Torbay and South Devon NHS
NHS Foundation Trust

JOB PLANNING POLICY

(MD24)

If you require a copy of this policy in an alternative format (for example large print, easy read) or would like any assistance in relation to the content of this policy, please contact the Diversity & Inclusion Officer on 01803 656705.

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Date of Issue:	November 2024	**Next Review Date:**	Oct 2024
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Author:	Head of Medical Workforce		
Directorate:	People Directorate		
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JLNC		16th May 2018	
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Links or overlaps with other policies:			
Need to list all policies that are referred to, or have links to this policy. List them in numeric order.			

Amendment History

Issue	Date	Reason for Change	Authorised
1.1	January 19	SPA Entitlement for New Consultants para 12.6	JLNC
1.2	Feb 2020	Clarification of weekend working arrangements for SAS para 19.9 to 19.11	JLNC
1.3	Oct 2023	Changes to the formatting; new Trust Structure and Job titles updated Change to Clinical supervisor tariff	JLNC

Torbay and South Devon NHS
NHS Foundation Trust

Rapid Equality Impact Assessment

Policy Title (and number)	Job Planning	**Version and Date**	Oct 2023 v1.3
Policy Author	Medical Workforce		

An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.

Who may be affected by this document?

Patients/ Service Users ☐	Staff ☒	Other, please state… ☐

Could the policy treat people from protected groups less favorably than the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Age	Yes ☐ No☒	Gender Reassignment	Yes ☐ No☒	Sexual Orientation	Yes ☐ No☒
Race	Yes ☐ No☒	Disability	Yes ☐ No☒	Religion/Belief (non)	Yes ☐ No☒
Gender	Yes ☐ No☒	Pregnancy/Maternity	Yes ☐ No☒	Marriage/ Civil Partnership	Yes ☐ No☒

Is it likely that the policy could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☒

Please provide details for each protected group where you have indicated 'Yes'.

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☐ No☐ NA ☒
Are the services outlined in the policy fully accessible[6]?	Yes ☐ No☐ NA ☒
Does the policy encourage individualised and person-centered care?	Yes ☐ No☐ NA ☒
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☐ NA ☒

EXTERNAL FACTORS

Is the policy a result of national legislation which cannot be modified in any way?	Yes ☐ No☒

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)

Documenting process for Medical Annual Job Planning

Who was consulted when drafting this policy?

Patients/ Service Users ☐	Trade Unions ☒	Protected Groups (including Trust Equality Groups) ☐
Staff ☒	General Public ☐	Other, please state… ☐

What were the recommendations/suggestions?

Does this document require a service redesign or substantial amendments to an existing process? ***PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below***	Yes ☐ No☒

ACTION PLAN: Please list all actions identified to address any impacts

Action	Person responsible	Completion date

Contents

1. Policy Statement

1.1 Job Planning for medical staff is an annual process in which the doctor/dentist has a formal structured meeting with their Clinical Service Lead to agree their individual programme of work. The Department/Service Manager may also attend this meeting with the prior agreement of the Consultant or SAS doctor. The job planning meeting is an opportunity to align the clinician's work to the corporate objectives and service capacity, to enhance the safety of service delivery, to agree personal development objectives and support work life balance.

1.2 The national Standards of Best Practice for Job Planning define the Job Plan as:

A prospective agreement that sets out a Clinicians' duties, responsibilities and objectives for the coming year. It should cover all aspects of their professional practice including clinical work, teaching, research, education and managerial responsibilities. It should provide a clear schedule of commitments. It should include personal objectives, including details of their link to wider service objectives, as well as details of the support required by clinicians to fulfil the job plan.

2. Purpose

2.1 The purpose of job planning is to value and reward the full range of work activities that clinicians undertake for the Trust and to ensure that the job plan of every Doctor is fair and equitable. It is an annual process to marry the needs and aspirations of the organisation with those of the clinician.

2.2 The policy and processes outlined in this document are consistent with national Terms and Conditions of Service for Medical and Dental Staff and aim to:

- Provide clarity of the roles and responsibilities in job planning;
- Provide guidance to support job planning;
- Standardise practice and ensure transparency and consistency;
- Ensure work patterns are safely aligned with the Trust's capacity and demand profile and specifically the business plans of the relevant services;
- Promote safety and quality through improved job planning.

