NHS WALES GIG CYMRU

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Amendment to the National Consultant Contract in Wales

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Foreword by the Minister of Health and Social Services

The new amended consultant contract for Wales, which has been accepted by the profession, the Service and by Government is good news for everyone including patients, staff and the health service as a whole.

It represents an endorsement of the hard work and negotiations which have been undertaken by the BMA, NHS Wales and Welsh Assembly Government.

The amended contract marks a significant step forward for the health service in Wales. It will encourage consultants to remain committed to the NHS with a more vigorous job planning system. The contract also includes the introduction of commitment awards for all consultants who work hard, deliver the treatment of patients required, have a good appraisal and generally show commitment to the NHS.

The actual work carried out for the NHS will increase and no private practice is to be undertaken in NHS time. This contract will also hopefully give a significant boost to the recruitment of consultants in Wales.

It shows what can be achieved when we all work together. It is now time to move forward together to continue with improving the health service in Wales.

Jane Hutt

Jane Hutt AM
Minister for Health and Social Services

PREFACE

Welsh Assembly Government, NHS Wales and BMA Cymru Wales (herein after to be referred to as Forum Terms and Conditions Committee (FTCC)) have agreed the following amendments to the regulation of the Consultant Contract in Wales, via the job planning process. These create :

- A basic full time working week of 37.5 hours, in line with other NHS staff
- Better definition of the working week
- Organisational clarity through a revised job planning process
- A new salary scale with enhancements and additional increments
- Improved arrangements for on-call remuneration
- New arrangements for clinical commitment and clinical excellence awards
- A commitment to improve flexible working
- A shared commitment to enhance the quality of service for the benefit of patients

These amendments are intended to improve the Consultant working environment, to improve Consultant recruitment and retention, and to facilitate health managers and Consultants to work together to provide a better service for patients in Wales. This is an integral part of the modernisation of NHS Wales.

Any betterment agreed in any of the other UK countries will be reviewed in light of its potential effect on Consultant recruitment and retention in Wales. These amendments will be kept under review by the FTCC and will be the subject of a first formal overall review by December 2005.

CHAPTER 1

JOB PLANNING

Introduction

1.1 Effective job planning underpins the majority of the amendments to the regulation of the Consultant Contract in Wales.

1.2 In particular, the job planning process is the vehicle for the Consultant and the employer to agree the composition and scheduling of activities into the sessions that comprise the working week, mutual expectations of what is to be achieved through these, and for discussing and agreeing changes on a regular basis.

1.3 The system of mandatory job planning applies to all Consultants, including clinical academics.

1.4 Annual job plan reviews will continue to be separate from but supported by the new appraisal system. Both appraisal and job plan review will be supported by improved information.

1.5 Employers and Consultants will draw up and agree job plans, setting out the Consultant's duties, responsibilities and expected outcomes. After full discussion with the Consultant, decisions will be made as to how and when the duties and responsibilities in the job plan will be delivered, taking into account the Consultant's views on resources and priorities.

1.6 Job plans will set out a Consultant's duties, responsibilities, time commitments and accountability arrangements, including all direct clinical care, supporting professional activities and other NHS responsibilities (including managerial responsibilities). It will be a contractual responsibility to fulfil these elements of the job plan.

1.7 Job plans will set out the agreed service outcomes. These will be expected to reflect different, evolving phases in Consultants' careers, and appropriate continuing professional development requirements. The delivery of outcomes will not be contractually binding, but Consultants will be expected to participate in, and make every reasonable effort to achieve these. Pay progression via commitment awards will be informed by this process.

1.8 Where Consultants work for more than one NHS employer, a lead employer will be designated and an integrated single job plan agreed.

1.9 Where a Consultant disagrees with a job planning decision, there will be an initial referral to the Medical Director (or an appropriate other person if the Medical Director is one of the parties to the initial decision), with provision for subsequent local resolution, or appeal, if required (Paragraphs 1.34 – 1.39).

Principles

1.10 The principles are:

- Mandatory job planning for Consultants.
- Annual job plan review, supported by the agreed appraisal system and by improved information with appropriate external benchmarks.
- There will be joint responsibility to draw up and agree job plans setting out main duties, responsibilities and expected outcomes.
- Job plans to cover all aspects of a Consultant's practice in the NHS including research and teaching.
- Employers are responsible for ensuring Consultants have the facilities, training, development and support needed to deliver agreed commitments.
- Job plans should reflect agreed duties, responsibilities and expected outcomes with an interim job plan review if these change, or need to change significantly during the year.
- Equally explicit recognition of duties, responsibilities and agreed expected outcomes for clinical academics as for other Consultants.

The Job Plan

1.11 The job plan will set out the main duties and responsibilities of the post and the service to be provided for which the Consultant will be accountable.

1.12 This will include, as appropriate

- Direct clinical care duties

- Supporting professional activities
- Additional responsibilities
- Any other agreed external duties
- Any agreed additional sessions

As set out in Chapter 2 – The Working Week.

1.13 Managerial responsibilities

The job plan will include any management responsibilities, recognising that specific responsibilities and duties will vary between Consultants.

1.14 Accountability arrangements -

The job plan will set out the Consultant's accountability arrangements both professional and managerial within the NHS organisation. Accountability will be :

- managerially typically to the Clinical Director or Medical Director, and, ultimately, the Chief Executive; and
- professionally to the Medical Director, who is accountable to the Chief Executive

The Consultant will comply with the requirements of the GMC's "Good Medical Practice" and/or GDC's "Maintaining Standards".

Time and Service Commitments

1.15 After discussion the employer and Consultant will draw up an agreed timetable specifying the nature and location of all activities in the working week including direct clinical care sessions, supporting professional activities, additional responsibilities, sessions and any other agreed duties.

1.16 A job plan will cover on call and out of hours commitments. Regular predictable commitments arising from on-call responsibilities will be scheduled into sessions. Rota commitments will also be specified.

Outcomes

1.17 Outcomes will set out a mutual understanding of what the Consultant and employer will be seeking to achieve over the next 12 months – based on past experience and reasonable expectations of what might be achievable in future.

1.18 Outcomes may vary according to specialty but the headings under which they could be listed include:

- Activity and safe practice
- Clinical outcomes
- Clinical standards
- Local service requirements
- Management of resources, including efficient use of NHS resources
- Quality of Care

1.19 Outcomes need to be appropriate, identified and agreed. These could include outcomes that may be numerical, and/or the local application of modernisation initiatives.

1.20 Delivery against the job plan may be affected by changes in circumstances or factors outside the control of the individual – all of which will be taken into account at job plan review and considered fully and sensitively in the appraisal process. Consultants will be expected to work towards the delivery of mutually agreed outcomes set out in the job plan.

1.21 Outcomes should be kept under review, and the Consultant or Employer will be expected to organise an interim job plan review if either believe that outcomes might not be achieved or circumstances may have significantly changed. Employers and Consultants will be expected to identify problems (affecting the likelihood of meeting outcomes) as they emerge, rather than wait until the job plan review.

Job Plan Review

1.22 The job plan will be agreed between the employer and the individual Consultant on appointment to the post and reviewed annually at the job plan review. The job plan review will be supported by the same information that feeds

into appraisal, and by the outcome of the appraisal discussion. Interim job planning reviews will be conducted where duties, responsibilities or outcomes are changed or need to change significantly within the year, or where the time commitment involved breaches the contract hours Trigger Point (Chapter 2, Paragraph 2.26).

1.23 The job plan review will usually be carried out by the same person who undertakes the appraisal, in most cases the Clinical or Medical Director. The job plan review will cover the job content, outcomes, time and service commitments.

1.24 Job plan review will be an opportunity for the employer and the Consultant to address :

- Whether agreed outcomes need to be reviewed
- The adequacy of resources and,
- The need for amendment to time and service commitments

1.25 Following the discussion at the job plan review, the Chief Executive will confirm to the Consultant whether the job plan review is satisfactory, or is unsatisfactory. A satisfactory job plan review will result when a Consultant has :

- Met the time and service commitments in their job plan
- Met the agreed outcomes in their job plan, or – where this is not achieved for reasons beyond the individual Consultants control – has made every reasonable effort to do so
- Participated satisfactorily in annual appraisal, job planning and the setting of outcomes
- Worked towards any changes identified as being necessary to support achievement of the agreed outcomes in the last job plan review

1.26 This will inform decisions on pay progression. Commitment Awards will be paid automatically on satisfactory review, or in the absence of an unsatisfactory job plan review (Chapter 5).

1.27 Job plan reviews for all Consultants will take place within one month of the Consultant's incremental date, unless jointly agreed otherwise.

1.28 It is the employer's responsibility to arrange the job plan review within the relevant timescale, and for the Consultant to co-operate with this. In the absence of a job plan review a satisfactory result will be recorded.

1.29 Unsatisfactory job plan reviews may raise issues that need to be considered via the agreed Disciplinary arrangements.

Links with Appraisal

1.30 Job Planning is linked closely with the agreed appraisal scheme for Consultants, although in some cases the requirement for the appraiser to be on the Medical or Dental Register will mean that they are carried out by different people. Both the appraisal and the job plan review are informed by information on the quality and quantity of the Consultant's work over the previous year. Both processes will involve discussion of service outcomes, and linked personal development plans, including how far these have been met.

1.31 Appraisal is a process to review a Consultant's work and performance, to consolidate and improve on good performance and identify development needs which will be reflected in a personal development plan for the coming year. Appraisal discussion will cover working practices including the role of the individual Consultant in a clinical team, clinical governance responsibilities and continuing professional development as set out in the agreed personal development plan. The job plan will take account of outcomes of that discussion

1.32 Appraisal is also an opportunity to consider the longer-term career development of the Consultant. This will take account of how best to use the acquired skills and experience of a Consultant over their career in terms of benefiting other staff and the service. This will particularly be relevant in the latter stages of a Consultant's career, and will be used to inform discussions on the Consultant's time and service commitments during the job planning review, including the balance between direct clinical care and supporting professional activities sessions.

1.33 In addition, this will recognise that a Consultant's pattern of work may well change over the years. To facilitate this process, the Medical Director will arrange an interview in the Consultants mid 50's, or other appropriate time, during which the possible options are explored. These may include continuing with a mainly clinical commitment, or replacing this with some management or teaching activity, or altering the nature of the Consultants clinical work. Any changes will be subject to the exigencies of the service.

Agreeing the Job Plan and Appeals

1.34 If it is not possible to agree a job plan, either initially or at an annual review, this matter will be referred to the Medical Director (or an appropriate other person if the Medical Director is one of the parties to the initial discussion).

1.35 The Medical Director will, either personally, or with the Chief Executive, seek to resolve any outstanding issues informally with the parties involved. This is expected to be the way in which the vast majority of such issues will be resolved.

1.36 In the exceptional circumstances when any outstanding issue cannot be resolved informally, the Medical Director will consult with the Chief Executive prior to confirming in writing to the Consultant and their Clinical Director (or equivalent) that this is the case, and instigate a local appeals panel to reach a final resolution of the matter.

1.37 The local appeals panel will comprise : One representative nominated by the Consultant, and one representative nominated by the Trust Chief Executive. These representatives shall be from a panel nominated by BMA Cymru Wales and Trust HR Directors who have been approved as trained in conciliation techniques.

1.38 The panel will be expected to hear the appeal following the format of the employer's normal grievance procedure, and reach a decision which will be binding on both parties. Representatives will not act in a legal capacity.

1.39 In exceptional circumstances where a decision cannot be agreed, a second panel would be constituted with alternative representatives as set out in Paragraph 1.37.

Clinical Academics

1.40 NHS Trusts in Wales will work with Universities to agree the commitments with those on honorary contracts, and build a job plan accordingly. Job plans for Clinical Academics will recognise that their role encompasses their responsibilities for teaching, research and the associated medical services (Chapter 8).

CHAPTER 2

THE WORKING WEEK

Introduction

2.1 The new system for organising a Consultant's working week is described below.

2.2 The working week for a full-time Consultant will comprise 10 sessions with a timetabled value of three to four hours each. After discussions with Trust management (see job planning above), these sessions will be programmed in appropriate blocks of time to average a 37.5 hour week.

2.3 There will be flexibility for the precise length of individual sessions, though regular and significant differences between timetabled hours and hours worked should be addressed through the mechanism of the job plan review.

2.4 Work in evenings or weekends will only be undertaken with the voluntary agreement of the Consultant and the employer.

2.5 For a full time Consultant, there will typically be 7 sessions for 'direct clinical care' and 3 for 'supporting professional activities' (Paragraphs 2.20 and 2.21 below). Variations will need to be agreed by the employer and the Consultant at the job planning review.

Further consideration will be given to:

- 'Additional NHS responsibilities' that may be substituted for other work or remunerated separately

- 'other duties' – external work that can be included in the working week with the employer's agreement.

2.6 There will be scope for local variation to take account of individual circumstances and service needs. For example; management, teaching, research and development.

2.7 There will be scope for flexible working.

2.8 With the employer's and Consultant's agreement, specified **additional NHS responsibilities**, for instance additional work undertaken by clinical governance leads, Caldicott Guardians or Clinical Audit leads, may be included in the working week.

The employer and the Consultant will work together to manage such additional NHS responsibilities.

These responsibilities will be substituted for other activities or remunerated separately by agreement between the Consultant and the employer.

2.9 Certain **other external duties**, for example inspections for CHI or trade union duties, or duties in connection with professional healthcare organisations, may also be included in the working week by explicit agreement between Consultant and employer. The employer and the Consultant will work together to manage such external duties. Where carrying out other duties might affect the performance of direct clinical care duties, a revised programme of activities should be agreed as far in advance as possible.

2.10 Fee paying work including Category 2 (such as for government departments and additional work for NHS organisations) should not attract double payment. However, it may be carried out with the professional fee retained by the Consultant in the following circumstances, which will be agreed in the job plan review :-

1. When carried out in the Consultants uncontracted time or in annual or unpaid leave.

2. Where it is agreed the work involves minimal disruption to contracted NHS time. This may be particularly relevant in circumstances such as the undertaking of the occasional post-mortem examination for the Coroner's office. This will be considered as part of the job plan review.

3. Where such work constitutes a significant element of time, Consultants will identify this in the job planning process, and identify $37\frac{1}{2}$ hours of time provided to the NHS apart from this work.

If none of the above circumstances apply and the work is carried out within NHS sessions with no compensatory time provided elsewhere, the professional fee is remitted to the employer. Otherwise provision as set out in Terms & Conditions, Paragraphs 30 to 39.

2.11 Domiciliary visits as defined in Section 140 of Terms & Conditions, and Family Planning fees will attract a fee when undertaken outside NHS sessions.

Where it is agreed there is minimal disruption in undertaking this work during contractual time, the practitioner will retain the fee.

2.12 Sessions of "supporting professional activities" – mutually agreed at the job planning review, may be scheduled across the week such that up to one session of contractual commitment may take place outside the normal working hours leaving a similar period free in which there is *no* contractual commitment during normal working hours.

Supporting professional activities sessions will be exclusively devoted to NHS work. The location(s) of this will be discussed and agreed at the job planning review.

This will recognise the normal good practices for flexible working arrangements available to all NHS staff (Chapter 10 - Equal Opportunities).

2.13 For *full time* Consultants travelling time between their main place of work and home or private practice premises will not be regarded as part of those sessions. Travelling from main base to other NHS sites, travel to and from work for other NHS emergencies, and 'excess travel' will count as working time. 'Excess travel' is defined as time spent travelling between home and a working site other than the Consultant's main place of work, after deducting the time normally spent travelling between home and main place of work. Employers and Consultants may need to agree arrangements for dealing with more complex working days.

2.14 The contract will allow for **additional sessions** to be contracted separately up to and above the maximum permitted under the Working Time Regulations where agreed between employer and Consultant.

Principles

2.15 Structure of the working week should:

- Set clear levels of accountability and contractual commitments, alongside reasonable expectations of professional flexibility
- Recognise different patterns of work intensity, including emergency work
- Allow for flexible working patterns to facilitate the modernisation agenda.

Working Week

2.16 Welsh Assembly Government, NHS Wales and BMA Cymru Wales agree that the contract should not involve any element of clocking on and off and overtime payments will not be available. It is also recognised that there should be scope for variation, up and down, in the length of individual sessions from week to week around the average assessment set out in the job plan

2.17 The working week will be expressed in terms of sessions which for a full time Consultant will be 10.

2.18 Each session will typically be of between 3 – 4 hours duration.

2.19 The total normal hours in the working week will be 37½ hours.

2.20 **Direct clinical care** covers:

i Emergency duties (including emergency work carried out during or arising from on-call).

ii Operating sessions including pre and post-operative care.

iii Ward rounds.

iv Out-patient clinics.

v Clinical diagnostic work

vi Other patient treatment

vii Public health duties

viii Multi-disciplinary meetings about direct patient care

ix Administration directly related to patient care (e.g. Referrals, notes)

2.21 **Supporting professional activities** cover a number of activities which underpin direct clinical care, including:

i Training

ii Continuing professional development

iii Teaching

iv Audit

v Job Planning

vi Appraisal

vii Research

viii Clinical Management

ix Local clinical governance activities

2.22 Regular and significant differences between a Consultant's timetabled hours and the hours actually worked will need to be discussed as part of job plan reviews either at the planned annual review or an interim job plan review.

Flexibility

2.23 The contract will allow, by agreement between Consultants and employers, for flexible timetabling of commitments over a period. Flexible timetabling could help meet varying service needs by allowing adjustment to working patterns at different times of year.

It could, in some cases, fit with the need for teaching and research requirements. Examples could include:

- Offering the flexibility for a Consultant to focus on an intensive research project for part of the year or to alternate clinical and teaching duties across the year;
- Term time working
- Consultant of the week arrangements

2.24 When arranging flexible timetables, the contract as a whole will be expressed in terms of the annual equivalent of the working week. By agreement between the Consultant and the employer, the job plan will specify variations in the level and distribution of sessions within the overall annual total. A Consultant could thus work more or less than the standard number of sessions in particular weeks.

2.25 Any variations in the length of the working week will need to be considered within the provisions of the Working Time Directive.

2.26 It is recognised that Consultants may be undertaking more or less hours than the normal 37.5 hours in the week. Job planning review will be triggered if Consultants regularly work one session more (or less than) these hours each week on average. There will be no increase or decrease in remuneration until the job plan review is triggered by either party. In this event, the provisions of Paragraphs 2.27 – 2.31 below (Unrecognised Additional Work) will apply.

Unrecognised Additional Work

2.27 Where it is identified, through the job planning process, that a Consultant is undertaking a session or more a week of additional or pro rata for part-time work on a regular basis, in excess of their contracted hours, and not arising at the request of the employer, then the employer can request that such work be continued as additional sessions for the relevant period of time in excess of the contracted sessions, or discontinued as required.

