SENIOR MEDICAL STAFF JOB PLANNING POLICY

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Purpose of Agreement	This policy sets out the requirements for Job Planning for all doctors in non-training grades.
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Review and amendment log

Version Number	Review date	Amendment section no.	Page	Amendment made / summary	Changes approved by
1	November 2022	New policy written to explain the reasoning and process in which job plans are constructed.			Policy Steering Group, Clinical Executive Group

SUMMARY OF POLICY

Job planning for senior doctors is undertaken annually, in line with the relevant contract and terms and conditions. Job planning is also undertaken at the start of a new job or when roles and responsibilities substantially change. Job plans ensure that doctors have a clearly documented weekly schedule of duties, responsibilities and objectives which are both compatible with their reimbursement and achievable. A job plan should support the doctor's wellbeing and work-life balance. They enable clinical services to consider their overall senior doctors' resource to ensure that it is adequate to meet its needs; this maybe via a collective group job plan of all the senior doctors within a particular specialty or service.

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1. INTRODUCTION & PURPOSE

1.1 The workload of a doctor is complex, challenging, rewarding and sometimes overwhelming. Job planning seeks to ensure that the doctor and trust have clarity about what is expected, and the resources are available to ensure clinical commitments are to take place. The process ensures that doctors wellbeing is central to the negotiations, and that the objectives of the doctor and the trust are well aligned.

1.2 There is current considerable variation in job plans both internally to Solent, regionally and nationally. This document aims to support a framework for doctors and their line managers when undertaking the job planning process that reduces that variation.

2. SCOPE & DEFINITIONS

2.1 This policy applies to all non-training-grade doctors including locum, permanent, and doctors on fixed term contracts. It applies to speciality doctors, associate specialists, staff grade doctors, specialist doctors and consultants who hold a contract of employment or engagement with the trust (termed senior doctors for this document).

This policy will be followed when new job plans are being negotiated (for example, undertaking a new role or change to contracted hours) or on appointment to a new contract of employment. It is expected that existing job plans will move towards the new policy, in negotiation between the doctor and department. The policy does not apply to doctors in training programmes. Trust grade doctors, employed at training grades, will not need to have a job plan. Their work schedule should reflect the principles of this document.

3. PROCESS/REQUIREMENTS

3.1 All senior doctors should undergo an annual job plan review. This will be undertaken by their clinical director (CD), or his/her delegated clinical manager, who would usually be a doctor. CDs who are not medical doctors may undertake job planning for medical colleagues.

3.2 Either the doctor or the clinical manager may ask for a medical manager to join the conversation, and this request must be respected.

3.3 Operational managers or Chief Medical Officer Business Manager may be asked to join the conversation with agreement from both sides. Job plans should be reviewed when a new role is being considered to ensure it is achievable and when a change to hours of working is being negotiated. The job plan will cover all aspects of a doctor's work, including education and research. Doctors who work for more than one employer will have a job plan that covers all their employment, with one employer acting as the lead employer.

3.4 Doctors who have split their employment with one employer for taxation reasons should undertake job planning as if the two contracts were combined.

3.5 Once a job plan has been agreed with your line manager, it should then be inputted and documented onto the job planning system.

3.6 Job planning is not the same as annual appraisal. In Solent, appraisal happens in the summer and job planning in the winter. Appraisal is a supportive developmental process which supports revalidation as defined by the General Medical Council. A job plan should be presented at appraisal to support an informed discussion; it is not the role of appraisers to recommend changes to job plans, but they may wish to suggest a separate discussion between appraisee and their line manager.

3.7 Job plans are considered in programmed activities (PAs) which represent 4 hours (or half a day) of work during normal hours. A full-time member of staff is calculated at 10 PA's per week which equates for 40 hours. These can be broadly considered as those supporting DCC (direct clinical care), SPA (supporting professional activities), APA (additional programmed activities) and external duties (EDA). A consistent approach to job planning is necessary to ensure a fair and transparent approach for all doctors across the organisation and for business continuity.

3.8 Annualised job plans may also be agreed. Annualised hours can be hard to keep track of but can also enable flexibility for staff. Where job plans are annualised over a year each doctor will deliver an average of 42 weeks, excluding annual and study leave. Where study leave is not requested/authorised the annualised weeks will be increased accordingly. For individual components (e.g. clinics, lists) this is usually expressed as the number normally undertaken in a week multiplied by the number of weeks in the working year.

