# NHS Golden Jubilee

### **Meeting: NHS Golden Jubilee Board**

### **Meeting date: 25 May 2023**

### **Title: Service Planning and Job Planning in NHS GJ**

### **Responsible Executive/Non-Executive: Mark MacGregor, Medical Director**

### **Report Author: Mark MacGregor, Medical Director**

## 1 Purpose

### This is presented to the Committee for:

* Awareness

### This report relates to a:

* Legal requirement
* Local policy

### This aligns to the following NHSScotland quality ambition(s):

* Safe

## 2 Report summary

### 2.1 Situation

This report is being provided to the Board to make members aware of the Service Planning and Job Planning in NHS Golden Jubilee.

### 2.2 Background

* 1. Prospective annual job planning for consultants[[1]](#footnote-1), specialists[[2]](#footnote-2) and specialty doctors[[3]](#footnote-3) is a contractual requirement for doctors and their employers.
	2. The purpose is to agree duties and their time commitments, together with objectives for the coming year. This process was designed to ensure that doctors did not have unreasonable workloads, but also to ensure that they met their commitments.
	3. Time is allocated in 4 hour blocks referred to as Programmed Activities (PAs). PAs can be:
		1. Direct clinical care (DCC) for direct patient care (including clinical administration).
		2. Supporting professional activities (SPA) such as clinical governance, medical education or research.
		3. Additional responsibilities (AR) – formal roles for the NHS which are beyond the normal range of consultant activities, such as Clinical Director.
		4. External duties (ED) – duties for external bodies such as GMC, BMA, Royal Colleges – may be externally funded, but not always.
	4. A standard full time job plan consists of 10 PAs, equating to 40 hours. Each PA should be delivered 42 times per year, but the PAs can be averaged over the course of a year (“annualisation”). PAs over 10, are called Extra Programmed Activities (EPAs) and can be discontinued with 3 months’ notice on either side.
	5. Failure to implement job plans can lead to mistrust on both sides. It leaves a lack of clarity about expectations and often leaves problems undiscovered, and so unresolved. In the event of a dispute or disciplinary process, absent or out of date job plans leave the employer at a considerable disadvantage.
1. **Service Planning**
	1. Job planning involves a discussion between the individual doctor and their medical line manager, where the doctor states what they want to change in their job plan and the line manager states what the service needs. After negotiation, this should lead to a mutually agreed job plan. Whilst the aim of job planning is to agree a prospective working pattern which is mutually acceptable to the organisation and the individual, there are some cases where conflicting priorities may lead to a more adversarial approach. Also a purely individualised approach may lead to imbalances and inequities developing across a team.
	2. Service planning provides a neutral context for teams by designing the service around the needs of patients and brings consultants and managers together to agree priorities, manage demand and plan for future service development. It is a transparent process and provides a forum to raise concerns and gain consensus.
	3. Individual job planning is informed by the service plan, and the consultant’s scope of practice.

The British Medical Association and NHS GJ Local Negotiating Committee are supportive of the concept of service planning.

1. **Local Implementation of Service Planning**
	1. At NHS GJ we implemented service planning in 2020, and this year was the third iteration (2021-22 was omitted due to the pandemic). It has evolved into a four step process.
		1. Collate data on demand and funded capacity (typically September each year). The clinical director (CD) together with the service manager agree the demand and funded job plan capacity for the coming year. This is based on previous year’s demand and capacity, any unmet demand or waiting list initiative (WLI) expenditure; and any known or expected expansion (eg normal rate of growth, new commitment to another board).
		2. The CD presents the data as a draft service plan to the consultant/SAS team for discussion (October-November). Do the data seem correct? Are the balances between priorities appropriate? Are there new activities the team wish to develop? After discussion and agreement amongst the consultants/SAS team and the operational team (which may take more than one meeting) the CD finalises the service plan. There is likely to be a demand-capacity mismatch, usually excess demand. The team should agree how to address that for the coming year: discontinuing activities, transferring activities to other less costly staff groups, recruitment, EPAs, waiting list initiatives (WLIs should only be used for temporary situations). This information feeds into the recruitment and finance plans. The team agree how to divide up specific roles and activities amongst themselves.
		3. The CD and service manager present the service plan to the Divisional Director, Associate Medical Director and the Associate Director of Finance for approval (late November).
		4. The CD and service manager present the service plan to the Executive Leadership Team for approval (December).
		5. The CD meets with individual consultants/SAS and agrees job plan (January – February). Any mediations or appeals should be dealt with in March.