2.28 These additional sessions will be voluntary, and can be ended at the request of either the Consultant or the employer, with reasonable notice.

2.29 They may be undertaken during the working week in uncontracted time within an agreed overall annual total.

2.30 Such sessions will be paid initially at plain time rates, then at a premium rate of 1.25 after 24 months, and subsequently at a higher premium rate of 1.5 after 48 months.

2.31 There will be an expectation that such work will be eliminated or undertaken in other ways over a period of time.

Planned Additional Sessions

2.32 Consultants may be requested by their employer to carry out additional sessions from time to time in excess of their contracted sessions.

2.33 These additional sessions will be voluntary.

2.34 They may be undertaken during the working week in uncontracted time within an agreed overall annual total.

2.35 Remuneration for such work will be locally negotiated between the employer and the Consultant.

Waiting List Initiative Sessions

2.36 Waiting List Initiatives work may be requested by the employer to be carried out in addition to the Consultant's contracted sessions.

2.37 These additional sessions will be voluntary.

2.38 Such sessions may be undertaken in uncontracted time.

2.39 Remuneration for such work will be at the rate set out in the Annex when carried out on Trust premises. All aspects of such work will be taken into account in calculating such sessions, e.g. time taken to see patients pre and post operatively.

Additional responsibilities

2.40 Some Consultants have additional responsibilities agreed with their employer which cannot reasonably be absorbed within the time available for supporting activities. These will be substituted for other work or remunerated separately by agreement between the employer and the Consultant. Such responsibilities could include those of:

- Caldicott guardians
- Clinical audit leads
- Clinical governance leads
- Undergraduate and postgraduate deans, clinical tutors, regional education advisor
- Regular teaching and research commitments over and above the norm, and not otherwise remunerated
- Professional representational roles

2.41 Responsibilities of Medical Directors, clinical directors and lead clinicians will be reflected by substitution or additional remuneration agreed locally.

Other duties

2.42 Certain other external duties, including work for other NHS organisations, might be specified as within the working week by explicit agreement between

Consultant and employer based on a clear understanding of the sessions that will be fulfilled.

Such duties, all of which must be explicitly agreed in advance, and may involve a rearrangement of clinical activities, could include:

- Trade union duties
- Acting as an external member of an Advisory Appointments Committee
- Undertaking assessments for the NCAA
- Reasonable quantities of work for the Royal Colleges in the interests of the wider NHS
- Specified work for the General Medical Council
- Undertaking inspections for the Commission for Health Improvement or other health regulatory bodies

2.43 For any other professional activities which are not covered in the job plan, depending on the nature of the duties, paid professional leave or unpaid leave may be available.

2.44 Study leave, with pay and expenses will be granted regularly. Employers may, at their discretion, grant further study leave above the limit as set out in Paragraph 252 of Terms and Conditions of Service, with or without pay. Otherwise, time taken out of the working week for such commitments will be treated as annual leave

2.45 All Consultants will be eligible to apply for sabbatical leave (Chapter 14, Paragraphs 14.5 – 14.9).

2.46 All time taken out of the agreed working week (annual leave, professional or study leave) will have to be agreed in advance, where possible with at least six weeks notice. Paragraph 215 Terms and Conditions will continue to apply.

Clinical Academics

The above arrangements will apply to Clinical Academics employed by, or working under, an honorary contract with NHS Wales, except as set out in Chapter 8.

CHAPTER 3

ON CALL / EMERGENCY WORK

3.1 All emergency work that takes place at regular and predictable times (e.g. post-take ward rounds) will be programmed into the working week on a prospective basis and count towards a Consultant's sessions. Less predictable emergency work will be handled, as now, through on-call arrangements. The arrangements for recognising work arising from on-call duties are described below.

Availability and Emergency Work

3.2 In cases where there is a very rare need for a Consultant to be called outside the time-tabled working week, employers and Consultants will review the need for on-call arrangements.

3.3 Consultants will be required to be contactable throughout the on-call period.

3.4 As a principle work actually carried out when a Consultant is on call and required to work will be recognised and remunerated.

3.5 The first three hours of work done during on call periods per week – averaged over a six month period – unless specifically agreed otherwise will attract one direct clinical care session of time within the working week. Where this averages less than three hours, this will attract the appropriate proportion of a session of time.

3.6 The existing out of hours intensity banding will continue to apply at new enhanced rates as set out in the Annex.

3.7 Consultants will not normally be resident on call.

3.8 In exceptional circumstances where the Consultant is requested and agrees to be immediately available, i.e. 'resident on call', this will be remunerated at three times the sessional payment at Point 6 of the Consultant salary scale, excluding commitment awards and Clinical Excellence awards. In such circumstances, there will be an agreed compensatory rest period the following day.

For these purposes, a session will comprise four hours and apply between 5pm and 9am weekdays and across weekends.

3.9 If such situations occur persistently, the employer will need to review options, with the appropriate Clinicians, to find an alternative arrangement.

Other emergency re-calls

3.10 Consultants not on an on-call rota may be asked to return to site occasionally for emergencies but are not required to be available for such eventualities. Emergency work arising in this way should be compensated through a reduction in other sessional activities on an ad hoc basis.

Where emergency recalls of this kind become frequent (eg more than 6 times per year), employers should review the need to introduce an on-call rota.

Reviewing frequent on-call rotas

3.11 Welsh Assembly Government, NHS Wales and BMA Cymru Wales are committed to working with the medical profession to eliminate unnecessary on-call responsibilities and to minimise the number of Consultants on the most frequent rotas (1 in 1 to 1 in 4).

3.12 In conjunction with implementation of these amendments, NHS Trusts in Wales will be asked to identify the reasons for high frequency rotas and produce action plans for reducing, and where possible, eliminating such rotas.

3.13 Where Consultants have onerous out of hours duties, the job plan review will be used to ensure that there is adequate flexibility to provide compensatory rest.

3.14 The European Working Time Regulations will apply and be implemented.

3.15 The FTCC will continually review out of hours payments, and this will form part of the formal review, the first of which will take place by December 2005, and at dates to be agreed thereafter. This will address options for compensation including financial remuneration where appropriate.

CHAPTER 4

PAY AND PAY PROGRESSION

Principles

4.1 The system of pay progression for Consultants will:

- ensure fairness and consistency
- reward sustained good performance
- reward long-term commitment to the NHS
- facilitate better career development for Consultants
- ensure minimum duplication and bureaucracy for employers and Consultants
- encourage modernisation and innovation in NHS Wales

Summary

4.2 Under the new pay arrangements –

- there will be a higher starting salary;
- there will be two additional incremental Points on top of the salary scale to allow for automatic progression to a higher maximum basic salary;
- there will, in addition, be 8 commitment awards, occurring at three-yearly intervals for all Consultants, awarded automatically on satisfactory job plan review or in the absence of an unsatisfactory job plan review (Chapter 5);
- there will also be an England and Wales Clinical Excellence Awards scheme (Chapter 5);

- existing Consultants will progress through commitment awards on the same basis as new Consultants, but with quicker progression on satisfactory review or in the absence of an unsatisfactory job plan review for more senior Consultants (as set out in Chapter 12 - Transitional Arrangements).

4.3 The new payscale is set out in the Annex.

CHAPTER 5

COMMITMENT & CLINICAL EXCELLENCE AWARDS

5.1 In Wales, new Commitment and Clinical Excellence Awards Schemes, will replace the existing discretionary Points and distinction awards.

Principles

5.2 The new Awards scheme will:

- be transparent, fair and based on clear evidence;
- be open and accessible to all Consultants;
- better reward those Consultants who continue to contribute effectively to service delivery and patient care on a sustained basis, and those who contribute most to the NHS, recognising their contribution to innovation and modernising the service;
- support the practical application of skills and knowledge (including teaching and research) for the benefit of patients;
- be related to a satisfactory appraisal and job plan review;
- allow Clinical Excellence awards to be reviewed regularly;
- ensure fair distribution between academic and non-academic award holders.
- recognise innovation and modernisation

5.3 The scheme will comprise:-

(i) a regular progression of **commitment awards** available to all Consultants throughout their career once they have reached the top of their incremental scale, who have demonstrated their commitment to the service by satisfactory Job Plan Review or by the absence of unsatisfactory job plan reviews; and,

(ii) a number of Clinical Excellence awards available to those Consultants who have made outstanding contributions to the development of the service

and/or the greatest levels of achievement in research and/or teaching whether locally, nationally, UK-wide or internationally.

Commitment Awards

5.4 All Consultants will be eligible for a Commitment Award once they have completed three years service after reaching Point 6 on the Consultant Pay Scale, and then at three-yearly intervals after they have received their previous Commitment Award, until they have achieved the eight Commitment Award levels available under the scheme.

5.5 It is anticipated that the overwhelming majority of Consultants will achieve Commitment Awards on a regular basis.

5.6 The appropriate Commitment Award will be paid automatically in the absence of an unsatisfactory annual job plan review over the required period.

5.7 The aim is to help the Consultant achieve satisfactory outcomes for the benefit of the service. Therefore, any potential obstacles to achieving satisfactory outcomes must be raised and discussed between the Consultant and their employer as soon as these become apparent, and not be delayed until the next planned review. This is to enable any remedial action to be taken and avoid an unsatisfactory job plan review wherever possible.

5.8 In the rare event of an unsatisfactory job plan review, the employer will give details of the reasons for such a result, in writing, record whatever remedial action is agreed, and give a defined timetable for its completion. If such agreement is not reached, there will be recourse to the appeal process (Chapter 1, Paragraphs 1.34 – 1.39).

An interim job plan review will be arranged no longer than 6 months following the unsatisfactory job plan review.

5.9 If the Consultant has remedied the situation, a satisfactory job plan review will be recorded as usual.

If the interim job plan review is also unsatisfactory, the Consultant will receive a formal letter outlining the reasons for deferring their commitment award for the period of one year. This deferment will also be subject to a right of appeal as agreed (Chapter 1, Paragraphs 1.34 – 1.39). Deferment may continue in subsequent years if agreed corrective action has not been completed at the next scheduled job plan review.

5.10 Each level of Commitment Award is worth an amount per annum, which is permanent, superannuable and is set out in the Annex.

Clinical Excellence Awards

5.11 There will be a national Clinical Excellence Award scheme for England and Wales. All awards will be governed by a common rationale and objectives with the criteria and eligibility for awards set nationally in line with current England and Wales arrangements, unless otherwise amended.

There will be a standard nomination form for all levels of award, which will contain details of the current level of award and the level of award for which the Consultant is being considered.

5.12 The new Advisory Committee on Clinical Excellence Awards (ACCEA)) will make these awards, and will publish an annual report, which will include information on the distribution of higher awards.

5.13 Consultants who have at least one years' experience at consultant level will be eligible for Clinical Excellence awards. Criteria will be developed to ensure that Consultants whose duties are not primarily concentrated on front line care, e.g. clinical academic and public health doctors, are able to receive Clinical Excellence awards based on their overall contribution to the NHS. Consultants at age 55 will be invited to apply for a higher award on the basis of their local contribution, subject to sustained levels of excellence locally. Consultants delivering a wholly local contribution will be eligible to progress to the top level of Clinical Excellence awards.

5.14 There will be four levels of Clinical Excellence Award worth an accumulative amount per annum, as set out in the Annex. i.e. once the first level of Clinical Excellence Award is made, this replaces any Commitment Awards previously made to the Consultant and higher Clinical Excellence Awards replace any existing Clinical Excellence Award the Consultant is then receiving.

5.15 The CEAC will, subject to the application of strict guidelines, be permitted to make a higher level Clinical Excellence Award to a Consultant without the need for the Consultant either to have been previously awarded any lower level Clinical Excellence Awards, or to have been in receipt of any commitment awards.

5.16 All levels of award will be paid in addition to a Consultants' basic salaries :

- Higher awards will subsume the value of any clinical excellence award held previously.

- Awards will be paid on a pro rata basis to part-time staff

- Awards will be uprated, subject to the recommendations of the Doctors and Dentists Pay Review Body

5.17 Consultants with existing discretionary Points or distinction awards will retain these awards and will be eligible to apply for further awards under the new scheme in the normal way. Each existing discretionary Point will be converted into a commitment award and each existing distinction award will be protected without loss or detriment.

CHAPTER 6

DISCIPLINARY ARRANGEMENTS

The Disciplinary Arrangements for Medical and Dental Staff in Wales are the subject of continuing negotiations.

In the meantime, existing procedures and circulars will apply.

CHAPTER 7

Modernisation & Innovation

7.1 Welsh Assembly Government, NHS Wales and BMA Cymru Wales confirm their commitment to work together to ensure the best services possible for patients through a modern patient-centred service

7.2 In line with "Good Medical Practice" and "Maintaining Standards", individual Consultants will work with their employer to :-

- continue to identify appropriate ways of better organising and delivering their service to reflect the patient experience locally and best practices elsewhere;

- continue to adapt their clinical practice to reflect emerging best practice and professional standards;

- contribute to both the planning and implementation of changes in the wider organisation and delivery of services to reflect the appropriate balance between, e.g.:

    - primary, secondary and tertiary care

    - inpatient, day case and outpatient care

    - care provided in the patient's home, in a community or a hospital setting

    - the use of new technology to facilitate better diagnosis, treatment and communication with patients and other care providers, and to use resources efficiently and effectively;

- contribute to and, as appropriate, lead the development of new skills amongst other healthcare staff or service providers – within appropriate professional standards and guidance – to the benefit of patients and patient care delivery.

- endeavour to work with clinical and other colleagues to enhance relationships to further these aims, eg through team working.

7.3 BMA Cymru Wales has produced the following, 'Consultants leading the Modernisation Agenda for Wales', which sets out further guidance on practical examples of modernisation.

CONSULTANTS LEADING THE MODERNISATION AGENDA FOR WALES

Changes in medical science occur at a breath taking pace, yet many of today's innovations and certainties will be redundant or revised in a few years time. The provision of Health services also has to change rapidly to accommodate new treatments, patients' expectations, the current medico-legal and political environment, and the way in which doctors work.

Consultants in the NHS in Wales are at the forefront in adapting to changed circumstances, finding innovative solutions to intractable problems and often changing their practice radically to adapt to new methods of working to improve patient care. Ten doctors from Wales were identified in a recent BMA publication, "Pioneers in patient care : Consultants leading change", and there are examples of outstanding practice throughout Wales.

The Welsh Consultants and Specialists Committee (WCSC) proposes an "NHS Wales Service Innovation Board". This group would be led by clinicians who enjoy the respect of their colleagues and with a track record of research and innovation. The group would be tasked to identify areas of best practice and evaluate innovations, using evidence-based tools, then disseminate the best ideas and practice across Wales. The process would need to be continually audited to demonstrate clear evidence of patient and service benefit, and would require political support and funding.

AREAS OF DEVELOPMENT

Coping with Demand

The annual winter bed crisis and overwhelmed casualty departments are the first port of call for journalists looking for a health story.

Some casualty departments have provided innovative solutions to circumvent the current lack of capacity in the system which include –

- Triage at the front door by a Consultant and senior nurse, who allocate patients either to minor injuries where they are seen and treated by a

nurse practitioner, or to major injuries, where they are seen and managed appropriately by a senior doctor.

- Nurse practitioners are able to order radiology and pathology investigations, saving time.

- Walk in centres at smaller hospitals, where nurse practitioners can manage minor conditions.

- A "see and treat" policy, which reduces the amount of time spent by patients in the casualty department before being admitted or discharged.

- Ambulatory Care centres at larger hospitals catering for full day surgery lists.

Shortage of Doctors

Most specialties are having to adapt to the reduction in junior doctors hours and the increased amount of training required by SHO's and SpR's. Solutions include –

- Consultants training nurse practitioners and other health professionals to take on practical procedures, usually performed by doctors, e.g. endoscopies in gastro-enterology, ultrasound examinations in radiology, microscopic management of discharging ears in ENT and chronic disease management in diabetes, rheumatology and asthma.

- More imaginative use of the Staff and Associate Specialist Grade specialists to take on more challenging tasks.

- Many senior doctors now work in teams with other professionals who provide semi autonomous clinical care. Physiotherapists will now see and treat back pain and sports injuries, speech therapists assess and treat stroke patients, voice disorders and dysphagia. Audiological scientists assess and treat vertiginous patients. Senior psychiatric nurses and psychologists can do much of the work previously done by psychiatrists freeing Consultants to tackle increasing medico-legal responsibilities.

- Nurse practitioners also have a role in training medical students and junior medical staff in specialised areas in addition to improving the practical training of nurses on the wards and supporting primary care.

Changing the delivery of local services

The increased complexity of managing many conditions, and reduced numbers of junior medical staff able to provide round the clock care will mean the redesign of services across Wales. This process is more likely to be successful if lead by clinicians with local ownership in contrast to a top down imposed political "solution".

Solutions which Consultants have already devised to overcome these difficulties include:-

- Innovative cross cover arrangements
- Improved use of IT and telemedicine to access expert advice from a regional centre
- Local networking to ensure that specialist care is provided to large geographical areas
- Good relationships with regional referral centres to allow patients to be treated locally (hub and spoke approach)
- Imaginative shared care arrangements for community patients.

Research and Development

All Consultants are trained in research methods and possess scientific curiosity, but often lack the time and support to pursue their ideas. Any individual involved in research and innovation is more likely to be receptive to new ideas and modernisation, more likely to challenge out dated methods of practice and to be using cost effective, evidence based best practice to improve patient care.

Necessity is often referred to as the mother of invention. There are many examples of Consultants in Wales who have developed new treatments, new instruments or new ways of working. Very often these individuals are relatively unsupported, as research grants and the research and development machinery are now increasingly geared to large institutions or multi centre cancer trials. Small but useful innovations need to be able to be implemented quickly, and with the minimum of formality.

We would suggest re-invigorating the small grant scheme in Wales, where a clinician would have to go through a minimum of bureaucracy to start a project.

In addition, a "Welsh innovator" award would further help to foster grass roots ideas.

User Involvement

The public, quite rightly, wants a greater say in how services are planned and managed. Clinicians in mental health services have begun to lead the way around Wales :

- Numerous small projects allow patients, carers and voluntary organisations to design services around their needs with the advice and support of professionals.

- The evidence base is expanding with patients being encouraged to suggest research into issues which matter to them.

- Expert patients are encouraged to help themselves and others to actively manage their own illness alongside the professionals.

New ways of working

Partnerships are starting to develop where the particular knowledge and enthusiasm of voluntary organisations is matched with supervision from clinicians and other professionals to provide the best use of a variety of local resources and expertise. This ensures services that are seamless, relevant and efficient as well as effective. They can also help to manage the problems of staff shortages in the NHS. An unexpected side effect has been the ability of these projects to aid recruitment and retention. Clinicians have discovered it is stimulating to work with non-professionals, and the innovative projects allow flexible working solutions for many who would otherwise have to leave the NHS.

