- private commitments are rearranged where there is regular disruption of this kind to NHS work; and private commitments do not prevent them from being able to attend a NHS emergency while they are on call for the NHS, including any emergency cover that they agree to provide for NHS colleagues. In particular, private commitments that prevent an immediate response should not be undertaken at these times.

2.5 Effective job planning should minimise the potential for conflicts of interests between different commitments. Regular private commitments should be noted in a consultant's job plan, to ensure that planning is as effective as possible.

2.6 There will be circumstances in which consultants may reasonably provide emergency treatment for private patients during time when they are scheduled to be working or are on call for the NHS. Consultants should make alternative arrangements to provide cover where emergency work of this kind regularly impacts on NHS commitments.

2.7 Where there is a proposed change to the scheduling of NHS work, the employer should allow a reasonable period for consultants to rearrange any private sessions, taking into account any binding commitments entered into (e.g. leases).

Provision of Private Services alongside NHS Duties

2.8 In some circumstances NHS employers may at their discretion allow some private practice to be undertaken alongside a consultant's scheduled NHS duties, provided that they are satisfied that there will be no disruption to NHS services. In these circumstances, the consultants should ensure that any private services are provided with the explicit knowledge and agreement of the employer and that there is no detriment to the quality or timeliness of services for NHS patients.

Information for NHS Patients about Private Treatment

2.9 In the course of their NHS duties and responsibilities consultants should not initiate discussions about providing private services for NHS patients, nor should they ask other NHS staff to initiate such discussions on their behalf.

2.10 Where a NHS patient seeks information about the availability of, or waiting times for, NHS and/or private services, consultants should ensure that any information provided by them, is accurate and up-to-date and conforms with any local guidelines.

2.11 Except where immediate care is justified on clinical grounds, consultants should not, in the course of their NHS duties and responsibilities, make arrangements to provide private services, nor should they ask any other NHS staff to make such arrangements on their behalf unless the patient is to be treated as a private patient of the NHS facility concerned.

Referral of Private Patients to NHS Lists

2.12 Patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient.

2.13 Where a patient wishes to change from private to NHS status, consultants should help ensure that the following principles apply:

- a patient cannot be both a private and a NHS patient for the treatment of one condition during a single visit to a NHS organisation;
- any patient seen privately is entitled to subsequently change his or her status and seek treatment as a NHS patient;
- any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status;
- patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients; and
- should a patient be admitted to an NHS hospital as a private inpatient, but subsequently decide to change to NHS status before having received treatment, there should be an assessment to determine the patient's priority for NHS care.

Promoting Improved Patient Access to NHS Care and Increasing NHS Capacity

2.14 Subject to clinical considerations, consultants should be expected to contribute as fully as possible to maintaining a high quality service to patients, including reducing waiting times and improving access and choice for NHS patients. This should include co-operating to make sure that patients are given the opportunity to be treated by other NHS colleagues or by other providers where this will maintain or improve their quality of care, such as by reducing their waiting time.

2.15 Consultants should make all reasonable efforts to support initiatives to increase NHS capacity, including appointment of additional medical staff.

Part III – Managing Private Patients in NHS Facilities

3.1 Consultants may only see patients privately within NHS facilities with the explicit agreement of the responsible NHS organisation. It is for NHS organisations to decide to what extent, if any, their facilities, staff and equipment may be used for private patient services and to ensure that any such services do not interfere with the organisation's obligations to NHS patients.

3.2 Consultants who practise privately within NHS facilities must comply with the responsible NHS organisation's policies and procedures for private practice. The NHS organisation should consult with all consultants or their representatives, when adopting or reviewing such policies.

Use of NHS Facilities

3.3 NHS consultants may not use NHS facilities for the provision of private services without the agreement of their NHS employer. This applies whether private services are carried out in their own time, in annual or unpaid leave, or – subject to the criteria in paragraph 2.8 - alongside NHS duties.

3.4 Where the employer has agreed that a consultant may use NHS facilities for the provision of private services:

- the employer will determine and make such charges for the use of its services, accommodation or facilities as it considers reasonable;

- any charge will be collected by the employer, either from the patient or a relevant third party; and

- a charge will take full account of any diagnostic procedures used, the cost of any laboratory staff that have been involved and the cost of any NHS equipment that might have been used.

3.5 Except in emergencies, consultants should not initiate private patient services that involve the use of NHS staff or facilities unless an undertaking to pay for those facilities has been obtained from (or on behalf of) the patient, in accordance with the NHS body's procedures.

3.6 In line with the standards in Part II, private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients. Only in unforeseen and clinically justified circumstances should an NHS patient's treatment be cancelled as a consequence of, or to enable, the treatment of a private patient.

Use of NHS Staff

3.7 NHS consultants may not use NHS staff for the provision of private services without the agreement of their NHS employer.

3.8 The consultant responsible for admitting a private patient to NHS facilities must ensure, in accordance with local procedures, that the responsible manager and any other staff assisting in providing services are aware of the patient's private status.

18. APPENDIX 3 - PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM

Southern Health and Social Care Trust
Quality Care - for you, with you

PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM

Private Patient: Yes ☐ No ☐ **Non-Ordinarily Resident in UK:** Yes ☐ No ☐

Name of Patient:			
Address:			
Postcode:	Telephone No:		
Date of Birth:			
H&C Number:			
Name of Insurer:		**Self Funding**	☐
Insurer Policy No:			

I have been seeing this person as a private patient. They are to be admitted / referred to _____ Hospital on _____ as an _____

Inpatient Referral	☐	**Obstetrics** ☐ Estimated Duration of Stay	**Medical** ☐ Estimated Duration of Stay	**Surgical** ☐ Estimated Duration of Stay	**T & O** ☐ Estimated Duration of Stay
Day Case Referral	☐				
Diagnostics (Inpatient or Outpatient)	☐	**Laboratory** ☐ [please detail]	**Radiology** [pleas ☐ detail]	**Other** [e.g. ☐ Pharmacy]	

Undertaking to Pay Confirmation To be completed by Consultant			
I have advised the patient named above of the estimated hospital charges and of my fees			
Signed Consultant		**Date**	
Undertaking to Pay To be completed by the person who will pay the account			
I understand and agreed to pay Southern Health and Social Care Trust all charges[1] associated with this episode of care[2] .Where the Consultant may deem further procedures/investigations necessary which will incur additional charges, I understand that this may result in a different cost from that quoted to me and I undertake to pay the full costs incurred.			
Signed Patient		**Date**	

RETURN TO PAYING PATIENTS OFFICE CRAIGAVON AREA HOSPIAL/DAISY HILL HOSPITAL [email:payingpatients@southerntrust.hscni.net]

[1] A list of Tariffs is available from the Private Patients office

[2] Episode of Care – The total treatment of either an inpatient or day case patient from diagnosis through to discharge

Southern Health and Social Care Trust - A Guide to Paying Patients

19. APPENDIX 4 APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

Southern Health and Social Care Trust
Quality Care - for you, with you

APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

Name of Patient:	
Address:	
Postcode:	
Date of Birth:	
H&C Number:	
Name of Consultant	
Date of Last Private Consultation	

I have been seeing this person as a private patient. He/she has now been referred to Hospital as an NHS patient.

		Clinical Priority
Inpatient Referral	☐	
Outpatient Referral	☐	
Day Case Referral	☐	

Signed Consultant	
Effective Date	

Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in A Code of Conduct for Private Practice.

PLEASE FORWARD TO PAYING PATIENTS OFFICE [paying.patients@southerntrust.hscni.net]

20. APPENDIX 5 PRINCIPLES GOVERNING RECEIPT OF ADDITIONAL FEES – SCHEDULE 11

Principles Governing Receipt of Additional Fees - Schedule 11

1. In the case of the following services, the consultant will not be paid an additional fee, or - if paid a fee - the consultant must remit the fee to the employing organisation:

- any work in relation to the consultant's Contractual and Consequential Services;
- duties which are included in the consultant's Job Plan, including any additional Programmed Activities which have been agreed with the employing organisation;
- fee paying work for other organisations carried out during the consultant's Programmed Activities, unless the work involves minimal disruption and the employing organisation agrees that the work can be done in HPSS time without the employer collecting the fee;
- domiciliary consultations carried out during the consultant's Programmed Activities;
- lectures and teaching delivered during the course of the consultant's clinical duties;
- delivering lectures and teaching that are not part of the consultant's clinical duties, but are undertaken during the consultant's Programmed Activities.
- Consultants may wish to take annual leave [having given the required 6 week notice period] to undertake fee paying work [e.g. court attendance] in this instance the consultant would not be required to remit fees to the Trust.

This list is not exhaustive and as a general principle, work undertaken during Programmed Activities will not attract additional fees.

2. Services for which the consultant can retain any fee that is paid:

- Fee Paying Services carried out in the consultant's own time, or during annual or unpaid leave;
- Fee Paying Services carried out during the consultant's Programmed Activities that involve minimal disruption to HPSS work and which the employing organisation agrees can be done in HPSS time without the employer collecting the fee;
- Domiciliary consultations undertaken in the consultant's own time, though it is expected that such consultations will normally be scheduled as part of Programmed Activities1;
- Private Professional Services undertaken in the employing organisation's facilities and with the employing organisation's agreement during the consultant's own time or during annual or unpaid leave;
- Private Professional Services undertaken in other facilities during the consultant's own time, or during annual or unpaid leave;
- Lectures and teaching that are not part of the consultant's clinical duties and are undertaken in the consultant's own time or during annual or unpaid leave;

- Preparation of lectures or teaching undertaken during the consultant's own time irrespective of when the lecture or teaching is delivered.

This list is not exhaustive but as a general principle the consultant is entitled to the fees for work done in his or her own time, or during annual or unpaid leave.

And only for a visit to the patient's home at the request of a general practitioner and normally in his or her company to advise on the diagnosis or treatment of a patient who on medical grounds cannot attend hospital.

21. APPENDIX 6 - UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED

Southern Health and Social Care Trust
Quality Care - for you, with you

UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED

Name of Patient:	
Address:	
Postcode:	
Date of Birth:	
Hospital Number:	

Site: Craigavon ☐ Daisy Hill ☐

I was allocated an amenity bed on (date): _____ **(time)**

Ward: _____ **Consultant:** _____

I undertake to pay the Southern Health Social Care Trust £39 per night for an amenity bed, which has been provided for me at my request.

Number of days Amenity Bed required: _____

I understand that if I am required to stay in hospital more days than anticipated, the midwifery staff will ask me if I wish to continue and pay for the amenity bed, or if I wish to be transferred to the open ward.

Patient's Signature: _____ **Date:** _____

Midwife's Signature: _____ **Date:** _____

To be completed by WARD CLERK OR MIDWIFE when patient is being transferred /discharged from an amenity bed.

Date transferred / discharged from amenity bed _____

Signed by midwife / ward clerk when transferred / discharged _____

22. APPENDIX 7 – AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES

HSC Southern Health and Social Care Trust
Quality Care - for you, with you

AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES

I *(name)* _____

Request that any monies due to me from patients in relation to fees from
(description of activity)

_____

_____

_____

_____

_____

_____

_____

Shall be transferred to *(Charity title and reference)* _____

For its sole use in the advancement of its aims in accordance with the Trust Deed until directed otherwise by me in writing.

This request is to take effect from (date*):* _____

Signed, sealed and delivered by: _____
(Full name in BLOCK CAPITALS)

Date: _____

In the presence of: _____

Date: _____

Address:: _____

_____

_____

_____ **Postcode:** _____

_____

23. APPENDIX 8 - PROVISIONS GOVERNING THE RELATIONSHIP BETWEEN HPSS WORK AND PRIVATE PRACTICE - SCHEDULE 9

1. This Schedule should be read in conjunction with the 'Code of Conduct for Private Practice', which sets out standards of best practice governing the relationship between HPSS work and private practice.

2. The consultant is responsible for ensuring that their provision of Private Professional Services for other organisations does not:

   - result in detriment to HPSS patients;
   - diminish the public resources that are available for the HPSS.

Disclosure of information about Private Commitments

3. The consultant will inform his or her clinical manager of any regular commitments in respect of Private Professional Services or Fee Paying Services. This information will include the planned location, timing and broad type of work involved.

4. The consultant will disclose this information at least annually as part of the Job Plan Review. The consultant will provide information in advance about any significant changes to this information.

Scheduling of Work and Job Planning

5. Where a conflict of interest arises or is liable to arise, HPSS commitments must take precedence over private work. Subject to paragraphs 10 and 11below, the consultant is responsible for ensuring that private commitments do not conflict with Programmed Activities.

6. Regular private commitments must be noted in the Job Plan.

7. Circumstances may also arise in which a consultant needs to provide emergency treatment for private patients during time when he or she is scheduled to be undertaking Programmed Activities. The consultant will make alternative arrangements to provide cover if emergency work of this kind regularly impacts on the delivery of Programmed Activities.

8. The consultant should ensure that there are arrangements in place, such that there can be no significant risk of private commitments disrupting HPSS commitments, e.g. by causing HPSS activities to begin late or to be cancelled. In particular where a consultant is providing private services that are likely to result in the occurrence of emergency work, he or she should ensure that there is sufficient time before the scheduled start of Programmed Activities for such emergency work to be carried out.

9. Where the employing authority has proposed a change to the scheduling of a consultant's HPSS work, it will allow the consultant a reasonable period in line with Schedule 6, paragraph 2 to rearrange any private commitments. The employing organisation will take into account any binding commitments that the consultant may have entered into (e.g. leases). Should a consultant wish to reschedule private commitments to a time that would conflict with Programmed Activities, he or she should raise the matter with the clinical manager at the earliest opportunity.

Scheduling Private Commitments Whilst On-Call

10. The consultant will comply with the provisions in Schedule 8, paragraph 5 of these Terms and Conditions. In addition, where a consultant is asked to provide emergency cover for a colleague at short notice and the consultant has previously arranged private commitments at the same time, the consultant should only agree to provide such emergency cover if those private commitments would not prevent him Or her returning to the relevant HPSS site at short notice to attend an emergency. If the consultant is unable to provide cover at short notice it will be the employing organisation's responsibility to make alternative arrangements and the consultant will suffer no detriment in terms of pay progression as a result.

Use of HPSS Facilities and Staff

11. Where a consultant wishes to provide Private Professional Services at an HPSS facility he or she must obtain the employing organisation's prior agreement, before using either HPSS facilities or staff.

12. The employing organisation has discretion to allow the use of its facilities and will make it clear which facilities a consultant is permitted to use for private purposes and to what extent.

13. Should a consultant, with the employing organisation's permission, undertake Private Professional Services in any of the employing organisation's facilities, the consultant should observe the relevant provisions in the 'Code of Conduct for Private Practice'.

14. Where a patient pays privately for a procedure that takes place in the employing organisation's facilities, such procedures should occur only where the patient has given a signed undertaking to pay any charges (or an undertaking has been given on the patient's behalf) in accordance with the employing organisation's procedures.

15. Private patients should normally be seen separately from scheduled HPSS patients. Only in unforeseen and clinically justified circumstances should a consultant cancel or delay an HPSS patient's treatment to make way for his or her private patient.

16. Where the employing organisation agrees that HPSS staff may assist a consultant in providing Private Professional Services, or provide private services on the consultant's behalf, it is the consultant's responsibility to ensure that these staff are aware that the patient has private status.

17. The consultant has an obligation to ensure, in accordance with the employing organisation's procedures, that any patient whom the consultant admits to the employing organisation's facilities is identified as private and that the responsible manager is aware of that patient's status.

18. The consultant will comply with the employing organisation's policies and procedures for private practice

Patient Enquiries about Private Treatment

19. Where, in the course of his or her duties, a consultant is approached by a patient and asked about the provision of Private Professional Services, the consultant may provide only such standard advice as has been agreed between the employing organisation and appropriate local consultant representatives for such circumstances.

20. The consultant will not during the course of his or her Programmed Activities make arrangements to provide Private Professional Services, nor ask any other member of staff to make such arrangements on his or her behalf, unless the patient is to be treated as a private patient of the employing organisation.

21. In the course of his/her Programmed Activities, a consultant should not initiate discussions about providing Private Professional Services for HPSS patients, nor should the consultant ask other staff to initiate such discussions on his or her behalf.

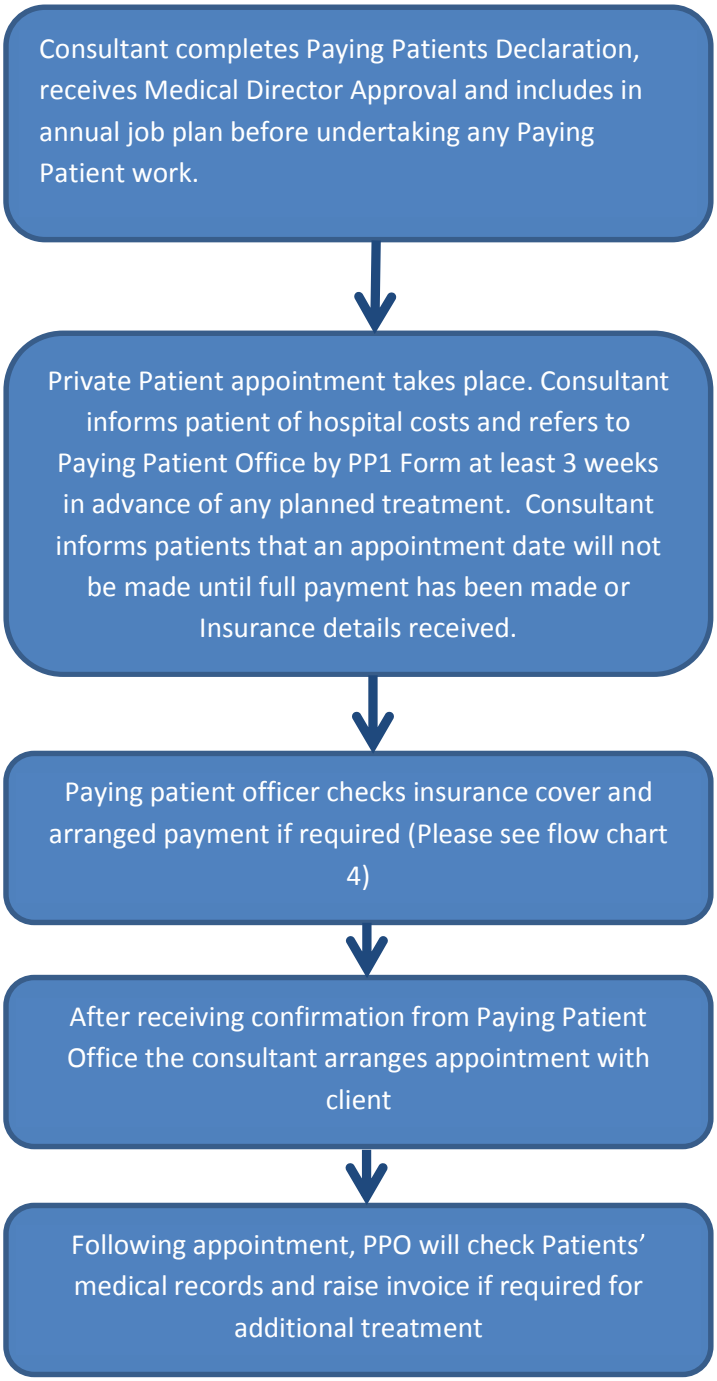
22. Where an HPSS patient seeks information about the availability of, or waiting times for, HPSS services and/or Private Professional Services, the consultant is responsible for ensuring that any information he or she provides, or arranges for other staff to provide on his or her behalf, is accurate and up-to-date.

Promoting Improved Patient Access to HPSS Care

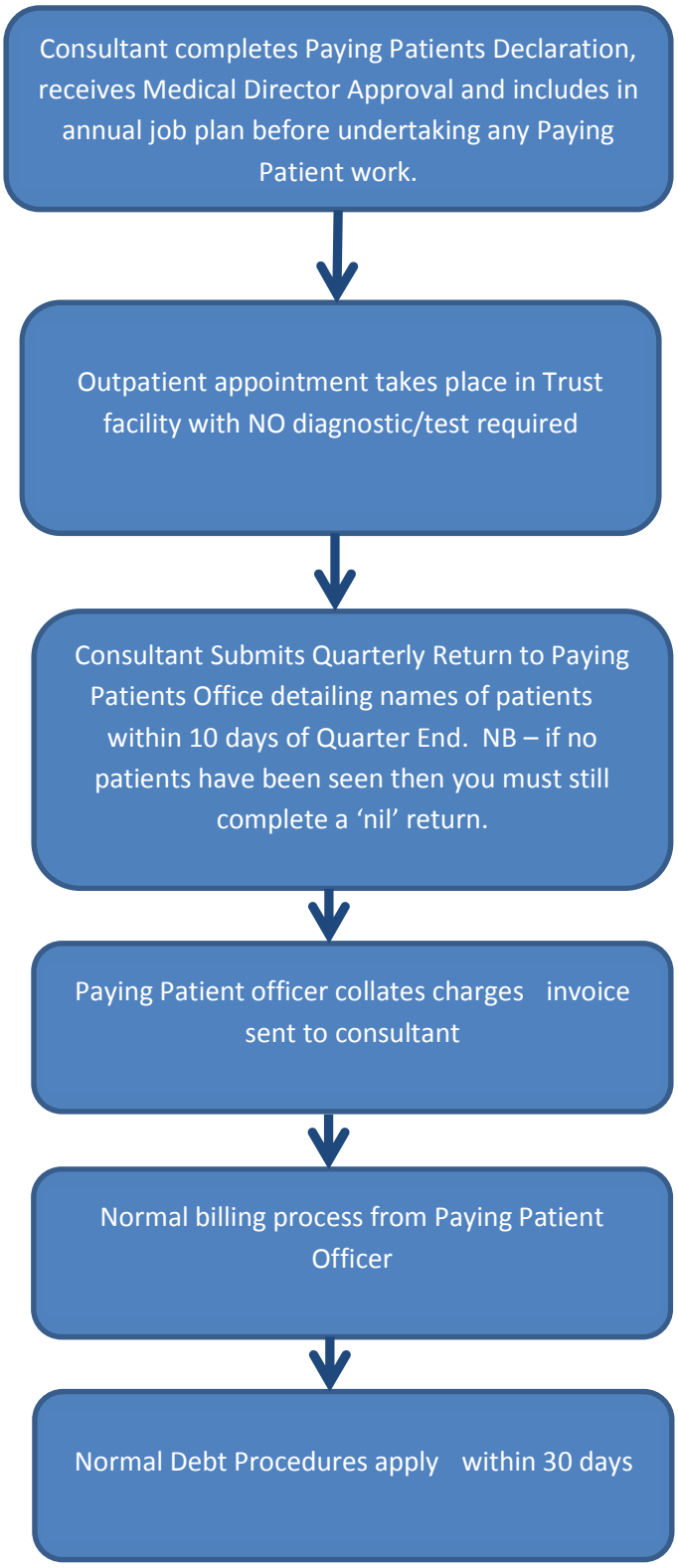
23. Subject to clinical considerations, the consultant is expected to contribute as fully as possible to reducing waiting times and improving access and choice for HPSS patients. This should include ensuring that, as far as is practicable, patients are given the opportunity to be treated by other HPSS colleagues or by other providers where this will reduce their waiting time and facilitate the transfer of such patients.