3.9 **OBJECTIVE SETTING**

3.9.1 The Job Plan will include appropriate personal objectives that have been agreed between the clinician and his or her clinical manager and will set out the relationship between these personal objectives and local service objectives. Where a clinician works for more than one NHS employer, the lead employer will take account of any objectives agreed with other employers. Objectives should remain focused on key strategic and service aims. More general contractual requirements, such as the need to retain professional registration, participation in mandatory training or adherence to trust policies and procedures do not necessarily need to be included as separate objectives as they are the expectations of being an employee.

3.10 **DIRECT CLINICAL CARE (DCC)**

3.10.1 DCC is activity directly relating to the prevention, diagnosis, or treatment of illness. This includes emergency duties (see below), operating sessions (including preoperative and post-operative care), ward rounds, outpatient activities, clinical diagnostic work, other patient treatment, administrative duties directly linked to patient management and any public health duties.

3.10.2 Multidisciplinary Team (MDT) meetings that relate directly to patient care and/or treatment planning for specific patients should also be counted as DCC time. Where MDT meetings have a mixed agenda (e.g. part clinically care based, part Directorate/team meeting), only the element

relating to direct patient care will count towards DCC time with the other element noted as a Supporting Professional Activity.

3.10.3 Any administration that is directly related to the above (including but not limited to referrals and notes) will also be allocated as DCC time. The PA allocation will vary according to the administrative requirements of a particular role but will be broadly similar within a specialty. As a broad principle, DCC administrative time should be calculated over a reasonable period to determine how much time is required and considered to be a reasonable allocation. A work diary may be beneficial in this instance as a means of recording work.

3.10.4 A family job planning meeting may be used to identify a consensus allocation within the specialty for DCC commitments (e.g., administration, ward rounds, pre/post-op, MDT etc.).

3.10.5 When there is a mismatch between demands on doctor time and available PAs within the family job plan this will need resolution. The service may decide that there are other ways to deliver activity (e.g., non-medics), that an activity should be stopped, or an opportunity turned down, or that a business case needs to be developed.

3.11 **ON-CALL**

3.11.1 On-call is recognised in the job plan through an availability supplement and through DCC PAs allocated for predictable and unpredictable emergency work over the number of weeks specified in the job plan required information.

3.11.2 Availability supplements for the relevant contracts are displayed in appendix B.

3.11.3 Programmed Activities for on-call are based on the actual work undertaken when individual clinicians are on call. This includes telephone advice, travelling time to site for emergencies, regular ward rounds associated with on-call and clinical interventions onsite.

3.11.4 PAs for on-call/emergency work should include both predictable and unpredictable emergency work and travel time which should be programmed into the working week.

3.11.5 Predictable emergency work is work that takes place at regular and predictable times, often because of a period of on-call work (e.g., post-take ward rounds, trauma lists, etc.).

3.11.6 Unpredictable emergency work is that which arises during the on-call period and is associated directly with the clinicians' on-call duties (except in so far as it takes places during a time for scheduled Programmed Activities), e.g., recall to hospital to operate on an emergency basis.

3.11.7 It is recommended that each specialty agree and review regularly what they consider as predictable and unpredictable emergency work.

3.11.8 Clinicians are expected to deputise for absent colleagues where practicable for unexpected absence for a period of up to 72 hours, including in a different geographical location. This does not include acting down.

3.11.9 Consideration of the need to cover planned absence should therefore be given when agreeing on a job plan. Prospective cover will be recognised with PA allocations for DCC. Where deputising is not practicable, it is the clinician's responsibility to bring this to the attention of their manager.

3.12 ADDITIONAL PROGRAMMED ACTIVITIES (APA)

3.12.1 APAs are agreed roles that are in addition to the doctor's usual contract. A full-time contract is 10 PAs per week. Part time doctors may agree to a new role that increases their PAs temporarily or permanently. If permanent, this is a change to their contract, but if temporary this session is an APA and will be reviewed at least annually. APAs that are agreed taking a doctor over 10 per week are always temporary.