These are all in their infancy, and will need recurrent funding to keep them going and should be included as part of the service commissioning and resource allocation. Consultants involved therefore ensure that all projects are rigorously and scientifically evaluated to ensure that they work before asking for this commitment of public money.

Education and Training

The changing demographics and values of society make it essential that medical education changes to produce doctors who are equipped for the uncertainties of these new ways of working. We also need to ensure that young people are

encouraged to enter and remain in the health professions. Welsh educational establishments are at the forefront of innovations in flexible training and support for clinicians with disabilities, as well as the monitoring and retraining of those who find the pace of change too fast.

Summary

The future of the Health service in Wales is the most challenging task facing the Welsh Assembly Government. The proposals above would harness and mobilise effectively the creativity and skills already present in front line staff.

A highly trained, well-motivated and innovative Consultant workforce is the key to ensuring a service capable of responding to our current difficulties and the challenges of the future. Consultants remain at the cutting edge of innovation and modernisation in the Health service. We particularly welcome the Welsh Assembly Government in their non-confrontational and collaborative attitude to Consultants in Wales, and look forward to working together to achieve a healthier future for the people of Wales.

CHAPTER 8

CLINICAL ACADEMICS

Principles

8.1 Clinical Academics undertake both academic and service commitments, irrespective of who employs them. As such, both University and NHS representatives need to be involved in agreeing and implementing the amendments set out in this document.

8.2 The existing principle of parity with NHS Clinical Consultant Colleagues should continue to apply for Clinical Academics holding an Honorary Consultant Contract.

Provisions

8.3 The job planning process as set out in Chapter 1, will apply to Clinical Academics in relation to their NHS commitments.

8.4 A University and an NHS representative will be present with the Clinical Academic in all job plan reviews. With agreement by all parties, this may be one and the same person.

8.5 All Clinical Academics will have a joint appraisal arranged by their employer, with both a University and NHS representative involved. With agreement by all parties, this may be one and the same person.

8.6 Clinical Academics who hold an honorary Consultant Contract that work 4 Direct Clinical Care sessions and two Supporting Professional Activities sessions will be treated as if they are a whole time NHS consultant as defined in Chapter 2. If they work fewer than 6 sessions they will be treated as part-time, as set out in Chapter 10. Normally up to one Clinical Teaching session or Clinical Research session from the NHS sessions can be considered as part of the Direct Clinical Care sessions. Otherwise further Teaching and Research sessions will be available in the 4 non-NHS sessions.

8.7 Clinical Academics will be eligible for, subject to satisfactory job plan reviews, commitment and clinical excellence awards as set out in Chapter 5.

8.8 All Clinical Academics will be eligible for a commitment award once they have completed three years service after reaching Point 6 on the clinical senior lecturer/professional pay scale and then at three yearly intervals after they have received their previous commitment award, until they have achieved the eight commitment award levels available under the scheme. The appropriate commitment award will be paid automatically on satisfactory review, or in the absence of unsatisfactory job plan reviews over the required period.

8.9 Clinical Academics with existing discretionary points or distinction awards will retain these awards and will be eligible to apply for further awards under the new scheme in the normal way. Each existing discretionary point will be converted into a Commitment Award, and each existing distinction award will be converted into the appropriate Clinical Excellence Award.

8.10 Where on call is worked, this will be remunerated on the same basis as an NHS consultant.

8.11 All Clinical Academics will have a joint induction programme arranged by their employer to facilitate their introduction to their new role with both their Trust and University.

8.12 All Clinical Academics will adhere to Trust policies and procedures while carrying out their duties under their honorary contracts.

8.13 Clinical Academics are eligible to apply for sabbaticals as set out in Chapter 14, based on joint agreement between the Trust and University.

8.14 All Clinical Academics will work with the Trust who award their honorary contract to meet the Modernisation and Innovation Agenda for Wales, as set out in Chapter 7.

8.15 All other provisions relating to Clinical Academics will apply as per their University contract.

CHAPTER 9

PRIVATE PRACTICE

Principles

9.1 Any Consultant undertaking private practice must demonstrate that they are fulfilling their NHS commitments.

9.2 There must be **no** conflict of interest between NHS work and private work.

9.3 The needs of patients in the NHS will not be prejudiced by the provision of services to private patients.

9.4 Work outside NHS commitments will not adversely affect NHS work, nor in any way hinder or conflict with the needs of NHS employers and employees.

9.5 NHS facilities, staff and services may only be used for private practice with the agreement of the NHS employer.

Disclosure of Information about Private Practice

9.6 Consultants will inform their employers of any conflicts between their NHS commitments and their private practice and work with their employer using the job planning process to resolve any such conflicts.

9.7 This process will be undertaken at least annually or more frequently if changes for either the Consultant or employer warrant job plan review.

9.8 The Consultant will be required to inform their Chief Executive of any issues arising from their private practice which might significantly affect their ability to fulfill their NHS Commitments as soon as possible.

Schedule of Work

9.9 Consultants will not undertake private practice which prevents them being available to the NHS when on-call.

A Consultant with a low likelihood of recall may undertake appropriate private practice when on-call for the NHS, with the prior agreement of their NHS employer that this will not affect their availability for NHS commitments. There

will be exceptional circumstances in which Consultants may reasonably provide emergency or essential continuing treatment for an existing private patient during NHS time on the basis of clinical need. Consultants will make alternative arrangements to provide cover where work of this kind impacts on NHS commitments.

9.10 The Consultant will ensure that there will be clear arrangements to avoid the risk of private commitments disrupting NHS commitments, e.g. by causing NHS activities to begin late, or to be cancelled.

9.11 If NHS sessions are disrupted the Consultant should rearrange the private sessions. Agreed NHS commitments will take precedence over private work. The job planning process will determine when NHS sessions are to be scheduled. Where there is an agreed change to the scheduling of NHS work, the employer will be required to allow a reasonable period for Consultants to rearrange any existing private sessions.

The Transfer of Patients between the NHS and Private Sector

9.12 When a patient is seen privately and it is agreed they will subsequently be transferred to a NHS waiting list, the patient will be entered on the list at the same Point as if they had been seen under NHS arrangements. The arrangements for this are covered by the guidance set out in "Management of Private Practice in Health Service Hospitals in England and Wales" (the 'Green Book').

9.13 Where an NHS patient seeks information about availability, or waiting times, for NHS and/or private services, practitioners should ensure that any information provided by them is accurate, to the best of the practitioner's knowledge and belief.

Use of NHS Facilities and Staff

9.14 Consultants may not use NHS facilities or staff for the provision of private services without the approval of the appropriate NHS body.

9.15 Consultants may use NHS facilities for the provision of fee paying services, as set out in Chapter 2, either in their own time, in annual or unpaid leave, or with the agreement of the NHS employer in NHS time where work involves minimal disruption.

CHAPTER 10

EQUAL OPPORTUNITIES

Part-Time and Flexible Working Principles

These are as follows:

10.1 To encourage flexibility on the part of employers as an aid to recruitment and retention of doctors with other commitments.

10.2 To ensure that these doctors do not suffer direct or indirect discrimination because of their needs.

10.3 To ensure that these doctors are able to keep up to date and continue their professional development.

10.4 To avoid penalising employers who recognise the need for flexible working arrangements and the particular needs of some employees.

The Working Week : Part Time Consultants

10.5 Sessional commitments for part time Consultants will be seen essentially pro rata with weighting on the supporting activities sessions. In the exceptional case that there is no teaching commitment at all the weighting may lean the other way with mutual agreement.

10.6 The principle is that the Consultant must be able to undertake all teaching, audit, and clinical governance activities required by the Trust within the time allowed for supporting activities. The same applies to direct patient care.

10.7 Direct clinical care activities will not intrude on time for supporting professional activities except in very occasional emergency situations.

10.8 The usual break-down of direct clinical care and supporting professional activities sessions will be as follows, taking into account the hours devoted to these activities :-

Total Sessions	Direct Patient Care	Support Activities
9	6	3
8	5	3
7	5	2
6	4	2
5	3	2
4	2	2
3	2	1

10.9 Apart from these time-tabled sessions a part-time Consultant has no NHS commitment during the working week.

10.10 Variations on the balance of sessions may be agreed between the Consultant and their employer.

10.11 These will need to reflect the requirements for continuing professional development agreed in appraisal and job planning reviews.

10.12 Out of hours work: The same payment will be awarded to part time doctors who work the equivalent amount of on call as full timers on their rota. Otherwise payment will be pro rata. If a doctor is expected to be on call on a day they do not normally work, time off in lieu or extra payment will be agreed, in a normal working week.

10.13 Consultants working part time will not be expected to carry the same caseload as a full time Consultant. Numbers of patients seen, population covered, etc., will be calculated pro rata.

Flexible Working

10.14 Some Consultants may find it convenient to do their routine work at weekends or outside normal working hours in order to balance their other commitments. Employers will make serious attempts to accommodate any such requests promptly. The rate of pay will be no higher than if the doctor was working normally. These doctors will be entitled (with a reasonable period of notice) to return to a normal pattern of work when they are ready. This must not be used by employers to exploit part time workers and must only be applied at the request of a Consultant for personal reasons.

10.15 Some Consultants may wish to vary the number of sessions worked each week to cover other commitments, for example school holidays or higher degree courses. Employers will make serious attempts to accommodate these requests and pay will be calculated on an annualised basis. These doctors will be entitled (with a reasonable period of notice) to return to a normal pattern of work when they are ready. This rule must not be used by employers to exploit part time workers and must only be applied at the request of a Consultant for personal reasons.

CHAPTER 11

WHITLEY COUNCIL & OTHER TERMS AND CONDITIONS

11.1 The amendment of the National Consultant Contract in Wales constitutes changes to the provisions set out in the Terms and Conditions of Service for Hospital Medical and Dental Staff, Doctors in Public Health Medicine and in the Community Health Service in England and Wales Handbook (the 'England and Wales Handbook') as listed in Appendix VI to the Terms and Conditions of Service for Hospital and Medical and Dental Staff, Doctors in Public Health Medicine and in the Community Health Service in Wales Handbook (the 'Wales Handbook') first published in December 2003.

11.2 Appendix VII of the Wales Handbook also gives a look-up table showing where provisions of the former England and Wales Handbook are covered in the Wales Handbook.

11.3 Otherwise all other provisions set out in the England and Wales Handbook have been incorporated into the Wales Handbook and, together with the relevant provisions set out in the General Whitley Council Handbook, remain unchanged.

CHAPTER 12

TRANSITIONAL ARRANGEMENTS

Payscale Assimilation

12.1 All Consultants who are in post on the due date of this amendment will transfer across to the corresponding Point on the revised payscale, i.e.

Former Payscale Point		**Revised Payscale Point**
Minimum	to	Minimum
1	to	1
2	to	2
3	to	3
4	to	4

12.2 Any Consultant already at the maximum Point (4) of the former payscale on the due date will progress to Point 5 of the revised payscale with effect from 12 months after the due date, and Point 6 (the new maximum incremental Point) of the revised payscale with effect from 24 months after the due date

12.3 Any Consultant **not** already at the maximum Point (4) of the former payscale on the due date, will retain their current incremental date, and progress up the scale by one Point on each subsequent incremental date until they reach the new maximum Point (6) on the revised payscale.

Commitment Awards

12.4 Any Consultant in receipt of Discretionary Points on the due date will have these automatically converted into the equivalent number of Commitment Awards with effect from the due date. Any such Commitment Awards will count towards the maximum number of eight such awards available under the scheme.

12.5 Any Consultant aged 57 or over at the due date will receive their first Commitment Award upon reaching Point 6 (the new maximum) of the Consultant salary scale, and at three-yearly intervals thereafter. This is subject to the Consultant only being able to receive a maximum number of 8 such awards including any Commitment Awards arising from the conversion of Discretionary Points set out in Paragraph 12.4.

12.6 Any Consultant aged between 51 and 56 at the due date will receive their first Commitment Award one year after reaching Point 6 (the new maximum) of the Consultant salary scale and at three-yearly intervals thereafter. This is subject to the Consultant only being able to receive a maximum number of 8 such awards including any Commitment Awards arising from the conversion of Discretionary Points set out in Paragraph 12.4.

12.7 Any Consultant aged between 43 and 50 at the due date will receive their first Commitment Award two years after reaching Point 6 (the new maximum) of the Consultant salary scale and at three-yearly intervals thereafter. This is subject to the Consultant only being able to receive a maximum number of 8 such awards including any Commitment Awards arising from the conversion of Discretionary Points set out in Paragraph 12.4.

Job Plan Reviews

12.8 Individual employers will agree with their local Consultant body the actual timing of job plan reviews for existing Consultants in post on the due date for the first few years following implementation of this amendment.

12.9 This will allow such reviews to be spread within the early part of the year as agreed locally, but with the aim of bringing job plan reviews to within one month of the anniversary of the award of the previous Commitment Award to that Consultant.

12.10 Job plan reviews must be timed to give any Consultant at least 6 months to undertake any corrective action identified as a result of an unsatisfactory job plan review, before they would incur a deferment of a Commitment Award.

Protection

12.11 Where a Consultant in post on the due date receives a lower level of earnings, (as defined in Paragraph 12.13), he/she will have his/her previous level of earnings protected on a personal basis for 12 months, provided that he/she is undertaking the same or greater level of activities set out in his/her job plan.

12.12 This protection will continue to apply during the twelve months provided that the Consultant remains in that post and continues to undertake the same (or greater) level of activities. The Consultant will also receive the benefits of any pay award during this period on their protected earnings.

12.13 Earnings, for these purposes, will include – and will only include – all of the following paid to the Consultant by their NHS employer as a result of their NHS commitments as set out in their agreed job plan:- basic salary, Commitment Awards (or converted Discretionary Points), Clinical Excellence Awards (or converted Distinction Awards), additional sessional payments, additional management or responsibility allowances, out-of-hours Intensity Banding payments, and any other earnings that are superannuable under the NHS Pensions Scheme.

CHAPTER 13

IMPLEMENTATION

13.1 The amendments set out in the Terms and Conditions of Service for Hospital Medical and Dental Staff, Doctors in Public Health Medicine and in the Community Health Service in Wales Handbook constitute changes to the provisions set out in the Terms and Conditions of Service for Hospital Medical and Dental Staff, Doctors in Public Health Medicine and in the Community Health Service in England and Wales Handbook (the England and Wales Handbook), and are issued by the Minister for Health and Social Services for the National Assembly for Wales in exercise of powers conferred by Regulations 2 and 3 of the NHS (Remuneration and Conditions of Service) Regulations 1991 and paragraph 11 of Schedule 3 of the NHS Act 1977. As such they amend the terms and conditions of all staff working under the provisions of the England and Wales Handbook within NHS Wales with effect from the due date.

13.2 The due date from which the amendment is effective is 1st December 2003, with the exception of the creation of Point 5 on the Consultant salary scale, which is effective from 1st December 2004, and Point 6 on the Consultant salary scale, which is effective from 1st December 2005.

CHAPTER 14

MISCELLANY

NHS Pension Scheme

14.1 Welsh Assembly Government, NHS Wales and BMA Cymru Wales have agreed that basic salary (including the additional incremental Points), commitment awards and Clinical Excellence awards and out of hours intensity supplements will be superannuable.

Induction

14.2 Every newly appointed Consultant in NHS Wales will have a high level induction programme arranged by their employer to facilitate their introduction to their new role and organisation, and ensure that they have the necessary resources to give them a sound start to their contribution to patient care services locally.

14.3 Such an induction programme will include high level introductions to senior management and clinical colleagues, as well as the normal corporate and departmental induction processes.

14.4 A guide to the elements that might be included in such programmes is set out in the supplement to this Chapter.

Sabbaticals

14.5 During their career as a Consultant within NHS Wales each Consultant will be entitled to seek a paid sabbatical for a period of up to three months to undertake activities away from their normal duties that will subsequently benefit their patient care work.

14.6 The basis for any proposed sabbatical will arise out of regular job plan reviews and/or appraisals and be subject to the agreement of the employer. The exigencies of the service and spreading the taking of sabbaticals across the Consultant body within the organisation must be factors on when and how a sabbatical is undertaken. However its timing and nature must also reflect the appropriate stage in the career, and the particular interests of the Consultant.

14.7 A reasonable level of financial support for the necessary additional costs involved in undertaking such a sabbatical will be granted by the employer, and during the period of the sabbatical, appropriate locum cover will be provided.

14.8 Proposed alternative ways of taking such a sabbatical break, e.g. over two separate but shorter periods of time, can also be considered by the employer provided the combined amount of time and costs involved in total are no higher than those set out above.

14.9 The process for determining the award of sabbaticals will be agreed locally in line with the principles of openness, transparency and equal opportunities.

Facilities

14.10 In line with good employment practice, Trusts should endeavour to supply medical staff with a pleasant social area, preferably with catering facilities to enable them to informally refer and discuss patients and meet each other in a confidential environment.

Good quality child care, sports and social facilities should be available for all staff.

SUPPLEMENT TO CHAPTER 14

CONSULTANTS INDUCTION PROGRAMME

Elements that might be part of this could include :

1. Briefings from senior management colleagues, such as

   - Chief Executive, re e.g. strategic direction of Trust as a whole and for their particular service and corporate governance principles and arrangements.

   - Medical Director re e.g. Trust clinical governance principles and arrangements, and Trust Standards for clinical practice;

   - Nursing Director re e.g. service quality and patient / public involvement arrangements within Trust, and nursing practice issues;

   - HR Director, re e.g. medical workforce planning and development issues, overall workforce development issues, and employment policies practices and expectations;

   - Finance Director re e.g. resource allocation and control systems, service development processes, activity recording and information systems;

   - Trust Chairman, re e.g. overall aims, direction and ethos of the Trust.

2. Briefing from senior clinical colleagues, such as

   - Clinical Director re e.g. service aims and modus vivendi of Directorate, job planning and appraisal processes

   - Clinical leads within the Trust on areas such as clinical audit, CPD, clinical effectiveness, risk management, R & D, clinical standard setting

   - Chairs of relevant professional / other bodies within the Trust, e.g. Hospital Medical Staff Committee, Local Negotiating Committee, etc.

3. External Briefings from, e.g. appropriate colleagues in LHB, Regional Office, relevant Regional / all Wales clinical networks. This to include relevant links with primary healthcare colleagues in particular.

Any programme will need to be tailored to the needs of the individual Consultant, and delivered in locally appropriate ways.

In a large Trust this may be based on a regular programme for a group of newly-appointed colleagues, in smaller Trusts on ad hoc individualised programmes. The social aspects of induction also need to be addressed, recognising the value of informal social events to build relationships and help the newly-appointed Consultant and their family to quickly feel part of their local healthcare community.

