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## An approach to departmental job planning in cellular pathology

**A**s a clinical director of pathology your Editor has tried to get his head around histopathology job plans on numerous occasions. Not easy – individual job plans are fine but looking at all the plans at once is not. All is not lost, however. Here the histopathology team at Warwick Hospital has come up with a wonderful system to facilitate this.

### Introduction

Job planning is a key process underpinning the organisation of the cellular pathology service. It forms the basis for:

- an individual consultant's contract
- productive team working within the consultant group
- an understanding with management regarding workload and staffing.

It is apparent from conversations with colleagues locally and nationally that many individuals and departments struggle with this process and that job-planning issues may be a source of conflict between individuals in a department and/or between the department and management.

This article is intended to act as a job-planning 'toolkit', offering a practical solution and illustrating how an outline job plan can be built to function on three levels. In our view, decisions on the approach to key aspects of the job plan should be made on a group/departmental basis that are evidence based, consistent, transparent and fair to each individual within the group. By open, regular job-planning discussion, encouraging and empowering all the consultant colleagues in the decision-making process, the head of department or director of service has a mandate to act on behalf of the group in the annual job-planning review with managerial colleagues. The emphasis is to place the job-plan review within the context of the entire consultant team through an evidence-based and open group/departmental discussion.

### The departmental job plan can work at three levels of complexity

#### Level 1

At the first level, the job plan can simply list the breakdown and detail the components of the plan for an individual within the consultant group. This allows simple calculations of available time/programmed activities (PAs) within the plan for delivery of different elements of the service. However, at a time when increasing workload pressures are commonplace, this 'list' alone is of little

value when it comes to managing workload issues or protecting supporting programmed activities (SPA) time for the individual.

#### Level 2

By applying workload scoring, it is possible to define the appropriate share of the workload for an individual consultant within the department, dependant on available reporting time in the job plan. Total available reporting time in the department can be calculated and monitored against current workload. For example, evidence of an increasing workload can be highlighted and can become the basis for negotiation with managerial colleagues. Benchmarking is possible against other departments using the same workload scoring approach. This retrospective approach to workload scoring may indicate the individual's previous (annual) workload or highlight an imbalance, but lacks a mechanism to address that imbalance prospectively.

#### Level 3

The job plan can dovetail with a prospective and equitable workload distribution system so that SPA time is protected by ensuring that total workload 'pushed' to an individual equates to the available reporting time in their job plan.

### How is the departmental job plan presented?

The job plan is presented on a computer spreadsheet. The consultants' individual job plans can be presented in columns, with no limit to the number of columns in the spreadsheet. Simple or more complex calculations can be put in place to total key aspects such as total available PAs, total SPA time, available reporting time and workload figures. When used at level 3, if there are changes in individual circumstances (such as retirement or a move to part-time working), the spreadsheet can be immediately updated so that the workload can continue to be equitably distributed.

### Populating the spreadsheet: the approach to SPAs

The current consultant contract is time-based. The basic contract splits the working week into 10 PAs of 4 hours each. A split of 2.5 SPAs to 7.5 direct clini-

cal care (DCC) PAs has been the usual arrangement. SPA time is allocated to recognise time required for activities such as continued professional development (CPD) and appraisal. At a time when Trusts are targeting SPA time in the consultant's individual job plan and expect to see clear justification for any additional SPA time evidence based, the approach to SPA time, as presented here, has proven robust in job-planning negotiations.

Our current approach has been to allocate every consultant 20% of total basic contracted time as SPA time (i.e. 8 hours or 2 PAs for a 10 PA contract, 5.6 hours for a 7 PA contract) to allow for CPD, EQA participation and appraisal. Consultants who have taken on leadership or managerial roles are allocated additional SPA time in their job plan, with each role and time allocated to them agreed by the consultant group at regular job-planning meetings. We have labelled this 'non-routine' SPA time and, as a result, across a department consultants have different total SPA time in their job plans. An example level 1 job plan is presented in Table 1.