24. The consultant will make all reasonable efforts to support initiatives to increase HPSS capacity, including appointment of additional medical staff and changes to ways of working.

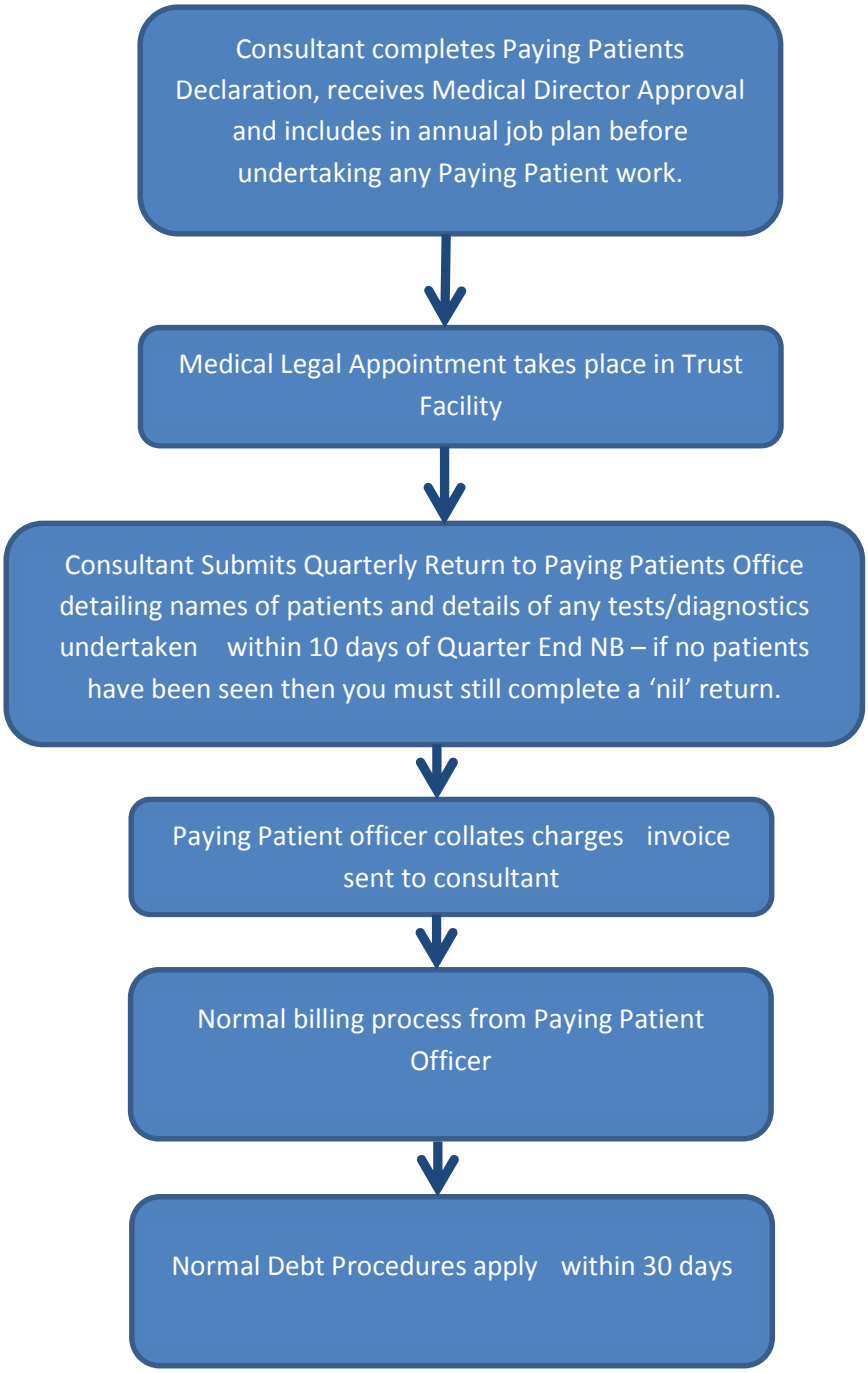
24. FLOW CHART 1 - PAYING PATIENTS [Inpatients]



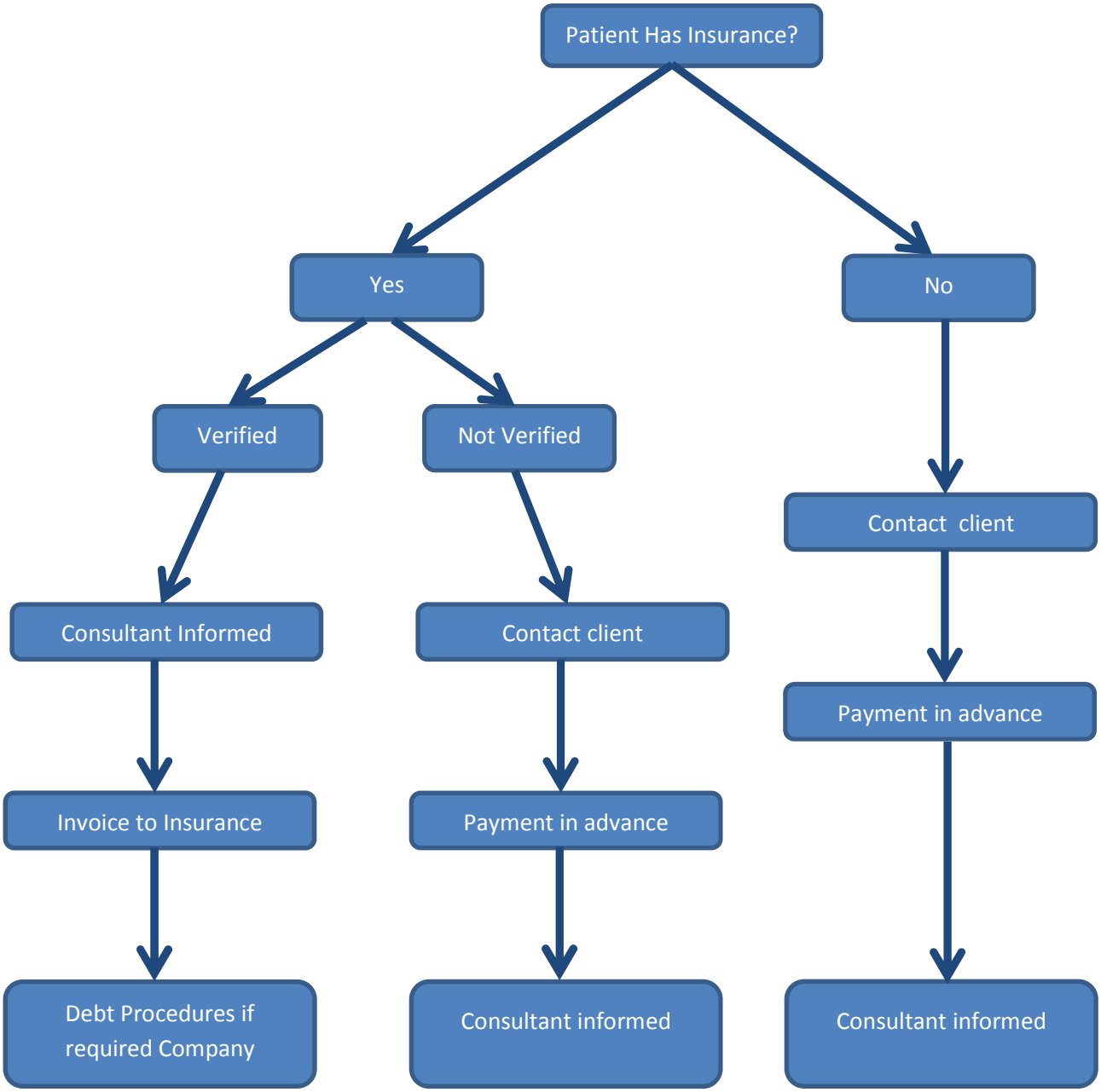
25. FLOW CHART 2 - PAYING PATIENTS [Outpatients]



26. FLOW CHART 3 - PAYING PATIENTS [Fee Paying Services]



27. FLOW CHART 4 – PATIENT INSURANCE



Services not using e-triage	
ORTHOPAEDIC GERIATRICS	Planned e-triage commencement Jan/Feb 2021
HAEMATOLOGY	Planned implementation postpone due to service pressures
NEPHROLOGY	Currently taking a break from e-triage, will relook at recommencing early 2021
GENERAL MEDICINE	Minimal referrals to this service but working with service looking towards implementation early 2021
BREAST SURGERY	Consultants not currently keen on e-triage – reengaged with service
GERIATRIC MEDICINE	Currently engaging with service

Health and Social Care Board

0023/18

Query Request Form

Requires Immediate Response: Yes

Reason for Immediate Response: Required as an action following Internal Audit review of management of private patients

☐	**Data Definition**	☒	**Recording Issue**
☒	**Technical Guidance**	☐	**Other**

Name: Roberta Gibney **Date:** 8th August 2018

Organisation: BHSCT **Contact Number:** Personal information redacted by USI

Subject Heading: PAS OP Referral Source Code – Private to NHS

a) Issue: ***Please provide as much detail as possible in order for the query to be considered and resolved as quickly as possible. This query form will be published on SharePoint when resolved.***

Belfast Trust requests a Referral Source Code on PAS for outpatients who change status from Private to NHS. Currently there is no guidance for identifying such patients.

Patient who attends Trust as a private patient has category recorded as PPG. When treatment completed OP registration should be closed with Discharge Reason – Treatment Completed, however if during their treatment the patient decides to change status to NHS the OP registration should be closed with Discharge Reason – Transfer to NHS and a new OP registration opened:
PAS with referral source PTN (Private to NHS) (suggested code), mapped to Internal Value (2) and CMDS Value (11) on Referral Source Masterfile and category as NHS.

This will ensure that the original category of PPG is not overwritten to NHS and the information recorded as per the Draft Technical Guidance on Private and Overseas Patients is not lost.

Belfast Trust request that the above is adopted as regional PAS Technical Guidance.

b) Response:

When a patient transfers from Private to NHS during their treatment period the OP registration should be closed using:

Discharge Reason code: TNHS – Transfer from Private to NHS

A new OP registration should be opened using:

Referral Source code: PTN – Private to NHS

Approved by: Acute Hospital Information Group

Date: 11/09/2018 **Response Published:** Yes / ~~No~~

Email: [redacted]
HSC Data Standards Helpdesk: ([redacted]

These forms are available on the Information Standards & Data Quality SharePoint Site at *http://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Helpdesk.aspx*

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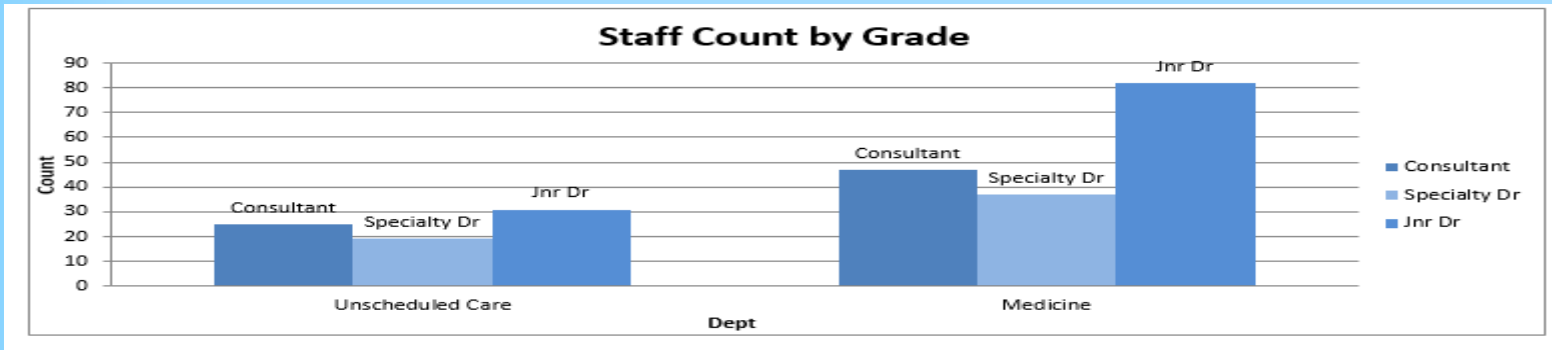
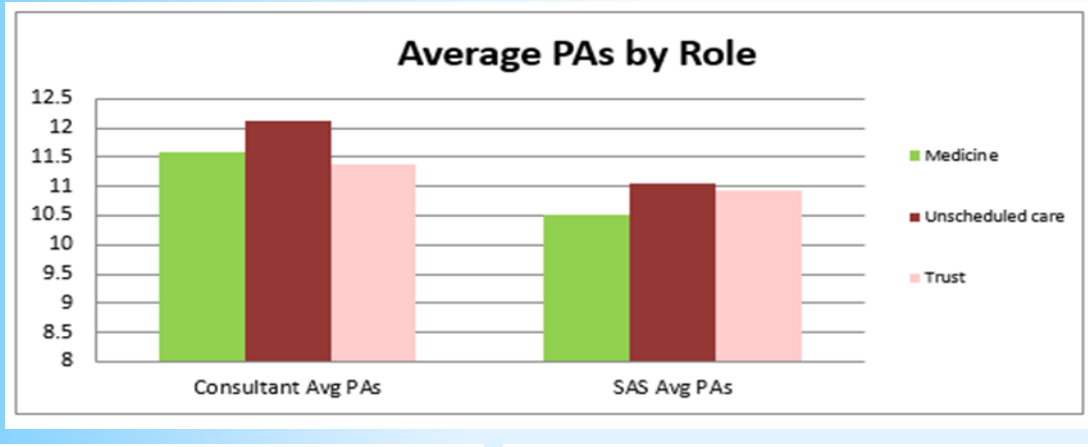
Medical Workforce Information Dashboard

Period: Feb 22 – Apr 22

Summary Metrics of Staff and Locums

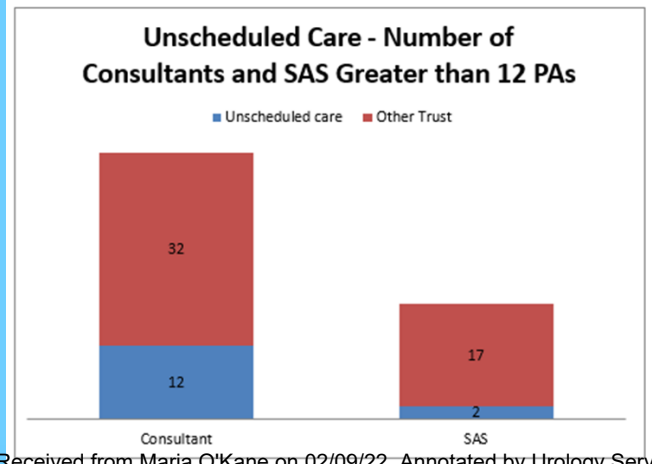


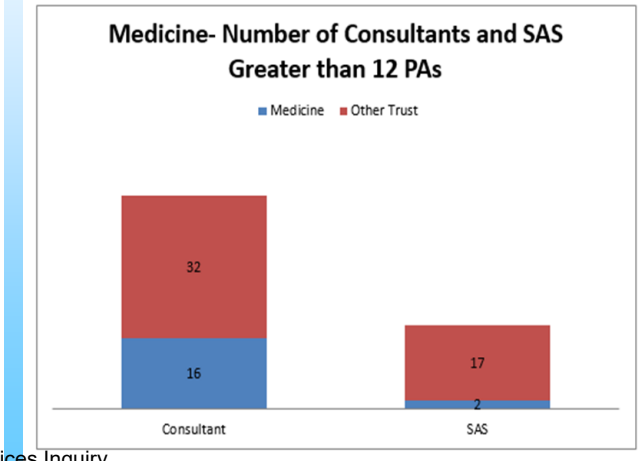


Average PAs

Within both Medicine and Unscheduled Care there are a number of Consultants working over and above 10PAs and the Trust average of 10.92 PAs

Within Unscheduled Care 12.11 PAs and in Medicine 11.59 PAs for consultants



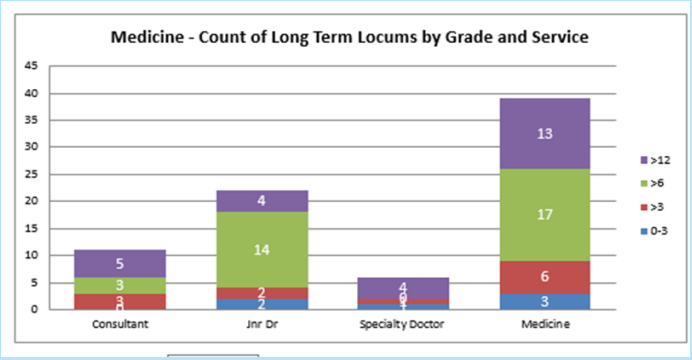


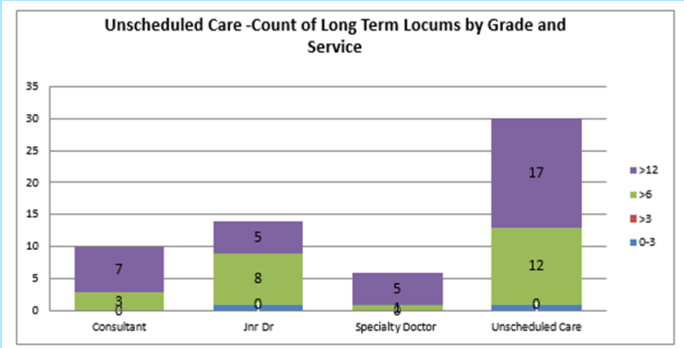
Greater than 12 PAs

12 Unscheduled Care Consultants and 2 SAS doctor currently work over 12 PAs

16 Medicine Consultants and 2of SAS doctors currently work over 12 Pas

Across the Trust (exc Med & USC) 32 Consultants and 17 SAS doctors currently work over 12 Pas

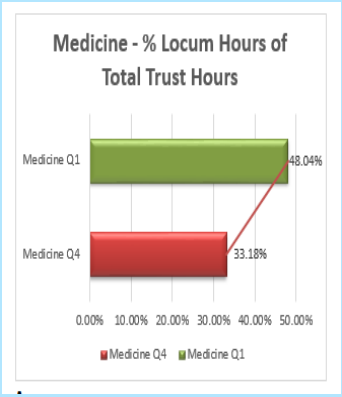


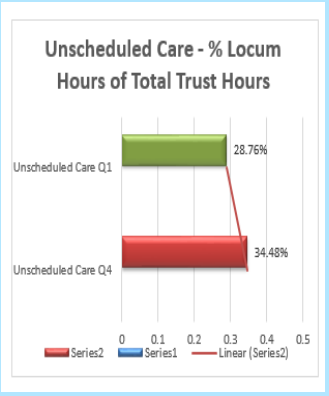


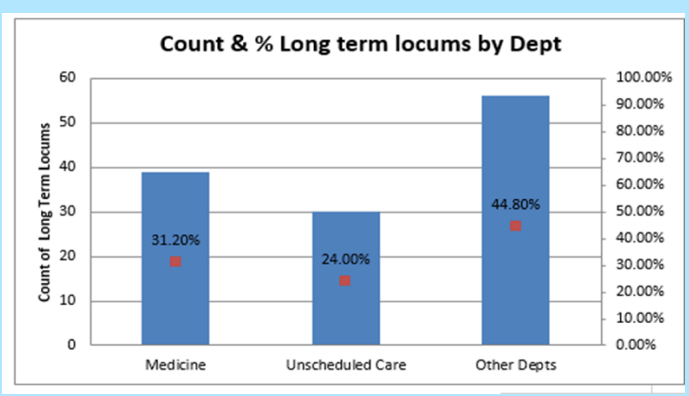
Long Term Locums

Within Medicine and Unscheduled Care there are 12 Consultants have been engaged in the Trust for 12 months with 3 engaged >48 months, 4 engaged >36 months and 3 engaged > 24 months. The DoH guidelines advise that a locum consultant should not be engaged for any longer than a 6 month period.

There are also within Jnr Dr level high numbers of long term locums with 11 engaged for over 12 months in Medicine & MUSC, with 7 engaged for > 24 months



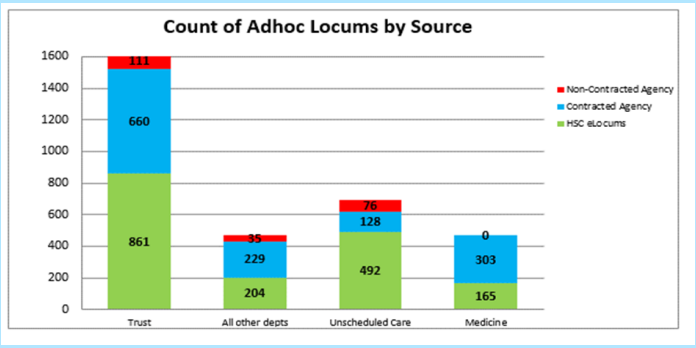


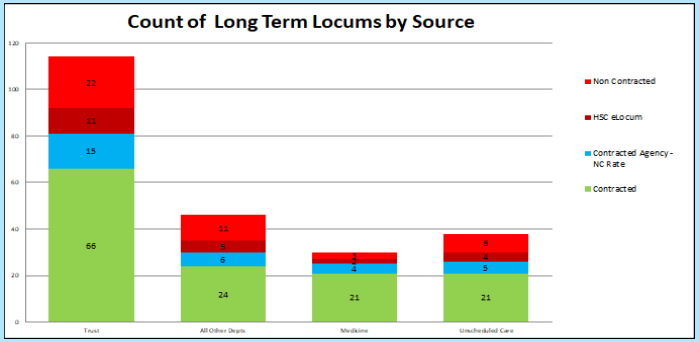


% and Count of Locums

55.2% of adhoc locum hours within the Trust are within Medicine and Unscheduled Care

As at 28th Feb there are 125 Long Term Locums within the Southern Trust. 55.2% (69 Locums) of Long Term Locums are engaged within Medicine and Unscheduled Care.