ANNEX

1. With effect from the due date defined in Chapter 13, Paragraph 13.2, the following rates will apply to Consultants (including Clinical Academics) employed, or working under an honorary contract within NHS Wales :-

a) Consultant Salary Scale (Chapter 4)

Point 0 (minimum)	£63,000 p.a.
Point 1	£65,035 p.a.
Point 2	£68,440 p.a.
Point 3	£72,395 p.a.
Point 4	£76,910 p.a.
Point 5	£79,485 p.a.
Point 6 (maximum Point of salary scale)	£82,065 p.a.

b) Commitment Awards (Chapter 5)

Will each have a value of £2,835 p.a. (maximum of eight such awards).

c) Clinical Excellence Awards (Chapter 5)

Will be in four levels, with a cumulative value (subsuming Commitment Awards and lower Clinical Excellence Awards) as follows :-

£31,404 p.a.

£41,290 p.a.

£51,613 p.a.

£67,097 p.a.

Clinical Excellence Awards will be expected to mirror the England and Wales arrangements.

d) Out of Hours Intensity Banding Payments (Chapter 3)

Band 1	£1,920 p.a.
Band 2	£3,840 p.a.
Band 3	£5,760 p.a.

e) Waiting List Initiative Sessional Rate (Chapter 2, Paragraphs 2.36 – 2.39)

Will be £500 per session.

2. All the rates quoted in this Annex are at 2003/04 rates. The rates will be reviewed annually on 1 April. The rates will be increased by 3.225 per cent from April 2004 and by a further 3.225 per cent from April 2005 subject to this value remaining within 1.5% of RPI(X). Should RPI(X) fall outside these values the FTCC will either agree on the uplift or refer it to the Review Body on Doctors' and Dentists' Remuneration (DDRB). Thereafter, the rates will be agreed following the recommendations of the DDRB.

National Assembly for Wales
MOVING FORWARD WITH CONSULTANTS:
Implementation Process for Trusts in NHS Wales

IMPLEMENTATION PROCEDURE

PROJECT MANAGEMENT

Trusts are recommended to set up a local implementation project team responsible for the effective introduction of the amended consultant contract and for the introduction of effective job planning arrangements in accordance with the amended contract, the NHS Wales Consultants Job Planning Guide, and this implementation procedure.

The local implementation project team will be accountable to the Chief Executive and include senior medical, HR, general manager and LNC representatives. The project team will have an identified Project Manager, who will be expected to develop a project plan and share this, together with regular progress reports on implementation, with the HR Director, NHS Wales via the Pay Modernisation Team, who in turn will advise the Director, NHS Wales and the FTCC on progress.

The Pay Modernisation Team will continue to provide training, advice and act as the reference point for queries as in the pilots exercise.

PRINCIPLES:

1. Consultant job planning is a major vehicle for helping facilitate health managers and consultants to work together to provide a better service for patients in Wales. It is an integral part of the modernisation of NHS Wales. As such it is essential that Chief Executives and other colleagues, including HR, Medical and Finance Directors, take a strong personal interest in ensuring the process is rigorous and the outcomes appropriate and challenging.

Job planning is an important opportunity for taking forward initiatives locally to better design and deliver services to meet patient needs and service priorities and all those participating or connected with the process need to recognise and nurture this. The full benefits of job planning will, therefore, only be achieved over time through its influence on service change.

As such the job planning process, and the issues which arise from it, will be a normal element in NHS Wales and Trust performance management processes.

2. Job Planning process will have three stages:

- describing existing work;
- review;
- agreeing required future work.

The first and third stages will normally be conducted by the consultant, and their clinical director and general manager (or equivalents). The review stage, however, will involve a much wider process, including the need to involve other staff groups or service providers as appropriate.

In some specialties it may be that part of the job planning process will be undertaken on a team basis. This would be particularly relevant where the same issues affect all consultants in the specialty, or require collective solution. Such an approach has been adopted, e.g. in anaesthetics, during the pilots exercise. Where job planning does take place on a team basis, each individual team member should still agree a schedule of individual commitments.

3. The third stage can only be reached after considering:

- information and issues from the first stage;
- reviewing arrangements with the wider clinical team;
- reviewing arrangements with other groups of staff or service providers as appropriate;
- and taking account of service delivery priorities, including relevant local and wider modernisation and innovation initiatives, and best clinical practices and performance indicators (eg using CHKS or similar data).

4. Trusts will need to have an audit trail for demonstrating that an appropriate, rigorous and consistent approach to job planning has been followed.

Stage 1: Describing Existing Work

5. The first stage will be a significant exercise in the first year. In subsequent years this will then need to review progress against the previous year's job plan, and confirm changes that have occurred in-year and the issues to be considered before agreeing the job plan for the coming year.

6. Specifically the first stage will identify:

a. existing patterns of work and activities;

b. pressures and constraints the consultant feels are causing them difficulties;

c. any factors causing work over the past year to exceed the 'trigger point' of a full session (i.e. 3.75 or more hours on average per week) **above or below** the consultant's contracted work of 37.5 hours per week (for a full time employee);

d. whether this reflects work the employer has requested to be undertaken;

e. whether the consultant is willing to continue to undertake this;

f. if this is a temporary phenomena or is likely to be on-going; and,

g. the level of on-call work done averaged over a six month period (or a shorter period if agreed).

7. The first stage will also (after the first year) need to advise the Chief Executive on whether there has been a satisfactory job plan review as this will confirm the consultant's Commitment Award pay progression. A satisfactory job plan review will result when a Consultant has:

a. met the time and service commitments in their job plan;

b. met the agreed outcomes in their job plan, or – where this is not achieved for reasons beyond the individual Consultant's control – has made every reasonable effort to do so;

c. participated satisfactorily in annual appraisal, job planning and the setting of outcomes;

d. worked towards any changes identified as being necessary to support achievement of the agreed outcomes in the last job plan review.

Stage 2: Review

8. Issues arising from the first stage will need to be reviewed and discussed with other members of the clinical team to:

a. ensure a balanced workload between members of the team;

b. identify alternative ways of organising service delivery, including those proposed by the consultant during the first stage, to ensure a reasonable workload for individual members of the team and help further develop service quality and efficiency;

c. act as a stimulus for debating and agreeing, in line with clinical governance principles, steps to further improve clinical practice;

d. take account of local and wider initiatives for modernising services and introducing innovation;

e. agree an appropriate set of outcomes, relevant to the specialty, that are challenging, holistic, transparent and innovative;

f. compare outcomes and activities with appropriate (external) indicators or benchmarks;

g. identify constraints preventing the above, and appropriate action to address these;

h. identify issues relevant to other groups of staff, clinical teams or service providers.

An appropriate manager appointed by the Chief Executive will have a key role in assisting with a number of the above points.

9. Such issues will need to be reviewed and discussed similarly with other groups of staff, clinical teams or service providers as appropriate.

10. The Clinical Directorate (or equivalent) with the appropriate input from senior executives within the Trust, will have a pivotal role in ensuring these discussions are well-informed by wider service priorities and modernisation and innovation initiatives;

11. The clinical team, lead by the Clinical Director with the general manager (or equivalents), will have a key role in determining a set of outcomes relevant to the specialty. The headings for these could include:

a. activity and safe practice;

b. clinical outcomes;

c. clinical standards;

d. local service requirements;

e. management of resources, including efficient use of NHS resources;

f. quality of care.

Outcomes need to be appropriate, identified and agreed. These could include outcomes that may be numerical, and/or the local application of modernisation initiatives.

Stage 3: Confirming the Job Plan

12. Following this, the consultant's job plan for the coming year can be agreed and confirmed.

13. While the job plan discussions will normally be between the consultant and their clinical director and with the relevant general manager (or their equivalents), the final job plan will need to be signed off by the Chief Executive in view of its significance both for the individual consultant in terms of future Commitment Awards but also for the direction and delivery of the service as a whole.

Monitoring Progress

14. Action arising as a result of the job planning process and resource availability and allocation issues will also be key tasks for the Clinical Director and general manager to address, together with monitoring progress.

15. The consultant, the Clinical Director and the general manager will, as appropriate, need to flag up factors likely to affect the achievement of the job plan as soon as these become apparent so that appropriate remedial action or adjustments to the job plan can be made.

16. The outcomes of the job planning process need to be an integral part of the organisation's performance management processes recognising "balanced scorecard" principles including service modernisation and innovation, and clinical governance requirements.

17. In the interests of accountability, transparency and public confidence the organisation's job planning processes and outcomes will be the subject of regular audit.

JOB PLAN PROFORMA

The attached example of the single sheet job plan proforma successfully developed by the pilot Trusts for use in the first stage of the job plan review, is recommended to be used. In particular, this was used to help establish the consultant's current pattern of work and as a basis for discussing the different elements that made up this work. A copy of the longer Job Plan Interview Proforma used in the pilots to summarise afterwards the outcomes of the job plan discussion is also commended to provide a consistent basis for collating and analysing information.

OTHER FEATURES /INTERPRETATION ISSUES

1. **Balance between direct clinical care (DCCs) and supporting professional activities (SPAs):** will need to be determined on an individual basis, based on the agreed and defined activities that the individual reasonably requires to undertake to maintain their professional contribution to the service – this may, for example, vary between specialties, individuals and reflect the stage of their career.

The existing Consultant Study leave entitlement of 30 days over three years has not been changed. It may be that occasionally Consultants will need to exceed this figure and this could be accommodated, by agreement between the consultant and the employer at the job planning review, by reducing the Consultant's SPAs per week over a set time.

The amended Consultant contract gives a typical split for a full-time consultant of 3 SPAs and 7 DCCs. Variations to this ratio will need to be agreed by the employer and the Consultant at the job planning review.

2. **The working week:** is based upon an average of 37.5 hours per week. Such hours can, by agreement, be spread across the week to include work in evenings, at night, or at weekends. **No** definition of the hours constituting a **normal working day** is included in the amended contract, but it is clearly specified that any agreement by a consultant to work in evenings, night-time or at weekends is entirely voluntary outside of their on-call and emergency work, or where the Consultant has agreed to participate in a shift system.

Where a consultant agrees to undertake part of their basic working week at such times, this will enable them to identify corresponding periods of free time in the normal working week when they have no contractual commitments to their employer.

All emergency work that takes place at regular and predictable times (e.g. post-take ward rounds) will be programmed into the working week on a prospective basis and count towards a Consultant's sessions. Less predictable work done while on-call will be averaged over a six month period (or suitable agreed shorter period) and an assessment made at the following job plan review which will allow for such time – up to a maximum of an average of three hours per week (equivalent to 1 session) – to be treated as part of their DCC sessions. This means that work done whilst on-call up to this level is then treated as part of the consultant's basic working week.

It is expected that Trusts will work together with consultants to seek to eliminate unnecessary on-call responsibilities and to minimise the number of consultants on the most frequent rotas.

If at job plan review the Consultant has voluntarily offered to undertake part of their basic working week outside the normal working hours (under the flexible working arrangements of the contract), and this is agreed with their employer, then the scoring for Out of Hours Intensity payments will be related to work necessarily performed outside of these agreed working hours.

3. **Tolerance points:** for unplanned changes in the level of work over and above the reasonable normal requirements of the job, e.g. as a result of service "creep", an average of one full session of work (i.e. an average of at least 3.75 hours per week) will be needed over or under the contracted working week to initiate a job plan review (or an interim job plan review). This will prompt a discussion about how such work could be reorganised or delivered in other ways. If this work is still required on a regular basis (typically over a year), and the consultant agrees to commit themselves to continue this extra work, then this would attract an additional session payment for each complete extra session (i.e. of an extra 3.75 hours) of work. These additional sessions will be voluntary, and can be ended at the request of either the Consultant or the employer, after discussion and with reasonable notice to enable alternative arrangements to be planned. Changes in the level of work of less than a full session will not be considered sufficiently significant to require a review.

This mechanism is intended to balance professionalism with providing protection for a consultant against continued uncontrolled increases in their working time on the one hand, whilst avoiding "clock-watching" and having to provide detailed accounts of their working time in normal circumstances on the other hand.

However the aim would be to eliminate the need for such work over a period of time (e.g. by reallocating work to other colleagues, undertaking the work in a different way or discontinuing this, developing the roles of other staff or service providers to undertake at least some of this work, or by employing additional consultants), with any associated payments ceasing when the extra work was no longer required to be done.

4. **Travelling time:** has to be recognised as part of the discussion on a consultant's working time when, e.g. the consultant needs to travel between sites during their working day, or has to travel to and/or from a particularly distant site in order to deliver the service. This will need to be linked with any wider considerations of designing how services are delivered to take account of effective use of the time of professional staff. Particular arrangements will need to be developed locally to take account of specialties where consultants may need to visit clients who are geographically distant.

Future consultant appointments will recognise in job descriptions etc that the modern delivery of healthcare will often involve delivering services from more than one location, and that these are liable to change over time. On this basis a consultant would be able to choose (subject to relevant clinical governance considerations regarding being able to return to the appropriate site(s) within an acceptable period of time to respond to emergencies) an appropriate place to live.

It is recognised that the old '10 mile limit' on how far away a consultant can live, is no longer appropriate – the time taken to be able to return to the relevant site(s) for emergency work purposes now being the necessary consideration.

5. **Location of work:** will vary depending on the nature of a consultant's work and their varying responsibilities. The normal locations from which a consultant will undertake their NHS commitments will be agreed through the job plan review and confirmed in their job plan.

The appropriate locations for DCC sessions will usually be determined by the nature of the work. SPA sessions, however, may offer the potential for greater flexibility – while the locations of some activities such as teaching are likely to be predetermined, other activities such as preparing presentations might be undertaken in any one of a number of settings and it is envisaged that, in appropriate circumstances, **up to one** SPA session per week could be agreed to be undertaken at home or away from the consultant's normal place of work.

Appropriate expected outcomes will need to be agreed for such work, as with other aspects of a consultant's commitments.

Many consultants will also have other responsibilities such as the supervision of juniors which will mean in practice the great majority of their time will be spent at the sites or locations where their services are delivered, however the amended Consultant contract recognises – in line with good modern employment practice and the professional nature of a consultant's role – that by agreement some of these activities may be undertaken at home or elsewhere.

6. **CPD activities:** CPD requirements will be identified through the Consultant's appraisal. This will need to inform the job plan review so that due allowance can be made to accommodate aspects such as agreed CPD activities within planned SPAs. CPD activities, like any SPA activities, will be undertaken to help achieve a particular purpose. CPD activities will have been agreed as part of appraisal where outcomes would be assessed appropriately.

7. **Timescales:** the timing of the first stage of the job planning process should normally be designed to determine whether or not the consultant has had a satisfactory job plan review within one month of their incremental date, unless jointly agreed otherwise. How quickly the remaining stages of the job plan review leading to an agreed job plan for the coming year can be completed will vary.

The whole process is likely to take longer in the initial years as all those involved become familiar with the process and the issues involved. The first round of job planning will only commence after job planning guidance has been issued and job planning training undertaken early in 2004, and may not then be completed in many cases for several months.*

8. **Outcomes** will need to be developed by each clinical team and their general manager for their specialty, in discussion with the employer's senior executives. These might reflect information available, with every effort to be made by the employer to ensure such information is valid, accurate and agreed with the Consultant, from established sources of best practice and benchmarking data as well as local service priorities and clinical governance considerations, including clinical need. They could also take account of Assembly healthcare policy directives and the local application of national modernisation and innovation initiatives, including guidance developed by the NHS Wales Service Innovation Board, the body of senior clinicians and other senior colleagues from NHS Wales being established to identify, evaluate and disseminate areas of best practice across Wales.

* Many Consultants in the pilot Trusts may feel they have already undertaken the first stage, but should either they or their employer wish to revisit this, then they are entitled to do so.

9. **Unrecognised additional work sessions:** decisions regarding payment of additional sessions for unrecognised additional work will only be made at the conclusion of the job plan review process (i.e. at the third stage), when the job plan for the coming year is being agreed. In those situations identified **in the first year** of job planning, where it is accepted that the work for which any additional session is to be paid had been being undertaken at least since the amended contract came into effect, these sessions would be paid retrospectively to 1 December 2003. In subsequent years any new such sessions identified would not be paid retrospectively.

10. **Fee paying work:** including Category 2 (such as for government departments and additional work for NHS organisations) should not attract double payment. However, it may be carried out with the professional fee retained by the Consultant in the following circumstances, which will be agreed in the job plan review :-

- when carried out in the Consultants uncontracted time or in annual or unpaid leave;

- where it is agreed the work involves minimal disruption to contracted NHS time. This may be particularly relevant in circumstances such as the undertaking of the occasional post-mortem examination for the Coroner's office. This will be considered as part of the job plan review;

- where such work constitutes a significant element of time, Consultants will identify this in the job planning process, and identify 37.5 hours of time provided to the NHS out with this work.

If none of the above circumstances apply and the work is carried out within NHS sessions with no compensatory time provided elsewhere, the professional fee is remitted to the employer.

For the minimal disruption provisions to apply, the consultant will need to be able to demonstrate through the job plan that they are delivering 37.5 hours or more of work for the NHS outside of such fee-paying work if they are to retain the relevant professional fees.

11. **Private practice:** any Consultant undertaking private practice must demonstrate that:-

a. they are fulfilling their NHS commitments;

b. there must be **no** conflict of interest between NHS work and private work;

c. the needs of patients in the NHS will not be prejudiced by the provision of services to private patients;

d. work outside NHS commitments will not adversely affect NHS work, nor in any way hinder or conflict with the needs of NHS employers and employees; and,

e. NHS facilities, staff and services may only be used for private practice with the agreement of the NHS employer. Consultants will not undertake private practice which prevents them being available to the NHS when on-call.

A Consultant with a low likelihood of recall may undertake appropriate private practice when on-call for the NHS, with the prior agreement of their NHS employer that this will not affect their availability for NHS commitments. There will be exceptional circumstances in which Consultants may reasonably provide emergency or essential continuing treatment for an existing private patient during NHS time on the basis of clinical need. Consultants will make alternative arrangements to provide cover where work of this kind impacts on NHS commitments.

The Consultant will ensure that there will be clear arrangements to avoid the risk of private commitments disrupting NHS commitments, e.g. by causing NHS activities to begin late, or to be cancelled. If NHS sessions are disrupted the Consultant should rearrange the private sessions. Agreed NHS commitments will take precedence over private work. The job planning process will determine when NHS sessions are to be scheduled. Where there is an agreed change to the scheduling of NHS work, the employer will be required to allow a reasonable period for Consultants to rearrange any existing private sessions.

