual agreement (see Model terms and conditions of service for a salaried general practitioner employed by a practice or PCO and the provision for additional sessions).

(11) Assessment of workload: an employed GP contracted to work an 8 hour day should not be expected to see the same number of patients as a partner who works a 9 or 10 hour day. Just because partners decide to attend meetings in addition to existing around clinical commitments does not mean it would be appropriate for salaried doctors to do so if this means an unpaid increase in their hours work. Such an arrangement would necessitate additional payment or time-off in lieu.

(12) Surgery times: should make a realistic allowance for late arrival of patients, overrunning, as well as necessary time to make urgent referrals which cannot wait until the next worked session. A session finish time of 5.30 would require the last booked appointment to be at at 5 pm (or earlier if the doctor only works one day a week and needs to finalise all referrals the same day). The time at the end of surgery will depend on the length of the surgery, on when the doctor will next be in to act on referrals, and perhaps the practice's policy on patients who attend late for their appointment.

(13) Visits: these are usually expected to take 30 minutes. Any estimation made should be realistic and, for example, in rural practices, a longer time would be necessary where extended travelling time for visits will need to be taken into account. It is preferable to indicate a number rather than a range. Where a range is indicated for a day, it is advisable to agree a maximum weekly limit so that where visiting time erodes admin time on one day the balance can be redressed on another day without a exceeding contracted hours. There should be clarity about the cut-off time when the visits become the responsibility of the doctor on call.

Commonly asked questions

Sessions vs hours?

It has been traditional to talk about sessions in general practice. Under the retainer scheme a session was originally defined as 3-3.5 hours.

Under the new GMS model salaried GP model contract:

- Full time is 9 sessions or 37.5 hours per week
- The length of a session is therefore 4 hours and 10 minutes
- CPD entitlement is one session per week /4 hours per week on an annualised basis for full time practitioners and *pro rata* for part-time practitioners.

Calculating the contractual commitment (working hours) is key to calculating the appropriate level of entitlement to bank holidays, continuing professional development (CPD) and pensionable service.

Can I work for periods of duty that are shorter than 4 hours?

Yes there is nothing to stop you agreeing with your employer a job plan with the following hours:

9 am - 3 pm Monday
9 am - 12 pm Tuesday
9 am - 12 pm Wednesday

The contracted hours are 12 hours per week, or 12/37.5 of full time.

How do I calculate my CPD entitlement if I don't work a multiple of the standard session length?

The annual CPD entitlement in hours is equal to the weekly contracted hours x 4.86. For the example above the CPD entitlement is 12 hours x 4.86 = 58 hours *per annum* (or 14 sessions, with a session being 4 hours and 10 minutes). Please see the table of sessions on p.8 of this guidance.

Can practice team meetings or informal team meetings over coffee count towards the CPD entitlement?

Not all meetings are educational. Primary care team meetings are an essential part of the work of all GPs and an important activity in their own right. These meetings may have as overriding priorities coordinating the care which the team provides to patients, discussing clinical practice standards and developing practice protocols, as well as providing mutual support for the individual practitioners. Many of these activities are essential to the management of the practice and to clinical governance. The salaried GP model contract makes provision for attendance at these meetings outwith the CPD entitlement, and therefore time spent at these meetings should not be deducted from the CPD entitlement. Some of these informal meetings may have mentoring value. And it is for the employee to decide with his/her educational supervisor how his/her personal mentoring will best be provided.

Should the job plan include unpaid breaks?

As a general rule the answer is NO. This is because:

(1) The gaps between fixed clinical commitments are crucial opportunities for communication between team members whether this is as formal team meetings, or informally. Unpaid breaks fail to recognise the professional attitude of GPs who have traditionally been prepared to have working lunches, discussing cases, practice issues, or where there is a high workload, catching up on paperwork.

(2) Short breaks of, for example, 30 minutes, which preclude the GP from absenting himself or herself from the surgery will generally mean that he/she will be considered and treated as available for queries by staff, other health care professionals, GP registrars or patients.

