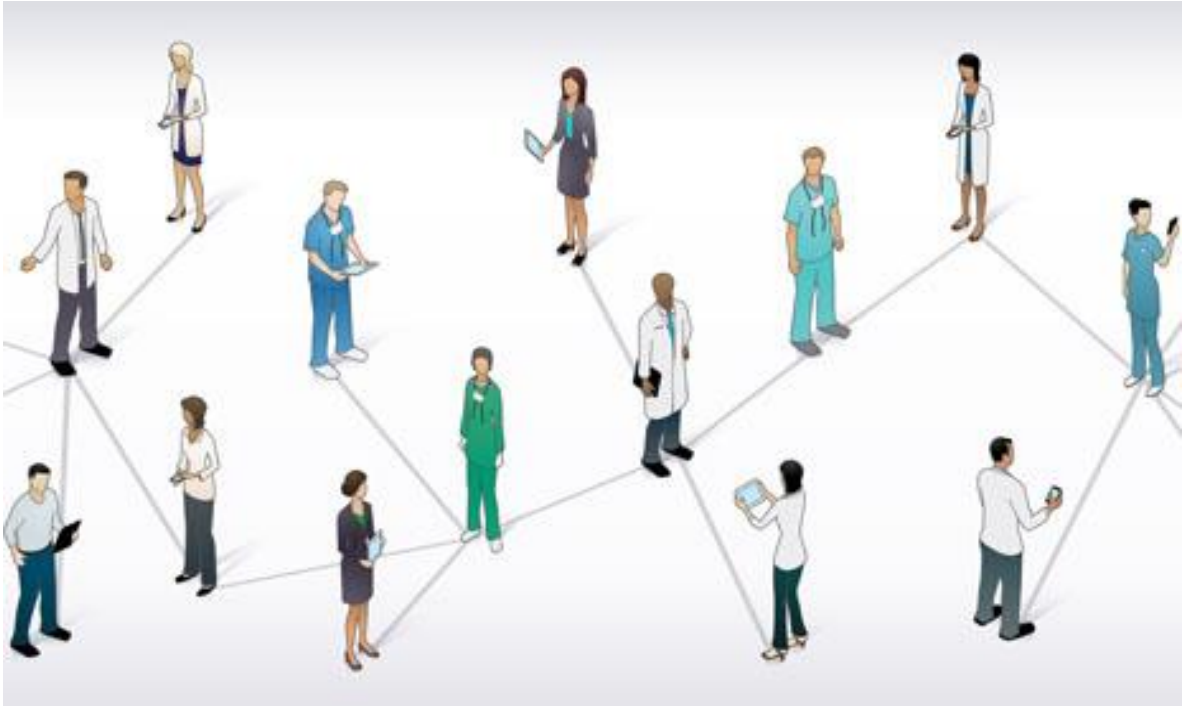
A GUIDE TO JOB PLANNING FOR DERMATOLOGISTS

-



BAD Clinical Services Committee
Clinical Services Unit
July 2018

Table of Contents

1. Introduction

1.1 What is a Job Plan?

The job plan is an annual prospective agreement between the employer and the Consultant, setting out:

- The work the Consultant does for the Hospital/Trust/Board, and in the case of Clinical Academic Consultants,[1] work they also do for the University;
- The personal and local service objectives to be achieved by the Consultant and supported by the Trust;
- When and where that work is done;
- How much time the Consultant is expected to be available for work;
- What resources are necessary for the work to be achieved, e.g. facilities, administrative/clerical/secretarial support, office accommodation, IT resources etc.;
- What external duties are performed outside the Trust;
- What flexibility there is around the above.

Objectives should be set for most of the activities the consultant has agreed in their job plan. This can be explicit – in a stated objective, or implicit in the agreed job schedule and annually agreed Programmed Activities (PAs) delivered. The process should follow the SMART formula (Specific, Measurable, Achievable and agreed, Realistic, Timed and tracked).

Where a consultant works for more than one NHS employer, the lead employer will take account of any objectives agreed with other employers.

The BMA provides an excellent job planning diary for each area of the UK for all grades of medical doctors to help with job planning discussions. Refer to local and national terms & conditions of service.

1.1.1 Job Plan Review

The Job Plan Review should be undertaken on an annual basis and interim basis to identify:[2]

- What factors affect the achievement or otherwise of objectives;
- The adequacy of resources to meet objectives and any potential organisational or systems barriers that may affect the doctor's ability to carry out job plan commitments or achieve objectives;
- Any possible changes to duties or responsibilities required/desired by either party;
- Ways of improving management of workload;
- Planning and management of the Consultant's career;
- Timetabling of sessions/site where work is delivered.

[1] Job planning for consultant clinical academics should apply the Follett principles to agree an integrated job plan with the consultant.

[2] Schedule 3 of the Terms and Conditions of Consultants Contract.

Please note: doctors will not be penalised for failing to meet objectives for reasons beyond their control, such as illness, or due to a lack of agreed supporting resources. However, both the employing body, and the Doctor have a responsibility to identify potential problems with achieving objectives as they emerge rather than waiting for an annual job planning review meeting.

1.1.2 The Link with Consultant Appraisal

The appraisal process is separate to the job planning process. Making sure that job plans reflect and support personal development objectives, agreed within the appraisal process, is a good way of ensuring that the necessary supporting resources have been allocated.