12. **Other responsibilities:** generally other responsibilities undertaken by consultants outside of DCCs, SPAs and any agreed additional sessions for direct clinical work will be regarded - and remunerated - as responsibility allowances. This will include activities that some consultants may undertake at some stages in their careers, such as acting as the local clinical audit lead or a clinical tutor, undertaking external roles on all-Wales or UK-wide bodies, or management roles such as being a Clinical Director. By their nature, it is often difficult to identify the specific time commitment involved in such activities. They will, therefore, **not** be included in the time allocated as part of the normal working week in the

job plan, and attract separate remuneration in accordance with local arrangements, **unless** the consultant agrees with their employer that these should replace part of their basic (in the case of a full-timer) 10 sessions.

13. **Part-time consultants:** where as part of the job plan review it is identified that a part-time consultant is, in fact, required to work beyond their contracted hours or more to discharge their NHS responsibilities, they should be given the option of moving to a full-time contract if they agree to maintain this level of workload, or of having an appropriate reduction in their workload to bring these in line with their contracted hours. The reasons causing such extra work will, of course, need to be examined to ensure the most appropriate way forward is identified in the interests of all parties.

14. **Appeals panels:** will comprise two individuals, one each drawn from panel lists nominated by BMA Cymru Wales and HR Directors in Wales, who have been approved as trained in conciliation techniques. The panel will hear the appeal in accordance with the employer's normal grievance procedure, and reach a decision which will be binding on both parties. Representatives will not act in a legal capacity.

In exceptional circumstances where a decision cannot be agreed by the members of the panel, a second panel would be constituted with alternative representatives.

15. **The amended contract:** will be reviewed formally by the FTCC by December 2005. It is anticipated the FTCC will have a continuing role both in maintaining this agreement, and in any subsequent changes to terms and conditions for consultants within NHS Wales.

JOB PLAN PROFORMA DEVELOPED BY PILOT TRUSTS

REVISED JOB PLAN: _____

A. WEEKLY TIME-TABLE OF DIRECT CLINICAL CARE DUTIES					
		Sessions	Hours	HOSPITAL/ LOCATION	TYPE OF WORK
MONDAY	AM				
	PM				
TUESDAY	AM				
	PM				
WEDNESDAY	AM				
	PM				
THURSDAY	AM				
	PM				
FRIDAY	AM				
	PM				
WEEKEND					
ON-CALL					
Other Direct Clinical Care Sessions:					
TOTAL					

NOTE: ONLY DIRECT CLINICAL CARE COMMITMENTS SHOULD BE INCLUDED IN THIS TIME TABLE

The above Job plan has been agreed at the job plan review. Signed off :

Consultant ..... Date ...../...../.....

B. AVERAGE NUMBER OF HOURS SPENT EACH WEEK ON NHS DUTIES	
TYPE OF DUTY	**AVERAGE NO. OF HOURS WORKED**
Emergency duties [inc. work on-call]	
Operating sessions [including pre and post-operative care]	
Ward rounds	
Out patients	
Clinical diagnostic work	
Other patient treatment	
Public health duties	
Multi-disciplinary meetings about direct patient care	
Adminsitration directly related to patient care	
Training	
Continuing Professional Development	
Teaching	
Audit	
Job Planning	
Appraisal	
Research	
Clinical Management	
Local Clinical Governance Activities	
Unrecognised Additional Work	
Planned Additional Sessions/Waiting list Initiatives	
Additional Responsbilities	
Management Responsbilities	
Other extent relevant NHS duties	
Travel/Other [specify]	
Rota Arranagements eg 1:4 and number of sites covered	
TOTAL	

NOTE: COMPLETION OF THIS TABLE DOES NOT GIVE RISE TO A CONTRACTUAL DUTY TO WORK BEYOND THE ACTUAL CONTRACTUAL COMMITMENT

Medical/Clinical Director ..... Date ...../...../.....

CONSULTANTS CONTRACT PILOT JOB PLAN INTERVIEW PROFORMA

Name: _____

Speciality: _____

Base Site: _____

Trust: _____

CONSULTANT CONTRACT PILOT JOB PLAN INTERVIEW PROFORMA

Current Contact (please circle as appropriate)

fulltime/max Part time/Part time/Honorary

Number of NHS Sessions: _____ Direct Clinical Care: _____ Supporting Professional Activities: _____

AVERAGE NUMBER OF HOURS SPEND EACH WEEK ON DUTIES:

Type of Duty	Number of hours in an average week	Sessions Allocated	Comments
1. Direct Clinical care:			
Emergency duties (including emergency work carried out during or arising from on-call)			
Operating Sessions including pre and post-operative care			
Ward Rounds			
Outpatient Clinics			
Clinical Diagnostic Work			
Other Patient Treatment			
Public Health Duties			
Multidisciplinary meetings about direct patient care			
Administration directly relating to patient care			
TOTAL			

Type of Duty **2. Supporting Professional Activities**	Number of hours in an average week	Sessions Allocated	Comments
Training			
Continuing Professional Development			
Teaching			
Audit			
Job Planning			
Appraisal			
Research			
Clinical Management			
Local Clinical Goverance Activities			
3. Unrecognised Additional Work:			
4. Planned Additional Sessions:			
5. Waiting List Initiatives:			
TOTAL			

Type of Duty	Number of hours in an average week	Sessions Allocated	Comments
6. Additional Responsibilies (eg. Caldicott Guardians; Clinical Audit Leads; Clinical Governance Leads; Other Regular Teaching and Research; Professional Representation Roles)			
7. Management Responsibilities			
(eg. Medical Director, Clinical Director, Lead Clinician)			
8. Other (external) Relevant NHS Duties:			
Sub Total of hours/sessions worked			
9. On-call duties:			
Please indicate on-call rota			
Average time spent on telephone calls per week			
Out-of-hours work undertaken within the hospital whilst on-call			
Total hours worked on-call			

Type of Duty	Number of hours in an average week	Sessions Allocated	Comments
10. Other Fee-Paying Work: (Details of any changes in eg. Category 2, Dom Visits, Private Work. Excluded from normal working week)			
11 Service Outcomes: (Outcomes may vary according to specialty but the headings under which they could be listed include: Activity and Safe Practice Clinical Outcomes Clinical Standards Local Service Requirements Management of Resources Quality of Care (NB. Further work being undertaken regarding these).			
12. Service Implications: To identify any variations in service activity levels for the coming year as a result of the job plan review (ie. Reduction or change in activity or ways of working)			

NHS WALES

CONSULTANTS

JOB PLANNING GUIDE

Pay Modernisation

December 2003

CONTENTS

Job Planning: Best Practice Guidelines

KEY POINTS

- A consultant job plan should be a prospective agreement that sets out a consultant's duties, responsibilities and expected outcomes for the coming year. In most cases, it will build upon the consultants' existing NHS commitments.

- Effective job planning is based on a partnership approach enabling consultants and employers to:

    - better prioritise work and reduce excessive consultant workload;

    - agree how a consultant or consultant team can most effectively support the wider objectives of the service and meet the needs of patients;

    - agree how the NHS employer can best support a consultant in delivering these responsibilities;

    - provide the consultant with evidence for appraisal and revalidation

    - comply with Working Time Regulations.

- Under the recommended standards set out in this guidance, consultant job plans should:

    - set out agreed expected personal outcomes and their relationship with the employing organisation's wider service objectives

    - set out how the employer will support consultants in delivering agreed commitments, e.g. through providing facilities, training, development and other forms of support;

    - include a work schedule that covers all professional work, including teaching, research, management or other service responsibilities and clinical governance activities, and takes into account discussion on any non-NHS commitments that could affect this;

    - set out agreed arrangements for the location(s) at which consultants carry out their duties and responsibilities, including identifying work that can be carried out flexibly;

- set out agreed arrangements for carrying out Category 2 and other similar work, based on the underlying principles that such work should not disrupt NHS duties and that there should be no 'double payment';

- be reviewed annually;

- be undertaken on a team basis, where this is likely to be more effective.

- NHS employers should ensure a dialogue with clinical academics and university employers to agree a single overall job plan and ensure mutual awareness of academics' commitments.

- Where these standards set out recommended good practice for consultants, the criteria for clinical excellence awards will include evidence that consultants are meeting those standards.

JOB PLANNING: BEST PRACTICE GUIDELINES

1 INTRODUCTION

1.1 These standards of best practice are designed to apply to all medical and dental consultants employed by the NHS in Wales.

1.2 Where these guidelines set out recommended standards of practice for consultants, adherence to those standards will form part of the eligibility criteria for commitment and clinical excellence awards (as set out in paragraph 2.7).

1.3 This document refers to 'consultants' and 'NHS employers' throughout. It is recognised that some consultants also have employment relationships with the University sector, with responsibilities for research and teaching. These responsibilities and the interests of University employers are of equally high priority and should be actively considered and taken into account when agreeing the single overall job plan.

1.4 Job planning should not be a time consuming or resource intensive process. If used well by both parties, it can be a highly effective tool for planning how the work of consultants and consultant teams, together with associated resources, can be most effectively and efficiently organised.

1.5 Effective job planning, covering the full range of consultants' NHS duties, should have strong mutual benefits both for consultants and for NHS employers. For consultants it should help:

- clarify the commitments that are expected of them and the resources and other support they can expect from the employer to help meet these commitments;
- prioritise work and better manage excessive workload;
- promote flexible working;
- support, where appropriate, a phased approach to consultant careers
- provide evidence of current practice that could form part of the evidence for GMC revalidation procedures.

1.6 For NHS employers, effective job planning should help in:

- planning the most effective use of overall resources;

- supporting compliance with the Working Time Regulations

- agreeing and providing transparency as to how consultants' work can most effectively support the employing organisation's wider objectives subject to compliance with GMC's "Good Medical Practice" and GDC's "Maintaining Standards"; identifying possible changes in capacity, skill mix and/or ways of working; and

- agreeing appropriate time and resources to support clinical governance, quality improvements, teaching, education and research.

The wider context

1.7 To maximise improvements to patient care, NHS employers need to work closely with consultants to help re-define services around the needs of NHS patients. Ways of working for NHS consultants and wider clinical teams work need also to take into account:

- the planned expansion in consultant numbers;

- the commitment of the medical profession in Wales to innovative practice and service modernisation, for example, as set out in the BMA document, "Consultants leading the Modernisation Agenda for Wales";

- the implementation of the European Working Time Directive for doctors in training; and

- modernising medical careers and changes to teaching and education practices.

1.8 Alongside these changes, the NHS should be seeking to make ongoing improvements to the quality of consultants' working lives. This includes:

- helping manage consultant workload, through effective deployment of consultant expansion, optimum prioritisation of work, better administrative support, and greater delegation of some duties to other members of the health care team;

- supporting consultants who wish to work in more flexible ways, for instance by enabling consultants to organise elements of their work at different times in the week, subject to service needs, or to work on a part-time basis to reflect personal circumstances, and using annualised hours or

similar approaches, where appropriate, to fit around childcare or other responsibilities, or introducing job shares;

- a more planned and phased approach to consultant careers, with – for instance – greater opportunities for more senior consultants to adapt their range of duties and greater use of sabbaticals; and

- greater recognition for those who make a sustained commitment and/or outstanding contributions to the NHS.

- Ensuring suitable consultant office space is available.

- Providing a pleasant social area, preferably with catering facilities to enable consultants to informally refer and discuss patients and meet each other in a confidential environment.

2 OVERALL APPROACH AND PROCESS

Scope of job plan

2.1 A job plan should be a prospective agreement that sets out a consultant's duties, responsibilities and expected outcomes for the coming year. It is likely to build on the duties, responsibilities and expected outcomes set out in the job plan for the previous year. It is separate from, but linked to, the appraisal process.

2.2 The job plan is the outcome of the job plan review, a discussion and agreement between the consultant and their employer on progress against the expected personal outcomes agreed in the previous job plan, and of the consultant's agreed expected personal outcomes for the coming year.

2.3 The job plan should cover all aspects of a consultant's professional practice including clinical work, teaching, education, research, and managerial responsibilities.

2.4 The job plan should cover:

- the consultant's main duties and responsibilities (see section 3 of this guidance);
- scheduling of commitments (see section 4);
- expected personal outcomes, including any continuing medical education and training, and their relationship with wider service objectives (see section 5); and
- the support needed in fulfilling the job plan (see section 6).

Agreeing a job plan

2.5 Job planning requires a partnership approach. Job plans should be drawn up and agreed between the consultant and their employer as a result of the job plan review. This will be a detailed discussion, which will usually be carried out by the same person who undertakes the consultant's appraisal – in most cases the Clinical or Medical Director. The consultant should prepare for the job plan review meeting by maintaining a record of how they have carried out their existing job plan.

2.6 The Chief Executive of the NHS organisation should ensure that all consultants have agreed job plans, and will confirm to the consultant whether the job plan review is satisfactory.

2.7 Following the discussion at the job plan review, the Chief Executive will confirm to the Consultant whether the job plan review has been satisfactory, or has been unsatisfactory. A satisfactory job plan review will result when a Consultant has:

- Met the time and service commitments in their job plan
- Met the agreed outcomes in their job plan, or – where this is not achieved for reasons beyond the individual Consultants control – has made every reasonable effort to do so
- Participated satisfactorily in annual appraisal, job planning and the setting of outcomes
- Worked towards any changes identified as being necessary to support achievement of the agreed outcomes in the last job plan review.

2.8 This will inform decisions on pay progression. Commitment Awards will be paid automatically on satisfactory review, or in the absence of an unsatisfactory job plan review.

2.9 Job planning is separate from, but should be closely linked to, the process of consultant appraisal and agreement of personal development plans. Job planning may help provide a record of a consultant's practice that could form part of the evidence for appraisal and revalidation.

Job plan reviews

2.10 A job plan review should take place annually. The review should normally take place as soon as possible after the annual appraisal meeting, and should (following the transitional arrangements for introducing the 2003 amendments to the Consultant Contract in Wales), take place within one month of the Consultant's incremental date, unless jointly agreed otherwise.

2.11 Either the consultant or the clinical manager may wish to propose an interim job plan review, for instance where duties, responsibilities or expected outcomes have changed or need to change significantly within the year.

2.12 The review should be designed to:

- consider what factors have affected the carrying out of the duties and responsibilities set out in the job plan;
- consider progress against the expected personal outcomes in the job plan and the factors involved;
- consider current levels of workload;
- agree any changes to the consultant's duties and responsibilities, taking into account opportunities in relation to staffing, skill mix and ways of working and, if the consultant wishes, the scope for more flexible ways of working;
- agree a plan for achieving a consultant's expected personal outcomes;
- agree what support the consultant will need from the organisation and from colleagues to help achieve these outcomes.

2.13 The job plan review should also be the occasion for reviewing the relationship between NHS duties and any private practice where these may lead to any conflict of interest with, or affect the delivery of, the Consultant's NHS commitments.

2.14 To support a more planned and phased approach to consultant careers, it would be good practice to hold a broader career review from time to time. In particular it is expected that the Medical Director of the NHS employer will arrange an interview in the Consultant's mid 50's, or other appropriate time, during which the balance of a Consultant's pattern of work will be reviewed and can be agreed to be amended subject to the exigencies of the service.

Where agreement cannot be reached on a job plan

2.15 Consultants and employers should make every possible effort to agree job plans. In the rare circumstances where a consultant and employer fail to reach agreement on the content of a job plan, either initially or at a job plan review, they should follow the procedures set out in the consultant's terms and conditions of service designed to resolve these differences informally, and, failing this, for formal appeal if the consultant so requests.

3 AGREEING DUTIES AND RESPONSIBILITIES

3.1 The job plan should set out the main duties and responsibilities of the post and the service to be provided, for which the consultant, or group of consultants, will be accountable.

3.2 These responsibilities will distinguish between direct clinical care duties, supporting professional activities, academic research and teaching, additional responsibilities for their main employer, and other duties and activities within the wider NHS.

3.3 For a full time consultant, there will typically be 7 sessions for 'direct clinical care' and 3 for 'supporting professional activities' (see boxes below). Variations will need to be agreed by the employer and the consultant at the job planning review.

Consideration should also be given to any:

- 'Additional NHS responsibilities', which may be substituted for other work or remunerated separately; and,
- 'other duties' – external work that can be included in the working week with the employer's agreement.

There is also scope for local variation to take account of individual circumstances and service needs in, for example; management, teaching, research and development.

3.4 Examples of these types of duties, responsibilities and activities include:

Direct Clinical Care Covers:

i. Emergency duties (including emergency work carried out during or arising from on-call).

ii. Operating sessions including pre and post-operative care.

iii. Ward rounds.

iv. Outpatient clinics.

v. Clinical diagnostic work

vi. Other patient treatment

vii. Public health duties

viii. Multi-disciplinary meetings about direct patient care

ix. Administration directly related to patient care (e.g. Referrals, notes)

Supporting Professional Activities Covers:

A number of activities which underpin direct clinical care, including:

i. Training

ii. Continuing professional development

iii. Teaching

iv. Audit

v. Job Planning

vi. Appraisal

vii. Research

viii. Clinical Management

ix. Local clinical governance activities

Academic Research & Teaching

For some consultants, all or a significant part of their main responsibilities may cover other aspects of health provision such as providing medical education, formal teaching and academic research.

Additional Responsibilities for Main Employer

Some Consultants have additional responsibilities agreed with their employer which could include those of:

i. Medical Directors, Clinical Directors and lead clinicians

ii. Caldicott guardians

iii. Clinical audit leads

iv. Clinical governance leads

v. Undergraduate and postgraduate deans, clinical tutors, regional education advisor

vi. Regular teaching and research commitments over and above the norm, and not otherwise remunerated

vii. Professional representational roles

All such agreed contributions will be covered in the job plan, regardless of whether they are remunerated separately or whether they form part of the consultant's main contract and substitute for other sessions.

Other Duties and Activities within the Wider NHS

Again, Consultants will often participate in such work at different stages of their career, and this may be specified as part of the job plan by agreement between the consultant and employer. Such duties might include:-

i. Trade union duties

ii. Acting as an external member of an Advisory Appointments Committee

iii. Undertaking assessments for the NCAA

iv. Reasonable quantities of work for the Royal Colleges in the interests of the wider NHS

v. Specified work for the General Medical Council

vi. Undertaking inspections for the Commission for Health Improvement or other health regulatory bodies

3.5 At the discretion of the employer, paid professional leave or unpaid leave may be available for other professional activities not covered in the job plan.

4 AGREEING SCHEDULING OF COMMITMENTS

Timetabling and location of job plan commitments

4.1 The consultant and employer should use the process of job planning and job plan reviews to agree how and when the full range of commitments covered by the job plan should be delivered.

4.2 The Consultant and the employer will normally prepare a joint draft job plan that should then be discussed and agreed. The agreement will take into account the consultant's views on resources and priorities and the employer's ability to provide the necessary supporting resources.