2.3 In order to balance demand for services with available capacity, the Trust requires a medical workforce that is able to work with a degree of flexibility to meet patient needs and thereby deliver the accepted measures of high quality care. Job planning needs to recognise the complexities of the current environment we work in, and needs to reconcile individual aspiration with the requirement to improve productivity and deliver a consistent standard of high quality, safe patient care across the organisation. Job planning provides an opportunity for both the Trust and the individual clinician to review work patterns with a view to improving the clinician's work life balance within the exigencies of service provision.

3. Scope

3.1 This policy applies to Medical and Dental Consultant and SAS staff employed by Torbay & South Devon NHS Foundation Trust on a substantive contract, together with those on a joint contract with the organisation and another employer.

4. Equality and Diversity Statement

4.1 The Trust is committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics (as governed by the Equality Act 2010): sexual orientation; gender; age; gender re-assignment; pregnancy and maternity;

disability; religion or belief; race; marriage and civil partnership. In addition to these nine, the Trust will not discriminate on the grounds of domestic circumstances, social-economic status, political affiliation or trade union membership.

4.2 The Trust is committed to ensuring all services, policies, projects and strategies undergo equality analysis.

5. Roles and Responsibilities

5.1 Medical Workforce

Will oversee the introduction, operation and monitoring of Job Planning and provide advice in relation to the application of this policy, guiding Clinical Service Leads, Department/Service Managers and clinicians through the process. Medical Workforce will provide specific training for clinicians, Clinical Servcie Leads and Department/Service Managers to ensure awareness of the job planning process and to encourage a fair and consistent application.

Medical Worokforce are responsible for managing and maintaining the IT system used to record Job plans.

5.2 Responsibility of the Joint Local Negotiating Committee (JLNC)

The JLNC will regularly review the fair and sensitive application of the job planning procedure across the Trust and will report any concerns to the Medical Staff Committee and the Trust.

5.3 Responsibility of the Chief Medical Officer (CMO)

The CMO has overall responsibility and accountability for ensuring medical job planning is completed annually in the Trust. The CMO will be responsible for providing assurance to the Trust Board.

5.4 Responsibility of the Deputy Medical Directors

The Deputy Medical Directors shall be responsible for overseeing job planning in the areas of their responsibility. Particluar areas of focus shall be:

- Ensuring that each Medical and Dental Consultant and SAS doctor has a current Job Plan which is subject to annual review (or interim review as necessary);
- Meeting with the Associate Medical Directors to discuss job planning issues
- Championing the use of team job planning across the organisation to ensure a consistent approach to job planning.

5.5 Responsibility of the Associate Medical Directors (AMD)

The Associate Medical Directors shall be responsible for overseeing job planning in their respective Care Groups. Particular areas of focus shall be:

- Ensuring that each Medical and Dental Consultant and SAS doctor has a current Job Plan which is subject to annual review (or interim review as necessary):
- Meeting with the Clinical Service Leads in their respective areas to discuss specialty specific issues and agree parameters for job planning;
- Support the team job planning process where required;
- Responsible for undertaking the job plans of the Clinical Service Leads;
- Ensure there is a consistent approach to job planning across their Care Group.

5.6 Responsibility of the Clinical Service Leads

The Clinical Service Lead shall ensure that;

- The Associate Medical Directors are aware of service priorities regarding job planning.

- They lead team job planning discussions or delegate as appropriate, supported by the Department/Service Manager;
- They liaise with the Department/Service Manager, to review the draft job plans for each Consultant and SAS doctor and dentist, for discussion at the individual job planning meetings;
- Ensure that the clinician is given appropriate time to address any problems;
- They ensure that consistency is applied across the team when clinicians are entering activities within their individual job plans;
- interim job plan reviews are undertaken as necessary, with the expectation that job plans are reviewed as changes to working arrangements take place;
- Clinicians are released to participate in job planning (within their core SPA);
- They work with the AMDs, and Department/Service Managers in the development of service and team objectives;
- They work cooperatively with the AMDs, and Department/Service Managers to address issues raised through job planning;
- Consultants and SAS doctors and dentists are aware of the Job Planning Policy and Procedure and understand the template documentation that must be used for all for job plans:
- Accurate job plans are captured within the Electronic Job Planning System
- Remuneration changes are made as appropriate.
- Service and/or team objectives are developed with their Department/Service Managers and the Associate Medical Director;
- Highlight promptly to the Associate Medical Director any areas of concern resulting from job planning discussions where this has not be resolved at a local level