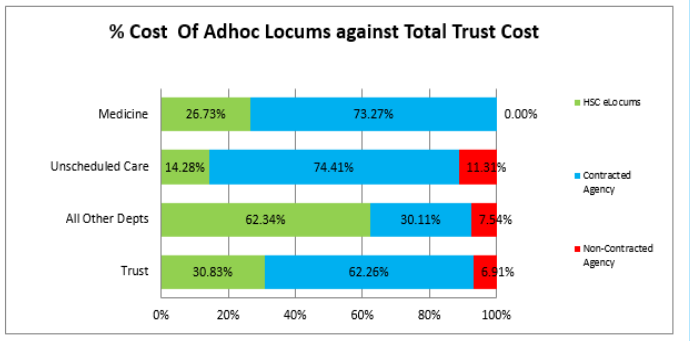


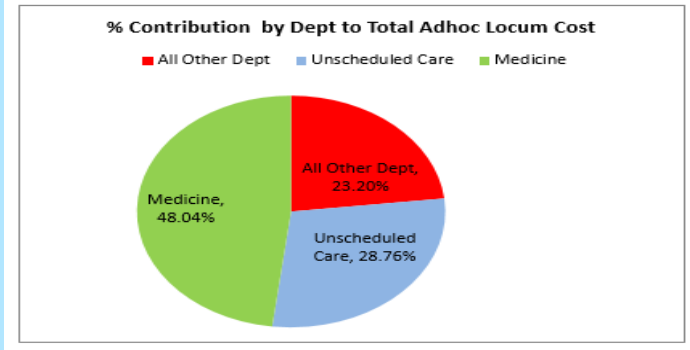
Locums by Source

From 1st Feb—30th April 22 the MLT have received 2427 locum shifts, 698 are Unscheduled Care and 743 are Medicine. Use of Contracted agency increased this quarter with lower usage of HSc Elocums for adhoc shifts.

Use of NCA increased for Medicine & Unscheduled Care in this quarter.

The Trust where possible should discourage the use of NCA . The M&D Framework is out for Tender currently and this situation may change from December 2021 onwards—we can explore options with PALS.



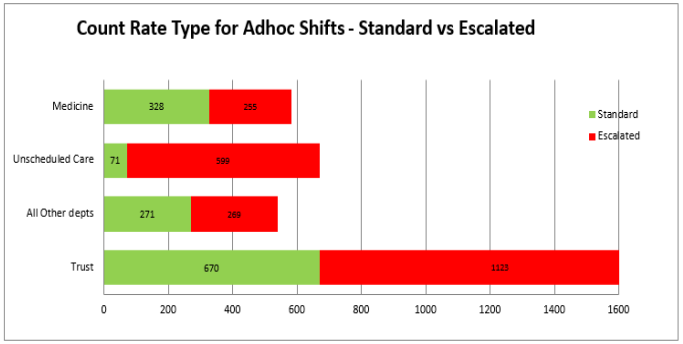


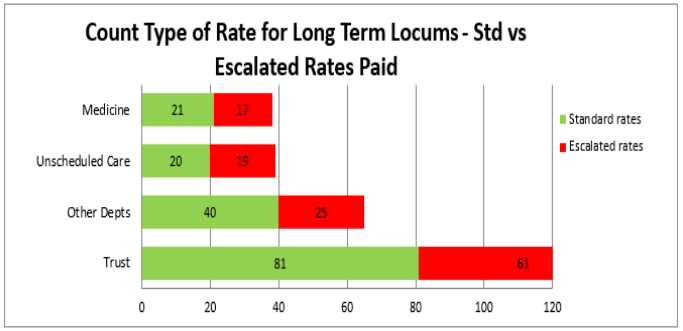
Adhoc Locums

Medicine and Unscheduled Care account for 76.8% of adhoc locum expenditure in the Trust >9.14% since previous quarter All other Service Areas only contribute 23.20%.

The use of NCA has decreased across the Trust since the last quarter by 3.14 % . However Unscheduled Care is 11.31% use of NCA. 1.6 times greater than the Trust %

Received from Maria O'Kane on 02/09/22. Annotated by Urology Services Inquiry

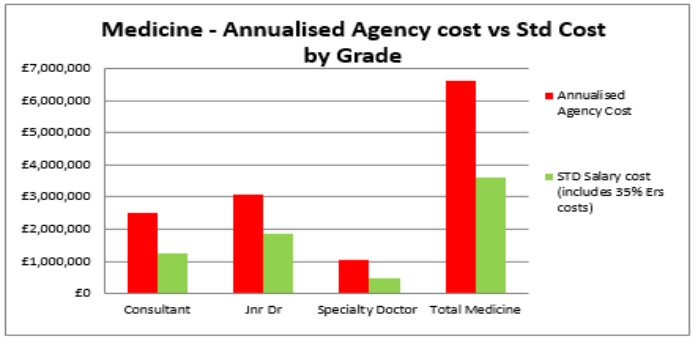


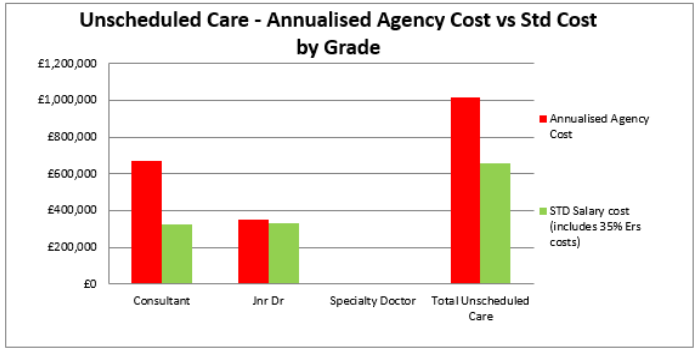


Standard v Escalated Rates

62.6% of shifts in the Trust are filled at escalated rates. This has increased by 13% since the last quarter.

Medicine has shown a slight 1.4 % increase in escalated shifts this quarter and Unscheduled Care—a 0.7% decrease from last quarter





Annualised Cost—same as previous quarter

Within both Medicine and Unscheduled Care agency cost is double what it would be if we employed doctors on the Trust T&Cs (inc. employers costs).

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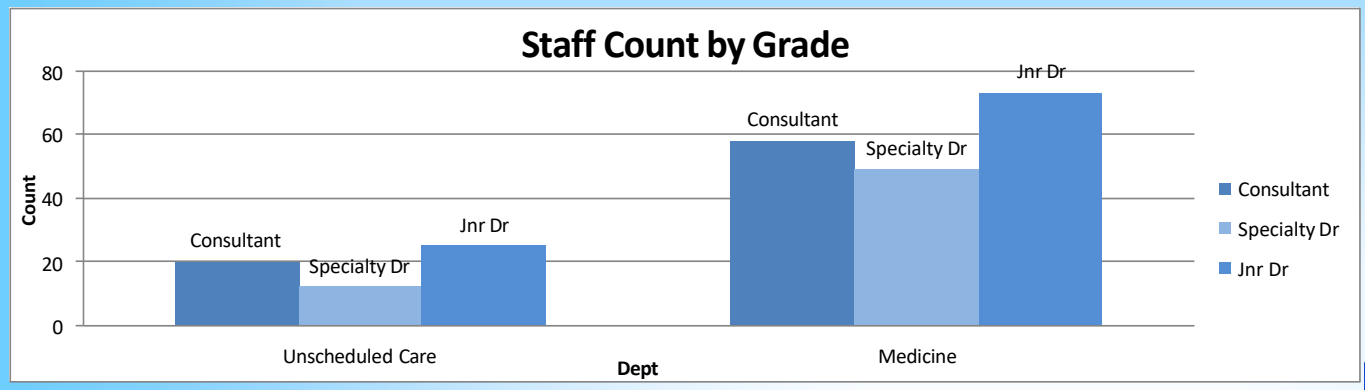
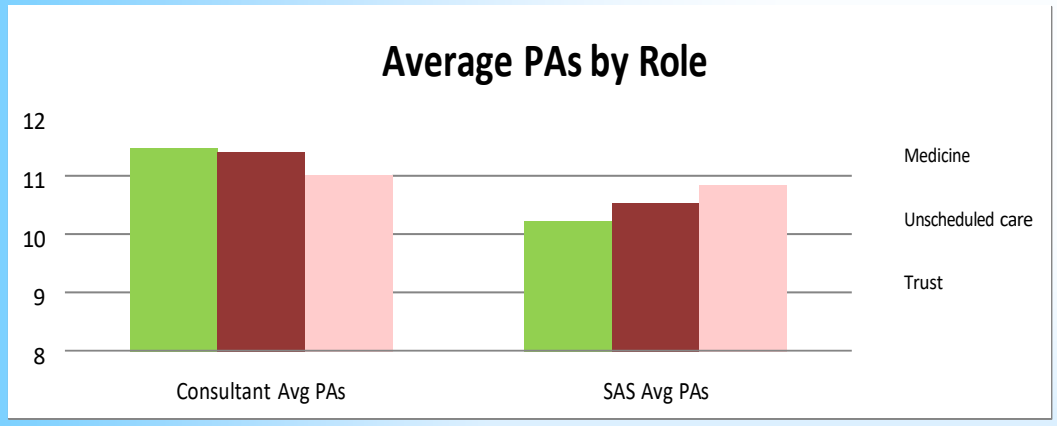
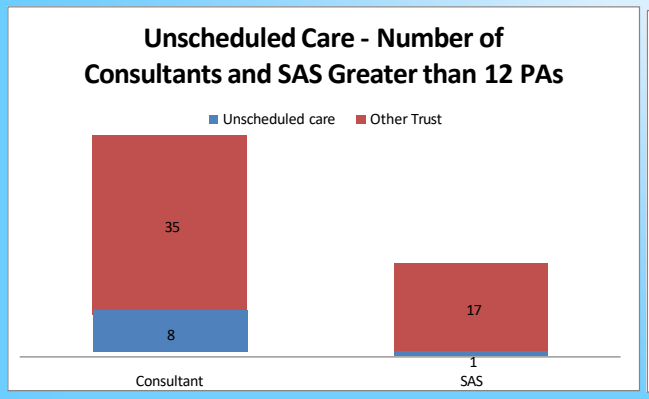
Medical Workforce Information Dashboard

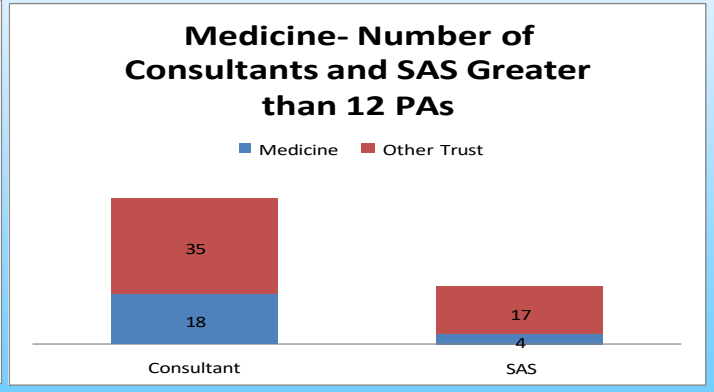
Period: Nov 21 — Jan 22

Summary Metrics of Staff and Locums









Average PAs

Within both Medicine and Unscheduled Care there are a number of Consultants working over and above 10PAs and the Trust average of 11.04PAs

Within Unscheduled Care 11.74 PAs and in Medicine 11.47 PAs for consultants

Greater than 12 PAs

8 Unscheduled Care Consultants and 1 SAS doctor currently work over 12 PAs

18 Medicine Consultants and 4 of SAS doctors currently work over 12 Pas

Across the Trust (exc Med & USC) 35 Consultants and 17 SAS doctors currently work over 12 Pas

Received from Maria O'Kane on 02/09/2022. Annotated by the Urology Services Inquiry.

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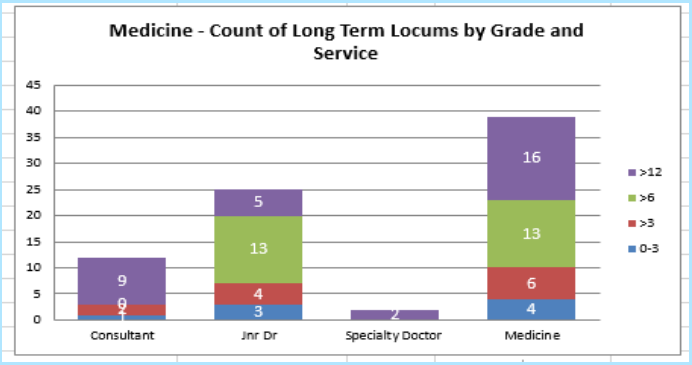
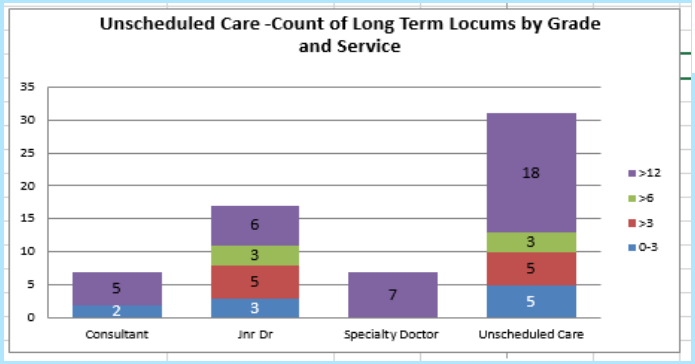
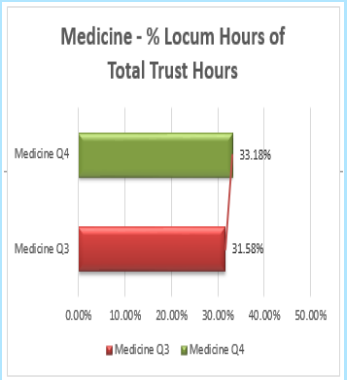
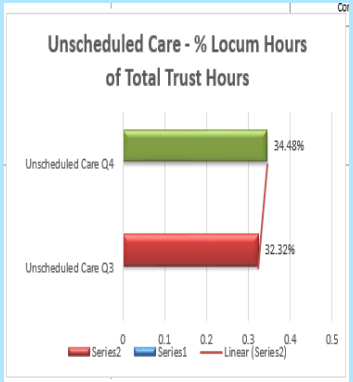
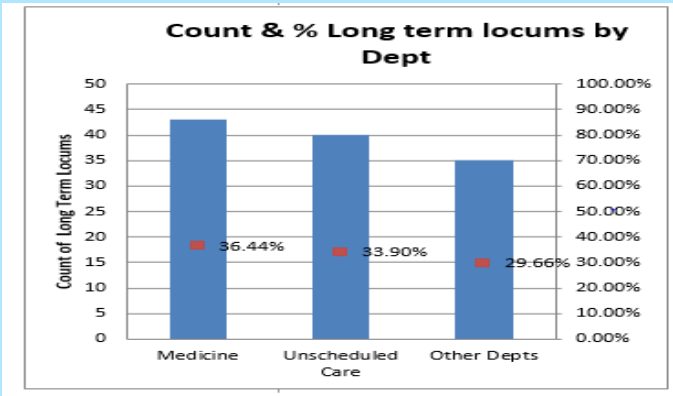
Period: Nov 21 - Jan21

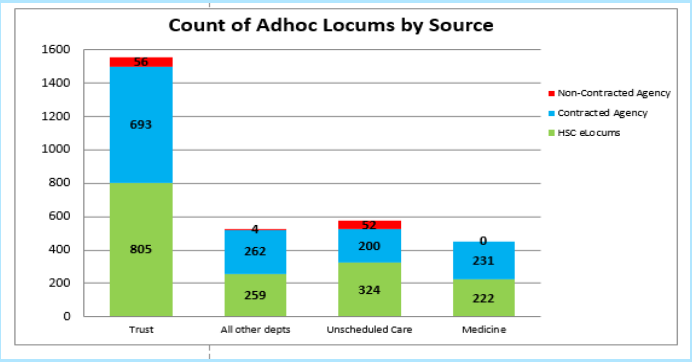


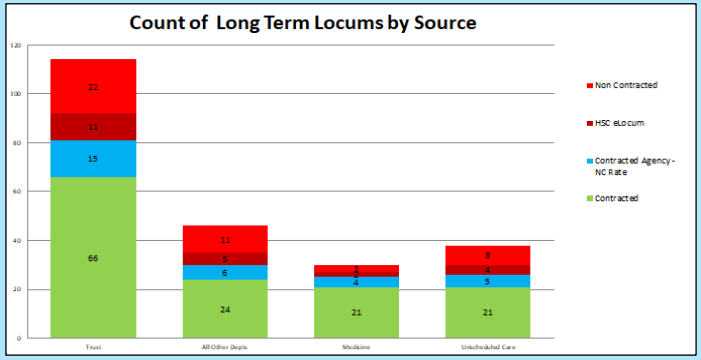


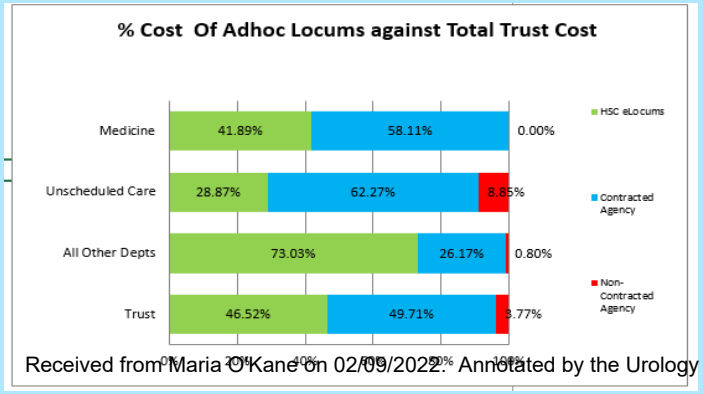


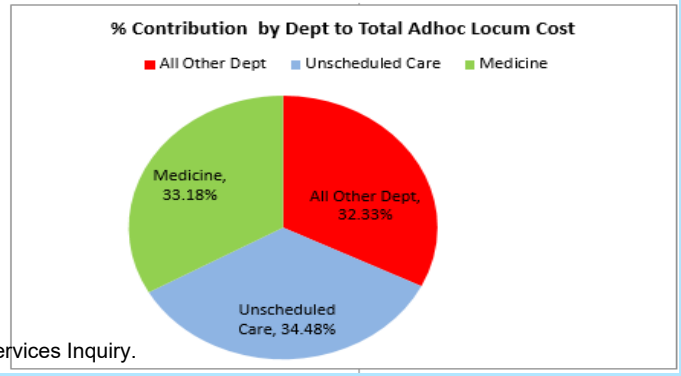












Long Term Locums

Within Medicine and Unscheduled Care there are 14 Consultants have been engaged in the Trust for 12 months with 5 engaged >48 months, 6 engaged >36 months and 2 engaged > 24 months. The DoH guidelines advise that a locum consultant should not be engaged for any longer than a 6 month period.

There are also within Jnr Dr level high numbers of long term locums with 11 engaged for over 12 months in Medicine & MUSC, with 7 engaged for > 24 months

% and Count of Locums

67.66% of adhoc locum hours within the Trust are within Medicine and Unscheduled Care

As at 28th Feb there are 118 Long Term Locums within the Southern Trust. 70.3% (83 Locums) of Long Term Locums are engaged within Medicine and Unscheduled Care.

Locums by Source

From 1st Nov —31st Jan 22 the MLT have received 2236 locum shifts, 746 are Unscheduled Care and 743 are Medicine. 394 of these shifts are extra help CAH.

Use of NCA decreased for Medicine & Unscheduled Care in this quarter.

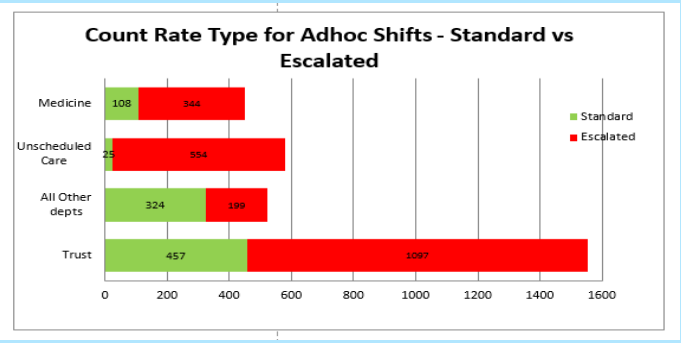
The Trust where possible should discourage the use of NCA . The M&D Framework is out for Tender currently and this situation may change from December 2021 onwards—we can explore options with PALS.

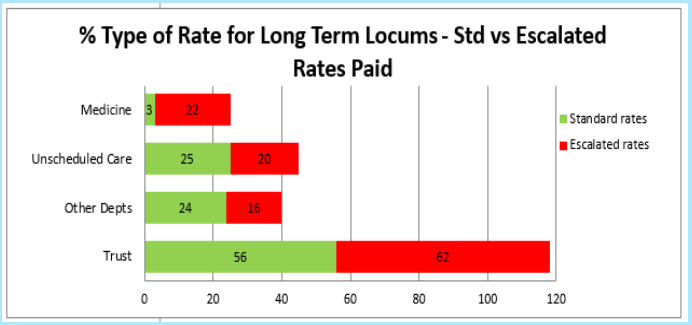
Adhoc Locums

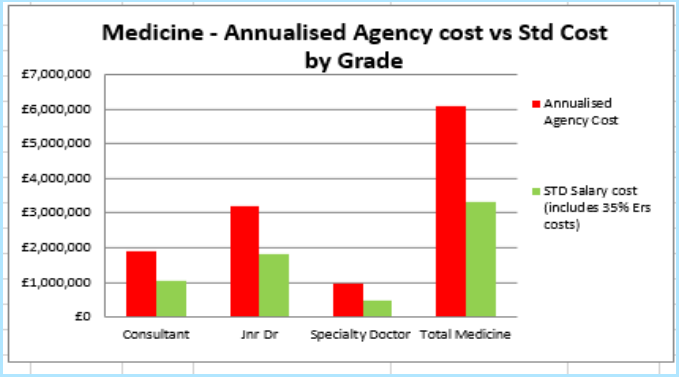
Medicine and Unscheduled Care account for 67.66% of adhoc locum expenditure in the Trust <2.16% since previous quarter All other Service Areas only contribute 32.33%.