3.12.2 In this context, Additional Programmed Activities must be formally reviewed as part of the annual Job Plan review and may be reduced or increased following the review subject to three months' notice on either side (which can be waived by mutual agreement). APAs may consist of DCC, Additional NHS Responsibilities and/or other External Duties and should be clearly identified as APAs on the job plan. There is no obligation on clinicians to offer or accept the offer of an additional PA except when they wish to perform Private Practice. For further details on additional programmed activity, please refer to the consultant contract.

3.12.3 Additional Programmed Activities which are regular features (non-ad-hoc) of the job plan, will continue to be paid during absences, including annual and sick leave.

3.13 TRAVELLING TIME

3.13.1 Where clinicians are required to travel away from their base for any work activity, the time spent travelling will be allocated as PA time within the job plan for that activity, e.g., time spent travelling to DCC activities will be allocated in the job plan as DCC PAs.

3.14 PRIVATE PRACTICE

3.14.1 Details of all regular private practice should be included in the job plan and schedule of Programmed Activities, including weekday evenings and weekends.

3.14.2 All private practice must be arranged and undertaken within the requirements of the Code of Conduct for Private Practice. In line with the Code of Conduct, the Trust will insist that private practice is not undertaken during scheduled DCC PAs without the CD's prior agreement. The Trust will only agree to this where time-shifting arrangements are formally agreed or where the work's income is passed to the Trust. In some circumstances, the trust may at its discretion allow some private practice to be undertaken alongside a clinician's scheduled NHS duties, if they are satisfied that there will be no disruption to NHS services. In these circumstances, the clinicians should ensure that any private services are provided with the explicit knowledge and agreement, in writing, of the CD. The overriding principle is that by providing private practice there should be no detriment to the quality or timeliness of services for NHS patients.

For consultants

3.14.3 Where an individual clinician wishes to undertake private work and is not already committed to at least a 10 PA job plan the trust may at its discretion offer an extra DCC PA to the clinician and his or her colleagues (see schedule 6 of contract) . Where the extra PA is declined by all applicable clinicians, and the clinician continues to undertake the proposed private work, the individual will not be entitled to receive pay progression during the year in question. If the trust requires a clinician to reduce from an 11 PA or greater contract, down to 10 PAs, this should not prejudice the clinician's right to undertake private work or receive pay progression.

3.14.4 Where the trust decides not to offer extra PAs, it may decide later to do so, and the same requirements will apply providing a reasonable period of notice is given consistent with the Terms and Conditions of Service 2003/2008 and the associated Code of Conduct for Private Practice.

3.14.5 When the trust offers no extra PA, the clinician may undertake the proposed private practice without jeopardising pay progression. Where the trust wishes to reschedule a clinician's activity to a time when they have private activity scheduled, the trust will seek to achieve this by discussion and agreement. Where this not possible the trust will give no less than three months' notice to allow the clinician to decide to reschedule their private practice, starting from the date of resolution of any job planning appeals processes.

3.15 FEE-PAYING SERVICES

3.15.1 Fee-Paying Services should be included in the job plan and schedule of Programmed Activities. They should only be undertaken during DCC or SPA time with the prior agreement of the CD and Department/Service Manager and where time-shifting arrangements have been agreed. Where this is the case, the clinician may retain the fees. Where such a time-shifting arrangement is agreed it will be reviewed regularly and either party can end it with reasonable notice, sufficient to allow the other party to make satisfactory alternative arrangements.

3.15.2 Fees for such services may also be retained by the clinician without time-shifting where there is minimal impact on other activities and is explicitly agreed, in writing, by the CD. For this purpose, minimal impact should be defined as not reducing Direct Clinical Care activity levels or the efficient use of trust resources. Such an arrangement will be reviewed regularly.

3.16 SPA

3.16.1 As with DCCs, SPA time should always support the role that the doctor is undertaking, and the activities undertaken fit with the objectives set by one or all the employing trusts. Therefore, the content of supporting professional activity time should be discussed and agreed at the job plan meeting. Individuals need to account for the time they spend on SPA in the same way as they need to account for time spent on DCC. Doctors when reviewing the time spent on these activities should consider the evidence required to support the activity concerned.