1. **Goals for 2023-24 Job Planning Round**
	1. **Timely and accurate job plans.** All job plans should be completed (signed off by all parties) by 31st March 2023. Ensure DCC in job plans is a realistic representation of the clinical work performed by the service.
	2. **Consistent job plans.** The use of service plans ensures agreed and equitable approaches for all doctors. Start and finish times of fixed sessions need to be consistent. A new national rostering system will be brought in later in the year, and applies to all staff. The system links in to the job planning system, and inaccurate variation in theatre or clinic start times may create problems. An SPA budget is allocated to each department equating to 2 PAs per consultant or SAS (see Appendix 1).
	3. **On-call entry in Allocate.** New on-call templates have been created in Allocate to minimise the risk of errors. These will replace all prior on-call entries used.
	4. **Work-life balance – 48 hour maximum.** CDs have been asked to take all doctors exceeding 48 hours down to a maximum of 48 hours per week (12 PAs for most)[[4]](#footnote-4). This is about protecting work-life balance, not cost-saving: any money freed up will be recycled into new posts. Approval to exceed 12 PAs requires AMD/MD approval. Approval is only likely to be given if A. there is a clear and deliverable plan to reduce to 48 hours in the future and it is essential for the clinical service to exceed 48 hours in the meantime, or B. there are specific characteristics of the service provided that make it impossible to deliver within the conventional 48 hour job plan.
	5. **Premium pay exception to 48 hours maximum.** Premium pay (for work outside 08:00-20:00 M-F) will, from 1st April, 2023, be paid as 1 PA for 3 hours, and there will be no associated premium supplement. This can create issues that cause a job plan to exceed 12 PAs. As this is purely down to an administrative change, we will accept job plans of 12.5 PAs for this year where that has been caused by the premium pay issue.
	6. **Clinical Leadership exception to 48 hours maximum.** All of our clinical directors practice in craft specialties, where maintenance of a certain volume of hands-on experience is essential for clinical performance (and credibility). However, clinical management also requires commitment of time. Balancing these two requirements has proven challenging as we reduce to a 48 hours maximum. CDs receive 3 PAs for the role (in addition to 1 SPA for personal requirements related to appraisal etc), compared to a typical consultant on 2 SPA. We have therefore agreed that CDs may have 1 PA over the amount agreed for their team. This means that they must only sacrifice one DCC PA of clinical activity compared to their consultant team, within a 52 hour week.
2. **Progress**
	1. Notification to commence service planning was issued to CDs and service managers on 16th October 2022, together with guidance, templates and required timelines. The completed service plans were presented to the Executive Directors Group on 19th December, 2023 and approved.
	2. The status as of 31st March, 2023 is described below for service plans (Table 1). An example service plan is shown in Appendix 2.
	3. Notification to commence job planning was issued to CDs, service managers and consultants on 24th February, 2023. This was delayed by 8 weeks from the usual 1st January, due to a payroll issue.
	4. The status as of 30th April, 2023 is described below for job plans (Table 2).
	5. Two job plans from the prior year (2022-23) remained incomplete at 31st March, 2023. One doctor remains in dispute over the job plan and the mediation process has been inappropriately protracted. The other doctor was not engaging with the process, but has now signed off his job plan on 15th March, 2023.