For simplicity, the spreadsheet has been limited to five consultants, but there is no limit to the number of columns (consultants). In this example, consultants are labelled A–E. Consultant A is working a standard 10 PA contract and has been allocated 4 hours of additional non-routine SPA time to act as head of department. Consultant B also has a 10 PA basic contract but receives one additional externally funded PA (for example, regional QA lead or SIFT-funded teaching). Consultant B has been also been allocated 1 hour of additional SPA time for an educational supervisor role. Consultant C works part time on a 7 PA contract with 1 hour non-routine SPA time allocated for a network cancer lead role. Consultant D has a standard 10 PA contract with 1 hour of non-routine SPA time added for audit lead. Consultant E receives one additional externally funded PA, but has dropped to a 9 PA basic contract. This consultant receives 1 hour of additional non-routine SPA time for being the autopsy lead. Note that with the

exception of consultants B and D, each consultant has an individualised total SPA time dependant on key department leadership roles. Also note that the spreadsheet has calculated remaining available clinical hours for each individual and given a total for the 'department'.

### Populating the spreadsheet: the approach to direct clinical care (DCC) PAs Multidisciplinary team meetings (MDT)

To account for preparation, attendance and time spent on issues post-MDT, set time can be allocated in the job plan. There are different approaches to account for this time. An arbitrary PA could be allocated for every consultant across the group, but allocating hours appropriate to the different demands of the specialty-specific meeting is perhaps a more fair and accurate approach. For example, the breast MDT meeting in our hospital is recognised to be more onerous than, say, the gastro-intestinal (GI) tract meeting, often taking 2.5 hours to deliver and with significantly more pre- and post-meeting input required. The group agreement would be, for example, that the breast pathologist would have 5 hours for MDT time in their job plan, but the GI pathologist would only require 3 hours. Some consultants may attend more than one MDT meeting, in which case a cumulative total can be agreed. In Table 2, note MDT time allocated varies between 3 and 6 hours between consultants. An even more flexible and equitable approach is to convert the hours agreed for each MDT meeting into a workload score and add the score to the daily total running workload score for the consultant who had attended the meeting. (See job plan level 3, below.)

### Cytopathology

Consultants reporting cervical cytology can have an appropriate number of hours per week allocated in the job plan for that role. Consultants reporting non-gynae cytology can be either allocated appropriate time, or cytology specimens can be allocated

Table 1: Level 1:  
Documentation of  
total contracted hours,  
non-clinical (SPA time)  
and remaining clinical  
hours

	A	B	C	D	E	Total
CONTRACTED PA	10	10	7	10	9	46
Temporary Additional PA (Funded)		1			1	2
Contracted basic hours (PAx4)	40	40	28	40	36	184
ROUTINE SPA (20% of basic hours)	8.0	8.0	5.6	8.0	7.2	36.8
NON ROUTINE SPA						
Head of Department	4					4
Educational Supervisors		1				1
Audit Lead				1		1
Autopsy Lead					1	1
Cancer Network Lead			1			1
Total SPA	12.0	9.0	6.6	9.0	8.2	44.8
REMAINING CLINICAL HOURS	28.0	31.0	21.4	31.0	27.8	139.2

Figure 1: Example of a Daily prospective workload scoring sheet with running workload total in 'Warwick points'

Week Starting: 19-Jul-10 Page 1 OF 4

	RAC: Running Total for month	NC: Running Total for month *Excluding haempath	FS: Running Total for month	SS: Running Total for month	Total	JS: Running Total for month	Total	NO Hem
MON 19/07/2010	5	17	40	40	5168	17	5163	
TUE 20/07/2010	3	17	40	40	5168	17	5164	
WED 21/07/2010	3	17	40	40	5168	17	5166	
THUR 22/07/2010	3	17	40	40	5168	17	5178	
FRI 23/07/2010	3	17	40	40	5168	17	5185	
	Running Total 5192	Running Total 5147	Running Total 4040	Running Total 3869	Running Total 5315			

keep JS light next  
Give bulk of work to RC+FS to push up their points.  
LIVE

W2k3b3-Cellularpathology/Histology/Cut up room/ALLOCATION COUNT.xls  
Version 1 Copy 1  
Created on 30/05/08 Created by SWP/ARME  
Doc ref LOG 9

a workload score as for surgical cases, and added to a consultant's total score.