1.1.3 The Key to a Successful Job Plan

The Job planning process should be consistent, fair and transparent. It should be:

- Undertaken in a spirit of collaboration and co-operation;
- Completed in good time, with adequate time made available to do this;
- Reflective of the professionalism of being a Doctor;
- Focused on measurable outcomes that benefit patients;
- Consistent with the objectives of the NHS, the employing body, teams and individuals;
- Accurate and honest in representing the time spent on work;
- Fully agreed and not imposed;
- Focused on enhancing outcomes for patients whilst maintaining service efficiency;
- In the case of Clinical Academics, consistent with the principles set out in the Follett Review;
- Clear of identification of supporting resources that the employer will provide to ensure the objectives can be met;
- Responsive to changing service needs;
- Follow national and local Trust guidelines.

1.1.4 Retire and Return

Job planning is still mandatory for those doctors who wish to 'retire and return'. The NHS has produced guidance for these doctors at https://www.gov.uk/government/publications/re-employing-staff-who-receive-an-nhs-pension, but it is important to note that many hospitals including Foundation Trust Hospitals also have their own additional 'retire and return' policies, e.g. stipulating length of time off before you can return. Doctors thinking about 'retire and return' are strongly advised to have a pre-retirement job planning meeting and discussion with their clinical lead and medical director.

1.2 What Makes up a Job Plan?

A full time Consultant job plan should clearly identify the work done in the 10 PAs (Programmed Activities) that constitutes their standard contractual duties. Programmed Activities may be scheduled either as a single block of four hours (3.75 hours in Wales), or sub-divided into smaller units of time.

These 'core' 10 PAs should include all:

- Direct Clinical Care (DCC);
- Supporting Professional Activities (SPA);
- Additional NHS Responsibilities and Duties (Trust based);
- External Duties (outside the Trust).

In general, a 10 PA Job Plan includes 7.5-8.5 DCC and 1.5-2.5 SPA. In Wales: 7 DCC and 3 SPA. In Scotland: 7.5 DCC and 2.5 SPA.[3]

Where a full time Consultant has taken on an additional role, the PAs for this role will replace existing PAs in the 'core' 10 PA job-plan. If the Consultant and Clinical Director agree that the Consultant's clinical workload should remain the same, then the additional PAs (APA) for direct care will be offered. Any PAs exceeding 10 can only be included in a job plan with the agreement of the Consultant, who cannot be forced to work more than 10 PAs.

An extra two Programmed Activities (above the 10)[4] may be offered to Consultants where additional clinical activity is required (not pensionable). In Scotland, this is known as an EPA[3]. Individuals may choose to opt out of the Working Time Directive (WTD) and work more than 12 PAs.

Where a consultant has a part-time contract, the employing organisation will need to agree the number of weekly Programmed Activities that should be included in the Job Plan. Extra PAs may also be awarded in excess of the main part-time contract.

Many Trusts now use electronic Job Plans e.g. Zircadian or Allocate. All activities are recorded by the minute ensuring that there are no overlaps or double-counting. How fractions of a PA are rounded up or down is not specified in the Consultant contract and is up to local agreement.

[3] Job Planning for the New Consultant Contract in Scotland. Guidance from BMA Scotland.
[4] Schedule 13 and Schedule 14 of the Terms and Conditions of Consultants Contract.

Activities that occur irregularly can be 'annualised'. The final Job Plan should be agreed with the clinical manager (Head of Service/Lead Clinician/Clinical Director).

Job plans will vary between consultants in the same department however some elements will be the same for all consultants and 'Team' job planning may facilitate a transparent and more efficient process, for example:

- Core SPA work (see below)
- Patient Administration;
- Ward Referrals/Ward work;
- Emergency/ On-call duties;
- Skin cancer MDT;
- Regional / Complex Cases clinic;
- SIFT (undergraduate) teaching;

Job plans may change throughout time, for example:

- Rotating roles – Skin cancer lead; Clinical lead; Research lead; Educational lead; Audit lead; Clinical Governance lead.
- Development of special interests.
- Variation in the number of trainees requiring supervision.
- Variation in teaching responsibilities.

Please refer to Appendix A - Summary of a Job Plan and Appendix B - Generic Clinic Timetable

2. What is Direct Clinical Care (DCC)

Clinical work directly relating to the prevention, diagnosis or treatment of illness. Usually this makes up 7.5 -8.5 of a 10 PA full-time contract:

- Outpatient Clinics;
- Travel time for clinics not at base hospital;
- Operating sessions including pre-operative and post-operative care;
- Ward rounds and in-patient work;
- Multi-disciplinary meetings about direct patient care;
- Clinical diagnostic work;
- Supervising the clinical work of other healthcare staff;
- Routine telephone advice and email advice to patients and colleagues;
- Teletriage and teledermatology work;
- Patient counselling;
- Diagnostic work;
- Emergency work (including emergency work carried out or arising from on-call);
- Patient related administration (including, but not limited to: referrals and notes, review of results, triaging referrals, dictation and letter signing, emails relating to a named patient);
- Incident investigation (if patient named).

Every 1PA DCC clinic/surgery session generally requires 0.25PA of patient related administration, with additional time for MDT, triage etc.

2.1 Emergency Work

The job plan should set out the frequency of the on-call rota.[5]

2.1.1 Predictable Emergency Work

This is emergency work that takes place at regular and predictable times, often as a consequence of a period of on-call work (e.g. post-take ward rounds). This should be programmed into the working week as scheduled Programmed Activity.

2.1.2 Unpredictable Emergency Work

Arising from on-call duties, this is work done whilst on call and associated directly with the Consultant's on-call duties, e.g. recall to hospital to see urgent admissions. It will also include offering telephone advice to colleagues.