3.16.2 Each doctor will be entitled to CORE & PERSONAL SPAs. Many will take on SERVICE SPAs.

3.16.3 **Core SPA** includes activities that enable the doctor to demonstrate that they are following *GMC Good Medical Practice* such as keeping up-to-date, collating feedback, quality improvement activity, maintaining a revalidation portfolio, statutory and mandatory training. Other tasks essential to working as a senior doctor, such as trust communications (e.g., email/other platforms such as TEAMS) and attendance at departmental meetings will also be undertaken as part of the core 1.5 SPA Therefore all doctors working 5PA and over will have 1.5 core SPA.

All doctors working less than 5PA will be entitled to 1 core SPA, those doctors working less than 3 PA will need to individually agree the appropriate SPA taking into consideration whether core SPA is accessed via a separate employer.

Study leave of up to 10 days will be in addition to this as per the Study Leave Policy for Senior Medical and Dental Staff.

3.17 SERVICE SPA ACTIVITY

3.17.1 Is used to support the non-DCC needs of the service and must have clearly defined roles, responsibilities, and objectives. These include specific activities related to teaching and training, governance, and leadership. Appendix C describes SPA roles commonly required within clinical services and the suggested attributed SPA allowance.

3.17.2 Clinical supervision for and by senior doctors is included as part of the doctors' usual clinical practice DCC as per the clinical supervision policy. Team meetings can be both DCC and SPA where clinical matters and non-clinical matters are discussed in the same forum.

3.17.3 Most full-time doctors will undertake service roles that take up further SPA time, including less than full time doctors. Service SPAs include Clinical lead, Governance lead, educational lead, QI/audit lead, Complaints lead or Junior Drs lead. This list is not exhaustive. The amount of time allocated to specific roles varies – for instance depending on the number of people who report to the person, or the size of the rota managed.

3.17.4 A full list of all DCC and SPA activities required to run each clinical service and overall service line should be available to support job planning processes and business continuity. Clinical services should aim to balance this with the availability of PAs within the service's family job plan.

3.18 ADDITIONAL TO CONTRACT

3.18.1 Senior doctors may wish to voluntarily undertake unreimbursed additional activities for professional reasons which are over and above their PA commitment. This should be discussed and recognised as part of the job planning process. These roles are termed 'additional to contract' in the trusts electronic job planning software.

3.19 ADDITIONAL NHS RESPONSIBILTY ACTIVITIES

3.19.1 In addition, senior doctors may undertake roles for the wider trust which have an allocated time commitment for a fixed period. These are termed Additional NHS responsibility Activities.

Examples include Director of Medical Education, named doctor for child safeguarding, Chair of Joint local negotiating committee (JLNC) and Guardian of Safe Working Hours. They must be agreed by the clinical director with a clear understanding on the impact of these commitments on the wider needs of the service. Appendix D lists ANR roles and suggested times for them.

3.20 EXTERNAL DUTY ACTIVITY

3.20.1 Senior doctors may undertake external duty activity (EDA), for example, roles within other NHS trusts, the deanery or within Royal Colleges. As with APAs these must be undertaken with the agreement of the clinical director with an understanding of the length of the commitment and of impact of the wider clinical service. Solent would not usually renumerate activates external to the trust unless funded by the external organisation or prior approval has been established from the Chief Medical Officer. Time-shifting may be agreed to accommodate such activity. Care should be taken to ensure that external activities do not disproportionately affect one type of activity (for instance always cancelling the same clinic) – time shifting should be used to fulfil the doctor's obligations.

3.21 JOB PLAN REVIEW PROCESS

3.21.1 Job plans will be reviewed at least annually, and on each change of working pattern. Job plans may be reviewed in groups (a family job plan), but each doctor should be given an opportunity to have a 1:1 conversation after a family job plan is agreed.

3.21.2 All doctors will have clinical and managerial supervision as part of their employment (see supervision policy). The output from SPA and DCC will be monitored via this process. If the supervisor has concern that the output is not being met, the concern will be escalated and managed.

3.22 PAY PROGRESSION

3.22.1 The terms and conditions for various types of contract make provision for a salary that rises through a series of pay thresholds (see section 9 for contract links). Passing through the thresholds is not automatic and specific criteria have to be met, although it is expected that progression will still be the norm.

3.22.2 Following the annual job plan review, the Clinical Director will inform the Chief Executive and Chief Medical Officer whether the criteria of the Terms and Conditions for the purposes of pay progression have been met.