4.3 The employer and consultant will agree a timetable setting out when and how the commitments set out in the job plan will be delivered and the nature and location of the activity, including their on-call/emergency commitments. This should cover all activities covered in the job plan, including medical and clinical responsibilities, personal management and development responsibilities, and any agreed additional responsibilities for the main employer or within the wider NHS (see section 3).

4.4 Specifying commitments in the job plan should be regarded as providing greater transparency about the level of commitment expected of consultants by the NHS. It should not in any way diminish professionalism or override clinical judgement.

4.5 The employer and consultant will, on a voluntary basis, agree flexible arrangements for timing of work to reflect service needs and personal circumstances. It may, for example, be appropriate that certain activities within the consultant's basic working week are scheduled during evenings, nights or weekends thus freeing up uncontracted time during the normal working week when the consultant has no NHS commitments.

4.6 Commitments during evenings and weekends, apart from those arising from on-call/emergency commitments should only be scheduled by mutual agreement between the consultant and his or her employer. Consultants have the right to refuse non-emergency work at such times without detriment to pay progression or any other matter.

4.7 The working week for a full-time Consultant will comprise 10 sessions with a timetabled value typically of three to four hours each. After discussion, these

sessions will be programmed in appropriate blocks of time to average a 37.5 hour week.

4.8 There will be flexibility about the precise length of individual sessions with, for example, scope for variation, up and down, in the length of individual sessions from week to week around the average assessment set out in the job plan. Regular and significant differences between a Consultant's timetabled hours and the hours actually worked will need to be discussed as part of job plan reviews either at the planned annual review or an interim job plan review, Job planning review will be triggered if a Consultant regularly works one session more (or less than) these hours each week on average.

4.9 The employer and consultant should agree the location(s) from which the commitments in the job plan will be carried out. There should be local flexibility to agree off-site working where appropriate.

4.10 Where job planning takes place on a team basis, each individual team member should still agree a schedule of individual commitments.

4.11 All time taken out of the agreed working week (annual leave, professional or study leave) should be agreed with the employer in advance.

4.12 The consultant should be responsible for making every reasonable effort to work to the agreed job plan and the employer for making every reasonable effort to provide the necessary supporting resources (see section 6).

On Call/Emergency Work

4.13 All emergency work that takes place at regular and predictable times (e.g. post-take ward rounds) will be programmed into the working week on a prospective basis and count towards a Consultant's sessions. Less predictable emergency work will be handled, as now, through the following on-call arrangements:

- The first three hours of work done during on call periods per week – averaged over a six-month period – unless specifically agreed otherwise will attract one direct clinical care session of time within the working week. Where this averages less than three hours, this will attract the appropriate proportion of a session of time.

- Consultants will not normally be resident on call.

- In exceptional circumstances where the Consultant is requested and agrees to be immediately available, i.e. 'resident on call', this will be remunerated at three times the sessional payment at Point 6 of the Consultant salary scale, excluding commitment awards and Clinical Excellence awards. In such circumstances, there will be an agreed compensatory rest period the following day.

- For these purposes, a session will comprise four hours and apply between 5pm and 9am weekdays and across weekends.

- Consultants not on an on-call rota may be asked to return to site occasionally for emergencies but are not required to be available for such eventualities. Emergency work arising in this way should be compensated through a reduction in other sessional activities on an ad hoc basis.

- Where emergency recalls of this kind become frequent (e.g. more than 6 times per year), employers should review the need to introduce an on-call rota.

Where Consultants have onerous out-of-hours duties, the job plan review will be used to ensure that there is adequate flexibility to provide compensatory rest.

The European Working Time Regulations will apply and be implemented.

Unrecognised Additional Work

4.14 Where it is identified, through the job planning process, that a Consultant is undertaking a session or more a week of additional or pro rata for part-time work on a regular basis, in excess of their contracted hours, and not arising at the request of the employer, then the employer can request that such work be continued as additional sessions for the relevant period of time in excess of the contracted sessions, or discontinued as required.

4.15 These additional sessions will be voluntary, and can be ended at the request of either the Consultant or the employer, with reasonable notice. They may be undertaken during the working week in uncontracted time within an agreed overall annual total. Such sessions will be paid at the rates set out in the terms and conditions of service. There will be an expectation that such work will be eliminated or undertaken in other ways over a period of time.

Planned Additional Sessions

4.16 Consultants may be requested by their employer to carry out additional sessions from time to time in excess of their contracted sessions. These additional sessions will be voluntary. They may be undertaken during the working week in uncontracted time within an agreed overall annual total. Remuneration for such work will be locally negotiated between the employer and the Consultant.

Waiting List Initiative Sessions

4.17 Waiting List Initiatives work may be requested by the employer to be carried out in addition to the Consultant's contracted sessions. These additional sessions will be voluntary. Such sessions may be undertaken in uncontracted time. Remuneration for such work will be at the rate set out in the terms and conditions of service when carried out on Trust premises. All aspects of such work will be taken into account in calculating such sessions, e.g. time taken to see patients pre and post operatively.

Clinical academics

4.18 In the case of consultants who are also clinical academics, or undertaking teaching activities away from their principal place of employment (e.g. at a university), job plans should take full account of both university commitments and NHS commitments.

4.19 The NHS employer should ensure that there is discussion with the university employer and the consultant to ensure that a single overall job plan is mutually agreed and that all parties are aware of the consultant's full range of commitments. Job planning should take account of the likelihood of medical or clinical responsibilities resulting in emergency care that may impact on other scheduled responsibilities.

4.20 There should be equal importance attached to NHS and university work, with clear delineations as to when a consultant is working for which employer.

Fee-paying work

4.21 Fee-paying work including Category 2 (such as for government departments and additional work for NHS organisations) should not attract double payment.

However, it may be carried out with the professional fee retained by the Consultant in the following circumstances, which will be agreed in the job plan review: -

- When carried out in the Consultants uncontracted time or in annual or unpaid leave; or

- Where it is agreed the work involves minimal disruption to contracted NHS time. This may be particularly relevant in circumstances such as the undertaking of the occasional post-mortem examination for the Coroner's office. This will be considered as part of the job plan review; or

- Where such work constitutes a significant element of time, Consultants will identify this in the job planning process, and identify 37½ hours of time provided to the NHS out with this work.

If none of the above circumstances apply and the work is carried out within NHS sessions with no compensatory time provided elsewhere, the professional fee is remitted to the employer.

4.22 The consultant and employer should agree as part of the job plan and job plan review how any fee-paying work of this kind is to be carried out, and, therefore, how the relevant professional fees are to be allocated.

4.23 Where changes to the pattern of fee-paying work are likely to affect the performance of duties set out in the job plan, the consultant should agree with the employer in advance how this should be handled and, where necessary, agree a revised schedule of NHS duties.

Non-NHS commitments

4.24 Any regular non-NHS commitments, including regular private commitments, that may affect the consultant's ability to meet their NHS commitments should be identified in the consultant's schedule to provide transparency, assist planning and timetabling of NHS work, and help organise out of hours cover (see also terms and conditions of service).

4.25 Scheduling of NHS work should take priority over the scheduling of non-NHS work, subject to the employer providing sufficient notice of any proposed change to the agreed schedule (see also terms and conditions of service).

Annualisation

4.26 Timetables may cover a week, but alternative approaches covering a number of weeks, or annualisation, may be adopted where appropriate and where agreed between consultant and employer.

5 AGREEING EXPECTED OUTCOMES

5.1 The job plan should set out agreed expected personal outcomes and their relationship with the employing organisation's wider service objectives.

Expected personal outcomes

5.2 A consultant's expected personal outcomes should be agreed as part of the annual job plan review. They should take into account:

- the needs of NHS patients and the employer subject to compliance with GMC's "Good Medical Practice and GDC's "Maintaining Standards";
- the development needs of the consultant
- the stage of the consultant's career;
- continuing medical education and training objectives; and
- any changes in ways of working agreed between the consultant and employer.

5.3 The nature of a consultant's expected personal outcomes will depend in part on his or her specialty, but they may include outcomes relating to:

- Activity and safe practice
- Clinical outcomes
- Clinical standards
- Local service requirements
- Management of resources, including efficient use of NHS resources
- Quality of Care

5.4 Outcomes need to be appropriate, identified and agreed. These could include outcomes that may be numerical, and/or the local application of modernisation initiatives.

5.5 Where outcomes are set in terms of output and outcome measures, these must be reasonable and agreement should be reached. They may, for example,

reflect a broad framework of outcomes agreed with their employer by the clinical team for that specialty.

5.6 Expected personal outcomes of this kind should represent a reasonable expectation of successful professional practice.

Relationship with wider objectives

5.7 The job plan should identify how the consultant's expected personal outcomes relate to any relevant service objectives for the NHS organisation, directorate or team.

Meeting expected outcomes

5.8 Agreed expected personal outcomes, although an integral part of the job plan, should not be contractually binding. Consultants should nonetheless make all reasonable efforts to work towards the achievement of these outcomes.

5.9 Expected personal outcomes should be agreed on the understanding that their achievement may be affected by circumstances or factors outside the control of the individual consultant or consultant team.

5.10 The aim is to help the Consultant achieve satisfactory outcomes for the benefit of the service. Therefore, any potential obstacles to achieving satisfactory outcomes must be raised and discussed between the Consultant and their employer as soon as these become apparent, and not be delayed until the next planned review. This is to enable any remedial action to be taken and avoid an unsatisfactory job plan review wherever possible.

5.11 In the rare event of an unsatisfactory job plan review, the employer will give details of the reasons for such a result, in writing, record whatever remedial action is agreed, and give a defined timetable for its completion. If such agreement is **not** reached, there will be recourse to the appeal process (see Section 2). An interim job plan review will be arranged no longer than 6 months following the unsatisfactory job plan review.

5.12 If the Consultant has remedied the situation, a satisfactory job plan review will be recorded as usual.

If the interim job plan review is also unsatisfactory, the Consultant will receive a formal letter outlining the reasons for deferring their commitment award for the period of one year. This deferment will also be subject to a right of appeal as

agreed (see Section 2). Deferment may continue in subsequent years if agreed corrective action has not been completed at the next scheduled job plan review.

The expected outcomes for the following year should then be agreed, including the support needed to help meet these.

5.13 The process of job planning and job plan reviews should be used to assess the resources and other support that the employer needs to make available to enable outcomes to be achieved, together with identifying and addressing any organisational or systemic blocks that may prevent the consultant or consultant team from achieving these.

6 AGREEING THE SUPPORT NEEDED TO FULFIL JOB PLANS

6.1 NHS employers are responsible for ensuring that consultants have the facilities, training, development and other support needed to help deliver the commitments in the job plan.

Resources

6.2 Employers and consultants should use the process of job planning and job plan reviews to identify the resources that are likely to be needed to help carry out job plan commitments and help achieve job plan outcomes. This may include facilities, administrative, clerical or secretarial support, IT resources and other forms of support.

6.3 The agreed resources should be specified in the job plan.

Identifying potential barriers

6.4 Both employers and consultants should proactively seek to identify potential organisational or systems barriers that may affect the ability to carry out job plan commitments and achieve job plan outcomes. For example, if a consultant identifies that delays are occurring in patient throughput because of delays in the provision of other services, then this should be raised with the employer during the job plan review. Agreed factors of this kind – and the employer's proposed actions for resolving the problem – should be noted in the revised job plan.

Personal development

6.5 NHS employers have a responsibility for the development of all their staff.

6.6 Personal development and continuing medical education are equally important aspects of a consultant's career. A consultant's developmental aspirations may change through the course of his or her career. As part of their personal development, consultants should have the opportunity to adapt their personal and career aims, improve their skills and take on new roles and responsibilities taking into account service needs.

6.7 Continuing medical education is a core principle that underpins clinical governance. Consultants are also required to demonstrate that their practice is up to date as part of the appraisal and revalidation process. In order to employ the safest and most up-to-date techniques, a consultant needs to be given

opportunities for further professional training and education. Consideration should also be given to reviewing onerous work patterns, particularly for consultants with longer experience.

6.8 The job plan should include agreed aims for personal development and continuing medical education and identify appropriate time and resources for these activities.

BMA
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WALES

The New Welsh Consultant Contract

Job Planning, The Working Week, On call and all that stuff

A Take You Through It Guide

Welsh Consultants and Specialists Committee

January 2004

FOREWORD BY JON OSBORNE

I write this foreword as an introduction and to give you some background details that led to the Welsh Consultant Contract 2003 for which this guidance has been produced.

Towards the end of 2002, the consultants and specialist registrars voted in a ballot on a framework document for a new UK Consultant contract that had been 4 years in the making. It was decisively rejected in England and Wales. The Department of Health in London did not carry out further negotiations with the BMA for some months. During this time of uncertainty the Welsh Assembly Government, who had been having informal exchanges with BMA Cymru/Wales, decided to formally enter into discussions, together with the NHS Trusts in Wales, to see if we could suitably amend the present contract to create one that was suitable for healthcare within Wales in the new century.

Accordingly a new body was formed, called the Forum for Terms and Conditions Committee, which had all three groups involved.

The BMA Cymru/Wales asked consultants, via Medical Staff Committees, what was required in an amended contract and a plan of action for negotiation was formulated.

This gestation finally produced a document that was presented to the Welsh Consultants and Specialists Committee on 17th July 2003 and which was duly endorsed. This happened to be the same day that the new Secretary of State for Health came to agreement with the BMA for a new contract in England. Four days later the Minister for Health and Social Services in the Welsh Assembly Government signalled that agreement in principle had been reached on amending the consultant contract in Wales in a combined press release.

Two pilot schemes were started to see if there were any major problems with the proposed document, and early in September all parties to the contract carried out road shows in all the Trusts.

A ballot of Consultants and Specialists Registrars was carried out in early November, and the results are shown: (Turnout 64.9%)

	Voted Yes		**Voted No**		**Total**
Total	1381	94.2%	85	5.8%	1466

The Welsh contract tries as far as possible to avoid a clock watching approach and relies on consultant's inherent professionalism to ensure patients are treated to the best possible standards. The contract also formalises the innovative approach shown by consultants to improving the service with a commitment to innovation and modernisation of patient care as we continue to adapt to almost constant change.

Obtaining the benefits from the contract requires some forethought. We hope this guide, which has been produced in consultation with the Welsh Assembly Government, provides you with a tool kit to help you through the job planning process. If you are encountering problems there is an initial informal resolution process through your medical director. Your local LNC and BMA IRO will also provide support. The FTCC, which comprises the following members, will continue to monitor the situation and raise any issues that are causing difficulty directly with the Assembly Government.

Mr. Jon Osborne	Chairman, WCSC	Consultant ENT Surgeon
Mr. Richard Hatfield	Vice Chairman, WCSC	Consultant Neurosurgeon
Dr. Tony Power	Past Chairman, WCSC	Consultant Radiologist
Dr. Tony Goodwin	Chairman, LNC Forum	Consultant Paediatrician
Mr. John Llewelyn	Vice Chairman, LNC Forum	Consultant Maxillofacial Surgeon
Dr. Iain Robbe	Chairman, MASC	Clinical Senior Lecturer
Dr. Neville Hodges	Chairman, Academy of Royal Colleges in Wales	Consultant Physician
Dr. Lika Nehaul	Chairman, WPHC	Consultant Public Health
Dr. Giselle Martinez	WCSC: Part timers	Consultant Psychiatrist
Mr. Mike Murphy	Chairman, WSASC	Staff Grade, Maxillofacial
Dr. Ian Benton	Chairman, WJDC	SpR, General Medicine
Mr. David Saunders	Co-opted from WCSC	Consultant Ophthalmologist
Dr. Bob Broughton	Welsh BMA Secretary	Up to 30th June 2003
Dr. Richard Lewis	Welsh BMA Secretary	From 1st July 2003
Mr. Tony Chadwick	Deputy Secretary BMA	
Mr. Andrew Cross	Assistant Secretary BMA	
Miss Karen Lazenby	Executive Officer BMA	
Mrs Rachael Jones	Committee Executive Secretary	

We thank you for your support of this process and trust that this new contract will improve your working life and the care of patients within Wales.

Jon Osborne,
Chairman, Welsh Consultants and Specialists Committee

4th December 2003

Introduction

The consultant contract in Wales was amended from 1st December 2003 in an agreement between the BMA Cymru Wales, the Welsh Assembly Government and NHS Trusts in Wales. We hope the agreement will improve financial reward, control the working environment and achieve a reasonable work life balance for Welsh consultants. The deal is also intended to aid recruitment and retention of consultants to Wales.

The Main Amendments include:

- A basic 37.5 hour working week.
- Session duration of 3-4 hours
- Typically 7 sessions of direct clinical care
- Provision that one session of supporting professional activities may take place at home or in the evening allowing uncontracted free time during the day. The Assembly Government has recognised the work undertaken by consultants at home e.g. preparing for teaching, research and CME.
- No requirement to provide an extra session of time to the NHS in order to acquire the right to undertake private practice.
- Existing unrecognised additional sessions for routine work to be entirely voluntary with no requirement for compulsory weekend or evening work.
- A payment escalator for existing unrecognised additional sessions.
- Extra sessions requested by the Trust to be voluntary and locally negotiated i.e. a time and price acceptable to both you and the Trust.
- Payment at three times the sessional rate and a period of compensatory rest for consultants asked to be unexpectedly resident on call.
- In the event of a job-planning dispute, an initial conciliation procedure followed, if necessary, by a balanced and fair appeals procedure that will be binding on the Trust and the consultant.

- A commitment award scheme to replace discretionary points, which will depend on achieving a satisfactory job plan. This is funded for 100% of consultants and will be achieved by nearly everyone.

- Early enhancement to basic salary, by increasing incremental points.

- Recognition of different patterns of work intensity, particularly later in a consultant's career.

- A sabbatical scheme.

- An intention by the NHS Trusts in Wales to improve working conditions for their consultant workforce.

- A good package for part timers and academics particularly with openness about individualised job planning.

- Flexibility and professionalism maintained as far as possible in the contract.

This guide is intended to help you negotiate a favourable result at your job planning meetings, which will be crucial in determining your pay and hours for the coming year. Achieving a satisfactory job plan review should be achieved by nearly everyone but will depend on agreeing outcomes for the following year in order to ensure payment of commitment awards. Your local LNC and the BMA centrally in Cardiff will be happy to provide support and advice in the event of difficulties.

JOB PLANNING

This is the essential part of the process. It is mandatory, with an annual review, and will inform the Commitment Awards scheme. The clinical managers and other appropriate staff within the Trusts will be trained to undertake this process. The main questions to ask (yourself and your manager) are:

What do I do during the week?

Where shall I do this work?

How much work shall I do?

Clearly the above will be governed by definitions of the WORKING WEEK.