(3) Where workload is exceptionally heavy, a salaried GP would most likely agree to help out with extras or visits over and above his or her agreed job plan even if scheduled to be on a break.

It is helpful to note guidance issued by the BMA in respect of breaks in hospital consultants' job plans (below).

The BMA consultants' committee guidance on breaks:

A proper balance of work and rest is vital to maintaining a healthy workforce. The BMA thus recommends that consultants should ensure adequate breaks from clinical work during the day. However the BMA believes that the nature of many consultants' work means that it is rarely possible for them to absent themselves from clinical duties and have a total break. This necessarily professional attitude to patient care means that during a day of clinical activity it is unlikely that many consultants will be able to free themselves from potential interruption so as to allow an unpaid lunch break. The professional nature of consultant work will allow breaks to be taken where possible, but their continuous availability during this time is a benefit to patients. Consultants normally exercise their judgement in taking breaks flexibly, at times chosen to minimise disruption to patient care and to promote the safety of patients.

The BMA consultants' committee guidance on lunch breaks:

There has been much discussion over the question of lunch breaks, and whether they should be included in programmed activity time and therefore paid, or counted as an unpaid 'gap' in the day. The answer is perhaps surprisingly simple.

Where there is not a real break from employed activities, then this should be recognised, with no break between Programmed activities. For example, the consultant who attends a lunchtime postgraduate meeting, multidisciplinary meeting or management meeting clearly has no break and the time must count as PA time. Similarly, consultants who eats lunch between cases in theatre, at their desk while reading clinical notes or in front of their computer while checking work e-mails have no real break.

The SiMAP ruling established that time spent at the workplace and at the disposal of the employer counts as work, even if the employee is able to sleep. So, the only sort of break which should be scheduled as unpaid, non-PA time is if there is a genuine break in activity, in particular when the consultant is able to leave the premises and be uncontactable, for example to take lunch in a nearby restaurant, walk in a park, on the beach or to go shopping. This should be stated clearly in writing by management, for the avoidance of any confusion. Further, management should make clear in writing what other arrangements they have made for the cover of patients, clinical emergencies, GP phone calls, ITU or CCU while you are not working at the lunch time. Further, they need to recognise the loss of flexibility and capacity that will follow from consultants needing to get clinical activities 'wrapped up' in order to get their lunch break before the next programmed activity begins.

In the vast majority of cases it makes far more sense to accept that consultants are very senior staff who eat lunch flexibly and at times which fit around patient care and without a genuine break from work. Many consultants will not have a lunch break outside of PA time, because few have genuine breaks between activity.

As for the working time directive, consultants have derogated from the rest periods so that compensatory rest can be taken at another time. Although regular breaks are desirable they are not mandatory and in any case the nature of consultants' working lives makes it difficult to take them at set times.

Job plan

MONDAY	
Start time	
Finish time (and time of last appointment)	
Hours worked this day	
Am surgery: number of patient, first and last appts	
Pm surgery number of patients, first and last appts	
Visits (number)	
Time for admin	
Meetings start and finish time	
Comments: e.g. adjustments to workload to allow attendance at monthly meetings	
Mentoring time	

TUESDAY	
Start time	
Finish time (and time of last appointment)	
Hours worked this day	
Am surgery: number of patient, first and last appts	
Pm surgery number of patients, first and last appts	
Visits	
Time for admin	
Meetings start and finish time	
Comments: e.g. adjustments to workload to allow attendance at monthly meetings	
Mentoring time	

WEDNESDAY	
Start time	
Finish time (and time of last appointment)	
Hours worked this day	
Am surgery: number of patient, first and last appts	
Pm surgery number of patients, first and last appts	
Visits	
Time for admin	
Meetings start and finish time	
Comments: e.g. adjustments to workload to allow attendance at monthly meetings	
Mentoring time	