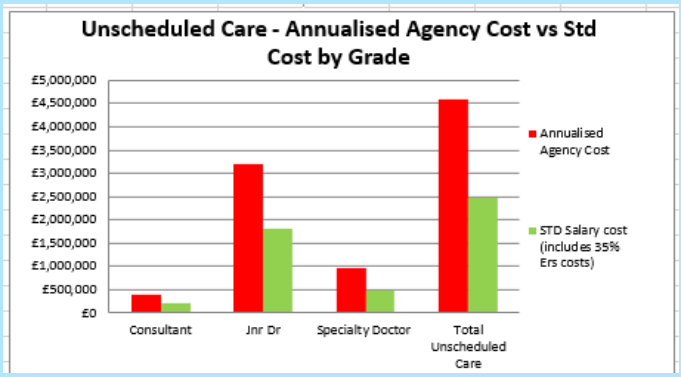
The use of NCA has decreased across the Trust since the last quarter by 1.88 % . However Unscheduled Care is 8.85% use of NCA. 2.3 times greater than the Trust %

Period: Nov 21 – Jan 22









Standard v Escalated Rates

70.5% of shifts in the Trust are filled at escalated rates. This has increased by 13% since the last quarter.

Both Medicine & Unscheduled Care have both should a % increase in escalated shifts this quarter. Medicine - 33.1% increase and Unscheduled Care—3.78% increase

Annualised Cost—same as previous quarter

Within both Medicine and Unscheduled Care agency cost is double what it would be if we employed doctors on the Trust T&Cs (inc. employers costs).

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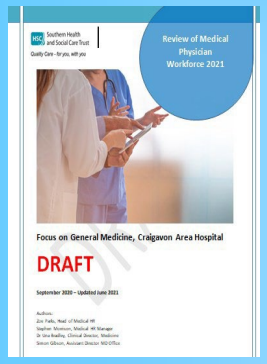
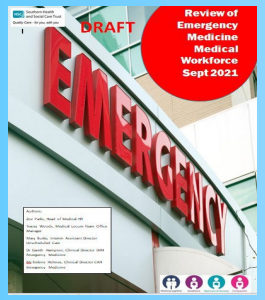
How can we reduce reliance upon agency locums in the Southern Trust





What can Medical HR do to help???

Medical HR are currently working with Assistant Directors an Consultants on a number of Workforce Planning initiatives:

- Review of Emergency Medicine Medical Workforce & Building our Medical Workforce Capacity – Daisy Hill Hospital—General Medicine & Review of Medical Physician Workforce 2021—Craigavon Area Hospital—General Medicine— are in progress

Upcoming CCT Figures—MUSC

Year/Speciality	Acute Internal Medicine	Cardiology	Dermatology	Emergency Medicine (run through)	Endocrinology and diabetes mellitus	Gastroenterology	Geriatric medicine	Renal medicine	Respiratory medicine	Rheumatology	Haemotology	Immunology	Infectious Diseases	Microbiology
2022	2	6	3	24	1	4	2	2	7	2	2	2	1	2
2023	2	9	2	24	2	5	3	3	5	2	3			
2024	3	8	0	5	4	3	3	2	4	2	2	1		
2025	2	2	2	3	2	1	5	3	3	2	2			
2026	0	1	0	9	1	3	0	0	0	2	3			
2027				17										
2028				1										
Total	9	26	7	83	10	17	13	10	19	10	12	3	1	

Review of Rotas

Clinical Fellow Positions—

Expansion of the Junior Medical Rota in CAH — Consideration should be given to expand the Junior Medical Rota in CAH so that the two extra help nights would also be included as part of this rota. This would reduce reliance upon locums, we could look at an expansion of the Medical Clinical Fellow Rota to include nights.

Rota at risk paper has been updated for Oct 2021 but still has to be shared with the service. Each service area along with Medical HR should review their rotas to ensure that they are fit for purpose and meet the demands/needs of the service. It would also be beneficial for each service area to have an elec-

Medical Recruitment — Where positions are filled by Medical Recruitment we should ensure that the agency locum is let go. As a Trust we should ensure that we are proactively trying to recruit for Trust appointed doctors rather than going to agency as a quick fix. Where there is maternity leave or a period of long term sickness we ask that you consider going to Medical Recruitment first. Whilst we appreciate this may take more time than securing a locum, it is a more sustainable, cost effective option and is better for the service

UPDATE—Regional Bank Locum Rates — Currently in NI the locum expenditure rate is £95.3 million. In 2017/2018 Regionally in NI £83 million was spent on Locums. This was an 192% increase over a 6 year period from 2011/2012 when the expenditure was £28.4 million.

Proposal

Grade	1. Top Point on NHS Pay scale for this grade per hour (2020/21 Payscale)	2. LATEST 20/21 Circular – Hourly rate on Double Max or 1.75% for non-training grades*	3.Current HSC E Locum Departmental Locum Circular Rate	4. Proposed Maximum Ceiling Internal Locum Rate* (Full Shift Rate) **75% for Non-resident**
FY1	£13.38	£26.76	£28	New £30ph
FY2/CT1-2	£20.86	£41.73	£38.07	New £40ph
ST3+ / Registrar	£24.79	£49.59	£46.14	New £50* per hour
SAS Junior (1.78%)* (Pt9)	£30.04	£53.47*	£46.14	New - £53ph
SAS Senior (1.78%)*	£36.97	£65.82*	£46.14	New - £65ph
Associate Specialist (1.78%)*	£45.76	£81.46*	£46.14	New - £80ph
Consultant (1.78%)*	£53.33 £71.10(Prem. Time)	£94.93*	No Circular Rate	£90 per hour £75 on-call @ home

Received from Maria O'Kane on 02/09/2022. Annotated by the Urology Services Inquiry.

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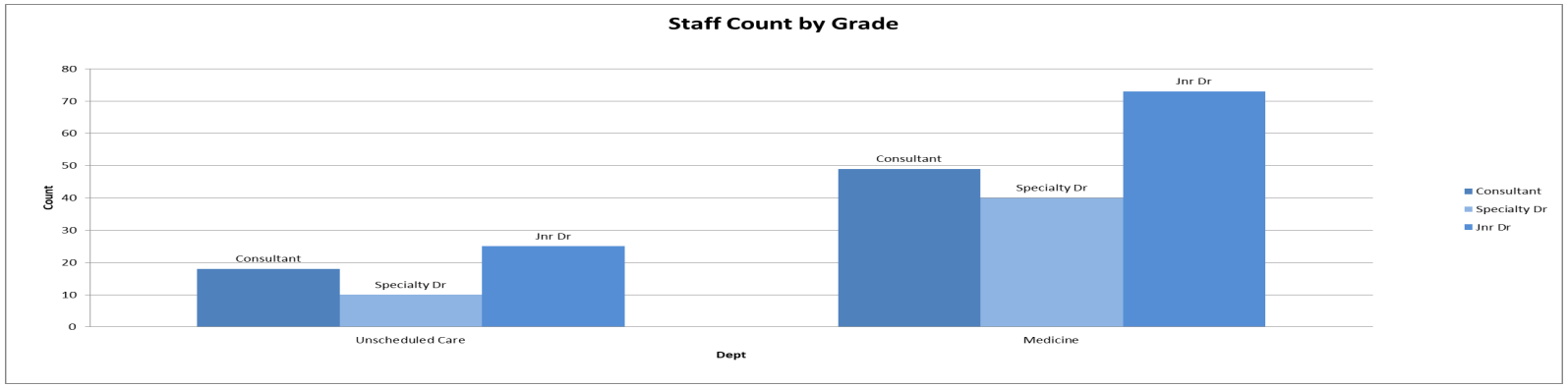
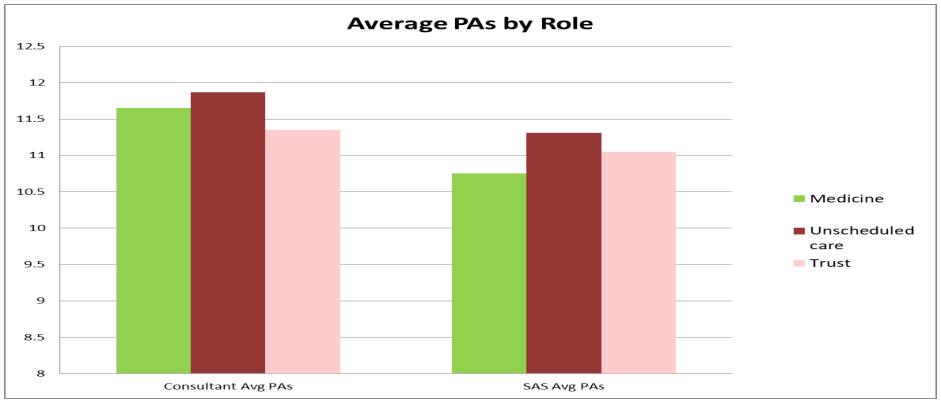
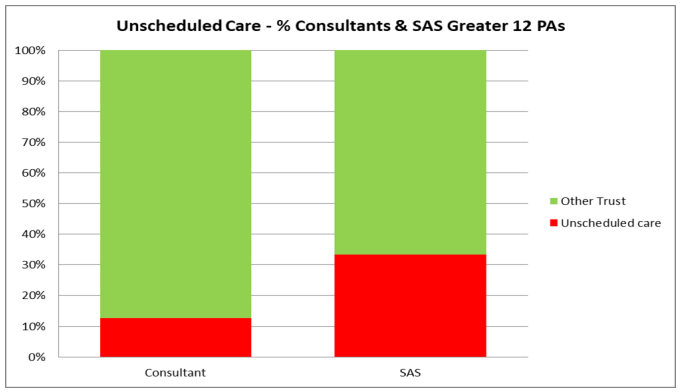
Period: Feb 21—Apr 21

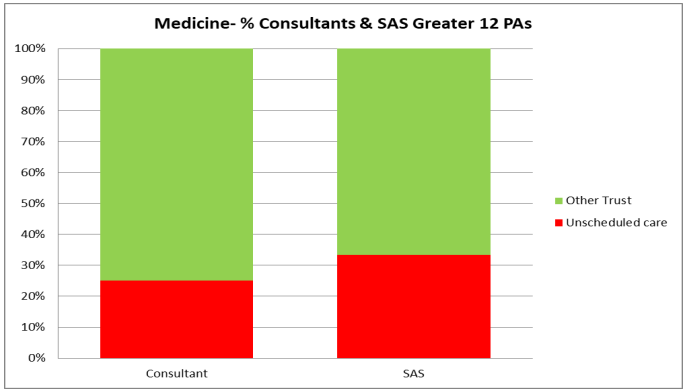
Medical Workforce Information Dashboard

Summary Metrics of Staff and Locums









Average PAs

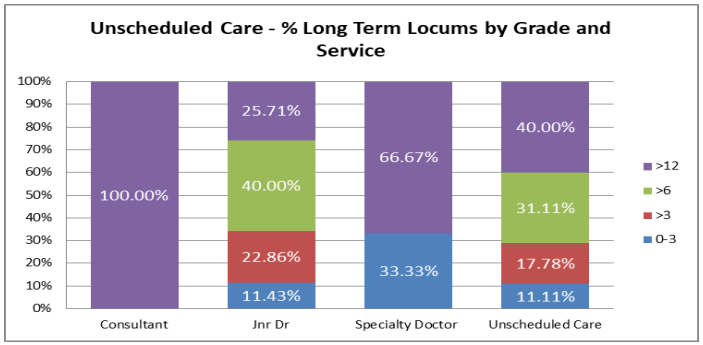
Within both Medicine and Unscheduled Care there are a number of Consultants working over and above 10PAs and the Trust average of 11.4PAs

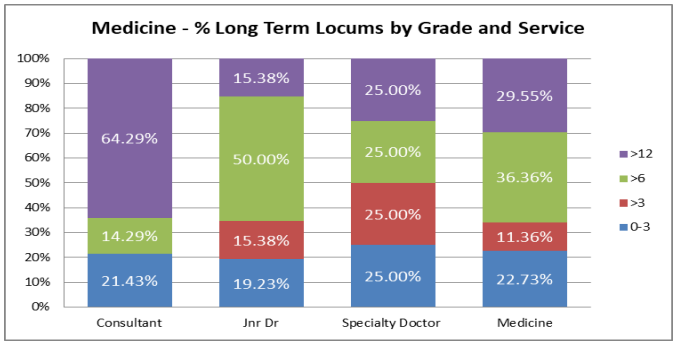
Within Unscheduled Care 11.7 Pas for consultants

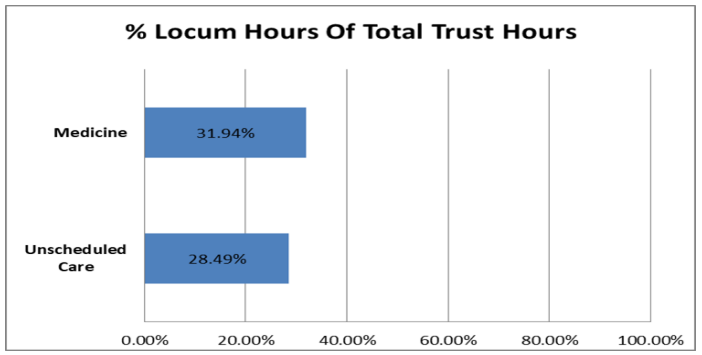
Greater than 12 PAs

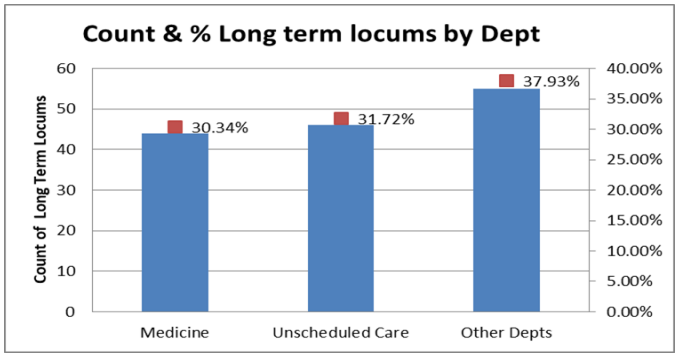
12% of Unscheduled Care Consultants and 32% of SAS doctors currently work over 12 PAs

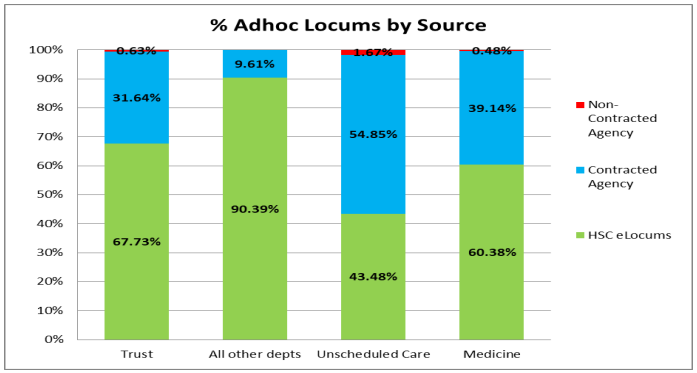
24% of Medicine Consultants and 32% of SAS doctors currently work over 12 PAs

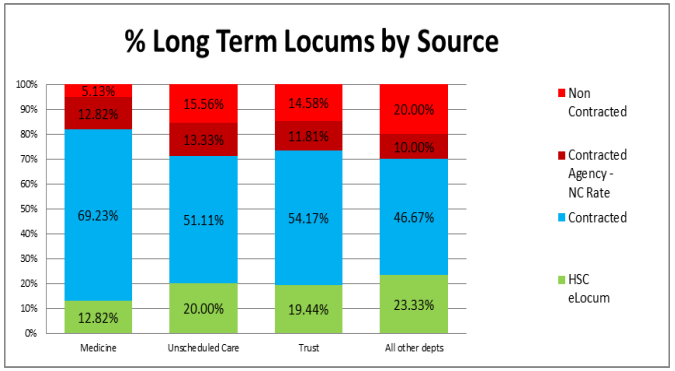


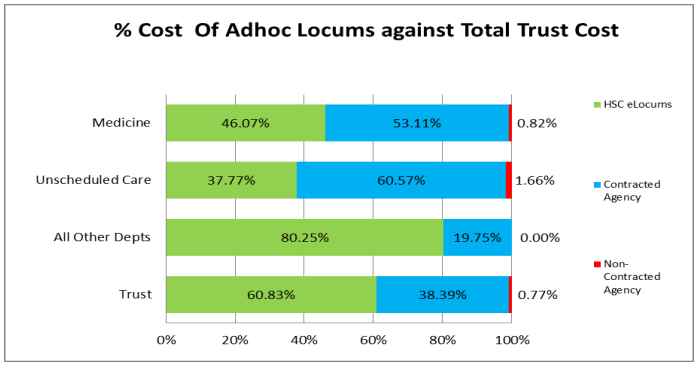


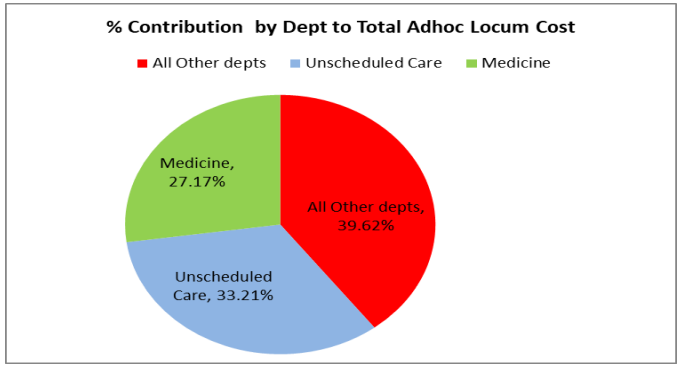












Long Term Locums

Within Medicine 64.29% and Unscheduled Care 100% of Consultants have been engaged in the Trust for 12 months +. The DoH guidelines advise that a locum consultant should not be engaged for any longer than a 6 month period.

At Specialty Dr level in Unscheduled Care there is 66.67% and Medicine 25% of Locums who have been engaged for 12 months +.

% and Count of Locums

Over 60% of adhoc locum hours within the Trust are within Medicine and Unscheduled Care

As at 21st June 2021 there are 145 Long Term Locums within the Southern Trust. 62.07% of Long Term Locums are engaged within Medicine and Unscheduled Care.

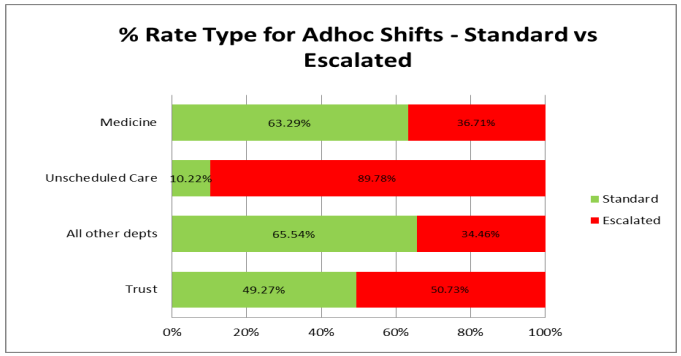
Locums by Source

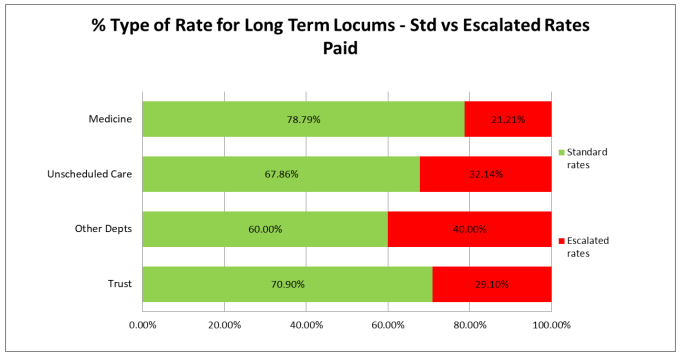
28.89% of Long Term within Medicine are engaged at non contracted rates which is greater than the Trust at 26.39%

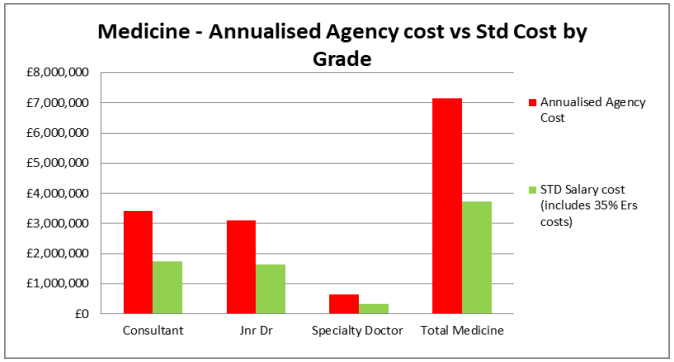
17.95% of Long Term within Unscheduled Care are engaged at non contracted rates

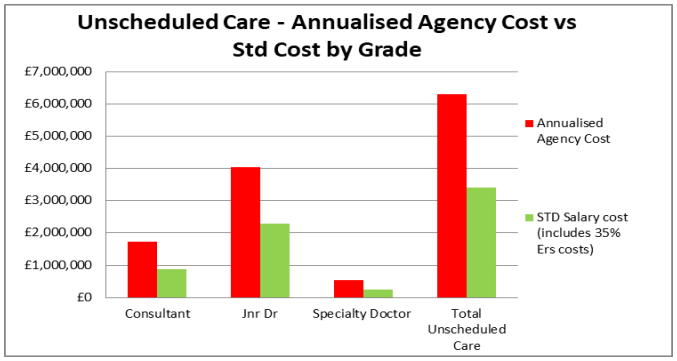
Adhoc Locums

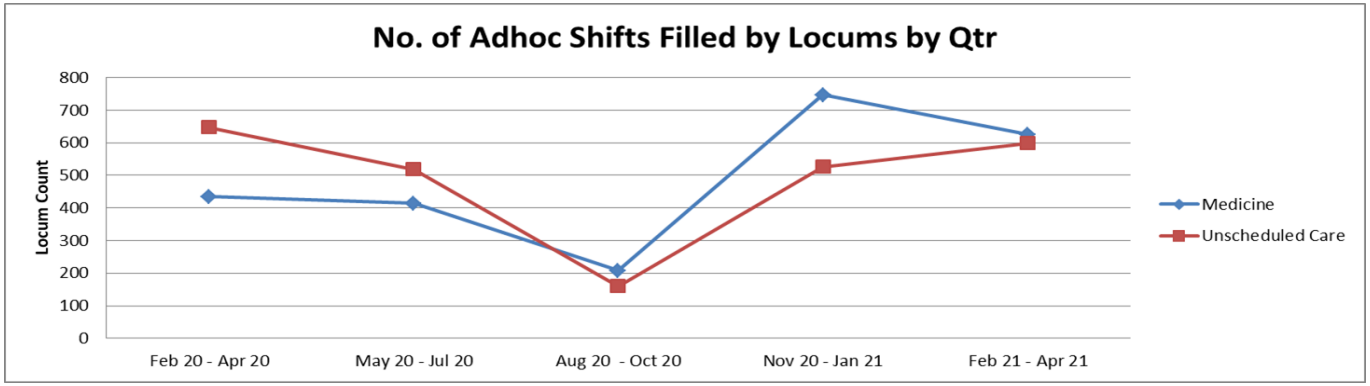
Medicine and Unscheduled Care account for over 60% of adhoc locum expenditure in the Trust. All other Service Areas only contribute 39.62%.