### Autopsy work

For hospital autopsies, The Royal College of Pathologists recommends appropriate time of around 3 hours per autopsy should be allowed for job planning. This could be allocated with a weekly average autopsy time in the job plan, or by allocating an appropriate workload score to the consultant per hospital (non-coroner's) autopsy. Coroner's autopsy work is dependant on the attitudes of the consultants in the department and upon the hospital management. There needs to be local agreement whether this work merits some recognition in job plans or lies outside the job planning process. There is a valid argument that for hospital deaths reported to the Coroner, time spent for clinical liaison should be recognised in the NHS job plan. We currently allocate 30 minutes per week in the job plan to reflect a low number of hospital autopsies. Remaining clinical hours and remaining surgical reporting hours after account is taken of MDT time, cytology reporting and autopsy work are shown in Table 2.

### Taking the job plan to level 2: agree a workload scoring system

The basic principle behind workload scoring is to allocate specimens a score that is equivalent to time, reflecting the complexity of the case. Two workload scoring systems have been published: the RCPATH system and the Warwick system.<sup>1,2</sup> Each system allocates a score in points to surgical specimens accounting for specimen complexity. Each equates points to time, for example the RCPATH recommends a workload of 10 points per hour, i.e. 1 college point = 6 minutes whereas one Warwick

point equates to around 10 minutes. The current College system allocates workload points retrospectively (once a case has been reported) based on specimen type, final diagnosis and includes the numbers of blocks, slides and stains that were required to report each individual case. The Warwick system adopts an averaging approach with workload scores being applied to a specimen on receipt to reflect the average time it takes to report the specimen based on specialty, site and preferred clinical diagnosis. In day to day practice, we use the Warwick scoring system for job planning (see Figure 1) but have illustrated our approach to job planning in this article using College points.

Once a scoring system is agreed, all specimens can be allocated a specialty code and a workload score. We have been using the 'redundant' code lines on the SNOMED system integral to our laboratory IT system to record the data items. Given that the IT system already records the reporting pathologist for each case, the system can be searched to provide audit data on individual consultant workload and breakdown of work by specialty and give a breakdown of departmental workload by specialty.<sup>3</sup> Total departmental workload can be scored and compared with available reporting time within the departmental job plan, and an individual's share of the departmental workload can be highlighted from the available reporting time on their job plan.

Table 3 assumes an annual departmental workload of 43 080 College points and shows the appropriate workload points per week and per year for each of five individual consultants, dependant on their available remaining surgical reporting hours identified in the job plan. The RC-

Path recommends that the working year is taken as 40 weeks to account for time lost due to annual, study, professional and sickness leave. Using the example job plan above, consultants in a department with 107.7 available surgical reporting hours for 40 weeks would be required to report at a rate of 10 College workload points per hour to get through an annual workload of 43 080 points (40 weeks x 107.7 hours x 10 points). This calculation can be used to monitor workload increase and act as a benchmark against other departments.

### Taking the job plan to level 3: equitable prospective workload allocation

In Warwick we have taken the job plan to the next level by implementing a 'time and motion', evidence-based, equitable, prospective workload allocation system that ensures each colleague receives the amount of work appropriate to the available reporting time in their job plan.<sup>2,4</sup> We used the Warwick scoring system (that lends itself to job planning) and our BMS allocate each specimen a specialty code and workload score in specimen reception. Work is allocated to consultants by specialty preference (agreed at our regular departmental job planning meetings) and a running score of workload points is kept on a simple spreadsheet, with running scores kept as equal as possible (I would scan or photograph our current sheet – as discussed above). In order that daily workload scores keep pace and are kept equal, consultants with less available reporting time in their job plan are allocated an individualised number of daily 'starter points' on the score sheet, and an average day's workload points are added to a consultant's score for any leave day taken (see Table 4).