**Table 1. Current status of 2023-24 Service Plans (31/03/23)**

|  |  |
| --- | --- |
| **Department** | **Service Plan Status** |
| Interventional Cardiology | Approved EDG 19/12/23 |
| Electrophysiology & Devices | Approved EDG 19/12/23 |
| SACCS | Approved EDG 19/12/23 |
| SNAHFS (Cardiology) | Approved EDG 19/12/23 |
| Cardiac Surgery | Approved EDG 19/12/23 |
| SNAHFS (Surgery) | Approved EDG 19/12/23 |
| Thoracic Surgery | Approved EDG 19/12/23 |
| Anaesthetics (Cardiothoracic) | Approved EDG 19/12/23 |
| Anaesthetics (Orthogeneral) | Approved EDG 19/12/23 |
| General Surgery | Approved EDG 19/12/23 |
| Ophthalmology | Approved EDG 19/12/23 |
| Orthopaedics | Approved EDG 19/12/23 |

**Table 2. Current status of 2023-24 Job Planning Round (30/04/23)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Department** | **N** | **Discussion** | **Awaiting 1st Sign-Off CD** | **Awaiting 1st Sign-Off Doctor** | **Awaiting 2nd Sign-Off AMD** | **Awaiting 3rd Sign-Off****MD** | **Signed Off** |
| AMDs | 2 | 1 |  |  |  |  | 1 |
|  CDs-HLD | 2 | 2 |  |  |  |  |  |
|  Cardiology | 24 | 9 |  | 9 | 6 |  |  |
|  C/T Surgery | 21 | 11 | 5 | 3 | 2 |  |  |
|  Other | 2 | 1 | 1 |  |  |  |  |
| **HLD Total** | **49** | **24****(49%)** | **6****(12%)** | **12****(24%)** | **8****(16%)** | **0** | **0** |
|  CDs-NES | 3 | 1 |  | 1 |  | 1 |  |
|  Anaesthetics | 37 | 11 | 1 | 9 | 9 |  | 7 |
|  General Surgery | 3 |  |  | 1 | 1 | 1 |  |
|  Ophthalmology | 8 |  |  | 2 |  | 1 | 5 |
|  Orthopaedics | 19 | 1 |  | 9 | 6 |  | 3 |
| **NES Total** | **70** | **13****(19%)** | **1****(1%)** | **22****(31%)** | **16****(23%)** | **3****(4%)** | **16****(23%)** |
| **GJ Total** | **121** | **37****(31%)** | **7****(6%)** | **34****(28%)** | **24****(20%)** | **3****(2%)** | **16****(13%)** |

1. **Successes and Failures**
	1. All department’s service plans were completed and presented on time. It remains uncertain whether there is genuine team engagement with the process across all departments. While understanding of the process and its relevance is growing, it is not universal. Time pressures also create challenges.
	2. An original aspiration of service planning at NHS GJ was to enhance the clinical voice feeding into organisational planning. The timescales of our process link in well with the Annual Delivery Plan, and give early sight of departmental pressures and aspirations for the coming year. Linkage with the finance team is less well-developed, with clinical teams having limited understanding of their income streams, budgets and expenditures.
	3. There has been variation in departmental approaches to presenting expanding services (including the phase 2 expansion) and proposed new services. This has led to frustration for teams who feel that they have presented new priorities but not had them approved, and challenge for the executive team in prioritisation of funding, ensuring that it aligns with overall strategy and priorities for other professions and non-clinical services.
	4. In 2022-23, 69 job plans were signed off prospectively by 31st March, 2022. This was a substantial improvement on previous years, as essentially no job plans had been signed off prospectively prior to that. This year, overall performance of job planning has deteriorated significantly primarily due to payroll issues which delayed the start of the job planning process by eight weeks, while the deadline for completion was only extended by four weeks. CD vacancies, illness and other issues have played a part (affecting 4 of 6 CDs), though interim and deputy CDs have made excellent contributions given the constraints on them.
	5. Converting service plans into job plans remains a significant administrative burden. This is despite increased experience of most CDs and consultants, and the fact that almost all consultants had completed job plans from the previous year. Administrative support to CDs may be more efficient and ensure a consistent approach across the organisation.
	6. There are 24 consultants on >12.5 PAs, of which 10 are on >13 PAs, and none >14 PAs. This represents an improvement compared to previous years. As job planning is still ongoing these numbers are expected to come down. Three will be addressed by a new appointment within the next few months.
	7. There are 24 doctors on high frequency rotas (1 in 4 or more frequent). Five will be addressed by a new appointment within the next few months. Although frequent, 10 are low intensity (on-call <1 PA). Nine relate to the cardiac transplant service.
	8. There has been increasing understanding of the features of *Allocate eJobPlan*, which has helped to improve accuracy and consistency. The on-call templates are now established centrally by HR, which reduces the administrative burden on CDs and consistency within teams. Standard reports are allowing quick review of consistency of job plan allocations within teams, and consistency with the approved service plan.
	9. The Board’s Internal Auditors completed an audit of the 2022-23 process and identified two medium risk areas:
		1. Training in the service planning, job planning and the use of *Allocate eJobPlan*
		2. Incomplete job plans by deadline

 These are consistent with our own assessment, and future plans.