Standard v Escalated Rates

Only 10.22% of unscheduled Care adhoc shifts are paid at standard rate and 89.78% are paid at escalated rate.

Annualised Cost

Within both Medicine and Unscheduled Care agency cost is double what it would be if we employed doctors on the Trust T&Cs (inc. employers costs).

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Local Trust Framework for Job Planning

Final

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Southern Health and Social Care Trust
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Local Trust Framework for Job Planning

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1. BACKGROUND & PRINCIPLES

- In 2004 the new consultant contract introduced a new and more robust system of job planning, which was also included in the new Speicalty Doctor and Associate Specialist contracts. The purpose of this local guide is to set out the Trust's approach to Job planning. The guidance also takes account of the introduction of an Allocate electronic Job Planning system.

- This document does not amend, discard or move away from national contracts, terms and conditions. It provides a framework for Job Planning to ensure consistency across the Trust. Please also refer to:

    - Department of Health Terms and Conditions of Service: Link Here
    - Consultant Job Planning – A Best Practice Guide July 2017 NHS Improvement July 2017 Guide
    - Regional Guidance on Job Planning for Medical & Dental Consultants in Northern Ireland April 2008: DOH Regional Guide April 2008 and the other associated documents
    - Regional Guidance on Job Planning for Medical & Dental SAS & AS Doctors in Northern Ireland: DOH Regional Guidance on Job Planning for SAS and Associate Specialist Doctors
    - Zircadian/Allocate Guide to E Job planning - Guide for Doctors & E Job planning Guide for Managers
    - SHSCT Medical Staff Annual Leave Guidance

- Job planning is a contractual requirement for consultants/SAS Doctors and employers.

- Directorate management teams and the consultants/SAS Doctors should approach the Job Planning process with professionalism, honesty, openness and accountability on all parts.

- The job planning process is prospective; therefore decisions made, will affect future work and payments. A prospective commencement date must be stated on the e-job plan.

- Clinical Managers must ensure they meet with their Service Manager and Performance and Review team prior to job planning to obtain relevant demand and capacity information for their specialty.

- All Job Plans over 12 PA's will be reviewed by the Senior Management Team periodically to ensure they are not out-with EWTD legislation. All doctors must ensure they comply with their responsibilities under this legislation to safeguard safe weekly working hours. This includes all hours worked in private practice and/or the independent sector.

2. JOB PLANNING CONSISTENCY COMMITTEE

2.1 To promote and facilitate Best Practice, A Job Planning Consistency Committee will be established to ensure job planning is consistent between specialties and across the Trust. The role of this group will be to provide assurance that job planning is in line with regional and Trust guidelines. It is anticipated this will be led by the Medical Director (or deputy) and involve input from the medical and service managers. A summary report will also be issued to BMA LNC annually. This group will review practices and suggest changes to help improve the job planning process on a prospective basis for the following year, with any changes being agreed through LNC.

3. ROLES & RESPONSIBILITIES

3.1 Clinical Directors and/or Associate Medical Directors

- Agree with directorate management demand and capacity for the specialty, shape of current service, aspirations of the service, must do's (clinical governance, local SABA requirements) etc.
- Clearly identify through job planning how the Trust's activity targets can be met. They should identify and commission any additional activity needed, or identify how to replace direct clinical care no longer required.
- Consider need for diary of on-call activity if numbers or activity levels have changed.
- Conduct effective job planning meetings
- Agree final job plan with individual doctor for the year and ensure it has been entered on the electronic job planning system in line with expected timescales. See Job Planning Cycle (section 4) for proposed timescales.
- Ensure all new starts have a job plan approved and signed within the first **three months** following commencement.
- Ensure a speedy response to all requests for interim job plan reviews
- Ensure all job plans are reviewed on an annual basis
- When necessary take part in the facilitation and appeals process.

3.2 Individual Doctors

- Participate in job planning and ensure it sets out all of their HSC duties and responsibilities, objectives and service to be provided.
- Participate in your job plan review with your Clinical Director/Associate Medical Director at least on an annual basis.
- Request an interim job plan review when your duties, responsibilities, accountability arrangements or objectives have changed or need to change significantly within the year.
- Enter your job plan onto the electronic job planning system within the Trust
- Request facilitation (via the medical director) when the annual job planning meeting with your Clinical Director/Associate Medical Director has not reached agreement

3.3 Service Directors

- Each Director will have accountability for ensuring all Consultant and SAS doctors have an agreed job plan on an annual basis within their Programme of Care.
- Support Clinical Directors and Associate Medical Directors in discharging their job planning responsibilities.
- Ensure that each doctor has the facilities, training, development and support needed to deliver the commitment in their agreed job plan
- Ensure all the relevant service information is provided to Clinical Directors and Associate Medical Directors on a timely basis for the year ahead so this can be factored into job plans – see timescales on Job Planning cycle (section 4).
- Sign off electronic job plans in a timely manner. If either party feels there is undue delay – they should contact the Head of Medical HR so timeframes can be reviewed.

3.4 Medical Director

- Be available to give advice and support as necessary
- Undertake job planning for the Associate Medical Directors
- Take a leading role in the facilitation and appeals process
- Promote and encourage consistency within job planning across the Trust
- Consider the need for establishing a Job Planning Consistency Committee as and when required to steer best practice.

3.5 Medical HR Department

- Provide general support and guidance in all aspects of the job planning process
- Ensure the electronic job planning system remains updated and fit for purpose
- Assist with compiling reports and summary job planning information as required.
- Notifying all changes to Programmed activities to the Payroll Department following notification of an approved signed job plan.
- Liaise with Allocate regarding any system related difficulties or update

4. JOB PLANNING CYCLE

- Job planning is an annual requirement for all consultants and SAS doctors within the Southern Trust. Job Plans that worked this year may not work next year. Whilst some doctors continue to work the same pattern every week, changing patterns of service delivery and doctor preferences increasingly demand variable patterns from week to week or part/fully annualised job plans.

- Job plans may need to be reviewed in year in response to activity changes, following new appointments or organisation change. Where this is necessary the Clinical Director or Medical Staffing HR Manager should "republish" the electronic job plan so that it can be edited by the clinical manager and/or consultant. The normal job planning process can then take place.

- To ensure all doctors have an approved job plan by 1 April each year; the following job planning cycle is proposed within the Southern Trust.

See following Page for Southern Trust Job Planning Cycle

Southern Health and Social Care Trust
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Job Planning Rounds
Target Dates & Timescales

Quarter 2	
July – September	Clinical Director prepares for next job planning round. Clinical Director considers if there is a need to undertake updated on-call diary. Clarify with Finance, what external funding may be available for the following year. Send early notification to consultants/SAS Doctors that new job planning Round due to commence for start date the following April.
Quarter 3	
October – December *Electronic reminders will be sent from the E Job planning system to reflect these target expectations.*	**Month of October:** Team specialty meeting to discuss; job planning requirements, team objectives, allocation of specific SPA's or additional roles and any required rota changes for the following year etc. ***1st November***: All job plans within the E Job planning system will be Locked Down centrally and republished to allow consultants to edit individual job plans. **November/December:** Individual Job Plan meetings to take place. **By 31 December:** All Job plans should be entered on electronic system and the electronic sign off process commenced. Where it has not been possible to agree a prospective job plan; a request for facilitation should be made to the Medical Director by the consultant or clinical manager. This should also be recorded on the e job planning system. **January:** A Job planning Consistency Committee to be convened to review a sample of agreed job plans to ensure consistency across clinical areas.
Quarter 4	
January to March the following year *Electronic reminders will be sent from the E Job planning system to reflect these target expectations.*	E Job plans progress through the sign off levels to ensure a fully signed off job plan achieved for 1 April. Facilitation meetings and Appeals to be arranged during this time where necessary to ensure agreements made for 1 April.
Quarter 1	
April to June the following year	Job plan effective 1 April

- *New Doctors should have a Job plan Review **within 3 months** of commencing in post.*

5. JOB PLANNING AND LINK TO PAY THRESHOLDS

5.1 Schedule 15 sets out the link between Pay Threshold and the Job planning process.

5.2 Consultants and SAS doctors must engage with the job planning process to ensure pay progression. Where it is not possible to agree a job plan; consultants should invoke/engage with the facilitation and appeal process, as this constitutes engagement for the purposes of pay progression.

6. ELECTRONIC JOB PLANNING SYSTEM

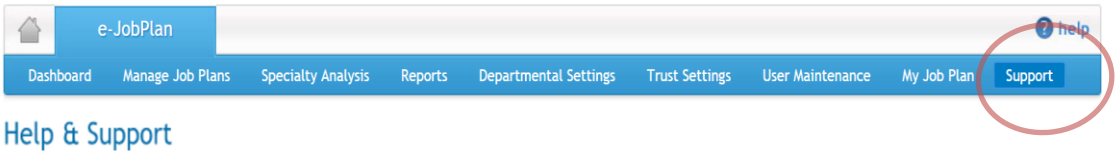
6.1 The e-Job Plan system is web based and can be assessed from any internet ready PC, MAC, smart phone or tablet (iPad) using the following link: www.healthmedics.allocatehealthsuite.com

6.2 Each consultant/SAS Doctor will be issued with a username and password to access the system. If doctors forget or lose their access details, there is a forgotten password link on the e-Job Plan homepage or you can contact the Medical Staffing HR Department who can reset or reissue these details.

6.3 The Trust is keen to retain the Job planning meeting between consultants/SAS Doctors and Clinical Directors. However, there is the facility for a virtual electronic job plan meeting subject to the agreement of both parties.

Training can be provided by the Medical HR Team however there are also user guides available for e Job planning systemZircadian/Allocate Guide to E Job planning - Guide for Doctors & E Job planning Guide for Managers

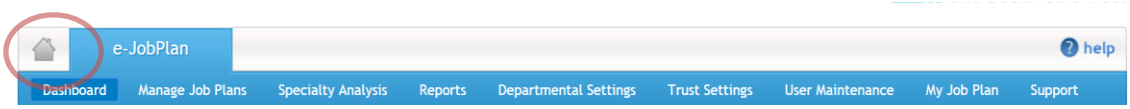
6.4 If a doctor is having trouble creating a job plan, Medical Staffing/HR will provide individual support using the online job plan wizard demo which allows you to familiarise yourself with how to create a job plan without saving or storing any data. - Link to Wizard Demo



Help & Support

6.5 Doctors are reminded to ensure they update their **preferences** to ensure they receive the appropriate email notifications that they wish to receive about their job plan. This is located at the top left of the screen when logged into the electronic job planning system.

6.6 When in the E Job Planning system - avoid clicking on the **Home** button as this will return you to Allocate Software Homepage. Use the **back button** or click on the blue menu bar to avoid this. If you do not have a management role, please be aware that your blue menu bar will only show the options for "My Job Plan" or "Support".



6.7 Details of the terminology used throughout the E-Job plan system as well as the calculation used in the on-call and routine work sections of the job plan are available to view online - Link here

7. KEY ELEMENTS OF JOB PLAN

7.1 Job plans should contain an agreed baseline of commitments detailing attendance and activity expectations for the year ahead. These should be transparently reviewed and agreed, and be clearly documented for future reference. Activity expectations should be based on a minimum of 41- 42 weeks in the working year. A job plan covers the whole of the week, including – where relevant weekends and nights (to ensure consistent delivery of high quality patient care) and takes account of all flexible working arrangements.

7.2 Key elements in a job plan are:

- Objectives
- Direct clinical care
- On-call and emergency work
- Supporting professional activities such as clinical audit participation, case note review and other activities relevant to the individual's revalidation
- Additional responsibilities and duties
- External duties
- Private professional services
- Fee-paying services
- Travel time
- Supporting resources

8. JOB PLAN OBJECTIVES

8.1 The job plan must help achieve service business plans and the Trust's organisational objectives. This is recognised and documented by NHS Improvement in their document "Consultant Job Planning a Best Practice Guide 2017". This can be achieved by incorporating meaningful job plan objectives within individual and team job plans (see section 9 for team job planning).

8.2 Objectives should be based on the latest evidence, subject to benchmarking where possible and designed to eliminate or reduce variation. Starting with objectives is the key to aligning consultants and employers, and makes it easier to review and adjust job plans. Translating the Trust's objectives into meaningful, measurable objectives in job plans allows consultants to identify changes required to support growth and efficiency in their service and ensure it remains attractive to commissioners.

8.3 You should agree objectives in 'SMART' form – that is, they should be:

S specific
M measurable
A achievable
R realistic
T timed

8.4 Job planning Objectives can take the form of a prediction of an indicative number of fixed clinical PA's delivered per year to help align service delivery plans and inform workforce planning. The prediction of clinical PA's expected each year should consider agreed annual leave, study leave and professional leave allocations. There may be some individual variation, particularly for individuals with specific agreed responsibilities.

8.5 The number of fixed activities (such as outpatient clinics or theatre lists) appearing in a weekly job plan is multiplied by the number of weeks in the working year (normally 42 weeks) to establish an indicative number of sessions per year, i.e. 52 weeks minus bank holidays, annual leave and study/professional leave. For example; if there are 3 PA's of outpatient clinics per week on the job plan, then the indicative annual clinic contribution should be 3 x annual working week (normally 42) = 126 expected clinics per year.

8.6 The objectives may also include an indicative estimate of activity within a session for example number of new/review patients per clinic, start and finish time and a time allocation for dictation/letter writing (if necessary). A clinical manager should use benchmarked national norms or accepted best practice to determine/alter new and review ratios. Clinicians will be encouraged to find new ways to discharge/review patients e.g. virtual clinics, telephone reviews, letters to patients or GP's agreeing primary care follow-up etc. This should be discussed with consultants at the outset of the job planning stage – e.g. at the team specialty meeting to prepare for the prospective job planning round.

8.7 Those responsible for scheduling PA's should note that any consultant/SAS Doctor wishing to complete their annual weeks commitment (e.g. if 2 theatre PA's/wk = 84 theatre PA's/year) in less time than the normal 42 working weeks may not be able to carry this out for the following reasons:

- *In order to carry out a DCC, a resource, usually involving other staff, will be required and it is unlikely that such resources will be available to accommodate a consultant/SAS Doctor wishing to work their annual commitment in a short time.*
- *On a full time contract with DCCs and SPA's, the only way to work an annual commitment in less than the agreed weeks would be to exceed the EWTD.*
- *The idea behind these changes to the job plan are to spread out the work evenly across the year to the mutual benefit of both the Trust and the consultants, resulting in a safer environment for patients and a healthy life/work balance for the consultants.*

If the AMD / CD feel that a service will be better supported/delivered through such an arrangement, then such flexibility may be agreed in these circumstances.

8.8 One of the criteria as set out in Schedule 15 which determines if pay thresholds can be awarded relates to meeting Personal Job Plan Objectives. Where a consultant/SAS Doctor does not meet personal objectives for reasons outside their control, the Trust will not use this as criteria for deferring pay progression. For example, factors which may affect this could include the impact of sick leave, planned or unplanned. These issues should be discussed and agreed at job planning.

JOB PLANNING – GENERAL POINTS

8.9 In all instances, consultants/SAS Doctors and clinical managers should ensure there is no double counting of time within job plans. One example of this might be where a doctor is undertaking teaching whilst in an outpatient clinic such activity should only be counted once for programmed activity purposes. The clinical manager and the doctor should agree the appropriate split between DCC and SPA.

8.10 It is the Trust's intention that job planning should work towards no doctor being contracted to work more than an average total of 48 hours in order that the Southern Trust fulfils its responsibilities regarding standards set out in the European Working Time Directive. In practice this normally translates to a 10 + 2 PA contract.

8.11 Clinical Managers may request medical staff to work more than 10 PAs per week or to take on additional responsibilities. If so, the consultant and the clinical director or manager must agree the additional PAs or responsibility allowance. Additional PAs should be reviewed annually as part of the job plan review. However both parties can end the agreement outside the job planning review with three months' notice. Additional programmed activities should normally be for direct clinical care work unless specifically agreed with the Trust during job planning.

8.12 Direct clinical care is work directly relating to the prevention, diagnosis or treatment of illness, i.e. clinical, clinically related activity including patient administration. The consultant's schedule of PAs should clearly describe the type of direct clinical care activity, as well as when and where it is undertaken. For full time DCC Allocation should normally be between 6.5-7.5 PA's (26-30hours) and include all patient related activities such as ward round, theatre lists, procedure lists, MDT meetings, consultations, outpatient clinics, emergency reviews, labour ward and patient administration.

9. TEAM JOB PLANNING

9.1 The presence of a team job plan is entirely acceptable so long as each individual agrees to participate without coercion and also have an individual job plan.

9.2 The total workload (DCC, SPA, On-call) for a group of consultants/SAS Doctors should be estimated and then each element factored into individual job plans. The principal of team job planning is that all DCC and SPA activity is seen as shared and collective responsibility.

9.3 The following should be considered when developing a team job plan:

- Determine what direct patient care activities are required to deliver the service.
- Identify the number of consultant hours required to deliver each activity.
- Determine the number of weeks in the year when each activity occurs. (e.g. 42)
- Determine the annualized hours for each activity.
- Quantify how many consultants/SAS Doctors are available week to week to deliver the service (taking account of absences for annual/study leave).
- Divide the annualized hours by the number of consultants/SAS Doctors available to determine the average DCC working week per full time consultant.
- Quantify the total SPA commitment as well as any additional duties (e.g. Additional Responsibilities/External Duties) across the team.
- Determine the total weekly PA figure. If this figure lies outside 10 PA's basic contract, discussions will be needed about how to manage the gap – e.g. additional Programmed activities, consultant expansion, new ways of working.

9.4 Individuals within the team should have personalized job plans based on their individual commitments. It would be good practice that the team agree and sign a statement about how they work as a team defining their shared objectives. Where objectives are team based, the role of each individual consultant needs to be clear. This should include details of shared objectives and responsibilities and will ensure joint ownership and shared responsibility for success of the team plan.

9.5 If you are considering a team Job Planning approach – you should refer to the regional documentation (listed in the introduction section) for more guidance on devising these job plans effectively. The Medical HR Department can also assist where necessary.

10. ANNUALISED JOB PLANNING

10.1 There may be some consultants/SAS Doctors who have activities that do not fall on a regular weekly basis and therefore do not lend themselves to preparing a weekly job plan. Therefore it will be necessary to have an element of their job plan annualised. However, the principles of job planning remain unchanged.

10.2 Where a consultant/SAS Doctor undertakes irregular clinics or additional roles, this will need to be annualized. For example, if a consultant has been approved to take on an examining role (EPA's) which will involve approximately 5 days per year – this is annualized as follows: 5 full days per year equate to 40 hours/yr, or 10 programmed activities. 10 PA's divided by 42 weeks = 0.23 PA per week.

10.3 As with all aspects of Job planning the decision whether to annualise a Job plan or not must be by mutual agreement. At the outset, managers and doctors should agree that activity relates to measurable outputs and that arrangements reflect the professional nature of the contract and doctors continuing responsibility for care as set out in the GMC Good Medical Practice.

10.4 The electronic job planning system is able to capture and calculate accurately many of the complexities of annualisation. Help and assistance is also available from the Medical HR Department where necessary. Examples of annualisation of the contract can also be found in the BMA/NHS Employers "*A guide to Consultant Job Planning – Find the Link in Section 1 of this document*". Annualised activities recorded under "no specified day" should only reflect those activities which occur irregularly during the year.

11. ON-CALL ACTIVITY

11.1 This is recognised in two ways: an availability supplement and a PA allowance for time worked. All consultants on the same rota at the same frequency should have the same availability supplement and the same PA allowance for hours worked. Associate Medical Directors and Clinical Directors should monitor this on a regular basis given the frequency of new appointments and changes in participation levels.

11.2 On-call rotas should be monitored by a diary exercise at least every two years, more often if a change has taken place or if either side requires a review. It is a mandatory requirement for consultants to undertake a diary card exercise when asked to do so. The definition of on-call duties and emergency work is in schedules 8 and 16 of the Terms and Conditions. Depending on the frequency of on-call duties, it is recommended that the diary exercise should include at least two to three on-call cycles for the outgoing job plan year to determine a fair average.

11.3 Allocations for unpredictable emergency work must be evidenced by a diary data on a team basis. For example:

- A diary analysis indicates 37 hours of unpredictable on-call activity worked by the team in 1 week.
- 37 hours / 3 = 12.3 PA's of unpredictable on-call activity per week for the team.
- To allow for prospective cover – 12.3 x 52 weeks / 42 working weeks = 14.5 PA's.
- This must be divided by the number of consultants on the on-call rota e.g. 16 consultants on rota = 0.91 PA each for on-call.
- Therefore if a consultant team was offered 0.91 PA for unpredictable on-call, this equates to approximately 37 hours per week. It is useful to ask if this represents the actual workload. If not, a re-diary card exercise may need to be undertaken.

11.4 Change to workload/New Appointment/Consultant leaving - All new consultants must have a Job Plan review within the first three months following their start date. This means that Clinical Directors will need to meet with new doctors in post within the first month to commence the job planning process.