[5] Schedule 5: Recognition for emergency work arising from on-call duties.

2.1.3 On-Call Availability Supplement

Those Consultants required to participate in an on-call rota; the clinician will be paid a supplement in addition to basic salary, in recognition of his or her availability to work during on-call periods. The level of supplement will depend on both:

- The contribution of the Consultant to the on-call rota (see table below) and;
- The category of the Consultant's on-call duties (A or B - most Dermatologists will be Category B).[6]

Less than full-time Consultants, whose contribution when on call is the same as that of full-time Consultants on the same rota, should receive the appropriate percentage of the equivalent full-time salary.

	Category A	Category B
High frequency: 1–4 Consultants	8.0%	3.0%
Medium frequency: 5–8 Consultants	5.0%	2.0%
Low frequency: 9 or more Consultants	3.0%	1.0%

Category A applies where the Consultant is *typically* required to return immediately to site when called or has to undertake interventions with a similar level of complexity to those that would normally be carried out on-site. Category B applies where the Consultant can *typically* respond by giving telephone advice and/or by returning to work later.

2.2 Inpatient Work

Job plans should include time for the care of in-patients. These may be patients admitted with skin disease or patients under other teams who develop skin problems. In many hospitals, Dermatology care is moving from a fixed ward base to multidisciplinary involvement with Dermatology patients on multiple wards. This must be reflected in job plans, with inpatients also receiving expert, dedicated dermatological nursing care.

- Ward rounds - leading and training a team including registrars, specialist nurses and students, usually occur for Dermatology inpatients twice weekly, but may occur more often with severely ill patients.
- Referral work - urgent requests for dermatological opinions on acute admissions require review on ward rounds. These frequently reduce length of stay in hospital.

[6] BMA and NHS Employer Job Planning Guide – On- call Duties

2.3 Outpatient Work

Outpatient work is the core work of most Dermatologists. The nature of these clinics varies considerably; the list of common clinics below is not exhaustive (a clinic is assumed to be a 4-hour session):

- General Dermatology clinics - the ratio of new to follow-up patients and time allocated varies depending on the type/complexity of the cases seen. On average 12-16 patients may be seen in a clinic. The BAD recommend 20 minutes for a new patient and 15 minutes for a follow up. For general clinics, a ratio of New to Follow Up (N:FU) of 1:1.6 is recommended. When supervising trainees or teaching medical students, the numbers will change (see below);

- Skin cancer / 'see-and-treat' clinics - various models are used. See-and-treat clinics provide surgery on the first visit, reducing the numbers seen. Biopsy results can be given via nurse-led clinics or consultant virtual/telephone clinics and patients only seen for review if clinically necessary.

Specialist clinics within Dermatology include (this is not an exhaustive list):

- Paediatrics - A ratio of up to 1:2 N:FU is required. 10-12 patients per clinic. Where there are specialised paediatric nurses running their own clinics, the N:FU will be lower than this. In specialised paediatric dermatology clinics, longer time per patient will be needed.
- Skin allergy. Patch Testing Clinics. 8-12 patients in 4 hours for visit 1; 3 hours for visit 2 and 4 hours for visit 3. This equates to ~20 mins on the Monday and Friday appointments.[7] For complex type 1 allergy clinics where prick testing and/or challenge testing is done during the consultation, appointments may be up to 1 hour.
- Medical Dermatology. Complex medical dermatology clinics (including combined rheumatology clinics) with patients on multiple immunosuppressive medications requiring monitoring and full examination of people with limited mobility and with dressings may require 30 minutes/ for both new and follow up patient with separate dressing facilities available.
- Photodermatology. 30 mins for new, 15 mins for follow-up.
- Psychodermatology. 45 mins for new, 30 mins follow-up.
- Genital clinics. 30 mins for new 15 mins for follow-up (Add 30 mins if same day biopsy is incorporated).
- Complex case clinics. Regions and large departments hold multidisciplinary clinics weekly or monthly for complex cases. This should be counted as DCC.

2.4 Specialised Dermatology Services

There are designated centres for the provision of specialised services. PAs for this and any supporting MDT activity should be highlighted in job plans. As of January 2011, national commissioned group services in England exist for: Xeroderma Pigmentosum, Epidermolysis Bullosa, Ehlers-Danlos syndrome, Neurofibromatosis types 1 and 2, Fabry disease and Cryopyrin diseases. National Bechet's centres are in London, Birmingham and Liverpool.

[7] British Assoc. of Dermatologists (BAD) Cutaneous Allergy Working Party Report 2014.

2.5 Skin Surgery

Surgery lists may include biopsies, day-case skin surgery lists including Mohs' micrographic surgery and laser lists (requiring a laser-safe area and general anaesthetic facilities for children). Skin surgery will usually take 30 minutes for a skin biopsy, 45 minutes for a simple excision on body, 45 minutes for primary excision and closure head and neck and 60-90 minutes for more complex flaps and graft repairs. An individual case of Micrographic surgery with closure in the unit can take at least 2.5 hours. These times do not include 'turnaround' time which depends on trained nursing support and efficiency.