### Summary and discussion

A complete departmental job plan is shown in Table 5 (again limited to 5 consultants for simplicity, but it can be extended to any number of consultants), which encompasses all three levels of the job plan and dovetails with an equitable prospective workload allocation system. When using a working computerised spreadsheet, key calculations can be set up to total available hours, workload scores and daily 'starter points'. The spreadsheet can be repopulated following any changes to individual circumstances and will seamlessly recalculate the daily starter points for each colleague.

This approach to job planning and style of presentation is a valuable asset in regular intra-departmental job planning meetings (that should be a running agenda item) and form the basis for discussion with managerial colleagues. Our evidence-based approach (based on time and motion studies, in addition to fully documented roles and a detailed breakdown of our annual clinical workload) has proven helpful in maintaining excellent working relationships between colleagues and in our annual job-planning discussions with our hospital managerial colleagues.

We have used College points to illustrate the job-planning approach in the tables in this article, but in practice use the Warwick system as it lends itself better to job planning. The current College workload system has proven difficult to use and apply in practice, limiting its utility in job planning due in part to the complexity of the specialty scoring tables and some inconsistency in scoring approach between specialties.<sup>5,6</sup> A College working group is currently revisiting its system and a revised document is expected by Spring 2011.

Table 2: Level 1B:  
Weekly available  
surgical reporting  
hours

REMAINING CLINICAL HOURS	28.0	31.0	21.4	31.0	27.8	139.2
Cytopathology		4			4	8
Hospital autopsy	0.5		0.5	0.5		1.5
MDM	4	5	3	6	4	22
REMAINING SURGICAL REPORTING HRS	23.5	22.0	17.9	24.5	19.8	107.7

Table 3: Level 2  
Annualised workload  
(College points)

REMAINING SURGICAL REPORTING HRS	23.5	22.0	17.9	24.5	19.8	107.7
Points per week per pathologist	235	220	179	245	198	1077
Points per year per pathologist	9400	8800	7160	9800	7920	43080

Table 4: Dovetailing  
job planning with a  
prospective workload  
allocation system  
(College points)

REMAINING SURGICAL REPORTING HRS	23.5	22.0	17.9	24.5	19.8
Points per week per pathologist	235	220	179	245	198
Points per day per pathologist	47	44	36	49	40
Average points per day	43	43	43	43	43
Starter points	-4	-1	7	-6	3
Corrected starter points	2	5	13	0	9

Table 5: Full job plan dovetailing with a prospective workload allocation system (College points)

	A	B	C	D	E	Total
CONTRACTED PA	10	10	7	10	9	46
Temporary additional PA (funded)		1			1	2
Contracted basic hours (PAx4)	40	40	28	40	36	184
ROUTINE SPA (20% of basic hours)	8.0	8.0	5.6	8.0	7.2	36.8
NON ROUTINE SPA						
Head of Department	4					4
Educational Supervisors		1				1
Audit Lead				1		1
Autopsy Lead					1	1
Cancer Network Lead			1			1
Total SPA	12.0	9.0	6.6	9.0	8.2	44.8
REMAINING CLINICAL HOURS	28.0	31.0	21.4	31.0	27.8	139.2
Cytopathology		4			4	8
Hospital autopsy	0.5		0.5	0.5		1.5
MDM	4	5	3	6	4	22
REMAINING SURGICAL REPORTING HRS	23.5	22.0	17.9	24.5	19.8	107.7
Points per week per pathologist	235	220	179	245	198	1077
Points per year per pathologist	9,400	8,800	7,160	9,800	7,920	43,080
REMAINING SURGICAL REPORTING HRS	23.5	22.0	17.9	24.5	19.8	107.7
Points per week per pathologist	235	220	179	245	198	1077
Points per day per pathologist	47	44	36	49	40	215
Average points per day	43	43	43	43	43	
Starter points	-4	-1	7	-6	3	7
Corrected starter points	2	5	13	0	9	

The job-planning mechanism as presented in this article adopts a 'pushing' rather than 'pulling' approach to workload distribution. Given that many consultants have considerable time commitments and roles within the broader NHS, and outwith their formal departmental job plan, we believe this approach empowers a consultant to organise their working week more flexibly, whilst still reporting a fair and equitable share of the departmental workload.

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