THURSDAY	
Start time	
Finish time (and time of last appointment)	
Hours worked this day	
Am surgery: number of patient, first and last appts	
Pm surgery number of patients, first and last appts	
Visits	
Time for admin	
Meetings start and finish time	
Comments: e.g. adjustments to workload to allow attendance at monthly meetings	
Mentoring time	

FRIDAY)	
Start time	
Finish time (and time of last appointment)	
Hours worked this day	
Am surgery: number of patient, first and last appts	
Pm surgery number of patients, first and last appts	
Visits	
Time for admin	
Meetings start and finish time	
Comments: e.g. adjustments to workload to allow attendance at monthly meetings	
Mentoring time	

On call duties

Start time	
Finish time	
Frequency	
How many on calls in a year?	
Does this extend the normal day? If so by how many hours	
Arrangement to take time back in lieu e.g. one session in lieu per month on last Thursday pm of month in lieu of extended day by 1hour4 on calls/month	

Continuing Professional Development (CPD) provision within this post: CPD Entitlement in sessions

Number of contracted session per week	9	8	7	6	5	4	3	2	1
CPD sessions per annum	44	39	34	29	24	19	15	10	5(*8)

CPD entitlement per annum in sessions	
CPD entitlement per annum in hours **of weekly contracted hours X 4.86.** *e.g. if contracted to work 18 hours/week the annual CPD entitlement is 87.5 hours/annum or 21 sessions of 4 hours and 10 minutes***.**	
Time to be spent in practice educational meetings (on working days): *e.g. weekly educational meeting lasting one hour is 44 hours a year or 10.5 sessions*	
Time to spent on CPD activities away from the practice: e.g. example for a 5 session GP: *total annual entitlement is 24 sessions a year (101hours) of which 44 are used attending weekly practice educational meetings, this leaves 57 hours (13.6 sessions) to be taken at a frequency of one day off for CPD out of practice every 7 weeks.*	

NB periods of duty do not need to be exact multiples of sessions e.g. short days are permissible as long as the hours are all counted e.g. 2 days 9am to 3pm and one day 9am to 1340pm = 4 sessions.

MEETINGS			
Day of week	Time	Frequency (wkly/ mthly)	Topic content: e.g. clinical team mtgs, educational, business

Specialist roles within a practice

(*Please complete one sheet per role)*

Definition of role e.g. practice lead in diabetes
What skills and knowledge base will be required to carry this out?:
What support will the individual receive from within the practice? Key admin support (name) and their role Key managerial support (name and their role)
What support will the GP receive from outside the practice? e.g. local groups of experts
Other comments

Job plan diary

The aim of the diary is to:

1. inform the annual job plan review
2. help prevent and resolve disputes about whether job plans are being followed and contracts honoured.

General points

1. Coding can be done at a simplistic level (just ABCD,) or include more detailed codes e.g. I1, I2, I3 etc where specific questions are posed.

2. There is an additional column for recording location of duties and also for separating duties for the practice from duties carried out for external organisations and possibly remunerated separately. This may not be required every time, but may be useful where time is used flexibly between internal and external duties and all parties want to be satisfied that separate roles are being honoured.

3. The list is not exhaustive and additional codes may be added, especially to the external activities.

4. A balance needs to be struck between details and practicality. Making the recording too onerous may jeopardise its accuracy. The level of detail in the diary should be agreed by employer and employee before the diary is carried out, and agreement should be sought regarding a suitable 4 weeks period which is felt to be truly representative of the workload.

5. It may be useful to record the location of duties including those done at home, but it is not essential.

6. It may be useful to code duties according to who the employer or contractor is, especially when these activities are fitted in to practice time.

Questions arising from the diary will usually fall into two categories:

1. Is the contract being honoured? That the hours are not excessive, CPD entitlement is correct etc.
2. Is the balance of activities appropriate? For example, is there adequate time for administrative work, meetings, mentoring, CPD etc.