11.5 *It is essential that if there has been a change to the workload or following a new appointment, the* on-call activity and PA allocation and on-call frequency for the team must be reviewed and the change notified to HR appropriately. For instance, if there has been a change to the on-call frequency e.g. High frequency (1 in 1 to 1 in 4); Medium frequency (1 in 5 to 1 in 8); Low frequency (1in9 or less frequent) which takes it from one category to another, a notification of this change must be completed immediately and the update reflected on the E Job planning system. **To avoid any over or under payments the Clinical Director must ensure the necessary changes are notified to the Medical HR Team for immediate action with payroll and this should subsequently be followed up with the necessary changes in Job Plans**.

Consultants

Frequency of on-call Rota	**Value of on-call supplement as % of full time basic salary**	
	Category A	Category B
High Frequency 1:1 – 1:4	8%	3%
Medium Frequency 1:5 – 1:8	5%	2%
Low Frequency 1:9 less frequent	3%	1%

Associate Specialists and SAS Doctors

Frequency of on-call Rota	
	% of Basic Salary
High Frequency 1:1 – 1:4	6%
Medium Frequency 1:5 – 1:8	4%
1:8 less frequent	2%

12. TRAVEL TIME

12.1 Travelling time between a consultant's/SAS Doctors main place of work and home (for purposes other than emergency work) or private practice premises will not be regarded as part of working time.

12.2 Where consultants/SAS Doctors 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 site(s) will be included as working time. Such working time (for travel) will be deemed to fall within the same category of Programmed Activity as the work undertaken at the other site(s).

12.3 Job Plans should be designed to minimize disruption of fixed clinical episodes by time spent traveling between sites e.g. arranging for a full day in one clinical area rather than movement between site A&B during the day.

12.4 Travel to and from work for HSC emergencies, and 'excess travel' will count as working time. 'Excess travel' is defined as time spent travelling between home and a working site other than the doctors main place of work, after deducting the time normally spent travelling between home and main place of work.

12.5 Working Example - If a consultant/SAS Doctor normally takes 45 minutes to travel from their base hospital (e.g. CAH) to an outlying clinic (e.g. DHH) and a doctor doesn't travel to base but goes straight from home to the outlying clinic, then they can claim for "excess time" in their job plan if it takes them longer to travel from home. Therefore if doctor X lives in Belfast and it takes them 1 hour to travel to DHH, then they could claim 15 minutes in their job plan. However if they lived further away and it took them 1.5 hours to travel to DHH straight from home (or they had to come to base first for clinical reasons) then they would claim 45 minutes in their job plan.

13. SUPPORTING PROFESSIONAL ACTIVITIES

13.1 In order for the Southern Trust to attract and retain medical staff, we want to ensure we foster and support a culture of continuing professional development, education and training. However, this does not mean that all doctors need necessarily be involved in all of these activities. The flexibility inherent in the contract would provide for the number of SPA PA's required to deliver agreed activities in a given department to be determined and allotted to those undertaking the work.

13.2 A minimum of 1.5 PA's for supporting professional activities should be allocated to all consultants and considered as the minimum time for a consultant's CPD for revalidation purposes. This allocation will be the same for full and part time consultants. A minimum of 1 PA for supporting professional activities should be allocated to all SAS doctors and considered as the minimum time for CPD revalidation purposes. (The difference from consultants reflects the differing contractual agreements)

13.3 Typical SPAs for CPD and revalidation includes; preparation for revalidation, personal study (e.g. CPD and attending trust educational meetings, grand rounds, audit meetings etc.); personal/professional administration e.g. preparation for appraisal and job planning, completing 360-degree feedback for colleagues etc.; mandatory training relevant to the specialty group, attendance at departmental audit and clinical governance meetings, contributing to national audits etc.; basic undergraduate and postgraduate teaching and attending regular specialty consultant meeting.

SPA work should be carried out on-site and timetabled, although it can be carried out off site with prior agreement of the Associate Medical Director. SPA should be protected time as far as practically possible with the appropriate facilities available to allow doctors to make best use of their CPD time. Any issues with the availability of appropriate facilities should be raised with the Clinical Director/Associate Medical Director. There may be flexibility on the timing and location of SPA activity but only after agreement with the CD/AMD and if this is included in an agreed job plan in advance. If a flexible SPA is agreed, it must be reviewed annually

14. ADDITIONAL HSC RESPONSIBILITIES & EXTERNAL DUTIES

14.1 **Additional HSC Responsibilities** – These are activities agreed between a consultant and the Trust and which cannot be absorbed within the time that would normally be set aside for SPA's. This would include roles such as APLS/ALS Trainer, Appraiser, Clinical lead for an element of service, clinical tutor, formal undergraduate teaching role, NIMDTA formal educational supervisor, BMA, Medical Staff Committee etc. should be timetabled into job plans accompanied by clear specific objectives for this work.

14.2 Where a clinical director or other clinical lead post becomes available, the Associate Medical Director in consultation with the Medical Director/Service Director should undertake an internal

expression of interest/appointment process. This will set out the nature of the role including time/PA allocation and the terms and conditions associated.

14.3 Each clinical manager needs to be aware of the roles of the consultant and how the roles are funded to ensure appropriate job planning. In some cases the allocation will vary among specialties, depending upon the required commitment and in some circumstances (e.g. Clinical Tutors), the number of junior doctors. Further guidance and support should be sought regarding teaching roles, their time commitments and job planning for them.

14.4 When an individual doctor is wishing to undertake a role within the wider HSC and/or seeking agreement from their Clinical Manager for the release of time within their job plan; they must complete the **SHSCT Additional HSC/External Duties Application Form** prior to acceptance. Service Directors must also been involved and advised of the commitment and its impact on delivering the job plan. The timing and duration of the role and an indication on whether the role is funded externally MUST accompany this request.

14.5 **External Duties** - The Trust would seek to facilitate consultants wherever possible for such work that is not directly for the Trust but is relevant to and in the interests of the wider HSC. All these roles require Trust approval and the **SHSCT Additional HSC /External Duties Application Form** must be completed prior to acceptance.

14.6 Where possible all Additional HSC or external duties MUST be included within the job plan with a clear time allocation and set within an agreed timeframe with a specific end date. It may be necessary to annualize due to the nature/irregular timing of the work. Clinical managers should seek to spread this work equitably across teams and the Trust where possible. Any agreement should acknowledge the importance of the priority of doctor's commitments to direct clinical care and supporting professional activities. Measurable objectives for this work MUST be discussed, agreed and be clearly specified on the job plan template.

14.7 Facilitating doctors for Additional HSC & external duties must be governed by the need to retain a balance between different elements of the job plan in a way that maintains the required delivery of services to patients in terms of both activity and quality. It is reasonable for the clinical manager to seek to secure/maintain required direct clinical care commitments.

14.8 Clinical Managers must keep copies of the External Duties/Additional HPSS Approval request form and provide details of such commitments to the Medical Director and the Senior Management Team in the Trust on request.

15. PRIVATE PRACTICE

15.1 Regular work for other providers must be identified on the job plan indicating time and location. Such work should not occur in remunerated PA time contracted to the Trust. It is the responsibility of the Clinical Director and the Consultant/SAS Doctor to ensure there is no double counting of time.

15.2 All consultants/SAS Doctors are expected to conform to the Northern Ireland Code of Conduct for Private Practice and the handbook concerning the management of private practice in Health Service Hospitals in Northern Ireland.

Appendix 1 – Additional HSC/External Duties Application Form

Southern Health and Social Care Trust

Request to undertake Additional HSC Duties or External Duties

To be completed by the Consultant requesting approval

Personal details	
Name:	
Specialty/Directorate:	
Base:	

Proposed Duty	
Request for: (please circle) **EXTERNAL DUTY** **ADDITIONAL HSC DUTY**	
Is this post externally funded? If so, please provide full details:	
Details of appointment (e.g. local, regional, national, name of body / organisation):	
Please provide a full description of the proposed duty, including anticipated start date, number of days, location, frequency of the commitment, tenure of contract (end date) and any anticipated expenses (expenses should normally be met by the external body):	
Please give details of any other duties for which you have received approval this year, prior to this current request:	

Impact on Regular Duties
Please give details of current Job Plan (DCC & SPA PA allocation):
Can the proposed commitment be accommodated within your existing Job Plan without increasing PA's? (I.e. aggregation of workload across the year) ☐ **Yes** ☐ **No**

If No, please provide further details e.g. anticipated increase in PA's will a Job Plan Review be undertaken and/or reassessment of Job Plans across the specialty? What will be the impact on clinical commitments?
Will any fixed commitments in your existing job plan be cancelled to undertake this duty? ☐ **Yes** ☐ **No**
Will professional / study leave be used to undertake this activity? ☐ **Yes** ☐ **No**
I understand I must seek approval from the Trust before accepting any external role that impacts upon my job plan. I am aware that any agreement is reviewed annually by the Trust.

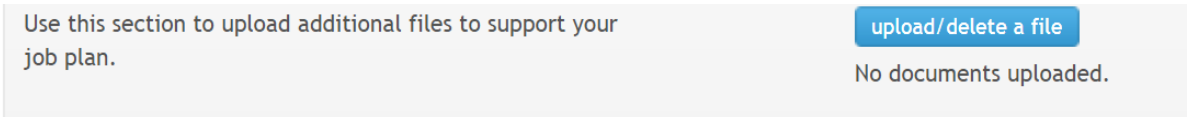
Signed by Consultant:	**Date:**

Approval Signatures

Some questions for the Clinical Manager to consider prior to approval*:*
Has agreement has been sought from consultant colleagues in the specialty? Are they supportive of this commitment? How will it impact their job plans? Will it be possible to maintain direct clinical care commitments? Is this consultant group "overrepresented" for external duties? Does the Trust receive funding for this role? Is the role in the interests of the wider HSC?

Associate Medical Director:	***Date:***	***Review Date:***
Director of Programme of Care:	***Date:***	***Review Date:***

This completed form should be completed and attached to the consultant's Job Plan template. The option to upload an associated document is available when editing your job plan under the Required Information section – see below:



A copy of the approved form should be emailed / posted to the Medical Director via their AD - Personal Information redacted by the USI **and the Medical Staffing Department.**

Approval authorisation	
Medical Director:	**Date Agreed:**

SHSCT Guidance on allocation of PA's for Additional HSC/External Responsibilities

PA allocation for all of these activities must have agreement of the Trust and reflect an accurate assessment of the time commitment required, considering the responsibilities & demands of the role, the size of the project/task and whether it is a single site, cross site, Trust level of regional level and/or in the case of teaching/training the number of doctors involved. The suggested PA allocations should only be used as a guide and actual allocations should reflect a thorough assessment of the specific role.

ROLES NORMALLY CAPTURED UNDER ADDITIONAL HSC RESPONSIBILITIES / EXTERNAL DUTIES:

Role	Role Description	Suggested PA Allocation	Approval From
NIMDTA Appointed Educational Supervisor	**Named NIMDTA Educational Supervisor** ***(This includes Foundation Education Supervisor roles)*** All trainees must have a named educational supervisor. In some circumstances this will be the same person as the clinical supervisor. A **named educational supervisor** is a trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a trainee's trajectory of learning and educational progress during a placement or series of placements. The educational supervisor is the key person is bringing together all the relevant evidence for a placement which enables a decision to be made as to whether it is safe for patients that a trainee should progress to the next stage of their training. **Responsibilities of the Educational Supervisor** 1. Support the trainee in developing their learning portfolio and evidence of competency 2. Ensure trainee understanding of and engagement with the assessment process 3. Ensure trainee completion of workplace-based assessments 4. Review trainee progress against the curriculum and decide whether placements have been completed successfully 5. Agree the best use of Study Leave to achieve required competencies and experience 6. Ensure that the trainee receives appropriate career guidance and planning 7. Meet the trainee in private at agreed, protected times in a placement in accordance with curricula requirements to ensure he or she makes the expected clinical and educational progress b. To conduct an induction interview within the first two weeks of a placement and develop a mutually agreed Learning Agreement and educational objectives and establish a supportive relationship c. At mid-point to carry out an appraisal based on the Learning Agreement d. At the end to carry out an appraisal to inform the trainee's ARCP e. Give regular, honest and constructive feedback according to the stage and level of training, experience and competence of the trainee	**0.125 PA per trainee per week**	**NIMDTA Trainer Agreement** **Additional HSC Responsibilities Approval proforma** Allocations must be added to Job Plans to facilitate payment

	f. Be approachable and available to a trainee to give advice and guidance on clinical, administrative, organisational and governance issues and to provide opportunity for the trainee to raise issued relating to training and support and manage in accordance with HSC Trust and NIMDTA policies g. Keep appropriate records of assessments h. Document all meetings and associated outcomes/actions agreed in the portfolio and review development of the portfolio by the trainee i. Liaise with others to share information over trainee progression 2. Attend meetings relevant to the educational supervision role and disseminate information to a trainee's Clinical Supervisor and the trainee as appropriate 3. Arrange for an appropriate colleague to fulfil the educational supervision role during any period of absence and inform the TPD if a period of absence will extend beyond 4 weeks. 4. Undertake a formal handover with the new Educational Supervisor.		

Role	Role Description	Suggested PA Allocation	Approval From
NIMDTA Appointed Clinical Supervisor	**Named Clinical Supervisor** For every placement, the doctor in training must have a named clinical supervisor. In some instances, this will be the same person as the educational supervisor. A **named clinical supervisor** is a trainer who is responsible for overseeing a specified trainee's clinical work throughout their placement in a clinical environment and who is appropriately trained to do so. Their role is to lead on providing day-to-day supervision of trainees, reviewing a trainee's progress and providing constructive feedback. **Responsibilities of the Clinical Supervisor** 1. Should be involved with teaching and training the trainee in the workplace 2. Should help with both professional and personal development 3. Must offer a level of supervision of clinical activity appropriate to the competence and experience of the individual trainee. 4. Support the trainee through direct supervision, close supervision and regular discussions, review of cases and feedback 5. Organise induction to the clinical department (covering duties of the post, particular responsibilities, departmental meetings, senior cover, cross-specialty induction when cross-cover is required, handover arrangements, bleep policies) 6. Agree specific and realistic specialty learning objectives appropriate to the level of the individual trainee	**0.125 PA per trainee per week**	**Additional HSC Responsibilities Approval proforma** Allocations must be added to Job Plans to facilitate payment

	7. Meet the trainee within a week of starting the placement and establish a supportive relationship 8. Provide regular review during the placement both formally and informally to ensure that the trainee is obtaining the necessary experience, included supervised experience in practical procedures and give constructive feedback on performance 9. Perform and oversee the work-based assessments detailed in the portfolio 10. Encourage trainee attendance at formal education sessions 11. Ensure a suitable timetable to allow completion of the requirements of the specific curriculum 12. Ensure that relevant information about progress and performance is made available to the educational supervisor to inform the end of placement appraisal and the Educational Supervisor's report 13. Should inform the Educational Supervisor should the performance of any individual trainee give rise to concern		

Role	Role Description	Suggested PA Allocation	Approval From
Trust Service Development Lead	Many directorate business and related meetings [service/clinical development] are scheduled during existing SPA or DCC, and do not therefore attract further SPA allocation.. A Director and AMD however can agree to "commission" and recommend specific, approved time limited service development projects providing full details of activities/ times and expected outcomes had been provided. In order to attract extra recognition these activities must be over and above time given in the job plan and not displace existing SPA or DCC time. These duties will only arise as a result of a request from an Operational Directorate team.	**Dependent on specific project and time intensity**	Formal Expression of Interest process Allocations must be added to Job Plans to facilitate payment

Role	Role Description	Suggested PA Allocation	Approval From
NIMDTA appointed ***Foundation*** Programme Director	Responsible for the overall management and quality control of a foundation programme that consists of 20-40 placements designed for foundation training across the region.	**1 PA per week**	Formally appointment process from NIMDTA Consultant responsible the approved allocation is added to their own job plan.

Role	Role Description	Suggested PA Allocation	Approval From
NIMDTA appointed Training Programme Director	Responsible for the management of both trainees and their specialty training programme.	**Determined by NIMDTA**	Formally appointment process from NIMDTA Consultant responsible the approved allocation is added to their own job plan.
NIMDTA appointed Head of school / Deputy Head of school	Each School is headed by a Director of Postgraduate Training, known as Head of School. This individual would be a joint Deanery/College appointment, accountable to the Postgraduate Dean, and professionally to a designated College Officer. Specific deputy directors could be appointed Deputy Head of School as justified by workload and available resources, some of whom might take on specific roles such as Flexible Training.	**Determined by NIMDTA**	Formally appointment process from NIMDTA Consultant responsible the approved allocation is added to their own job plan.
Royal College Roles e.g. College Tutor Regional Advisor	These roles fall under External Duties and are not ordinarily funded and as such should have prior Trust approval and specify the duration of the role. Responsibilities may include organizing and monitoring the delivery of training on behalf of the college and providing an educational leadership role.	**At the discretion of the Trust as these are often unfunded – between 0.25PA to 1PA may be allocated depending on the size of the specialty and number of trainees and if funding available to support.**	External Duties Approval Proforma Approval letter from College is desirable Consultant responsible the approved allocation is added to their own job plan.

Role	Role Description	Suggested Allocation	Approval
Trust Appointed Associate Medical Directors	The Role of the Associate Medical Director is set out in a separate document which outlines the core responsibilities including operational effectiveness of services, governance and professional practice standards and medical management.	Responsibility Allowance of £15,200 pa Specific time between 1PA - 3PA's to be allocated in Job Plans – to be agreed by Director/Med Director.	Formal Recruitment Process Allocations must be added to Job Plans to facilitate payment
Trust Appointed Non Operational Associate Medical Directors	Associate Medical Director for Education & Training Associate Medical Director for Research & Development	Specific time to be allocated in Job Plans – to be agreed by Director/Med Director.	Formal Recruitment Process Allocations must be added to Job Plans to facilitate payment
Trust Appointed Co-Director – Undergraduate Medical Education	Co-Director - Undergraduate Medical Education CAH Co-Director Medical Education & Training – Daisy Hill Hospital Clinical Sub Dean (QUB) for undergraduate Medical Education	Salaried Part Time Position. Specific time to be allocated in Job Plans – to be agreed by Director/Med Director.	Formal Recruitment Process Allocations must be added to Job Plans to facilitate payment
Trust Appointed Clinical Directors	Clinical Directors	Responsibility Allowance of £7,600 pa Specific time to be allocated in Job Plans – to be agreed by Director/AMD.	Formal Recruitment Process Allocations must be added to Job Plans to facilitate payment

ROLES NORMALLY CAPTURED UNDER ADDITIONAL SPA ALLOCATION:

Role	Role Description	Suggested PA Allocation	Approval From
SUMDE Undergraduate Teaching	It is agreed that recognition will be given for formal undergraduate teaching roles & commitments subject to details of full year timetable. As indicated above teaching delivered within DCC time can be mentioned in a job plan, but an SPA allocation will only be made if the teaching is delivered over and above, and in separate time. The PA allocation will be assessed on an annualised basis. The Trust is paid for this work through SUMDE monies, and will ultimately track the money to match income with expenditure. Verification of roles and responsibilities will be sought from AMD Medical Education.	Sub Dean for Under-graduate Education will determine appropriate PA allocation based on the amount of dedicated teaching time delivered including a time allowance for admin and assessment time. An annualized PA allocation is determined and this should then be factored into job plans.	Consultant responsible the approved allocation is added to their own job plan.
Southern Trust Appraiser	It is agreed that recognition would be given for the role of appraiser on the basis of the Trust Appraisal Scheme [4 hours per appraisee per year), including reading the folder prior to the meeting, the meeting itself, and the subsequent writing up of the record of the meeting, and attending to the duties of an appraiser as outlined in the Trust's scheme]] It is agreed that a consultant/SAS Doctor preparing for and attending his/her own appraisal will do so within core SPA time.	**1 PA per appraisee per year**	Consultant responsible the approved allocation is added to their own job plan.
Southern Trust Complex Rota organizer	It is agreed that ongoing responsibility for rolling rotas (consultant or junior) should not attract additional SPA allocation. A responsibility for rotas not undertaken by the generality of consultants can be recognized where this is particularly onerous. This includes a very complex rota for example where it involves liaison with other clinical disciplines and/or efficient use of or allocation of clinical staff time [e.g. a theatre rota to match nursing' surgical and anaesthetic resources].	This will be specialty specific – as ordinarily most rota's wouldn't be classed as complex and as such should be managed within existing PA allocations.	Where approved - consultant responsible the approved allocation is added to their own job plan.
Chair of M&M Meetings			

Southern Health and Social Care Trust

HR & MEDICAL DIRECTORATE ACTION NOTES

Thursday, 31st January 2019 @ 9:30am in
The Brackens Meeting Room, Craigavon Area Hospital

In attendance: Dr M OKane; Vivienne Toal; Simon Gilson; Helen Walker; Zoe Parks. Apologies noted from Malcolm Clegg.

1. **HR Structure (Medical HR / ADHR Acute / Medical Directorate)**

Helen gave Dr O'Kane update on role of Business Partner and the linkages with Medical Staffing.

2. **Medical Engagement**
   - **Junior Doctor Experience in SHSCT: Rotas at Risk Paper**
   - **Consultant Induction / Medical Management Roles**
   - **SAS Workforce**

Dr O'Kane advised she had completed a paper around the engagement piece.
ACTION: Dr OKane to share paper with group.

Dr O'Kane updated that she had been linking in with Laura Mott who has been working with various Trusts in the UK around engagement using an APP. She advised she may ask Laura to come over and present the work at SMT. Whilst it is more expensive than the MES work; it does seem to have potential to provide more specific detailed data.

Vivienne asked if Dr O'Kane would link in and update Maxine Williamson with this work as it would fall under her HR remit.

Zoe tabled the Rotas at Risk paper and outlined the huge challenges that are ongoing within a number of specialties in terms of increasing reliance on locums and risk or actual non-compliant pay bandings.

It was suggested that having a dedicated clinical lead with a role dedicated to look at flexible spend and safe working patterns would be welcomed. Dr O'Kane advised that she had met with Dr Gail Browne recently and had discussed the possibility of 2 PA's being offered under EOI with a focus on Education/Training. This could perhaps be incorporated into this role.