Sufficient time is required for full discussion where patient's concerns can be listened to and addressed.[8] Recent clarification of the law concerning consent (Montgomery vs Lanarkshire Health Board, 2015) mandates that, in the event an intervention or operative procedure is planned, the doctor is required to share all relevant information with the patient to help him/ her decide whether (or not) to proceed with an intervention or procedure. The patient must be carefully counselled, and the discussion documented as part of the consent process, or indeed the patient's reluctance to have a procedure performed.[9]

2.6 Skin Cancer MDT

Skin cancer MDTs are either specialised or local, and run weekly or alternate week 1-2 hours meetings reviewing cancer cases according to NICE guidelines. This will include review of histopathology and radiology. Some MDTs incorporate an MDT clinic for complex skin cancer patients to agree on best management plan, which includes non-surgical therapies, such as Photodynamic Therapy. MDT leads should have sufficient time allocated for pre- and post-meeting preparation.

Separate Skin Lymphoma MDTs are held in regional centres, requiring a different mix of specialists (e.g. haematologists and specialist histopathologists) from the standard skin cancer MDT. These are typically held monthly or bi-monthly.

2.7 Multidisciplinary Meetings (Non-Cancer Care)

Combined clinics between Dermatologists both with and without other hospital specialists exist for complex problems, e.g. involving rheumatology, plastic surgery, pathology, HIV, genital/oral diseases, psychiatry, paediatrics, genetics, stomas, eyes, vascular surgery and allergy.

2.8 Virtual Clinics

Where a face-to-face consultation is replaced with communication via letter or telephone (e.g. to give results, diagnosis, medication changes, answer patient queries etc.), this should be counted as DCC not administration time. Virtual clinics are run as per face-to-face clinics with a clinic list and notes, allowing 10 minutes per patients. e-Referral, triage and advice and guidance activity would be included in this work.

[8] General Medical Council: Consent: patients and doctors making decisions together (2008).

[9] Brit Assoc. of Dermatologists: Guide to Validating Consent: Dermatology Examinations or Treatments (2017).

2.9 Teledermatology

Teledermatology may be used for triage or advice and as part of an integrated consultant-led team subject to full clinical governance; there is no evidence that it can safely reduce referrals outside this setting. NHS e-Referral and other software platforms can be used to provide general practitioners and patients with rapid access to diagnosis and management advice, or to triage selected patients direct to surgery. Teledermatology clinics should be recognised in consultant dermatologists job plans.

The British Teledermatology Subcommittee of the BAD can offer advice on setting up or commissioning integrated teledermatology services within the framework of the UK standards.[10,11]

Recommended case numbers are approximately 25 cases in a 4-hour session (8-10 minutes per case). If teledermatology is used to triage patients directly for surgery or into specialist clinics, time must be allocated for clinical administration e.g. completion of surgical booking forms.

Teledermatology job planning should include:

- Viewing referral letters and additional attachments including patient drug history and consent
- Viewing images (~1-10 photos)
- Reviewing literature / evidence-based search for complex cases
- Typing comprehensive diagnosis and management plan, including range of diagnoses and treatment options and clear referral pathway if face-to-face review required
- Attaching documents / guidelines / web-links
- Printing images and referrals for patients triaged to surgery or clinic
- Completing surgical booking forms
- Phone calls to GPs or patients for complex cases requiring face-to-face review.

2.10 Weekend/Evening Working

With increasing pressure towards 7-day working, employers may request evening / weekend clinics. In the 2003 Consultant contract, routine work before 7am, after 7pm and at weekends is voluntary and remuneration is negotiable. In Scotland all PAs worked between 8am to 8pm Monday to Friday is paid at plain time rate. Work outside that or on public holidays may be paid at premium rates. However, Saturday mornings 9am to 1pm may be programmed into job plans if agreed. Employees should seek assurances that the same level of support will be available at these times e.g. admin, nursing, support services as would be available to them during Monday-Friday 9am to 5pm.

[10] Quality standards for Teledermatology http://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=794;

[11] Mobile photographic devices in dermatology have been produced by multi-stakeholder groups - https://www.pcc-cic.org.uk/sites/default/files/articles/attachments/telederm_report_aw_web4.pdf

2.11 Supervision of Trainees and Other Staff

Supervision of trainees and other staff must be taken into account and reduction of clinic numbers depending on the stage of training and number of trainees and additional members of staff supervising in the clinic.

For consultants supervising up to 2 junior medical or nursing staff clinics the BAD recommends up to 30% reduction of the consultant clinic list (9 new or 11 follow up or mix of the two) the actual number depends on the experience of the supervisee/s.

In larger training departments with consultant supervision of 3 or more inexperienced junior medical or nursing staff during a clinic, the consultant may not have his or her own list but be based centrally in the clinic and move from room to room enabling larger numbers of patients to be seen (Floating Consultant Clinic).

Trainee lists should have longer times to see patients, e.g. 30 mins for new and 20 mins for follow-ups. Varied according to experience.
Time within clinics or at other times should be allowed for supervision of nurse lead day case treatments.

2.12 Clinically Related Administration

Allowance for admin PA time varies around the country and will be in local agreement. 1-2 PAs depending on the number and type of clinics and allowance for dictation time. A complex medical clinic with drug request IFR/Blueteq paperwork, investigations and result checking will require more administrative time. Some clinicians allow for 30 mins of admin within the 4-hour clinic session in which case the numbers of patients should be reduced. In principle each 4-hour clinical session generates 0.25 PA of admin time.

Where paperless (electronic) systems are introduced it must be recognised that such systems often increase the time taken to undertake the task and increased time must be agreed within the job plan in order to safely adopt these.

Teletriage, email and telephone consultations, teledermatology and all other non-face-to-face patient care should be included under virtual clinical activity in job plan rather than under administrative time.