3.22.3 The doctor should be informed of the outcome. The process for dealing with disagreements is found in the terms and conditions in the relevant contract.

3.22.4 Doctors should not be penalised if objectives have not been met for reasons beyond their control. Employers and consultants will be expected to identify problems (affecting the likelihood of meeting objectives) as they emerge, rather than wait until the job plan review.

3.23 **SIGN OFF**

3.23.1 The agreed job plan will set out a schedule of PAs that sets out how, where and when duties and responsibilities will be delivered.

3.23.2 An annual review of objectives should be undertaken, even if the structure of the job plan is not changing.

3.23.3 What is agreed at the job planning meeting should be recorded electronically on eJobPlan with an agreed start date. The CD or CL (depending on local practice) should sign off the job plan.

3.24 **DISPUTES**

3.24.1 Most job plans will be agreed without difficulty. Where it has not been possible to agree a job plan or a doctor disputes a decision that he or she has not met the criteria required for pay progression, the process for dealing with disagreements is found in the terms and conditions in the relevant contract. Advice can be obtained from people partners, the CMO team, or the relevant job planning guidance documents (see reference list).

3.24.2 Problems should be raised with the clinical director of the service line.

3.24.3 Where the CD is the person responsible for signing off the job plan, the concern should be escalated to the CMO's team, who can advise about how to proceed.

3.24.4 If the dispute remains unresolved, the Doctor may wish to enact the procedure as described in the relevant contract and terms and conditions.

3.24.5 A doctor may ask to discuss their job plan with a peer. This does not form part of the formal process but informs and supports the doctor.

3.24.6 No disputed element of the Job Plan will be implemented until confirmed by the outcome of the appeals process.

3.24.7 Where a clinician is employed by more than one NHS organisation, the main employer will take the lead in resolving any issues.

3.25 **COMPLIANCE WITH POLICY**

3.25.1 Doctors struggling to comply with this policy should discuss the matter with their line Manager, Clinical Director or a Freedom to Speak Up Guardian who will do their best to solve the issue.

3.25.2 Breaches in compliance with the policy will be investigated under the terms of Maintaining Higher Professional Standards in medical and dental staff.

4. ROLES & RESPONSIBILITIES

4.1 **Senior doctors** (i.e. all doctors in non-training grades, except Trust Grade doctors in training grade posts) will engage in job planning.

4.2 **Clinical directors** will direct a job planning process within their service line. They may delegate the job to a colleague (for instance the clinical lead). They, or their delegee, will draft job plans and objectives in conjunction with the doctor. They will report their progress to the chief medical officer. Operational managers will enable the job planning process, joining in with meetings as invited, and providing information to inform family job plans

4.3 **People Services** will support managers in implementing the process, the electronic Job planning software and in issues requiring resolution.

4.4 **Chief medical officer** will support CDs in the process. They will receive reports and make themselves or a member of their team available for advice and dispute resolution.

4.5 **Medical Directorate Business Manager** will enable access to the electronic job planning system for all doctors. They will maintain a record of progress of job plans and report any issues to the CMO team

4.6 **Chief executive officer** will receive reports on the process. They will be available to hear appeals.

4.7 **Trust Board** will be responsible for ensuring that all doctors have a job plan, and that the culture and infrastructure of the trust supports Senior Doctors. They will be involved in the appeal process.

5. TRAINING

5.1 Doctors will be trained to use the electronic job planning software and the principles outlined in this document.

5.2 Clinical directors and other managers who will sign off job plans will be given training
People services will support doctors involved in disputes.

6. EQUALITY IMPACT ASSESSMENT

6.1 No adverse impact was found on any group of doctors in the implementation of this policy.

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1 Implementation will be monitored by the CMO team. Reports will be submitted to Responsible Officers Advisory Group and reviewed at Quality, Improvement and Risk Group.

7.2 The numbers of successful job plans, any disputes and there resolution will be recorded. The reasons for disputes, mediation and appeals will be examined, lessons learnt and necessary changes to policy and practise made.