THE WORKING WEEK

- 10 sessions of 3-4 hours.
- Average 37.5 hours per week.
- Typically 7 Direct Clinical Care sessions and 3 Supporting Professional Activities sessions
- Unrecognised additional work sessions.
- Planned additional sessions.
- Waiting list Initiative sessions.
- Additional NHS Responsibilities.
- On Call/Emergency work

Direct clinical care covers:

i Emergency duties (including emergency work carried out during or arising from on-call).

ii Operating sessions including pre and post-operative care.

iii Ward rounds.

iv Outpatient clinics.

v Clinical diagnostic work

vi Other patient treatment

vii Public health duties

viii Multi-disciplinary meetings about direct patient care

ix Administration directly related to patient care (e.g. Referrals, notes)

Supporting professional activities cover a number of activities which underpin direct clinical care, including:

i Training

ii Continuing professional development

iii Teaching

iv Audit

v Job Planning

vi Appraisal

vii Research

viii Clinical Management

ix Local clinical governance activities

Unrecognised Additional Work

This covers work being done at the moment (identified in your work diary), which is a session or more over the nominal 37.5-hour week (or pro rata for part-time work). Payment will not be for **fractions** of sessions. Note that these are voluntary. Job planning should ensure that you are only required to undertake an average 37.5 hours a week. If the employer requires this existing unrecognised but currently unpaid additional work to continue and you agree, it will be paid (in whole sessions) at the basic rate for 2 years then at 1.25 times and then 1.5 times the sessional rate after 4 years.

Planned Additional Sessions

These are sessions requested by management, to be carried out in addition to your agreed contracted sessions in your job plan. They are voluntary and you can negotiate any acceptable arrangement with the Trust.

Waiting List Initiative Sessions

Similarly these are carried out in addition to your agreed contracted sessions, voluntary and paid £500 per session. However if a session involves considerable

pre and postoperative care you may be able to negotiate more than one session. This work in the private sector has no earnings cap.

Additional NHS Responsibilities

Some Consultants have additional responsibilities agreed with their employer which cannot reasonably be absorbed within the time available for supporting activities. These will be substituted for other work or remunerated separately by agreement between the employer and the Consultant. Such responsibilities could include those of:

- Caldicott guardians
- Clinical audit leads
- Clinical governance leads
- Undergraduate and postgraduate deans, clinical tutors, regional education advisor
- Regular teaching and research commitments over and above the norm, and not otherwise remunerated
- Professional representational roles

On Call/ Emergency work

All emergency work that takes place at regular and predictable times (e.g. post-take ward rounds) will be programmed into the working week on a prospective basis and count towards a Consultant's sessions.

Less predictable emergency work will be handled, as now, through on-call arrangements.

The first three hours of work done during on call periods per week – averaged over a six month period – unless specifically agreed otherwise will attract one direct clinical care session of time within the working week. Where this averages less than three hours, this will attract the appropriate proportion of a session of time.

In exceptional circumstances where the Consultant is requested and agrees to be immediately available, i.e. 'resident on call', this will be remunerated at three times

the sessional payment at Point 6 of the Consultant salary scale, excluding commitment awards and Clinical Excellence awards. In such circumstances, there will be an agreed compensatory rest period the following day.

For these purposes, a session will comprise four hours and apply between 5pm and 9am weekdays and across weekends.

Outcomes

The quantity and quality required are ***outcomes***, described in Section 1.17 of the Contract.

Outcomes may vary according to specialty but the headings under which they could be listed include:

- Activity and safe practice
- Clinical outcomes
- Clinical standards
- Local service requirements
- Management of resources, including efficient use of NHS resources
- Quality of Care
- *Outcomes need to be appropriate, identified and agreed. These could include outcomes that may be numerical, and/or the local application of modernisation initiatives.*
- *Delivery against the job plan may be affected by changes in circumstances or factors outside the control of the individual – all of which will be taken into account at job plan review and considered fully and sensitively in the appraisal process. Consultants will be expected to work towards the delivery of mutually agreed outcomes set out in the job plan.*
- *Outcomes should be kept under review, and the Consultant or Employer will be expected to organise an interim job plan review if either believe that outcomes might not be achieved or circumstances may have significantly changed. Employers and Consultants will be expected to identify problems (affecting the likelihood of meeting outcomes) as they emerge, rather than wait until the job plan review*

- *The delivery of outcomes will not be contractually binding, but Consultants will be expected to participate in, and make every reasonable effort to achieve these. Pay progression via commitment awards will be informed by this process*

If the job plan is not agreed, then the following **appeals process** is invoked:

- *If it is not possible to agree a job plan, either initially or at an annual review, this matter will be referred to the Medical Director (or an appropriate other person if the Medical Director is one of the parties to the initial discussion).*

- *The Medical Director will, either personally, or with the Chief Executive, seek to resolve any outstanding issues informally with the parties involved. This is expected to be the way in which the vast majority of such issues will be resolved.*

- *In the exceptional circumstances when any outstanding issue cannot be resolved informally, the Medical Director will consult with the Chief Executive prior to confirming in writing to the Consultant and their Clinical Director (or equivalent) that this is the case, and instigate a local appeals panel to reach a final resolution of the matter.*

- *The local appeals panel will comprise:*

    - *One representative nominated by the Consultant, and one representative nominated by the Trust Chief Executive. These representatives shall be from a panel nominated by BMA Cymru Wales and Trust HR Directors who have been approved as trained in conciliation techniques.*

- *The panel will be expected to hear the appeal following the format of the employer's normal grievance procedure, and reach a decision, which will be binding on both parties.*

- *Representatives will not act in a legal capacity.*

- *In exceptional circumstances where a decision cannot be agreed, a second panel would be constituted with alternative representatives as set out in Paragraph 1.37.*

STAGE ONE: THE FIRST STEPS- COLLECT DATA

A workload diary showing tasks, phone calls and emergencies will be helpful in justifying on call sessions, supporting sessions and producing evidence for extra sessions of direct clinical care.

Use a suitable reference period (4-26 weeks..the longer the better).

Compile this diary using the enclosed scoring sheet. Be thorough and accurate. Account for everything. However be warned: ensure accuracy since this may be subject to management audit.

Record Direct Clinical Care Time:

a) "Predictable" On-Call

   i. high likelihood of happening on-call duty at regular and predictable times e.g. ward/unit rounds and work, handover time etc, work arising from on-call duties not already covered e.g. post-call acute lists, or additional administration which is predictable.

b) "Unpredictable" On-Call

   i. phone calls, returns to hospital, urgent or emergency operations etc which are irregular and unpredictable.

c) Clinical Administration

   i. Clinical letters, triaging referrals, MDT meetings about patients, analyzing diagnostic reports, results etc,etc.

d) Non-emergency Clinical work

   Seeing patients...clinics, rounds, lists, treatments, diagnostics etc

Record time for Supporting Professional Activities:

a) Training

b) Continuing professional development

c) Teaching

d) Audit

e) Job Planning

f) Appraisal

g) Research

h) Clinical Management

i) Local clinical governance activities

Record time spent on additional special responsibilities or external duties (governance, tutor, audit lead, GMC, Royal Colleges etc)

These may be included in your job plan by agreement.

Record time with category 2 and other fee-paying work.

Options:	Put in job plan then:-	Trust keeps fee
	Minimal disruption clause:-	Consultant keeps fee
	Do in own time:-	Consultant keeps fee
	Do 37.5 hours apart from category 2 work:-	Consultant keeps fee

STAGE TWO: The Calculations

A
Average **"predictable"** on-call work:
Total number of hours **on average** worked per week.
Divide by 3.75 to convert to sessions

B
Average **"unpredictable"** on-call work:
Two categories: Daytime
Evenings/Weekends
Total number of hours **on average** worked per week for each category
Divide daytime by 3.75
Divide evenings/weekends by 3
Add to give total sessions for unpredictable on call
NB: Maximum 1 session per week allowed

C
Average "patient administration activities" time:
Total number of hours **on average** worked per week.
Divide by 3.75 to convert to sessions

D
Average "Non-emergency clinical work" time:
Total number of hours **on average** worked per week.
Divide by 3.75 to convert to sessions

E
Average "Additional responsibilities" time:
Total number of hours **on average** worked per week.
Divide by 3.75 to convert into sessions

The Results for Direct Clinical Care

Add **A+B+C+D** to give you the total number of sessions of direct clinical care. This should normally give you a figure of **7**.

Box **E** sessions should be substituted for direct clinical care sessions or remunerated separately by agreement.

X
Average "Supporting Professional Activities" time:
Total number of hours **on average** worked per week.
Divide by 3.75 to convert to sessions

The Results for Supporting Professional Activities

Box **X** gives you the total for the week

The Weekly Workload

Add up Direct Clinical Care and Supporting Professional Activities sessions. If the total is more than 10 it should be possible during job planning to either reduce the workload or (if 11 or more) receive payment for whole sessions worked above 10 sessions. These extra sessions, which have previously been unrecognised (i.e.

not attracted any payment), are voluntary, and will initially be paid at plain rates, then after 24 months 1.25 times, after 48 months 1.5 times plain rate.

Rebalancing

Most consultants should average 7 sessions direct clinical care and 3 sessions supporting professional activities. If the supporting activities exceed 3, then you may need to agree a reduction. Similarly if direct clinical care significantly exceeds 7 sessions this should be addressed during job planning. The usual breakdown for Part-time consultants will be as follows:

TOTAL SESSIONS	DIRECT PATIENT CARE	SUPPORTING ACTIVITIES
9	6	3
8	5	3
7	5	2
6	4	2
5	3	2
4	2	2
3	2	1

Variations on the balance of sessions may be agreed between the Consultant and their employer.

STAGE THREE: PREPARING FOR JOB PLANNING MEETINGS

You cannot be too well prepared for your Job Planning Meetings. Prepare, prepare and again prepare. **Your Trust will look to discuss inconsistencies between consultants doing the same job, so an informal comparison of job plans within your directorate prior to the formal meeting would be sensible**. The Job Planning Meeting will be with your Clinical Director (or equivalent) who will normally be accompanied by appropriate manager. It will consist of a 3-stage process, which will have an initial interview to look at existing job plans, your views on changes and extra sessions you might agree. There will then be a review by the CD with the wider clinical team and then a final job-planning meeting to agree and finalise the situation.

Prior to the Job Planning meeting:

Look at:

- Direct clinical care duties.
- Supporting professional activities.
- Rota and on call commitment.
- Additional responsibilities.
- Any other agreed external duties.
- Any agreed additional sessions.
- Managerial responsibilities
- Accountability arrangements, to clinical director or medical director

Construct a draft timetable of what you feel might make a sensible job plan for the coming year. Your clinical director (or equivalent) will have had their own thoughts, but your preparing a draft will help the process of discussion and ultimate agreement. Variations to the ratio of sessions will need to be agreed by you and the employer at the job planning review.

Plan 7 sessions of DCC (or pro rata as per table above if part time). The first call on your time should be on-call emergency work, (boxes **A+B**). **This will create uncontracted time during the normal working week.** Once on call is allocated then add the remaining DCC activities to a total of 7 DCC. In the event that your diary shows more than an average 7 DCC work per week, identify the current unrecognised additional work being done and document separately. This work may include existing clinics, operating lists etc. You will need to discuss in the job planning meeting whether the Trust wish this work to continue or not. If they do, then additional DCC sessions (in whole sessions) may be added to your job plan by mutual agreement.

Plan 3 sessions of SPA (or pro rata as per table above if part time). These will be mutually agreed at the job planning review and may be scheduled across the week such that up to one session of contractual commitment may take place outside the normal working hours leaving a similar period free in which there is *no* contractual commitment during normal working hours. The remaining 2 SPA's have location to be agreed at job planning.

Note:

DCC's are all 'on site'. 'On site' means a work location as opposed to home. Add in Cat 2 and/or other fee-paying work as part of 7 DCC if you wish Trust to keep the fees. Alternatively agree 'minimal disruption' clause in job plan or leave out of job plan to do in own (uncontracted) time. Similarly Private Practice is to be carried out in your own (uncontracted) time. Note that Consultants may use NHS facilities for the provision of fee paying services either in their own time, in annual or unpaid leave, or with the agreement of the NHS employer in NHS time where work involves minimal disruption.

OUTCOMES

You will need to discuss and agree outcomes as part of the job plan:

> These will set out a mutual understanding of what the Consultant and employer will be seeking to achieve over the next 12 months- based on past experience and reasonable expectations of what might be achievable in the future.

Some outcomes may be individual but some can involve the unit, so discuss a unified approach with colleagues before any job planning meetings. Suggest your own outcomes and keep it simple so that they are readily achievable and can be shown to be so. It is likely that your clinical director may have some suggestions of his or her own with which you may or may not agree.

INTENSITY PAYMENTS

On-call payments have increased so a review of your intensity payments may be due to ensure you are on the correct banding. With information that you have obtained with your diary, complete the enclosed questionnaire (Appendix 1) and get your CD to sign it. Confirm your banding during your planning interview. Rota Commitments should be specified in your job plan also. If at job plan review you have voluntarily offered to undertake part of your basic working week outside the normal working hours (under the flexible working arrangements of the contract), and this is agreed with your employer, then the scoring for Out of Hours Intensity payments will be related to work necessarily performed outside of these **agreed working hours.**

STAGE FOUR: THE JOB PLANNING MEETINGS

At your Job Planning Meeting come to a mutual agreement or a plan for resolving any disagreement.

Ensure your CD/MD signs the plan, keep a copy, and send another to the appropriate manager identified by the Trust.

STAGE FIVE: JOB PLAN REVIEWS

Interim job planning reviews will be conducted where duties, responsibilities or outcomes are changed or need to change significantly within the year, or where the time commitment involved breaches the contract hours Trigger Point (one session over or under ‹33.75 hours or ›41.25 hours).

So it is in your interest to:

- Maintain a diary of work, if you think your workload is changing.
- Watch for outcomes and notify CD if there is a problem.
- Watch for service creep and ask for a review if average hours ›41.25

CLINICAL ACADEMICS

There are some special arrangements for clinical academics, but the process above will apply in relation to their NHS commitments.

Clinical Academics who hold an honorary Consultant Contract that work 4 Direct Clinical Care sessions and two Supporting Professional Activities sessions will be treated as if they are a whole time NHS consultant. If they work fewer than 6 sessions they will be treated as part-time. Normally up to one Clinical Teaching session or Clinical Research session from the NHS sessions can be considered as part of the Direct Clinical Care sessions.

Otherwise further Teaching and Research sessions will be available in the 4 non-NHS sessions.

AL (MD) W5/2000

ANNEX B

OUT-OF-HOURS WORK INTENSITY – QUESTIONNAIRE

Please complete the following short questionnaire, ticking the appropriate box or inserting the appropriate number as requested.

For the purposes of the questionnaire, the normal working day should be assumed to be Monday to Friday, and from 9am to 5pm (or equivalent). Please be as accurate as possible in completing the questionnaire, to avoid distorting the overall results.

Only record the details relating to the contract you have with the employer who sent you the questionnaire.

Q1a What contract do you have with the NHS employer who sent you this questionnaire?

Whole Time ☐

Part Time * ☐

Honorary (clinical academic)** ☐

* If part time, please indicate

- the number of sessions you receive _____
- the average number of hours worked for the NHS per week (excluding on-call) _____

** If honorary, please indicate

the number of sessions worked for the NHS _____

the average number of hours worked for the NHS each week (excluding on-call) _____

Q1b What is your main specialty? _____

Q1c In which year were you first appointed to a substantive post in the consultant grade? _____

Q2 What rota commitment do you work? _____

Rota ☐

1 in 2 ☐

1 in 3 ☐

1 in 4 ☐

1 in 5 ☐

1 in 6 ☐

Other – please indicate _____

No on-call commitment _____

If you participate in more than one rota, please give the aggregate commitment

The following questions relate to two forms of out of hours work: **on-call** i.e. the provision of a service of immediate advice or re-call for emergency duties; and other **out of hours** activities, more closely linked to normal day-time work carried out within the terms of the basic contract. This might include undertaking post-take ward rounds in the early morning, evening or weekend; or attending meetings necessarily held in the evening.

Q3a Please indicate the typical number of NHS work-related telephone calls received or required to be made per month (either on an on-call rota or at other times out of hours).

Calls made received per month whilst: _____

(i) On-call _____

(ii) Other out of hours _____

Total _____

Please do not count telephone calls which only request you to attend the place of work.

Q3b What proportion of total calls are typically received after 11pm and before your normal start time? _____

Q3c What proportion of total calls typically last more than 15 minutes? _____

Q4a Please indicate how often you normally have to remain at work, or are required to return to the place of work when on call. (Q5 covers returns when not on-call) _____

Remaining/Returning to work when on-call

More than 3 times a month – please specify _____

3 times a month _____

2 times a month _____

Once a month _____

Less than 4 times a year _____

Never _____

The place of work should be considered as the place where the work is carried out other than your normal residence e.g. patient's home, police station, nursing home, hospital, etc.

Q4b What percentage of these would typically occur after 11pm and before your normal start time? _____

Q5a Please indicate how often you normally have to work out of hours, either remaining at the hospital or other place of work or returning there, when not on-call.

Frequency of other out-of hours work

More than 3 times a month when not on-call – please specify _____

3 times a month when not on-call _____

2 times a month when not on-call _____

Once a month when not on call _____

Less than 4 times a year _____

None _____

Q5b What percentage of these would typically occur after 11pm and before your normal start time?

_____

ANNEX C

CONSULTANTS' INTENSITY SUPPLEMENTS

Guidelines on Out Of Hours Banding

We have agreed the attached questionnaire and scoring system with the BMA.

Each consultant should complete the attached questionnaire which will indicate the level of both on-call work that is the provision of a service of immediate advice or re-call for emergency duties; and other out of hours activities, more closely linked to normal day time work carried out within the terms of the basic contract. This might include undertaking post take ward rounds in the early mornings, evenings and weekends, or attending meetings necessarily held in the evening.

We have identified four factors that we believe capture the work intensity to which out of hours can give rise:

- The on-call rota commitment worked by the consultant
- Expectation of being telephoned/contacted outside the hospital
- Expectation of being called back into workplace for emergency work
- Work necessarily performed out of hours

These factors can be subdivided into different levels, indicating the different levels of intensity to which they give rise. Each factor then has a value attributed to it; and the overall score determines the intensity band (if any) in which the post is placed.