2.13 Travel Time

Where consultants are expected to spend time on more than one site during the course of a day, travelling time to and from their main base to other sites will be included as working time. The travel time to and from that place needs to be within the 4-hour PA or counted as additional DCC PA time in the Job Plan.[12] A recognised route planner is normally used to calculate this.

[12] Schedule 12: Other conditions of employment.

3. What are Supporting Professional Activities (SPA)?

These activities underpin direct clinical care and are essential for the delivery of quality care. With the employer's agreement elements of SPA may be scheduled flexibly and worked off-site

The consultant contract (2003) defined categories of PAs. Within a full-time framework of 10 PAs, the contract states that a full-time consultant would normally devote on average 7.5 PAs per week to DCC and 2.5 (3 in Wales) to SPAs. However, over the past decade, many new consultant appointments have been made with a reduction in the number of SPAs. Some Trusts have the minimum of 1.5 SPA.

In Wales all whole-time consultants have a fixed core of two SPA. A third SPA by mutual agreement is contracted for other specific activity.
http://www.wales.nhs.uk/sites3/Documents/433/ConsultantJobPlanGuidanceWales.pdf

The Royal College of Physicians guide on job planning stipulates that 1.5 SPAs would be the minimum required for revalidation only and without teaching/research/trainee supervision/department management responsibilities involved in the post. Approval is subject to the following provisos:

- A job plan review should take place after three months where the SPA allocation can also be reviewed;
- A statement that jobs with 1.5 SPAs were clinical only, with no commitment to teaching or research;
- An agreement that more SPAs would be allocated for other activities, such as supervision, teaching or research.

For consultants who have a contract for working up to 5 PAs, a minimum of 1 SPA should be in the job plan. A 5–8.5 PA job plan should include a minimum of 1.5 SPAs, and a job plan with 8.5 PAs and above would reasonably be expected to include 2 SPAs, to allow for supervision, service development and clinical governance. In Scotland 2.5 SPA if 8+ PA, 2 for 6-7.5, 1.5 for 4-5.5, 1 for 2.5-3.5.

3.1 SPA Activity

SPA activity includes:

Core (minimum required for revalidation, 1.5 PA)

- Continuing professional development
- Audit and clinical governance including critical incident/ mortality reviews/ complaints (where patient not named)
- Statutory and Mandatory training
- Preparing own Job planning and Appraisal

Additional (non-core)

- Rota coordinator
- Organising departmental teaching/ lectures/ regional meetings
- Training and assessment of trainees
- Formal teaching
- Medical education
- Research including recruitment into national trials e.g. BADBIR
- Clinical management
- Service development, including specialised services and audit.
- Travel time associated with the above

3.2 Additional Responsibilities (Employer Organisation Based)

The PAs listed are examples only and will be locally agreed with your employer organisation depending on the time commitments and responsibilities of the post.

- Clinical Lead/Clinical Director/Service Director (0.5 – 2 PA depending on department size – may be shared with deputy clinical leads);
- Skin Cancer/MDT Lead (0.25-1 PA). Where insufficient Cancer Nurse Specialist support, more PA time is required by the cancer lead;
- Educational Supervisor HEE and GMC[13] recommend 0.25 PA per trainee per week;
- Appraiser [5 or more per year] (0.25- 0.5 PA);
- SIFT [Undergraduate Teaching] (Variable);
- Research SPAs (Allocated by R&D);
- Medical director;
- Clinical audit lead;
- Clinical governance lead;
- Undergraduate dean;
- Postgraduate dean;
- Clinical tutor;
- Caldicott guardian.

[13] General Medical Council: "Named educational supervisors and named clinical supervisors may be GPs, consultants or staff, associate specialist or specialty doctors (SAS) doctors". ES must be given adequate time to perform their role and approximately 0.25 PA per trainee should be identified in their job plan.

3.3 Research SPAs

These will be additional to the core 1.5 SPA's. Arrangements will vary locally by trust but should reflect research activity agreed by the trust and measured in the job diary. The source of the funding and the principal reason(s) for the allocation of the research PAs will be documented and reviewed, at least biannually.

Transparency is key to the process of allocating research PAs and activity levels evidenced-based. Historical activity will not be rewarded unless it is sustained, and it should not be assumed that because a Consultant has had an allocation of time in their job plan with commensurate remuneration for research activity for some years that this should continue automatically, in the absence of continued performance. Clear objectives should be described for the continuation of research PA's which might include achieving a target for the number and complexity of patients recruited and being managed in ongoing studies, grant applications made, or papers published.

3.4 Teaching SIFT (Undergraduate) SPAs

These will be additional to the core SPAs and are allocated by medical management staff. It is important that the SIFT PAs paid to a department are used for teaching time and not used to support other work. Clear objectives of measurable teaching outcomes with annual reviews will be used to ensure ongoing high-quality teaching.
Where medical students are being taught then clinic numbers should be reduced to accommodate this and to take into account this activity. It is recommended that 30 minutes should be allocated for teaching students in a clinic by reducing patient numbers.

4. External Duties

These are external duties not DCC/SPA/Additional NHS and not included within the definition of Fee Paying Services or Private Professional Services but undertaken as part of the Job Plan by agreement between the consultant and employing organisation usually a role working for the 'wider NHS'.