8. REVIEW

8.1 This document may be reviewed at any time at the request of either staff side or management but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

9.1 References and links:

Good Medical Practice
https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice

Consultant's Terms and Conditions
Terms and Conditions – Consultants (England) 2003

Specialist 2021 Terms and Conditions
https://www.nhsemployers.org/publications/terms-and-conditions-service-specialist-grade-england-2021

Associate Specialist 2008 Terms and Conditions
https://www.nhsemployers.org/sites/default/files/2021-06/tcs-specialty-doctor-v4-2018.pdf?la=en&hash=162AA67BAEE7E54FFFE3E344D221E7F7776C3B8

Associate Specialist 2008 Terms and Conditions (BMA)
https://www.bma.org.uk/media/1108/terms-and-conditions-of-service-for-associate-specialists-in-england-april-2008.pdf

Job planning Guide (BMA)
A UK guide to job planning for speciality doctors and associate specialists (2012) BMA

Job planning guide (NHS Employers)
A Guide to Consultant Job Planning

Consultant contract appeals (NHS Employers)
The Consultant Contract Appeals document – NHS Employers

Private Practice Code of Conduct
78153-DoH-Code of Conduct Cov (nhsemployers.org)

Managing Performance of Medical and Dental Staff Policy
HR17 Policy for Managing Performance of Medical and Dental Staff v1

10. GLOSSARY

Annual Appraisal	a contractual requirement for non-training Doctors (Consultants, Speciality, Specialist and Associate Specialist Doctors (SAS), General Practitioners, Trust Doctors and Doctors on honorary contracts).
APA (additional programmed activities)	A paid activity that is in addition to core activities.
Clinical Services	The way the trust organises itself to provide services to patients
CD	clinical director
CL	clinical lead
CMO	Chief medical officer
DCC (direct clinical care)	Work directly relating to the prevention, diagnosis, or treatment of illness.
DMO	Deputy medical officer
EDA (external duties)	activities undertaken for an organisation other then one of the employing NHS bodies.
Family Job Plan	A job plan undertaken with a group of doctors
JLNC	Joint local negotiating committee
Lead Employer	where a doctor is employed by more than 1 organisation, one of the employers will act as lead employer for job planning (usually the employer for whom the doctor provides the greatest percentage of their working hours)
Normal time	Work undertaken between 7am-7pm (Mon-Fri) (7am to 9pm for those on Specialist Contract)
Premium time	Work undertaken at any other time.
Programmed activities	1 PA represents 4 hours of work in normal time, and 3 hours of work in premium time.
QIR	Quality Improvement and Risk Group
Revalidation	is the process by which Doctors will have to demonstrate to the General Medical Council that they are up to date and fit to Practice and that they are complying with the relevant professional standards
ROAG	Responsible Office Advice Group
Senior Doctors	speciality doctors, associate specialists, specialist doctors, staff grade doctors and consultants.
SPA (supporting professional activities)	activities that underpin Direct Clinical Care.
Time-shifting Arrangements	an arrangement that work displaced by an activity can be delivered at another time (e.g. admin carried out at home in the evening to allow for an afternoon meeting)

APPENDIX A: EQUALITY IMPACT ASSESSMENT (EIA)

Step 1: Scoping and Identifying the Aims

Service Line / Department	Corporate	
Title of Change:	Update of the **JOB PLANNING POLICY**	
What are you completing this EIA for? (Please select):	Policy	*(If other please specify here)*
What are the main aims / objectives of the changes	To update names and functions, to reflect post corona virus environment and remove job planning (as making new policy)	

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g. adjustment to the policy)*
Sex			x	
Gender reassignment			x	
Disability			x	
Age			x	
Sexual Orientation			x	
Pregnancy and maternity			x	
Marriage and civil partnership			x	
Religion or belief			x	
Race			x	

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers or other voluntary sector groups?)	Yes	DDNC happy with changes, no impact on any specific group identified
Have you taken into consideration any regulations, professional standards?	Yes	

Step 3: Review, Risk and Action Plans

How would you rate the overall level of impact / risk to the organisation if no action taken?	Low	Medium	High
	■	☐	☐
What action needs to be taken to reduce or eliminate the negative impact?	none		
Who will be responsible for monitoring and regular review of the document / policy?	Appraisal lead, ROAG		