ACTION: Dr O'Kane to back to Dr G Browne to discuss/agree a description of what is needs/outcomes expected and then proceed to EOI

Dr O'Kane asked if the majority of issues were within Medicine however Zoe advised that Surgery still needs a focus; given the registrars are working on a band 3 rota and the junior tier continue to cause difficulties in ENT/T&O and General Surgery. There would be scope to have an amalgamated compliant rota if we had the appropriate clinical engagement and agreement.

ACTION: Dr O'Kane to arrange meeting with Mark Haynes to discuss surgical issues.

- **Consultant Induction / Medical Management Roles**

Dr O'Kane advised that she had raised the concept of having 2 SPA's in job plans for the first year as part of an induction initiative at the AMD meeting. The intention would be that this would allow new consultants to complete statutory/mandatory training; time to complete an induction programme which may involve having a buggy with a GP/another colleague; training in voice recognition dictation etc.

ACTION: Zoe to send DR O'Kane a sample consultant Job Description to allow her to add a paragraph to describe the purpose of the additional ½ SPA.

There was some discussion on whether this 1/2SPA should replace DCC or be paid in additional to the expected job plan to avoid any impact on the service.

Once the concept was established it was important that we sold this aspect; make it stand out; include adverts on Twitter with some reference to it etc.

- **SAS Workforce**

Vivienne updated that the Chief Executive had recently received a phone-call from Richard Pengally around the local SAS initiative. This had come about as the BMA have written a letter to Andrew Dawson for a response. We are unable to make any further decisions on this matter given the departmental concerns.

ACTION: Dr O'Kane to speak with Dr N Chapman to agree how best we can use the departmental funding for the SAS leads (2PA's). Dr Chapman is currently paid 1PA. We cannot apply to the DHSSPS to release this money until we have someone in post.

3. **Job Planning**
   - **HR / Clinical Leadership Support**

Action: Zoe to pull together an invest to save job description to include a number of aspects of work that need some additional resource (with succession planning in mind.) This could cover the job planning piece; GMC liaison and international recruitment settlement support post.

4. **MHPS Cases / GMC Case Updates** ***(paper attached: password protected)***

ACTION: Medical Directors office to arrange a separate meeting with Dr O'Kane, Simon and Zoe to review in detail all the MHPS: NCAS; GMC cases and determine best approach moving forward.

In the future the key headlines would then be brought to this meeting for information.

5. **Physician Associates** ***(papers attached)***

Zoe advised the need for greater involvement amongst our clinicians to ensure everyone was aware the PA's are coming; what their induction needs are; their governance structure and supervision arrangements. Dr James Crockett also feels this is critical to ensure the success within the Southern Trusts. Other Trusts would appear to have much more involvement with their clinical staff and have their plans well in place for the PA's coming into post mid-March.

ACTION: Dr O'Kane advised she was due to meet with Dr Crockett soon to discuss this.

6. **International Recruitment**
   - **HR Support**
   - **Cuban Doctors**

Jackie Johnson the deputy Permanent secretary has become aware via Mr Francis Gallagher (community representative on Daisy Hill Pathfinder project) and they are exploring the possibility of different types of contract with the Cuban government for doctors.

ACTION: Zoe to check with TTM if they have links in China or if there is any active recruitment efforts in this country.

The following Agenda Items were deferred and it was asked if another hour could be found in diaries to take these items forward.

7. *Locum Doctors*
   - *Rates & Process*

8. *Doctors Leaving Training*

9. *LNC Preparation / Action Notes*
   - *Cross Site Working Paper (attached)*
   - *Papers for Approval (attached)*

10. *Any Other Business*

11.Date of Next Meeting:-
- ***To be confirmed***

Southern Health and Social Care Trust

HR & MEDICAL DIRECTORATE MEETING

Thursday, 2nd May 2019 @ 3.00pm in Seminar Room 1, Medical Education Centre, Craigavon Area Hospital

AGENDA

1. **Apologies – Helen Walker**
2. **Minutes of the Last Meeting – 31st January 2019**
3. **Action Points from Last Meeting**
4. **Medical Structures**
5. **Review of Structures for Doctors, Dentists and PAs in difficulty**
6. **International Medical Recruitment**
7. **Working Plan between Medical HR & MD Office**
8. **Update on Key Medical HR Issues / Challenges**
9. **Training for Medical Managers**
10. **Actions to Address Doctors Leaving Training and Appraisal for Agency Locums and Contract for Block Booking Locums**
11. **LNC Preparation / Action Notes**
12. **Any Other Business**
13. **Date of Next Meeting:-**
    - ***To be confirmed***

Southern Health and Social Care Trust

HR & MEDICAL DIRECTORATE MEETING

Thursday, 18th July 2019

AGENDA

1. **Apologies – Vivienne Toal**

2. **Review of Doctors in Difficulty Cases & Process**

3. **Draft Consultant Page Tiger Web portal – for comment/approval**
https://view.pagetiger.com/Hub/1MedicalHRHub
(Password Irrelevant information redacted by the USI **)**

4. **Ways to increase capacity document - See attached**

5. **Brief Update on LNC Guidance agreed and those still outstanding:**
   a. **Annual Leave –Minor amendments currently with BMA**
   b. **Study / Professional Leave**
   c. **Private Practice**

6. **Any Other Business**

7. **Date of Next Meeting:-**
- ***To be confirmed***

Southern Health and Social Care Trust

HR & MEDICAL DIRECTORATE MEETING

15 October 2019

AGENDA

1. **Proposal for new format – LNC**
2. **International Recruitment: Update on issues**
3. **Locum Doctors: Extras Engaged**
4. **Any Other Business**

Medical Directorate and HR Meeting	
	9 July 2020
	Dr M OKane (MO) Mrs V Toal (VT) Mrs Z Parks (ZP) Mrs Helen Walker (HW) Mr Stephen Morrison (SM) Mr S Gibson (SG) Mrs Maxine Williamson (MW)
Action Notes	**Update on Doctors and Dentists Oversight Group process** Dr MO advised she was content with the revised process for managing Doctors Dentists Oversight Group. (DDOG). To continue with revisions to timeslots next month. **Medical Leadership development** Maxine Williamson joined the call. Dr MO confirmed she had been speaking with Paula in the Leadership centre. She meets with the CD's/AMD's on a weekly basis every Thursday at 5pm Plan for an on-boarding session on 31 July 2020 via zoom **MW** to discuss and agree the on-boarding plan with Paula from Leadership centre. **BAME doctors provision** Dr MO advised about the numbers of overseas doctors joining the Southern Trust in recent times. We need to look at the different roles and expectations and a cultural piece to provide an enhanced induction. VT mentioned about the OSCE system that was set up for the overseas nurses when they first came to the Southern Trust. **SG** to liaise with Lynne Woolsy and Dawn Ferguson to see if this model could be used for the overseas doctors. **Physician Associates update** Simon gave an update on the PA's and how they had been deployed across the Trust. Initially the 6 had been deployed in Daisy Hill site during Covid but there are now moves to bring some across to the Craigavon site. **SG** to liaise with the Medical Assistant team and Eileen Donnelly re roles and responsibilities to ensure it is clear who is doing what. Consider need for new model. There may be a need to ensure roles are split out – including those for the FY1 doctors. Need to review how the consultant manages the entire team. Also review how they can tap into the nursing assistant pool **HW** to speak to Melanie to determine her views on a new model for this group **Medical Student Technician update + survey** These students have been used extensively across the Southern Trust and been very successful. Very positive feedback from survey and an indication they would return to the Southern Trust.

	There is currently a large cohort on the wards helping to cover significant shortages due to leave. They return to university at the end of August. The plan is they will transition over to a zero hours bank at that time so they can be used on an ad hoc basis when they are available. Simon Gibson acknowledged the work of Niambh OHanlon in Medical HR in assisting with this work. Medical HR had explored with nurse bank but determined the best fit model was HSC E Locums. **SG** to update Melanie/Director Acute on this plan **Locum contract for block bookings** **ZP** to circulate paper to Dr OK and HW Zoe gave an update and circulated a paper around the proposals for longer term bookings via our internal bank. To be discussed after SMT

Southern Health and Social Care Trust

HR & MEDICAL DIRECTORATE MEETING

20 August 2020

Venue: The Brackens Meeting Room

& Videoconferencing will be available
Via Zoom/Desktop Client (Can Siobhan or Vivienne Host?)

AGENDA

Apologies noted from Zoe

1. **Medical Leadership development**
2. **Locum Information**
3. **Job Planning**
4. **AOB**

Thursday 1st October 2020

HR & MEDICAL DIRECTORS GROUP MEETING

Meeting via Zoom

https://view.pagetiger.com/Medical-Staffing/virtualmeeting

Dr O'Kane, V Toal, Dr Diamond, S Gibson, S Hynds, H Walker, S Morrison, Z Parks

SAS DOCTORS ACTING UP TO CONSULTANT :

If extension to the 6 months is to be considered, we will need a reason why for each doctor.

ACTION: HR and MD to document reason why each doctor was "acted up", why an extension is necessary and the maximum timescale for this.

ACTION: MD to write to the Chief Medical Officer to ensure this is brought to his attention.

LNC AGENDA ITEMS:

Discussion took place around the topics raised at last LNC: Learning from Covid, Training needs for Junior, Medical HR Hub and Discharge letters.

ACTION: HR to check with Clifford Mitchell / Paula Tally if the feedback from the SAS CX session is available for review. We would like to share this at LNC. Also check if the overall Trust feedback would also be available.

ACTION: Simon/Dr Diamond to ask Dr E McCrory if she would do a quick presentation at LNC (21 October) around the new zoom training sessions/simulations that have been developed.

ACTION: Simon/Dr Diamond to ask Dr R Carville if she would do a quick update/presentation at LNC (21 October) around the Medical HUB launch in August 2020.

Vivienne updated group on the approach being suggested in Belfast Trust around remuneration for consultants/SAS who were resident on Covid Rotas. Proposal currently with Belfast Trust Board in absence of a Departmental decision.

ACTION: Simon/Dr Diamond to ask Laura McGuinness (Physician Associate) if she would provide an update/presentation at LNC (21 October) around their progress with discharge letters (in collaboration with Pharmacy and the Medical Students in Daisy Hill).

Dr Diamond updated the group that Dr Rose McCullagh has been completing training for the junior doctors on what needs to be within a discharge letter.

ACTION: Simon to check with Queens around the Medical Student curriculum to ensure there is something explicit around "how to write a letter", so that MST's can be involved in this task.

ACTION: Simon / Dr Diamond to follow up with Dr Carville around the pilot of the rota rostering system that was meant to be rolled out in Surgery. Need to identify blockages. Suggestion may need to move to Daisy Hill if unable to make this work in Craigavon.

SAS development Paper Sept 20 – Agreed we should continue to find ways of how we can improve our support for SAS doctors. Dr OKane agreed to establish a group to ask the SAS Lead to take forward the recommendations. Email issued to SAS leads/LNC Chair/Simon.

End of Meeting

Southern Health and Social Care Trust

HR & MEDICAL DIRECTORATE MEETING

Thursday, 5th November 2020

Venue: Virtual @ 11:30am

Videoconferencing will be available via Zoe Parks Zoom Meeting

https://southerntrust-hscni.zoom.us/j/85280601138?pwd=ZkUwY0NTM3ZySmdKQXMvSzZpMFg2UT09

AGENDA

- **Covid Payments**
- **International Doctors – cf Avoidable Crisis Paper** ***(Dame Doreen Lawrence)***
- **Medical Hub cf Junior Doctor Hub**
- **Educational Fellows**
- **Physician Associates**
- **Involvement of NEDs in MHPS Cases**
- **Job Planning 2021 Round**
- **Monitoring : Band 3 Outcomes**
- **Any other Business**
- **Date of next meeting:-**
  Thursday, 17th December 2020 @ 12:00noon

Southern Health and Social Care Trust

VIRTUAL HR & MEDICAL DIRECTORATE MEETING

Thursday, 17th December 2020 @ 12noon

Join Zoom Meeting
https://southerntrust-hscni.zoom.us/j/82111990532?pwd=WVB1dXJ3cFJZTU5aTjdjb2I3SEFkUT09
Meeting ID: Irrelevant information redacted by the USI
Passcode: Irrelevant information redacted by the USI

AGENDA

- **HR Dashboard**
  https://view.pagetiger.com/Medical-Staffing/virtualmeeting
- **Job Planning Process, Numbers & Sign Off (SPA new appointments)**
- **AMD/CD Appointments (Paeds)**

FINAL VERSION
Process for appointin

- **Data Protection Issues (AOB)**
- **Medical Mentoring – A Guide to Good Practice**

Mentoring Guide.pdf

- **Consultant Passport**
- **Any Other Business**

Date of next virtual meeting: ***Friday, 5th February 2021 @ 2:00pm***

2013

Southern Health and Social Care Trust

Quality Care - for you, with you

Process for appointing Associate Medical Directors and Clinical Directors into Medical Management

Final Version: March 2013

1. Introduction

1.1. The Southern Trust recognises the need for medical engagement in the leadership and involvement in the planning, design and delivery of our services. This document sets out the process for the appointment of medical management positions within the Southern Trust. The procedure is underpinned by the principle of selection of doctors through open competition ensuring a choice of candidates and appointment based on ability, attitude, leadership aptitude and potential.

1.2. The Medical Leadership Competency Framework, through integration into medical education and training, aims to ensure that doctors acquire appropriate management and leadership skills at all key stages in their career.

1.3. ***Figure 1: Medical Leadership Competency Framework***

The Medical Leadership Competency Framework (2010), developed by the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement, describes the leadership competences doctors need in order to become more actively involved in the planning, delivery and transformation of health services.

2. Process for Appointment

2.1. All medical management positions will be appointed via a formal Internal Trawl which is administered by Recruitment Services. When a request to fill a post by Internal Trawl is received the following steps will apply;

- A Job description and Personnel Specification will be completed and forwarded to Recruitment Services.

- An Internal Trawl Notice, covering memo, Job Description and Personnel Specification will be issued and circulated in accordance with the instruction from the relevant Service Director.

- Trawls will be circulated via email to all Trust staff. They are also advertised on www.hscrecruit.com to allow online applications.

- The normal Selection process will apply i.e. shortlisting and interview.

3. Principles for Leadership

3.1. The Southern Trust wants to promote and develop medical management roles that are effective, valued by the Trust and give job satisfaction to post holders. The following attributes are therefore important in the selection of doctors into management:

- A professional focus on patients and particularly patient safety
- A commitment to lead by example with regard to clinical and social care governance
- An ability to carry the confidence of colleagues through difficult situations
- A recognition of being part of the Trust management team and collaborative approach to achieving objectives
- A commitment to ensuring the professional medical agenda is maintained and delivered in the Trust through doctors and the teams they work within
- A commitment to representing the needs of the whole specialty/specialties and have dedicated time on both hospital sites.
- A willingness to develop leadership potential, setting expectations and leading by example.

4. Recognition

4.1. The Trust wants to ensure that all doctors engaged in management roles are rewarded appropriately for this work. The following recognition is offered:

4.2. Associate Medical Director

- Responsibility Allowance: **£14,900 per annum.** (This is a pensionable allowance)

- Dedicated time within job plans of between **1 – 3 PA's per week.** Depending on the role it is expected that up to a maximum of 3 Programmed Activities could be allocated. This time allocation will be timetabled into the job plan as additional HSC responsibilities and will be proportionate to the demands of the role, size of the division etc.

- Training and support to ensure doctors are equipped with the necessary skills to develop within their leadership role and increase breadth and depth of their leadership capacity.

4.3. Clinical Director

- Responsibility Allowance: **£7,450 per annum** (This is a pensionable allowance)

- Dedicated time within job plans up to a maximum of **1 PA per week.** Depending on the role it is expected that between 0.25 and 1 Programmed Activities per week could be allocated. This time allocation will be timetabled into the job plan as additional HSC responsibilities and will be proportionate to the demands of the role, size of the division etc.

- Training and support to ensure doctors are equipped with the necessary skills to develop within their leadership role and increase breadth and depth of their leadership capacity.

5. Duration of Medical Management Posts

5.1. Associate Medical Director and Clinical Director posts will be appointed for a period of **3 years** subject to satisfactory performance with annual performance reviews. After this period, the post will be re-advertised and subject to open competition.

6. Useful Links and Resources

http://www.e-lfh.org.uk/projects/leadership-for-clinicians/
LeAD is a free e-learning resource based on the Medical Leadership Competency Framework to help clinicians develop understanding of their role in contributing to the management and leadership of health care services.

https://www.fmlm.ac.uk/
The Faculty of Medical Leadership and Management have developed a comprehensive online collection of resources to help doctors in their day to day leadership roles.

http://www.institute.nhs.uk/building_capability/enhancing_engagement/medical_engagement_scale.html

A range of resources available. The NHS Institution for Innovation and Improvement have produced a useful summary of what is meant by shared leadership: *Shared Leadership: Underpinning of the MLCF* (pdf).

http://www.gmc-uk.org/Leadership_and_management_for_all_doctors_FINAL.pdf_47234529.pdf
Leadership and management for all doctors' publication.

http://www.leadershipacademy.nhs.uk/

A range of resources available: the academy works to develop outstanding leadership in health, in order to improve people's health and their experiences of the NHS.

Appendix Section

1. Sample Internal Trawl Notice of Medical Management Post
2. Sample Development Review for AMD Post

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APPENDIX 1: Sample Internal Trawl Notice

SOUTHERN TRUST VACANCY TRAWL

PUBLICATION DATE:

Further information on all posts listed in this trawl can be obtained the following ways:

- **Online at** www.HSCRecruit.com
- **E-Mail to** Personal Information redacted by the USI
- **Call in Person to Recruitment & Selection, HR Directorate, Hill Building, St Luke's Hospital Site, Loughgall Rd, Armagh BT61 7NQ**

If one of the above options is not accessible please contact the Recruitment Team on Personal Information redacted by the USI.

SECTION 1

Internal Trawl – Posts in this section are **open to all Southern Trust members of staff only** (whether permanent, temporary or bank/as and when required). Please note this excludes workers engaged through external Recruitment Agencies or by other means

Job Ref Number	Job Title	Band	Location	Closing Date	Hours	Additional Information
	Clinical Director	N/A	Craigavon Area Hospital, SHSCT		Part Time	

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APPENDIX 2: Sample Annual Review AMD Role

Role dimensions	Annual Objectives	Supporting Information for decision to be completed by doctor prior to review	Achieved?	Areas for Development completed by doctor prior to review
1. **Member of Directorate Management Team & Communication**	EG • Attend x Directorate Management Team meetings • Cross site meetings			
2. **Service development and improvement**	EG • % compliance with SBA delivery targets			
3. **Appraisal -** oversight of system for all medical staff within Directorate/sub-Directorate.	EG • Ensure all appraisals are complete by….			
4. **Job planning –** oversight of system for all medical staffing within Directorate/ sub-Directorate.	EG • Ensure all job plans are complete by…			
5. **Implementation of relevant Medical HR Policies**	EG • Implement policies such as annual leave, study leave, sickness absence. • Managing underperformance			
6. **Medical Governance Leadership**	EG • Leadership role in embedding Clinical & Social Care Governance • Role at governance forum • Attendance at meeting • Involvement in RCA's, incident investigations and complaints • Feedback loops			

Role dimensions	Annual Objectives	Supporting Information for decision to be completed by doctor prior to review	Achieved?	Areas for Development completed by doctor prior to review
7. Standards	• % Directorate adherence to new & existing standards e.g. NICE, NSFs, College • Assurance mechanisms • Role in implementation/adoption of new standards and guidelines • Mechanisms in identifying gaps			
8. Education & Training	EG • Implementation of actions raised in NIMDTA/RQIA visits by … • Ensure 100% EWTD compliance for all doctors by…. • Patient safety initiatives for junior doctors • Engagement with junior doctors • Involvement in junior doctor workforce planning			
9. Public Health and urgent operational Issues	EG • ***Any specific operational issues in this specialty should be listed here			
10. Staff Turnover	EG • Any unusual high turnover • Results of Exit interviews • Reasons for staff leaving department.			
11. Medical Leadership	EG • Evidence of succession planning • Communications with staff • Feedback loops • Evidence of clinical engagement			

SECTION 2 DEVELOPMENT PRIORITIES

PROFESSIONAL AND PERSONAL DEVELOPMENT RELATED TO ROLE OUTLINE AND PERFORMANCE		
Professional and personal development:	**WHAT? WHEN? HOW?**	**COMMENTS ON DEVELOPMENT ACHIEVED/APPLIED:**

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APPENDIX 3: SAMPLE JOB PROFILE

JOB DESCRIPTION

Ref:

Tile of Post: Associate Medical Director

Directorate/Division:

Operationally responsible to:

Professionally responsible to: Medical Director

Commitment: Maximum of 3 PAs - to be agreed with Director

Base:

JOB SUMMARY

The Associate Medical Director (AMD) will as a member of the Directorate Senior Management Team, play an active role in contributing to the strategic direction and the on-going provision of high quality services which are safe and efficient. Specifically the AMD will be responsible and accountable for the medical staff within the specialty and their role in the provision of services. As a senior medical leader within the Trust the AMD will work closely with the Director/ Assistant Directors to provide medical management within the Directorate and contribute to the overall vision, direction and performance of the organisation with respect to the medical staff and their role in service delivery. The AMD will also be responsible for the safety and capability of the medical workforce within the specialty, providing the Director with defined information for assurance purposes to the Medical Director. The AMD will demonstrate a commitment to lead by example with regard to clinical and social care governance.

The post (maximum 3 PA's per week) will be appointed for one year and may be extended at annual performance reviews up to a period of 3 years. After this period, the post will be re-advertised.