Examples include (the list is not exhaustive):

- Medical Royal College work (RCP regional representatives, council etc. members);
- Departments of Health/ other NHS duties e.g. GIRFT, Clinical reference groups (CRG)/ Clinical Expert Groups (CEG)/ NHS England roles /CQC/ NHS Education for Scotland/NHS Quality Improvement for Scotland or equivalent bodies;
- British Association of Dermatologists work including Officers, committee members and chairs, production of national guidelines (www.bad.org.uk, badged by NHS Evidence) and other roles in national specialist societies;
- National Institute of Health Research (NIHR);
- National Institute for Health and Clinical Excellence (NICE);
- Regional Cancer Networks/ Cancer Alliances/ Peer reviewers;
- General Medical Council;
- Specialist Advisory Council (SAC);
- British Medical Association (BMA) ;
- Regional Training Programme Director (TPD) (Medical and Dental Education Levy (MADEL) funded between 0.25 - 1.0 PA, dependent on number of trainees).
- Work for NHS Improvement, NHS England and National Specialised Commissioning and other NHS bodies.

Most of these types of work are not remunerated and consultants will need to work with their managers to determine what allocation of time may be appropriate. Special/ professional leave for any circumstances may be granted (with or without pay) at the discretion of the employer. Any potential commitment to external duties is likely to impact on the service provided at trust level and this should be discussed with colleagues and management before applying for the post so that:

- The impact on service can be assessed and managed;
- Any potential benefits to the organisation can be identified;
- There is fairness and transparency between team members at the outset.

5. Private Professional Services

Details of all private practice work must be recorded in the weekly timetable(s) and arranged, and undertaken, within the requirements of the Private Practice Code of Conduct.

Where a Consultant wishes to undertake private work and is not already committed to at least an 11 PA job plan (and the equivalent for part-time job plans with 1 additional PA pro rata), the Trust may offer an extra Direct Clinical Care PA to the Consultant and others in the same sub-specialty team. Anyone in the department may take up that additional PA. Where an extra PA is declined, and the Consultant continues to undertake the proposed private work, they may not be entitled to receive pay progression during the year in question. If the Trust requires a Consultant to reduce from an 11 PA or greater contract down to 10 PAs, this will not prejudice the Consultant's right to undertake private work. (Different arrangements exist in Wales).

6. Time shifting

In the new 2003 Consultant contract, there is no commitment on time shifting, e.g. for unscheduled SPA's and study leave and it is down to local negotiations. Time shifting allows consultants some flexibility in their timetable and allows the accommodation of unscheduled SPAs and other duties while protecting the capacity and effectiveness of the service.

Within a job plan a certain number of PA's are allocated to DCC, SPA, and External Duties/Professional Leave. Normally there is provision at individual job planning made for time to undertake all these duties and no payback is required.

If, however the cancelled activities are extra to this, or reduce the clinician's allocated commitment; the session should be paid back.

The key principles are that are that an individual cannot be paid twice for work done, and that flexible arrangements must not impact negatively on the efficient use of resources. The SPA/ED must be agreed and recorded through an approved departmental or trust process to protect both parties.

7. Annualisation

Many consultants (those with senior managerial responsibility, single parents, clinical academics etc.) do not have a working/domestic pattern that lends itself to preparing a job plan based on weekly activities. Both the consultant and the employing trust/health board (where applicable) may be best served by adopting a job plan that is wholly or partially annualised. A major advantage of an annualised job plan is that it will enable the trust to prospectively plan for seasonal activity peaks and troughs to meet demands and to have a clear understanding of the activities a consultant will deliver on a yearly basis.

Annualised job plans are likely to have some weekly fixed sessions and, in addition, will include the major responsibilities the individual will be expected to take on over the coming year and usually the relative amounts of time spent on each activity. The principles of job planning remain unchanged. The job plan should be a prospective document that sets out the requirements of the organisation and the priorities for the individual to meet those requirements. Like all other job plans it should include the objectives for the consultant, or team of consultants, and the support the organisation agrees to provide.
All, or part, of a job plan may need to be agreed on an annualised basis for the following reasons (the list is not exhaustive):

- Where a consultant has a significant managerial role (e.g. a full time medical director);
- Clinical variation;
- Social or domestic circumstances;
- Clinical academics.

As an example - an individual and the organisation may agree that during 28 weeks of school term time, an individual works an 11 PA job plan. In the remaining weeks only 8 PAs are worked, with the total amount being averaged over the year to derive a 10 PA job plan.

8. Criteria for Pay Thresholds*

It is normal for Consultants to achieve pay progression, but it is not automatic.

Following the annual job plan review, the clinical manager who has conducted the review will report the outcome, via the medical director, to the chief executive. The report will be copied to the consultant, and to the chief executive of any other NHS organisation with which the consultant holds a contract of employment. For the purposes of decisions on pay thresholds, the report will set out whether the consultant has:

- Made every reasonable effort to meet the time and service commitments in the job plan;
- Participated satisfactorily in the appraisal process;
- Participated satisfactorily in reviewing the job plan and setting personal objectives;
- Met the personal objectives in the job plan, or where this is not achieved for reasons beyond the consultant's control, made every reasonable effort to do so;
- Worked towards any changes identified in the last job plan review as being necessary to support achievement of the employing organisation's objectives;
- Taken up any offer to undertake additional PAs that the employing organisation has made to the consultant in accordance with Schedule 6 of the consultant contract (2003);
- Met the standards of conduct governing the relationship between private practice and NHS commitments set out in Schedule 9 of the consultant contract (2003).

*Different arrangements in Wales

9. Leave Entitlements

Leave is an entitlement but granting of leave is at the discretion of the Trust and must fit in with service delivery requirements.