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

Equality Assessor:	*Caroline Hutchings*	*Date:*	*20 October 2021*

Protected characteristic		Who to Consider	Example issues to consider	Further guidance
1.	**Disability**	A person has a disability if they have a physical or mental impairment which has a substantial and long-term effect on that person's ability to carry out normal day today activities. Includes mobility, sight, speech and language, mental health, HIV, multiple sclerosis, cancer	• Accessibility • Communication formats (visual & auditory) • Reasonable adjustments. • Vulnerable to harassment and hate crime.	Further guidance can be sought from: Solent Disability Resource Group
2.	**Sex**	A man or woman	• Caring responsibilities • Domestic Violence • Equal pay • Under (over) representation	Further guidance can be sought from: Solent HR Team
3	**Race**	Refers to an individual or group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	• Communication • Language • Cultural traditions • Customs • Harassment and hate crime • "Romany Gypsies and Irish Travellers", are protected from discrimination under the 'Race' protected characteristic	Further guidance can be sought from: BAME Resource Group
4	**Age**	Refers to a person belonging to a particular age range of ages (eg, 18-30-year olds) Equality Act legislation defines age as 18 years and above	• Assumptions based on the age range • Capabilities & experience • Access to services technology skills/knowledge	Further guidance can be sought from: Solent HR Team
5	**Gender Reassignment**	" The expression of gender characteristics that are not stereotypically associated with one's sex at birth" World Professional Association Transgender Health 2011	• Tran's people should be accommodated according to their presentation, the way they dress, the name or pronouns that they currently use.	Further guidance can be sought from: Solent LGBT+ Resource Group
6	**Sexual Orientation**	Whether a person's attraction is towards their own sex, the opposite sex or both sexes.	• Lifestyle • Family • Partners • Vulnerable to harassment and hate crime	Further guidance can be sought from: Solent LGBT+ Resource Group
7	**Religion and/or belief**	Religion has the meaning usually given to it, but belief includes religious and philosophical beliefs, including lack of belief (eg Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition. (Excludes political beliefs)	• Disrespect and lack of awareness • Religious significance dates/events • Space for worship or reflection	Further guidance can be sought from: Solent Multi-Faith Resource Group Solent Chaplain
8	**Marriage**	Marriage has the same effect in relation to same sex couples as it has in relation to opposite sex couples under English law.	• Pensions • Childcare • Flexible working • Adoption leave	Further guidance can be sought from: Solent HR Team
9	**Pregnancy and Maternity**	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In non-work context, protection against maternity discrimination is for 26 weeks after giving birth.	• Employment rights during pregnancy and post pregnancy • Treating a woman unfavourably because she is breastfeeding • Childcare responsibilities • Flexibility	Further guidance can be sought from: Solent HR team

APPENDIX B: AVAILIBILITY SUPPLEMENTS

These supplements were accurate at the time of publishing (June 2022). Care should be taken to look up the current figures .

Availability supplements for Consultants

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

SAS doctors

- **2008 contracts supplements**
  - More frequent than or equal to 1 in 4 - 6%
  - Less frequent than 1 in 4 or equal to 1 in 8 - 4%
  - Less frequent than 1 in 8 - 2%

- **2021 contracts supplements**

More frequent than or equal to 1 in 4:

- category A - 8%
- category B - 3%

Less frequent than 1 in 4 or equal to 1 in 8:

- category A - 5%
- category B - 2%

Less frequent than 1 in 8:

- category A - 3%
- category B - 1%

APPENDIX C: Service SPA ROLES

Service SPA - Most doctors will have some Service SPA in addition to their core SPA, combining to at least 2 SPAs for full time colleagues. With agreement, many doctors will have more than a total of 2 SPAs, to meet the needs of the trust or service line.

Some roles are needed in all service lines. Many of the roles can be multi-disciplinary, and maybe carried out by other colleagues. In some service lines, the management team will make a decision that some of these roles should be filled by a doctor.

The roles outlined below will vary in time allocated, and the suggestions are simply there as a guide.

In large departments some roles will be distinct, whereas in smaller service lines they will be operated as combined roles. For instance a large service line may have a doctor with a clinical governance role, who has 0.5 PA to oversee the clinical governance activity of the service line. In a smaller service line, this is likely to be in the role of the clinical leads or clinical director.