KEY RESPONSIBILIEIS

1. LEADERSHIP & MANAGEMENT RESPONSIBILITIES

The AMD will work closely with the Director/ Assistant Directors to provide effective leadership within the Directorate. He/ she will also contribute to effective service delivery within the department by managing implementation of the following policies;

Appraisal

- Coordinate the approved appraisal system, ensuring a process is in place and operating within guidelines
- Ensure necessary training (within the agreed budget) is available for medical staff (non-training grades) within the Directorate/ sub Directorate, manage the approvals process for same and oversee the Division's utilization of the budget for medical training and development
- Monitor the implementation of appraisal within recommended timescales
- Undertake appraisal for Clinical Directors
- Prepare an annual Directorate/ sub Directorate Appraisal report for the Director to submit to the Medical Director (in relation to required Annual Trust Board Report)

Job Planning

- Provide leadership and support for Job planning within the Division for consultants, Associate Specialists and Specialty Doctors
- Coordinate the implementation of Job Planning within Job Planning guidelines
- Monitor the completion of Job Plans within agreed timescales
- Undertake Job Planning for Clinical Directors and Lead Clinicians and any other relevant medical staff
- Advise and mediate in cases that cannot be resolved by Clinical Directors within existing job planning guidance
- Ensure that Job Planning process and outcomes reflects the Division/ Directorate's service capacity needs and Service and Budget Agreement with our Commissioner

Implementation of HR policies for medical staff

- Coordinate and monitor implementation of all relevant policies including
  Annual Leave
  Study Leave
  Performance
  Sickness absence
  Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support

Education and Training

- Liaise with the Associate Medical Director for Education and Training and College Tutors to ensure a plan is in place by specialty for the training of junior doctors in keeping with NIMDTA and GMC requirements (including managing the balance between service delivery and training demands)

- Provide leadership in implementing and achieving compliance with the European Working Time Directive

2. CLINICAL GOVERNANCE RESPONSIBILITIES

The AMD in conjunction with the Assistant Directors and Director will be responsible for having systems and processes in place to review and manage remedial action

emerging from incidents, complaints, risk identification and assessment, litigation, audit and clinical indicators.

The AMD will be directly responsible to the Service Director for patient safety. This includes ensuring processes are in place to identify, review and take remedial action when patient safety issues arise. The AMD will participate fully in the Trust's Clinical and Social Care Governance Working Body.

The AMD will be responsible for managing potential underperformance of medical staff within the Directorate. With full assistance from HR, the AMD will be responsible for leading the Trust's process for Maintaining High Professional Standards within the Division.

OTHER CLINICAL GOVERNANCE RESPONSIBILITIES

Divisional Governance Forum

- Chair the Divisional Specialty Governance Group and participate as agreed in Directorate governance arrangements
- Work with the Trust/ Directorate Governance Co-Ordinator to ensure effective governance of services

Standards

- Provide advice to the Service Director and colleagues on the application of existing and new standards and guidelines e.g. NICE, NSFs, Royal College Guidelines etc
- Work with relevant managers and colleagues on required implementation plans and lead the implementation of such plans in relation to the medical workforce and clinical practice
- Act upon the recommendations of any external audits/ reviews (e.g. RQIA, CMO's office, Child Protection etc) working on the development and roll out of an implementation plan in conjunction with the Director/ Assistant Director
- Assist in the preparation for external inspections

Public Health and urgent operational issues

- Provide advice to Director and colleagues (e.g. swine flu, HCAIs)
- Contribute as appropriate to the development and implementation of contingency plans and lead the implementation of these plans in relation to the medical workforce.

3. CORPORATE RESPONSIBILITIES

As a senior medical leader within the Trust the AMD will participate and contribute to the corporate performance of the Trust. He/ she will share responsibility with other senior managers in the Trust for Trust activities and for the overall performance, clinical and service strategy.

The AMD will also be required to;

- Attend meetings of the Directorate Management team and/ or regular meetings with the Service Director
- Contribute to the Business Plan of the Directorate to help achieve Trust Delivery Plan priorities
- Monitor activity against the plan and determine/ advise on required actions in conjunction with Director/ Assistant Directors
- Lead the implementation of such plans as they apply to the medical workforce and/or clinical practice

OTHER CORPORATE RESPONSIBILITIES

Service Development & Improvement:

- Maximise the effectiveness and efficiency of the services within the Division across the Trust's hospital network
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options
- Provide a medical perspective on protocols/ pathways related to service improvements
- Provide input to decisions on the medical capacity required for service developments.
- Provide clinical leadership on service reconfiguration within the Division and Directorate

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's specialty collective training and development budget for non-training medical staff
- Receive reports from Finance and work with Finance staff support on management of the budget
- Take account of medical staffing costs within the Job Planning contex

Communication

- Facilitate good communication with medical staff, (through planned meetings with consultant staff and other opportunities)

- Provide effective communication with other clinical and non-clinical managers in support of good multidisciplinary team working

- Actively promote the development of clinical and professional networks across the Trust's hospital network.

- Actively participate in the AMD Forum which is led by the Medical Director

GENERAL REQUIREMENTS

The post holder will be required to:

- Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

- Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

- Adhere at all times to all Trust policies/codes of conduct, including for example:
  - Infection Control
  - Smoke Free policy
  - IT Security Policy and Code of Conduct
  - standards of attendance, appearance and behaviour

- All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

- Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

- Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

- Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. It is not intended to be rigid and inflexible but should be regarded as providing guidelines within which appointee will work.

- It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

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PERSONNEL SPECIFICATION

JOB TITLE Associate Medical Director

DIRECTORATE

Ref No:

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

***ESSENTIAL CRITERIA** – these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Applicants must be a permanent Consultant within the Southern Health and Social Care Trust.

2. Hold a medical qualification, GMC registration with licence to practice and specialist accreditation (CCT)

3. Experience of leadership within a team that led to successful service development and/or quality improvement.

4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

The following are essential criteria which will be measured during the interview stage.

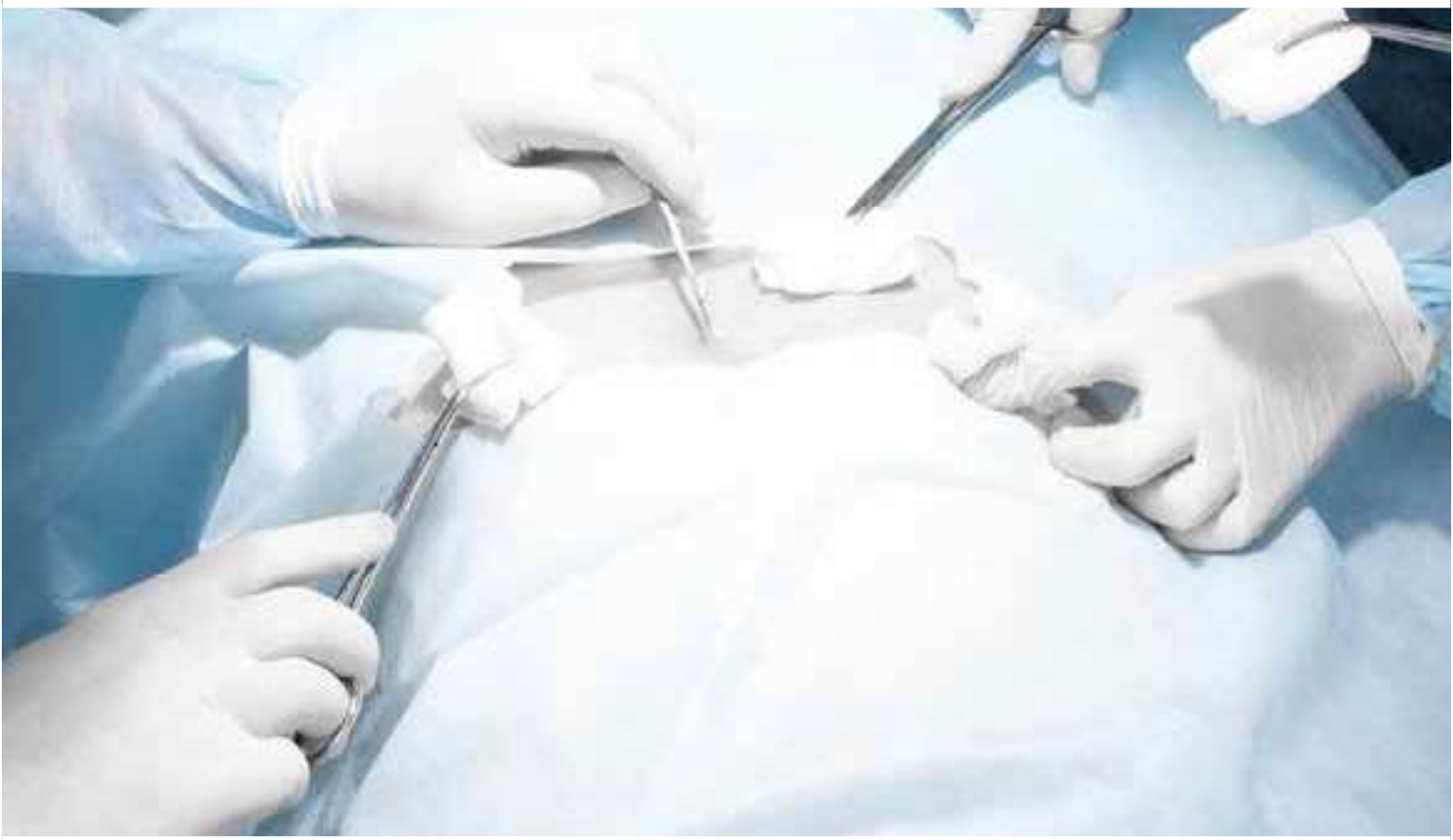
5. Effective communication skills to meet the needs of the post in full.

6. Be prepared to undertake clinical management development.

Candidates who are shortlisted for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. It is intended that shortlisted applicants will be assessed against criteria stated in this specification linked to all seven domains of the NHS leadership framework. Further details on the NHS leadership framework may be obtained from http://www.leadershipacademy.nhs.uk/discover/leadership-framework/supporting-tools/documents-2-download/

Mentoring

A GUIDE TO GOOD PRACTICE



Supports Good Surgical Practice

Domain 3: Communication, partnership and teamwork

Royal College of Surgeons
ADVANCING SURGICAL CARE

Published 2015
Professional and Clinical Standards
The Royal College of Surgeons of England
35–43 Lincoln's Inn Fields
London WC2A 3PE
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Mentoring

A GUIDE TO GOOD PRACTICE

RCS Professional and Clinical Standards
November 2015

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A. INTRODUCTION

Mentoring provides personalised developmental support and is recommended by the College for all surgeons.

With the rapid pace of change in healthcare organisation in recent years, surgeons not only face the challenges of maintaining the technical and clinical skills required of their specialty, they also have to adapt quickly to new organisational cultures and management structures. The report of the Mid Staffordshire Public Inquiry[1] stressed the importance of team-working and patient-centred leadership in promoting cultural change for the benefit of patient care.

Mentoring provides a unique opportunity for developing the leadership skills and confidence required to respond to these challenges. The concept of mentoring is explicitly encouraged in *Good Surgical Practice*[2] as well as being inherent in much of the College's professionalism agenda. Mentoring schemes can support surgeons' development by helping them adopt new approaches to situations and reflect on their practice. They provide an opportunity to develop new ways of thinking and behaving in both the mentee and the mentor. Mentoring can improve work performance, reinforce professional values and enhance surgeons' ability to deal with difficult situations and sensitive communications with patients and teams,[3] all contributing to better patient care over the course of a career.

B. WHAT CAN I LEARN FROM THIS GUIDE?

The College advocates mentoring at all stages of surgeons' careers. *Good Surgical Practice* requires surgeons to take responsibility to act as a mentor to less experienced colleagues and to seek a mentor to improve their own skills.[2]

Many surgeons will act as both a mentor and mentee at different points during their career. Whether or not they categorise it as 'mentoring', most surgeons would recognise and value the experience of forming a supportive relationship with a colleague who supports them in particular career goals or situations. This kind of informal mentoring relationship has a long history in surgery but not everyone meets a suitable mentor by chance and – for those who do not form these relationships in the normal course of their working lives, or would appreciate a more structured approach – an externally established mentoring relationship with agreed boundaries can provide opportunities to develop and improve within a supportive professional relationship.

This document is intended to provide practical guidance to surgeons acting as or seeking a mentor. It explains the nature and benefits of mentoring and identifies the principles of establishing and maintaining effective mentoring relationships. It is intended to complement the College's guidance *The High Performing Surgical Team - A Guide To Best Practice*[4] and to be used as a tool to support the implementation of the standards set out in *Good Surgical Practice*[2] relating to mentoring.

C. WHAT IS MENTORING?

There are many definitions for mentoring and it is often confused with training roles or remedial support. For the purposes of this document, mentoring can be described as:

'The process whereby an experienced, highly regarded, empathic person (the mentor) guides another individual (the mentee) in the development and re-examination of their own ideas, learning, and personal and professional development. The mentor who often, but not necessarily, works in the same organisation or field as the mentee, achieves this by listening and talking in confidence to the mentee'[5]

It is important to note that mentoring is not counselling, patronage or giving advice. Rather, mentoring supports the mentee to review their own situation and arrive at their own conclusions about actions to take. The main purpose of mentoring is to consider the whole surgeon and to develop general skills and attributes, ultimately to improve patient care by enabling the surgeon to perform to the best of her/his ability. These may not be clinical skills; mentoring is more likely to address issues related to effective team-working, leadership and management. Many mentoring discussions are around work–life balance, future development areas, dealing with challenges and team dynamics.

Table 1 lists other one-to-one helping relationships that use similar skills but are not mentoring. The difference between mentoring and teaching / patronage / preceptorship is the methodology used. Mentoring aims to help an individual develop through insight and self-awareness as opposed to just being told or shown in a robotic fashion. Some surgeons may benefit from having both a supervisor and a mentor. For example, a new consultant can work with a senior colleague in the same department for preceptorship but can also have the opportunity to be attached to a mentor who isn't in the same department and may not be so senior.

There is most overlap between mentoring and coaching. A mentor guides the mentee to shape their own attitudes and behaviour. Coaching could be viewed as building particular skills and focusing on a narrowly defined task or goal. There may be greater direct intervention from the coach, whereas a mentor may signpost the mentee towards opportunities.

'The European Mentoring and Coaching Council recognises the myriad of conflicting attempts to distinguish between coaching and mentoring […] *Mentoring is the word used by the Department of Health and in GMC reports, reason enough to hold on to the term* […] *There is an argument that the word 'mentor' is a relationship-describer like 'friend' or 'partner', whereas 'coach' implies a set of skills and activities'*[6]

Mentoring must not be confused with remedial action used to support a doctor in difficulty and care should be taken to maintain distinctions between mentoring as a normal part of a surgeon's professional life and remedial or supervisory relationships (sometimes colloquially referred to as 'targeted mentoring').

Key principles of mentoring:

- The mentoring relationship must be freely entered into and not coerced
- Discussion between mentor and mentee must take place in confidence (except where patient safety or the duty of candour supersedes this)
- The mentor and mentee must agree the boundaries of the relationship, ideally clearly defining goals and outcomes
- A mentoring relationship requires a time commitment on both sides and this should be agreed both in terms of the expected duration of the relationship and the frequency of meetings within that time
- The mentee should expect to set the agenda of mentoring discussions, with the mentor responding to this, rather than imposing his/her own view.

Table 1: Other one-to-one supportive roles with definitions to contrast from mentoring

Role	Activity
Mentor	Helping to shape an individual's beliefs and values in a positive way to help their self-awareness and personal development. Mentoring helps people take charge of their own development, release their potential and achieve results that they value. Mentoring is sometimes a longer-term career relationship with an experienced colleague, but can be just as useful as a single conversation. The mentor does not have to be in the same profession as the mentee and indeed does not necessarily have to be senior. While mentoring should be encouraged, it is an activity that cannot be imposed. Mentors require training. Good mentors never advise; they help the individual find the way of managing a dilemma or opportunity that best suits them. Mentoring is the process of a mentor encouraging the mentee to ponder about areas of challenge in their lives, either professional or personal, and through this interaction and with the aid of a tool box of 'mentoring tricks' allow the mentee to come up with their own solutions to their concerns and then importantly make changes happen to allow personal progress. There are several mentoring techniques. The most widely known and accepted is the Egan method (see Section K). Whilst one can learn the basics of Egan mentoring very quickly, to use it effectively takes time, effort and consistency in its application. The essence of mentoring is to allow the mentee through guidance with the mentor to come up with their own solutions to their own issues. Mentoring does not include 'telling'. The solution should not come from the mentor directly. Once telling happens the mentoring process becomes invalid. Additionally, quality assurance of the mentoring process is necessary through reflective practice of the mentor and through discussion with other mentors.
Coach	Developing a trusting and respectful relationship to help another person improve awareness of themselves and their situation, clarify priorities and establish commitment to an agreed time-framed action plan. This can be analogous to a tennis coach, with a clear plan for improvement of behaviour and performance. Coaching has many similarities with mentoring. The term 'coaching' is most often used when the interaction between the coachee and coach is of short duration, narrowly focused and involves a degree of 'telling' or 'showing' by the coach. Life coaches focus on wider issues, which may add to overlap of terms with mentoring. A coach must always be trained.
Perceptor	This term was coined by the nursing profession. It means guiding a newly qualified or newly appointed colleague through the uncertainties of early clinical practice while they find their feet. This might involve activities such as joint operating lists, clinics and ward rounds. Preceptorship is therefore similar to supervision, but between a senior and junior consultant. This again is not mentoring or coaching.

Teacher	Giving information to help someone develop cognitive skills and capabilities. Teaching, as opposed to simple learning, usually implies a more interactive relationship involving facilitation, assessment and feedback.
Educational supervisor	Directing a trainee during a phase of their training. This encompasses support, direction, feedback, observation, collation of information, advice and discussion. Educational supervisors are responsible to the Training Programme Director for delivery of a programme of training.
Clinical supervisor	Helping with teaching, training and feedback in the clinical setting. Clinical supervisors have specific roles and should have received training.
Session supervisor (eg Assessor for ISCP)	Carrying out a range of assessments and providing feedback to the trainee and supervisor to support judgements made about a trainee's overall performance. Assessors may be other members of the surgical team.[7]
Appraiser	A trained individual carrying out doctors' annual appraisals in preparation for a recommendation to the GMC on doctor's fitness to practise. Appraisers help with the formulation of the doctor's Personal Development Plan (PDP) and checking of progress on the previous PDP. Appraisal is different for doctors in training grades as it will be closely linked with their training and supervision.
Counsellor	Helping an individual improve performance by resolving situations from the past. Counsellors are trained and qualified individuals. Counselling can be suggested to an individual but cannot be compulsory – the individual must agree.
Clinical supervisor for a doctor in difficulty or remedial trainer	Some form of one-to-one supportive help is frequently recommended when an individual is facing concerns over his or her performance or has been designated as a doctor in difficulty for clinical or other reasons. The kind of support required is more often supervisory, instructional or remedial and the goals set are often external to the doctor. This is sometimes referred to colloquially as 'targeted mentoring'. Often several different modalities of help and/or retraining are needed, depending on the balance of conduct, competency or capability issues and the level of insight. It would be helpful to view the role as a 'supervisor' rather than a 'mentor' because the doctor in difficulty is not leading or directing this process. Guidance is available from both the College[8] and NCAS[9] on designing and implementing such retraining programmes. Those offering this specific help or supervision need training and support.
Patron	Patronage may be used to describe taking a more junior surgeon (or trainee/student) under your care and giving advice. This can be a helping mechanism but is not mentoring as it is not focused on the individual driving action.

D. WHAT ARE THE BENEFITS OF MENTORING?

To the mentee and their future patients

Mentoring schemes have proven effective at supporting surgeons' personal and professional development. It can improve their confidence and their ability to deal with difficult situations and challenging communications with patients.[3]

Participation in a formal mentoring relationship provides a forum in which the mentee can reflect upon their practice and professional behaviours, supporting their self-development and working through any concerns or issues. The mentor is an informed outsider who understands the context but is not directly involved so can retain a degree of impartiality. This allows issues to be addressed by the mentee before they can be magnified into problems, and may result in more effective future behaviours. Such changes to individuals' behaviours and attitudes may lead to improved working environments and ultimately better patient care.

To the mentor

The mentor is provided with an opportunity to reflect on her or his own attitudes and behaviours and reconsider these in light of others' experiences. The mentor is able to use and develop communication skills needed for effective team-working and leadership such as active listening and attentive thinking, seeking clarification and checking mutual understanding.[4] The mentor may also gain satisfaction from being helpful and developing someone else's skills.

To the department and organisation

Creating a culture in which mentoring is accepted as a normal way of working will encourage surgeons to view reflective practice, collaboration and team-working as normal. Individuals vary in their self-awareness and insight, and mentoring can prevent communication difficulties or similar issues from worsening into problems that have a negative impact on team-working and the smooth running of the organisation.

Mentoring can also widen the skills base and competencies of staff in line with the organisation's strategic goals. Succession planning is poor in many organisations and mentoring can empower staff to see themselves in future roles and to take the steps needed to be ready for future opportunities. It also helps increase morale and job satisfaction.

E. WHO IS MENTORING FOR?

Mentoring can be beneficial at any stage in a surgeon's career, and should not only be associated with crisis points in a surgeon's professional life. Surgeons should seek a mentor to improve their general skills and understanding of their performance and position within a particular context. For example, mentoring can be useful in assisting the mentee to understand organisational culture, manage challenging relationships or plan career development.

Mentoring is particularly encouraged at points of significant change, such as when taking on a new role. The GMC recognises the importance of mentoring for doctors in delivering safe, effective care immediately when taking on a new role.[10]

In particular, surgeons taking on a new role – such as newly appointed consultants – may benefit from being offered or finding a mentor. The first consultant appointment often represents the first time in a surgeon's career when she/he works outside the boundaries of a formal training programme and without formal supervision. As such, support from colleagues and peers should be expected; in addition, a formal mentoring relationship may allow the individual to feel more able to raise and discuss potentially sensitive issues.

Other points at which a mentoring relationship should be considered include return to practice after period of absence (eg maternity leave[11]), before, during or after a challenging period or when an individual is seeking to initiate change, e.g., in seeking career advancement.

Mentoring can be of particular benefit to people from a group that is under-represented in a particular field. Members of such groups may lack role models they can readily relate to. Providing mentoring opportunities to these individuals can help them feel more at ease in their role, identify goals they might not have considered and start with actions to reach these goals.

A number of publications and organisations have recommended mentoring for particular groups. Baroness Deech's report on women in medicine listed access to mentoring as its first recommendation.[12] In 2013, the Association of Surgeons in Training ran

a mentoring pilot of trainees, showing that setting good expectations leads to better success. The Charter[13] for SAS (Staff Grade, Associate Specialist and Specialty Doctors) further recommends a mentor, separate from the clinical supervisor. Doctors who are not in formal training programmes and peri-retirement surgeons may also benefit from the mentoring process.

With the reduction in surgical placements in foundation training and some attrition of trainees after obtaining a training post, a surgical mentor may be particularly beneficial for medical students, foundation doctors with aspirations towards surgery and core surgical trainees. This may help with their continued surgical thinking and development and their ability to put different phases into perspective alongside their long-term and short-term goals.