9.1 Annual Leave

A week's annual leave for a full time consultant is 5 days or 10 PAs. For less than full time consultants many Trusts have an annual leave calculator to help. For example, for an 8PA job plan a week would be 4 days.

Consultants are entitled to annual leave at the following rates per year, exclusive of public holidays and extra statutory days:
Annual leave entitlement against number of years of completed service as a consultant:

- Up to seven years 30 days;
- Seven or more years 32 days, 33 days in Wales & Scotland.

The leave entitlements of consultants in regular appointment are additional to 8 public holidays and 2 statutory holidays or days in lieu thereof. The 2 statutory days may, by local agreement, be converted to a period of annual leave. In Scotland the statuary days do not exist.

In addition, a consultant who, in the course of his or her duty, was required to be present in hospital or other place of work between the hours of midnight and 9am on statutory or public holidays should receive a day off in lieu.

With less than full time working and the move to more flexible job plans, e.g. annualisation, and shift work, the calculation of leave has become more complex. There is a move in some trusts to try to produce equity of leave in the different work patterns by calculating leave using PA's or hours worked during the time taken. This is not covered in the consultant contract and tends to be a trust initiative.

9.2 Professional and Study Leave

This includes:

- Study, usually but not exclusively or necessarily on a course or programme, for CPD
- Research
- Teaching and assessment
- Examining or taking examinations
- Visiting clinics and attending professional conferences for CPD
- Training

The recommended standard for Consultants is leave with pay and expenses within a maximum of 30 days (including off-duty days falling within the period of leave) in any period of three years for professional purposes within the United Kingdom. Authorities may at their discretion grant professional or study leave outside the United Kingdom with or without pay and with or without expenses or with any proportion thereof (Consultant Contract 2003).
Additional days can be allocated at the discretion of the Medical Director or supervisor where appropriate.

For external professional duties see Section 4.

10. Clinical Academics

The Employment of Clinical Academic is determined by the principles of the Follett Review. Duties of a Clinical Academic should be set out in a single integrated job plan which covers both the whole of their professional duties for both the Trust and the University. A nominated representative of the Trust and the University should be present with the clinical academic at their job planning meeting. The job plan must be jointly agreed by all parties and must include the Clinical Academic's management and accountability arrangements for both employers.

SPAs for research Jobs that have a defined academic component are usually clear cut. Where SPAs are expected to contain a contribution to research that is specified, it is reasonable that the following commitment is required, depending on the size of research study (RCP 2017):

- acting as principal investigator 0.1–0.5 SPAs
- acting as chief investigator 0.1–1 SPAs
- research and good clinical practice (GCP) training 0.125 SPAs.

11. Mediation and Appeals

If at the end of the Job Planning process a consultant is unhappy they have the right to mediation and appeal and can take someone along with them e.g. LNC representative or BMA support. When disputing a Job Plan it is important to keep a diary to use in evidence of the work load undertaken (Appendix F – Job Planning Appeals Flowchart).

Where a job plan has not been agreed because it is in dispute, and is subject to ongoing mediation/appeals processes, the individual should not suffer any detriment in terms of deferred pay progression or eligibility for Clinical Excellence Awards. A consultant is not required to accept a job plan with which they do not agree, simply to avoid a sanction. Indeed, the contractual position, which is also reflected in the joint job planning guidance, indicates that individuals should have 'participated satisfactorily' in the job planning process.

11.1 Consultant Wellbeing

Occupational burnout is characterised by exhaustion, lack of enthusiasm and motivation, feelings of ineffectiveness, depersonalisation, frustration and cynicism. Excessive workload, excessive administrative workload, increasing supervision of medical and paramedical staff, decreased feeling of personal achievement and lack of institutional resources are key stressors. The current national shortage of consultant dermatologists makes this a particular risk.

Job planning is an important part of preventing burnout and this might include adding additional elements of DCC – for example a pre-clinic meeting to plan patient care.

12. Resource Documents

- British Association of Dermatologists and British Photodermatology Group. Working party report on Minimum Standards for Phototherapy Services .
- British Association of Dermatologists and British Society for Paediatric Dermatology. Working party report on Minimum Standards for Paediatric Services 2012.
- British Association of Dermatologists and British Society for Cutaneous Allergy. Working party report on Minimum Standards for Cutaneous Allergy Services.
- British Association of Dermatologists and Psychodermatology UK. Working party report on Minimum Standards for Psycho-Dermatology Services 2012.
- British Association of Dermatologists. *Staffing and facilities for dermatological units*. 2006.
- British Association of Dermatologists. *The role of teledermatology in the delivery of Dermatology services*. 2010.
- British Association of Dermatologists. *Demand management and follow up ratios in Dermatology*.
- British Association of Dermatologists Commissioning Dermatology Services.
- Quality Standards for Dermatology: providing the right care for people with skin conditions. 2011. http://www.pcc-cic.org.uk/sites/default/files/articles/attachments/quality standards for Dermatology report.pdf
- RCGP Guidance and Competences for GPs with Extended Roles in Dermatology and Skin Surgery 2018. http://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-reresources/~/link.aspx?_id=470EAAC8BC424303AF004D4B108FC158&_z=z
- RCGP Accreditation of GPs with Extended Roles Terms and Conditions 2018. http://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/~/link.aspx?_id=470EAAC8BC424303AF004D4B108FC158&_z=z
- RCP Consultant Wellbeing Survey 2017 - https://www.rcplondon.ac.uk/projects/outputs/consultant-physician-wellbeing-survey-2017
- NHS Employers / BMA Guide to Consultant Job Planning, July 2011.
- NHS Employers / BMA Guide to job planning for Specialty Doctors and Associate Specialists, November 2012.
- NHS Employers - Job Planning for Consultant Clinical Academics (July 2006) http://www.nhsemployers.org/~/media/Employers/Documents/Pay%20and%20reward/job_planning_clinical_academics_010308_aw.pdf
- NHS Employer - Job planning toolkit http://www.nhsemployers.org/your-workforce/pay-and-reward/medical-staff/consultants-and-dental-consultants/job-planning
- Consultant Grade Terms and Conditions of Service, Scottish Government Health Directorates.
- NHS Employer Terms and Conditions - Consultants (England) 2003 (Version 10, April 2018). This handbook sets out the terms and conditions of service for consultants on the 2003 contract. It incorporates all amendments as at 1 April 2018.
- NHS Employer Terms and conditions of service for specialty doctors - England (2008) (Version 4, April 2018)
- NHS Employer Contract of employment for specialty doctors and associate specialists (Version 2, April 2018)
- NHS Employers guide to contracting for APAs
- NHS Employers Consultant Contract Appeals Guidance
- NHS Employers consultant contract – frequently asked questions (March 2009) http://www.nhsemployers.org/~/media/Employers/Documents/Pay%20and%20reward/NHSE_Consultant_Contract_FAQs.pdf