Band 1 (low intensity) 51-75 points
Band 2 (medium intensity) 76-90 points
Band 3 (high intensity) 91-130 points

OUT OF HOURS INTENSITY – SCORING SYSTEM

Q2 Rota Score

None	0
1 in 2 or 1 in 1	20
1 in 3	15
1 in 4	10
1 in 5	5
1 in 6	5
1 in 7, lower, other	2

Q3a(i) Calls On-call Score

None	0
16+	20
11-15	15
6-10	10
1-5	5

Q3a(ii) Calls NOT On-call Score

None	0
16+	20
11-15	15
6-10	10
1-5	5

Q3b % of calls after 11pm

%	Score
0	0
1-19%	1
20-39%	2
40-59%	3
60-79%	4
80-100%	5

Q3c % of calls more than 15 minutes

%	Score
0	0
1-19%	1
20-39%	2
40-59%	3
60-79%	4
80-100%	5

Q4a Returns WHEN ON-CALL

Number	Score
Never	0
Less than 4 a year	5
Once a month	10
2 times	15
3 times	20
More than 3	25

Q4b % of returns after 11pm

%	Score
0	0
1-19%	1
20-39%	2
40-59%	3
60-79%	4
80-100%	5

Q5a Returns WHEN NOT ON-CALL

Number	Score
Never	0
Less than 4 a year	5
Once a month	10
2 times	15
3 times	20
More than 3	25

Q5b % of returns after 11pm

%	Score
0	0
1-19%	1
20-39%	2
40-59%	3
60-79%	4
80-100%	5

APPENDIX 2

SAMPLE JOB PLANS FROM VOLUNTEERING FTCC MEMBERS

SURGERY: SMALL SPECIALITY

Week 1

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
0800							
0830		A	A				
0900	C	D	C	C	D		
0930	D	D	D	X	D	A	
1000	D	D	D	X	D	A	
1030	D	D	D	X	D	A	
1100	D	D	D	X	D	A	
1130	D	D	D	X	D		
1200	D	D	D	X	D		
1230	D	D	D	X	D		
1300		D					
1330		D		D			
1400	D	D		D			
1430	D	D		D			
1500	D	D		D			
1530	D	D		D			
1600	D	D		D			
1630	D	D		D			
1700	X	X	X	X			
1730	X	X	X	X			
1800							

Ward Round

Clinics

Inpatient Theatre

Daycase Theatre

Head and Neck Clinic

Patient administration

Audit/CPD/ Teaching Meetings **[SPA]**

Travelling

Uncontracted Time

Time Code	Hours per week
A	1.5
B	3 (from diaries)
C	1.5
D	23.5
	29.5
X	11
Total	**40.5**

Week 2

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
0800							
0830		A	A				
0900	C	D	C	D	C		
0930	D	D	X	D	X		
1000	D	D	X	D	X		
1030	D	D	X	D	X		
1100	D	D	X	D	X		
1130	D	D	X	D	X		
1200	D	D	X	D	X		
1230	D	D	X	D	X		
1300		D					
1330		D		D			
1400	D	D		D			
1430	D	D		D			
1500	D	D		D			
1530	D	D		D			
1600	D	D		D			
1630	D	D		D			
1700	X	X	X	X			
1730	X	X	X	X			
1800							

Addition Responsibilities

Interview selection committee for medical school entrants	3 x 3hours per year {9/43}	0.2hrs/week
Teaching dental students	4 x 2 hours per year {8/43}	0.18 hrs/week
Examining intercollegiate RCS	4 days per year	Special leave (MD)
Member FTTC	10 sessions per year	Special leave (MD)

Trade union activities

LNC Chairman	4 meetings per year
LNC Forum Vice Chairman	2 meetings per year
Welsh Consultants and Specialists Committee	3 meetings per year
Central Consultants and Specialists Committee	3 meetings per year
Welsh BMA Council	2 meetings per year
Hospital A Senior Medical and Dental Staff Meeting	1 meeting monthly
Hospital B Senior Medical and Dental Staff Meeting	1 meeting bimonthly

PSYCHIATRY: PART-TIME TIMETABLE

	MON	TUES	WED	THUR	FRI
9.00					
10.00					
11.00					
12.00					
13.00					
14.00					
15.00					
16.00					

	FREE = uncontracted time. Not available to the trust except by voluntary agreement.	
		Hours
D	Regular Ward Round	3
C	Seeing relatives/key worker	1
C	Mental health review tribunals/section 117 meetings etc	2
C	Outpatient letters	1
C	Team meetings	1
D	Outpatient clinics at CMHT base	5
D	Urgent assessments at CMHT base, community or ward of my own sector patients (ie emergency but not on call)	3
C	Other correspondence/telephone calls to and about patients	2
C	Preparing reports	1
B	Daytime on call	1.0
B	Out of hours on call (incl. Phone)	0.5
	Total direct patient care:	**20.5**
X	One to one clinical teaching (eg hot audit after outpatients)	1.5
	Educational supervision	1
	CPD	4
	Teaching and preparation	2
	College tutor responsibilites (including STC meetings, appraisals, interview panels etc)	4
	Other responsibilities including research, audit, planning and clinical goverance	2
	Special responsibilities eg medical staff committee, working group membership	0.5
	Total supporting activities:	**15**
	TOTAL	**35.5**

I am currently contracted for 4 fixed and 3 unfixed sessions including one specifically for my work as college tutor. If I remain in my present post with no reduction of responsibilities I would stand to gain 2 sessions of pay making my salary 9/10 of full time.

If the CD was so inclined he could ask me to reduce waiting lists by offering another outpatient clinic per week, which would bring me up to full time. Alternatively he could ask me not to have a second outpatient clinic on Thursday which would increase waiting times but save them some money and give me another morning off.

If I give up my role as college tutor I will lose a session of pay and gain another free half day.

Occasional DV fees retained by myself with CD agreement. (Minimally disruptive and integral part of job.)

I will be available on call every week with some limitations to my lifestyle and no extra payment (since this level of on call will not trigger intensity payments). However, if I have to be on call on one of the sessions I am usually free I will swap my on call or use this for SPA and claim a free session on another day instead.

Key

Ward Rounds

Theatre

Patient Admin/Multi disciplinary meeting

OPD Clinic

OPD Clinic Peripheral Hospital (Alternate weeks inlcuding travelling time)

Supporting Professional Activities
Teaching/CME/audit/governance/research etc
One session of supporting professional activities done in evenings

Uncontracted Time (Private Practice)

	MON	TUES	WED	THUR	FRI
08:00 - 09:00					
09:00 - 10:00					
10:00 - 11:00					
11:00 - 12:00					
12:00 - 13:00					
13:00 - 14:00					
14:00 - 15:00					
15:00 - 16:00					
16:00 - 17:00					
17:00 - 18:00					

Direct Clinical Care

Unpredictable On Call	= 2 hours per week (1 in 3 rota)
	= 2 x 4/3 = 2.6 hours when adjusted.
Ward Rounds	= 4 hours per week
Theatre	= 7 1/2 hours per week
Clinics	= 12/2 hours per week
Patient admin/multi disciplinary Meetings	= 4 1/2 hours per week
Total Direct Clinical Care	= *31.1 hours per week*

31.1/3.75 = 8.3 sessions of DCC

Supporting Activities

3 sessions.

Additional Unrecognised Sessions

Theatre extra 1.3 sessions worked over 37 1/2 hours. Will claim for one extra session.

Additional Responsibilities

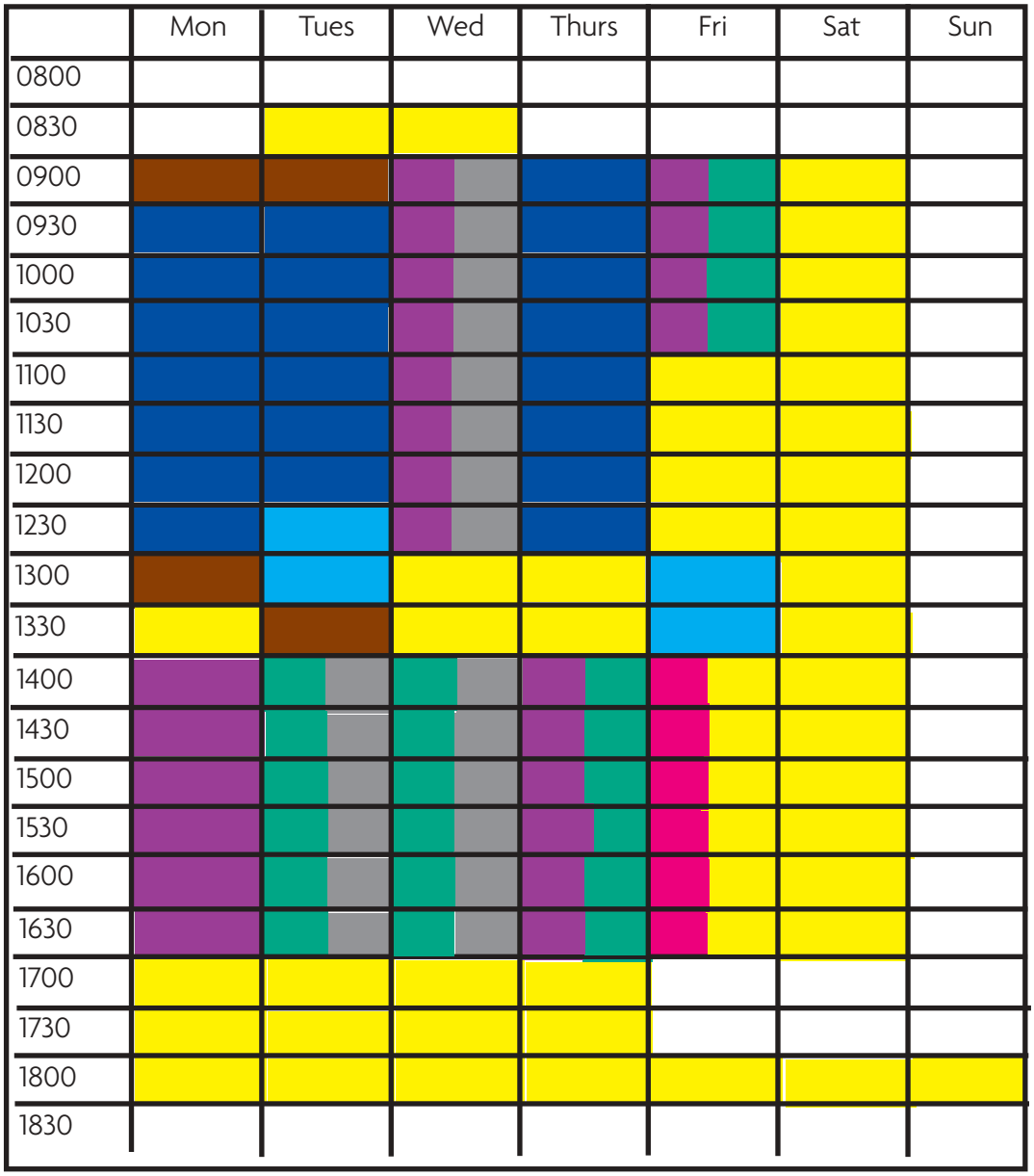
Educational Supervisor	=	0.5 hours per week
Organise International Otology Course at Hospital	=	0.5 hours per week
Chairman of Welsh Assembly Forum Terms & Conditions Committee	=	10 sessions per year (Special leave)
Assistant Editor Cochlear Implants International Journal	=	0.5 hours per week

Trade Union Activities

LNC Chairman	=	4 meetings per year
Chairman WCSC	=	3 meetings per year
Chairman Welsh JCC	=	2 meetings per year
Member CCSC	=	3 meetings per year
Member Welsh BMA Council	=	3 meetings per year
Member JCC	=	3 meetings per year
Member GP Sub Committee	=	4 meetings per year
Member Trust Medical Staff Committee	=	6 meetings per year

RADIOLOGY

Existing Job Plan



A Predictable work

D GI Screening

D Ultrasound

D Nuclear medicine

D General reporting

C CT Session

C Patient administration

X Audit/CPD/ Teaching Meetings **[SPA]**

Travelling

Uncontracted Time

Time Code	Hours per week
A	0.6
B	1
C	5.75
D	31.0
X	2
Total	**40.35**

ON-CALL

Out of hours work Monday- Friday 6 hours average during on call week.

Weekend work 6 hours average during on call week.

1:6 rota makes average 2 hour/week equivalent to 2/3 session per week (2.5 hours) giving an uncontracted session every 2 weeks out of 3.

SESSIONS

Total sessions worked are 10.5 direct clinical care, 0.6 SPA so there should be a reduction in DCC sessions by 3.5, and an increase of SPA by 2. Two weeks out of three 1 session of uncontracted time should be inserted. The Trust may wish to pay for 1-2 sessions of additional unrecognised sessions.

Additional Responsibilities

Member Radiology Subcommittee	4 x 3 hours per year	
Member FTTC	12 sessions per year	Special leave (MD)

Trade union activities

LNC member	4 meetings per year	Special leave (MD)
Welsh Consultants and Specialists Committee	4 meetings per year	Special leave (MD)
Central Consultants and Specialists Committee	4 meetings per year	Special leave (MD)
Negotiating Sub Committee, Central Consultants and Specialists Committee	4 meetings per year	Special leave (MD)
Vice Chairman, Welsh BMA Council	3 meetings per year	Special leave (MD)
Hospital Senior Medical and Dental Staff Meeting	1 meeting monthly	Special leave (MD)

General Paediatrics

Existing Job Plan:

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
0800							
0830							
0900							
0930							
1000							
1030							
1100							
1130							
1200							
1230							
1300							
1330							
1400							
1430							
1500							
1530							
1600							
1630							
1700							
1730							
1800							
1830							

A Predictable Emergency work

D Ward Round, Clinics

D Other clinical work

C Patient administration

X Audit/CPD/Teaching Meetings **[SPA]**

Travelling

Uncontracted time

Time Code	Hours per week
A	12/3 = 4
B	3
C	9.5
D	24
	40.5 (includes travelling)
X	5
Total	**45.5**

Direct Clinical Care

Unpredictable on-call	=	3 hours per week (1:3 rota)
Predictable on-call	=	4 hours
Non emergency clinical work	=	23.5 hours
Patient administration	=	9.5 hours
Travelling	=	0.5 hours

Sessions

Total time is 40.5 equivalent to 10.8 sessions of direct clinical care.

Supporting Professional Activities

Total time is 5 hours equivalent to 1.3 sessions. 1 evening session undertaken.

REBALANCING:

The Unpredictable on call makes 1 session of uncontracted time during the week, which will be used on Thursday afternoon.

Therefore Direct Clinical care sessions will be 9.8 sessions with 2.3 SPA. So a claim for 2 extra unrecognised sessions will be put to the Clinical Director.

Addition Responsibilities

Royal College Tutor		0.5 hours per week
Educational Supervisor		0.5 hours per week
Named Doctor for Child Protection		3 hours per week
Member FTTC	12 sessions per year	Special leave (MD)

Trade union activities

LNC Chairman	4 meetings per year	Special leave (MD)
Welsh Consultants and Specialists Committee	4 meetings per year	Special leave (MD)
Chairman, Welsh LNC Forum	3 meetings per year	Special leave (MD)
Hospital Senior Medical and Dental Staff Meeting	4 meetings per year	Special leave (MD)

JOB PLANNING YOUR OWN JOB

Stage 1

Look at your existing job and put it into the diary below:

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
0800							
0830							
0900							
0930							
1000							
1030							
1100							
1130							
1200							
1230							
1300							
1330							
1400							
1430							
1500							
1530							
1600							
1630							
1700							
1730							
1800							
1830							

If you have this as a computer copy, then fill in the areas as shown in the key on the following page:

Stage 2

Add up the hours for each type, and insert the average per week into the box on the following page. If your average hours are greater than 41.25 then you will have to reduce some of the sessions times. Remember to add the unpredictable on call times into the uncontracted time slots.

Stage 3

Put on the job plan other responsibilities as shown in the examples. Include rotas and managerial roles.

A Predictable work

D Non emergency clinical work

D Non emergency clinical work

D Non emergency clinical work

D Non emergency clinical work

C Patient administration

X Audit/CPD/Teaching Meetings **[SPA]**

Travelling


Uncontracted time

Time Code	Hours per week
A	
B	
C	
D	
	
X	
Total	

	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
	Work Code	On-call?	Work Code	On-call?	Work Code	On-call?	Work Code	On-call?	Work Code	On-call?	Work Code	On-call?	Work Code	On-call?
7 am - 7:30														
7:30 - 8:00														
8:00 - 8:30														
8:30 - 9:00														
9:00 - 9:30														
9:30 - 10:00														
10:30 - 11:00														
11:00 - 11:30														
11:30 - Noon														
Noon - 12:30 pm														
12:30 - 1:00														
1:00 - 1:30														
1:30 - 2:00														
2:00 - 2:30														
2:30 - 3:00														
3:00 - 3:30														

	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
	Work Code	On-call?	Work Code	On-call?	Work Code	On-call?	Work Code	On-call?	Work Code	On-call?	Work Code	On-call?	Work Code	On-call?
3:30 - 4:00														
4:00 - 4:30														
4:30 - 5:00														
5:30 - 6:00														
6:00 - 6:30														
6:30 - 7:00														
7:00 - 7:30														
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8:00 - 8:30														
8:30 - 9:00														
9:00 - 9:30														
9:30 - 10:00														
10:00 - 10:30														
10:30 - 11:00														
11:00 - 11:30														
11:30 - midnight														

	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
	Work Code	On-call?	Work Code	On-call?	Work Code	On-call?	Work Code	On-call?	Work Code	On-call?	Work Code	On-call?	Work Code	On-call?
Midnight - 12:30														
12:30 am - 1:00														
1:00 - 1:30														
1:30 - 2:00														
2:00 - 2:30														
2:30 - 3:00														
3:00 - 3:30														
3:30 - 4:00														
4:00 - 4:30														
4:30 - 5:00														
5:30 - 6:00														
6:00 - 6:30														
6:30 - 7 AM														

Work Code	Work Type
A	Predictable work
B	Unpredictable work
C	Patient administration
D	Non-emergency work
E	Additional responsibilities
X	Audit/CPD/Teaching Meetings [SPA]
Tr	Travelling
U	Uncontracted time

Time Code	Hours per week
A	
B	
C	
D	
E	
X	
Tr	
TOTAL	

CHECKLIST FOR ACTION

1) Start a diary now of your activity.

2) Check and validate activity information that your IT department has on you.

3) Construct an existing Job plan as above examples:

   a. Put down your clinics/rounds

   b. Put down patient admin

   c. Put down "on call" time

   d. Put down SPA sessions

4) Rebalance the sessions to obtain the typical 7:3 ratio.

5) Put the uncontracted time within the working week.

6) Have you got more DCC sessions than 7?

7) Do you want to do the sessions or press for payment?

8) Complete the Out-of-Hours Intensity Questionnaire.

9) Go to the first Planning interview with the above.

10) Take the lead in discussion. It is your working life!

11) If you cannot agree at the second interview then follow the appeal structure.

12) Speak to your LNC if you have problems.