Title	Description	Hours per week
Trust Appraiser	Annual appraisal is mandatory for all staff and should be performed by colleagues with expertise and training in the appraisal process	0.25 PA Appraisals are undertaken April to September. Local agreement should be reached as to how the appraisal time is freed up, as a regular time (1-2 on a Thursday for instance) will not work. This may necessitate the displacement of DCC.
Clinical Lead - management/ development	To act as the lead for the clinical workforce	0.5 - 2 PA depending on size of service or team managed
Clinical Lead – diagnosis	To act as the lead for services supporting a particular group of patients	0.5 - 1 PA depending on size of patient group
Lead for junior doctors	To coordinate junior doctors within the department or service line	0 - 0.5 PA
Postgraduate Education Lead	To oversee the Continued Professional Development programme for junior doctors, middle grade doctors and consultants within service/service line	0 - 0.25 PA
Undergraduate Education Lead	To coordinate all undergraduate medical educational activity within Service/Service line	0.1 - 0.5 PAs per week
Undergraduate supervisors	Activities relating to medical students	0 - 0.5 PAs per week
Research - own projects	To complete research projects that are funded. Time agreed by clinical director.	Funded projects will specify amount of time
Medicines Management Rep	Provide clinical voice for service line at Trust Meds Management Group and disseminate information to service line	0.1 PA
Mortality and Morbidity lead	Oversight, reporting, scrutiny and learning from M&M	0 - 0.25 PA per week

Clinical Supervisor	Named individual who is responsible for supporting, guiding, and monitoring the progress of a named trainee for a specified period of time. This is a GMC recognised role. Should not be confused with clinical supervision, which occurs during usual clinical work and is recognised in DCC.	0.25 PA per trainee Clinical supervisors may have more than one trainee, and therefore proportionally more SPA time.
Educational Supervisor	Named individual who is responsible for supporting, guiding, and monitoring the progress of a named trainee for a specified period of time.	0.25 PA per trainee Educational supervisors may have more than one trainee, and therefore proportionally more SPA time.
Supervisor	Agreed time to supervise another member of staff (eg to complete non-medical prescriber qualification). Supervision of staff in a clinic may be agreed as DCC.	as agreed
Travel	Travel related to SPA activity	as agreed
Unspecified/other		as agreed

APPENDIX D: Additional NHS Responsibility (ANR) Roles

These roles are roles that the trust requires, that have job descriptions and agreed time allowances.

Each will be agreed with the CD, CMO and the doctor, and may be subject to a competitive interview

Caldicott guardian	Responsible for safeguarding the confidentially of patient information	0.1-0.5 PA
Clinical director	Responsible for setting the vision and direction for clinical services for the service line, taking a leading role in continuous and innovative development and successful service delivery.	Up to 5 PAs depending on size and complexity of service
Director of medical education	Responsible for Solent's formal training programmes in conjunction with Health Education England	2PAs
Clinical/College Tutor (responsible for post graduate training for a speciality for Solent)	Responsible for post graduate training in a department for all doctors	1 PA
Medical director	Leading on all aspects of clinical care, professional behaviours and standards, providing clinical leadership to the board, influencing outwards and inwards	6-10 PAs
Deputy Medical Director	Assisting Medical Officer, often in specific roles (eg professional standards, primary care liaison)	3-6 PAs
Guardian Safe Working	ensures that issues of compliance with safe working hours are addressed by the doctor and the employer or host organisation as appropriate	1 PA
Appraisal Lead	Provides structure for appraisal, ensuring all eligible doctors have a high quality, effective and supportive appraisal	1 PA
Named Doctor for Child Protection -	Support all activities necessary to ensure that the	2PA

	organisation meets its responsibilities to safeguard/protect children and young people, including advice to the board	
Named Doctor for Looked after Children	to assist health services in fulfilling their responsibilities to improve the health of looked-after children	1 PA
Research Lead	Person within a department with a defined role in leading research development and ensuring research growth.	0-1PA depending on research activity of the department May also have research time agreed funded by specific projects.
Medical Chair Medicine Management Group	Chair of meds management group (devolved from CMO)	0.25PA
SAS tutor	To support the educational, managerial and professional development of SAS doctors	1PA
SAS Advocate	Promote and improve support for SAS doctor's health and wellbeing	0.5 PA
Travel	Travel relating to ANR roles	As agreed
Union Duties	Local Negotiating Committee roles	Chair 0.5 Secretary 0.25
Other		As agreed