ACKNOWLEDGEMENTS

The BAD Officers would like to express their gratitude to the Clinical Services Committee members and our Specialty Society Presidents for their input into producing the Guide to Job Planning for Dermatologists. This guidance will provide an invaluable resource for our dermatology members and their management teams.

Clinical Services Committee Members	Hospitals
Dr Tanya Bleiker - Chair and Clinical Vice President	Derby Teaching Hospitals NHS Foundation Trust
Dr David Alderdice	Ulster Hospital, Northern Ireland
Dr Kurt Ayerst - Co-op Dermatology CRG chair	Kent and Canterbury Hospital, Kent
Dr Bernadette De Silva	Luton & Dunstable University Hospital
Dr Karen Gibbon - BAD Honorary Secretary	Barts Health NHS Trust
Dr Bronwyn Hughes	Portsmouth Hospital
Dr Carolyn Charman - Co-op e-Referral lead	Royal Devon & Exeter NHS Foundation Trust
Dr Richard Mallett	North West Anglia NHS Foundation trust
Dr Jennifer Yell	Trafford General Hospital
Dr Aamir Butt	North Lincolnshire & Goole Hospital
Dr Chandra Bertram	Royal Infirmary of Edinburgh
Dr Shireen Velangi	University Hospitals Birmingham NHS Foundation Trust
Dr Anshoo Sahota - Private Practice Lead	Barts Health NHS Trust
Amanda Roberts – Patient Representative	N/A
Specialty Society Presidents	
Dr Vindy Gupta – President of British Society of Dermatology Surgeons (BSDS)	Salford Royal NHS Foundation Trust
Dr Jason Williams - President of British Society of Cutaneous Allergy (BSCA)	Salford Royal NHS Foundation Trust
Dr Lindsay Shaw - President of British Society of Paediatric Dermatologists (BSPD)	Bristol Royal Infirmary

Appendix A: Summary of a Dermatology Consultant Job Plan

Activity	Workload	Programmed activities (PAs)
Direct clinical care		
Ward rounds, day-care supervision, nurse clinic supervision, ward referrals in hospitals with contractual agreements	Referrals from hospital colleagues; inpatient bed numbers vary	0.5-1.5
General outpatient clinics	12 for new clinic (20 min/consultation) *or* 16 follow-ups (15 min) *or* combination	3-5
Skin surgery	Number of cases depending on complexity	0-2.5
Skin cancer MDT	Weekly or alternate weeks	0.25-1
Dermatopathology	Variable	0-0.5
On-call duties	Variable	0-1
Administration and Management DCC	direct patient care, review of results, communication with other healthcare	1.5-2
Specialist clinics	e.g. paediatric, patch testing, phototherapy, psoriasis, skin cancer	0-2
Travel	Variable	0-1
Total number of DCC PAs		**7.5-8.5**
Supporting professional activities (SPAs)		
Work to maintain and improve the quality of healthcare	1.5 minimum for revalidation if no teaching/research/trainee supervision/department management	1.5 - 2.5
Other NHS Hospital Responsibilities	Medical Direct/Clinical Director/Lead Consultant in specialty/Clinical Tutor	Local agreement with Trust
External Duties	Work for deaneries/Training Programme Director/Royal Colleges/Specialist Societies/DH or other government bodies	Time for this has been agreed by NHS leaders

Appendix B – Generic Clinic Timetable

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	General OPD *Base Hospital* Including 30 minutes administration	Patient Administration *Base Hospital*	Ward Round & Referrals *Base Hospital*	Specialist/ General Clinic *Base Hospital* Including 30 minutes administration	Community OPD *Community Hospital* Including 60 minutes travel time PLUS 30 minutes administration
	08:30-12:30	08:30-12:30	09:00-12:30	08:30-12:30	08:00-12:30
PM	Surgical List *Base Hospital*	General OPD *Base Hospital* Including 30 minutes administration	Teaching *Base Hospital*	CPD /Audit *Base Hospital or Home*	MDT *Base Hospital* 13:00-15:00 Service Development *Base Hospital* 15:00-17:00
	13:00-17:00	13:00-17:00	13:00-17:00	13:00-17:00	13.00-17.00

Appendix C – Job Planning Appeals Flowchart