1. **Plan for Future**
	1. Vigorous efforts will be made to ensure completion of 2023-24 job plans by 31 May, 2023, including use of escalation processes if necessary.
	2. Proposed Changes for 2024-25
		1. We will deliver a further interactive seminar to CDs and service managers on service planning in August 2023. We will also create a video to describe the intention and benefits behind service planning for sharing with all consultants and SAS doctors. Formal training for CDs and HR staff on *eJobPlan* is being sought from *RLDatix* (the company behind the software).
		2. The Medical Director will work with the Director of Finance to improve the linkage with financial planning and so improve the understanding of the clinical teams of financial planning.
		3. The Director of Strategy, Planning & Performance is further developing the planning cycle so that developments arising from service plans can be appropriately prioritised, approved, deferred or declined.
		4. The implementation of eRostering is associated with a staff budget, and at least some of that may be able to contribute to support of CDs in the development and input of job plans. This should improve timeliness and consistency.
		5. We will aim to bring most doctors to ≤48 hour week (≤52 hours for CDs) by active recruitment. High frequency rotas will be addressed through additional recruitment or service redesign where feasible.

**Mark MacGregor**

**Medical Director**

**29 April 2023**

**Appendix 1. Indicative Departmental SPA Budgets**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Cardiology** | **Cardiothoracic** | **Anaesthetics** | **Orthopaedics** | **Ophthalmology** | **Gen Surgery** | **Other\*** | **TOTAL** |
| Consultants (headcount) | 25 | 16 | 35 | 19 | 8 | 4 | 3 | 110 |
| SAS (headcount) | 1 | 6 | 3 | 1 | 0 | 0 | 0 | 11 |
| Personal SPA | 26 | 22 | 38 | 20 | 8 | 4 | 3 | 121 |
| CDǂ | 3 | 3 | 3 | 3 | 3 | 3 | - | 18 |
| Dep CD/Leads[[5]](#footnote-5) | 2 | 2 | 4 | 2 | - | - | - | 10 |
| NSD Leads | 2 | - | - | - | - | - | - | 2 |
| Clin Governance | 1 | 1 | 2 | 1 | 1 | 0.5 | - | 6.5 |
| Audit | 1 | 1 | 2 | 1 | 1 | 0.5 | - | 6.5 |
| QI | 1 | 1 | 2 | 1 | 0 | 0.5 | - | 5.5 |
| Appraisal | 3 | 2 | 2.5 | 2 | 0.5 | 0.5 | 0.5 | 11 |
| Med Ed | 1 | 1 | 2 | 1 | 0 | - | - | 5 |
| Educational Supervision | 2 | 4.5 | 3.5 | 3.5 | 0.5 | 0.5 | - | 14.5 |
| **TOTAL** | **40** | **35.5** | **57** | **32.5** | **12** | **7.5** | **3.5** | **188** |
| **Remainder** | **12** | **8.5** | **19** | **7.5** | **1** | **0.5** | **2.5** | **51** |

ǂ 2 PAs of each CD’s SPA comes from corporate budget; \*Medical Microbiology, Radiology, Gastroenterology