Coding activities for diary

Direct clinical care		
Surgery appointments	Separate codes can be assigned to distinguish specialised clinics e.g. baby clinic, ANC, diabetes, minor ops. (e.g. A1, A2, A3, A4)	A
Home visits	Includes travelling time and recording in notes	B
Telephone	Telephone appointments and triage	C
On call time-	when has to be available for emergencies	D
Indirect clinical care		
Referrals	Written or by telephone To external services or to other Health care professionals within the practice	I1
Incoming Correspondence	Reading, actioning	I2
Results	Reading and actioning	I3
Prescriptions	Repeats and queries	I4
Team discussion of cases	Case conference or other PHCT meetings where patients are discussed, or telephone discussion	I5
Supporting clinical activities		
Business or partnership meetings	Business, management, employment issues, premises, tax, accounts, partnership agreement, etc	N
Clinical team meetings	Clinical matters- practice development, protocols, audit, practice guidelines, clinical governance	O
Practice meetings educational		P
Personal CPD	Private study, online modules, attending outpatient clinics, courses lectures, audit etc	Q
Appraisal	Preparation, meeting and follow up	R
External activities	Can also code X for covered by contract, Y if work for another employer e.g. PCT)	
Training registrar	And related activities e.g. trainers meetings	V1
Teaching students	And related activities e.g. preparation and training for this role	V2
PCT work		V3
Private work done during surgery time	Specially if remunerated separately e.g. appraisals for external GPs, drug trial work	V4

Diary of activities

Name:

Date:

	Activity code[1]	Location [2]	Employer/ contractor[3]
7am 730am			
730 am 8am			
8-830			
830-9			
9-930			
930-1000			
1000-1030			
1030-1100			
1130-1200			
1200-1230			
1230-1300			
1300-1330			
1330-1400			
1400-1430			
1430-1500			
1500-1530			
1530-1600			
1600-1630			
1630-1700			
1700-1730			
1730-1800			
1800-1830			
1900-1930			
1930-2000			

Additional codes to ones in guidance:

[1] See Activity codes- table which is included in this document

[2] This column will only be required occasionally where this is of special interest. Please indicate the codes you have decided to use (none suggested) and which locations they refer to in the documentation accompanying the diary.

[3] This column will only be required occasionally, where relevant. Please indicate the codes you have decided to use (none suggested) and which employers or contractors they refer to e.g. PCT, university etc. in the documentation accompanying the diary.

Job plan diary – analysis and review

Average time spent on:

		Daily :	Weekly (total divided by 4)
Direct clinical care		(*sum of below)*	(*sum of below)*
Surgery appointments	A		
Home visits	B		
Telephone	C		
On call time-	D		
Indirect clinical care		(*sum of below)*	(*sum of below)*
Referrals	I1		
Incoming correspondence	I2		
Results	I3		
Prescriptions	I4		
Team discussion of cases	I5		
Supporting clinical activities		(*sum of below)*	(*sum of below)*
Practice meetings	N		
Practice meetings	O		
Practice meetings educational	P		
Personal CPD	Q		
Appraisal	R		
External activities			
Training registrar	V1		
Teaching students	V2		
PCT work	V3		
Private work done during surgery time	V4		

Total weekly hours worked (on activities for the practice as required by contract excluding work for external organisations)	
Percentage of this time spent on direct clinical care (DCC)	
Percentage of this time spent on indirect clinical care (IDC)	
Percentage of this time spent on supporting clinical activities (SPA)	
Additional time spent on external activities (EA)	

Job plan review of diary

Name of employee

Employer's representative: Name

Date

	Comments and suggestions for review of Job Plan.
Is the number of hours worked consistent with the contract of employment?	
Is the practitioner able to attend practice meetings ? If not why and what can be done to promote inclusion ?	
Admin Does the doctor have sufficient time for admin ? Has delegation of task been discussed ? (e.g. coding, summarising , production of medical insurance reports, notes retrieval, etc)	
Problem areas identified:	

Practice developments, proposal for change in job plan by employer	