* The departmental SPA budget is fixed at 2 PAs per consultant/SAS (0.5 PAs for those on ≤2 PAs; 1 PA for those on >2-<5 PAs). Individuals may receive more or less than this depending on their contribution to these activities.
* The amounts for each purple shaded activity are indicative, and can be amended by the CD in discussion with the AMD. The “Remainder” SPA can be invested by the CD in any reasonable activity in discussion with the AMD eg research or education.
* In addition, departments have:
	+ 31.25 corporate SPA (AMD 10 PAs, appraisal lead 1 PA, DME 2 PAs, R&D director 1 PA, LNC chair 1 PA and 2 of the 3 CD PAs amounting to 12 PAs; R&D: 4 PAs for research; Phase 2: 0.25 PAs)
	+ 12.5 externally funded PAs (Scottish Government: 2 PAs for Realistic Medicine, 1 PA for clinical lead for organ donation; NES: 4 PAs for undergraduate teaching via ACT funds, 0.5 PA for an Academy role; CSO: 2 PAs NRS research fellowship; Royal College of Anaesthetists: 1 PA for research; Stryker: 2 PAs for research)

**Appendix 2. Example Service Plan: Cardiothoracic Anaesthesia**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Duration (hrs/d)** | **Premium Adjust** | **Wkly Frequency** | **No (of eg Theatres)** | **Annual Hours** | **Wkly PAs** | **%** |
| **On-call** |  |  |  |  |  |  |  |
| ICU predictable | 3 | 1 | 5 | 1 | 782 | 5 | 2% |
| ICU predictable | 2 | 1.3 | 5 | 1 | 695 | 4 | 2% |
| ICU unpredictable | 4 | 1.3 | 7 | 1 | 1,947 | 12 | 6% |
| CT Anaesthesia unpredictable | 4 | 1.3 | 7 | 1 | 1,947 | 12 | 6% |
| ICU weekends predictable | 15 | 1.3 | 2 | 1 | 2,086 | 12 | 6% |
| **Ward Rounds/Cover** |  |  |  |  |  |  |  |
| ICU1/Senior on/HDUs | 11 | 1 | 5 | 1 | 2,805 | 17 | 8% |
| ICU2 | 10 | 1 | 5 | 1 | 2,607 | 16 | 7% |
| **Theatres** |  |  |  |  |  |  |  |
| Cardiac (4) | 12 | 1 | 5 | 4 | 11,829 | 70 | 34% |
| Thoracic (2) | 12 | 1 | 5 | 2 | 5,914 | 35 | 17% |
| Cath lab (TAVI, SACCS + EP) | 11 | 1 | 1 | 3 | 1,626 | 9.7 | 5% |
| Lead Extraction | 11 | 1 | 0.5 | 1 | 271 | 1.6 | 1% |
| **Clinics/MDTs etc** |  |  |  |  |  |  |  |
| Pre-op Assessment | 8 | 1 | 4 | 1 | 1,577 | 9 | 4% |
| High Risk MDT | 2 | 1 | 0.25 | 1 | 26 | 0.2 | 0.1% |
| SNAHFS MDT | 2 | 1 | 1 | 3 | 296 | 2 | 1% |
| SACCS MDT | 3 | 1 | 1 | 2 | 296 | 2 | 1% |
| ICU MDT | 2 | 1 | 0.5 | 10 | 493 | 2.9 | 1% |
| **TOTAL** |  |  |  |  | **35,196** | **210** | **100%** |

* Available DCC PAs from current staff 188 PAs
* Deficit of 22 PAs equating to 3 WTE
* Service plan assumes full cover of all CT theatres (no WLI)
* Deficit of 22 PAs equates to:
	+ 924 sessions per year
	+ 308 theatre days (1.3 theatres over a year)
	+ WLI spend of £743k pa
	+ Sufficient to appoint 5 consultants

 **2.4 Recommendation**

Staff Governance and Person Centred Committee are asked to note this update for awareness.

1. Consultant Grade: Terms and Conditions of Service 2004, as subsequently amended. [↑](#footnote-ref-1)
2. Terms & Conditions of Service – Specialist Doctor in Scotland 2022. [↑](#footnote-ref-2)
3. Terms & Conditions of Service – Specialty Doctor in Scotland 2022. [↑](#footnote-ref-3)
4. Out of hours PAs are recorded as 1 PA for 3 hours (premium rate pay). In those circumstances it may be possible to have more than 12 PAs, while still working ≤48 hours per week. [↑](#footnote-ref-4)
5. The number of leads is based on the Dunbar number (5-9 direct reports). Dunbar R (1992) Neocortex size as a constraint on group size in primates. *J Hum Evol* 22: 469-93. [↑](#footnote-ref-5)