5.6.1 It would be helpful to undertake the following preparation in advance of job planning meetings;

- Review demand profile to understand delivery needs for coming year, including;
    - Calculating the number of PAs required to meet service needs;
    - Align the clinical capacity with the business plan;
    - Link the capacity with other departments/services;
    - Pressure points;
- Financial issues (e.g. affordability of job plans);
- Consider the impact of any workforce issues (including existing/planned gaps);
- Consider the existing job plan of the individual clinician and any aspirations of the individual clinician;
- Draft the job plan to discuss with the individual clinician at the job planning meeting

5.7 Responsibility of the Department/Service Manager

The Department/Service Manager shall be responsible for;

- Providing information on clinical activity and any other appropriate data, on an annual basis to the Clinical Manager to help inform the job planning process;
- Working with the Clinical Service Lead to ensure an up to date record is kept of all job plans in their area;
- To work cooperatively with Clinical Service Lead and Associate Medical Director in the development of service and/or team objectives;
- To work with Clinical Service Lead to support the process of team Job planning and to ensure consistency of application of acivities within individual job plans.

5.8 Responsibility of the Consultant/ SAS Doctor

Each clinician;

- Is contractually obliged to participate annually in job planning (or interim reviews as appropriate) and must ensure that they support the Clinical Manager in the timely and accurate submission of job plans.
- Engage in team job planning discussions within your team;
- Job plans must contain sufficient detail on PA allocations and agreed objectives and outputs for both DCC and SPA work;
- Is required to work within the framework of the agreed job plan;
- May seek an interim review of their job plan where there is a change in individual circumstances/working pattern;
- Is required to notify their Clinical Manager and Department/Service Manager of any significant circumstance that impacts on their job plan;
- Should consider the potential impact on their workload of issues such as expansion in Consultant numbers; changes in clinical practices etc. This does not remove from the Trust the duty not to undermine the clinician's duties as advertised on appointment.
- Should review and verify clinical performance data on an individual and specialty basis;
- Is required not to take on additional duties/roles (both internal and external) that impact on their work without the prior discussion and approval from the Clinical Service Lead who must discuss this with the Service Manager(s) (see Additional NHS Responsibilities below).
- Is required to declare any regular private practice activity within their job plan;
- May seek mediation and appeal where agreement is not reached on a job pla;
- Is required to have an up to date job plan in order to apply for clinical excellence awards and for pay progression.

5.8.1 To maximise the time in the job planning meetings doctors may take the following steps:

- Have a clear idea of the outcomes of the job planning meeting;
- Decide what their personal objectives will be for the coming year;
- Be willing to share all the elements of their work both internally and externally to enable a realistic agreement to be made;
- Be conscious of their peer's aspirations so that the job plan is agreed in a wider context;
- Be mindful of the broader clinical and corporate governance issues

6. Job Planning Process

6.1 Job planning for all Consultants and SAS doctors will take place annually and will commence in October and be completed by the end of January. Job planning may also take place during the year on an 'interim' basis to reflect service improvements, additional consultants within a specialty or other significant changes in workload.

6.2 All job plans should be entered onto the Trusts electronic Job planning system.

6.3 All job plans must be agreed and signed off by the individual consultant or SAS doctor concerned, Clinical Service Lead, Operational Service Manager and Associate Medical Director.

6.4 Team Based Job Plans

6.4.1 It is recommended that a team approach to job planning is adopted in the first instance. The intention of team job planning meetings is to enable all clinicians within the team to meet with the Clinical Service Lead and the Department/Service Manager, in advance of individual job planning meetings, to discuss any issues that are generic to all job plans within the team and to agree a consistent approach. This can include the number of PAs to be allocated to clinical activities, the amount of time required on average for clinical administration and on-call duties and the allocation of SPA roles within the team.

7. The Job Plan in Context

7.1 A job plan should be a prospective agreement that sets out an individual's duties, responsibilities and objectives for the coming year. Effective job planning is based on a partnership approach and should:

- Support the clinician in delivering safe, high quality patient care and support work life balance.
- Support the clinician to comply with CME, revalidation, appraisal, job planning and other duties required to promote individual development.
- Explicitly include detail on clinical activity to be delivered over the forthcoming 12 months, including detail of clinic/activity templates. Job plans will also include full detail of any SPA activity in terms of outputs expected and average time allocated for this where appropriate. This will be calculated against a typical working year of 42 weeks (to allow for annual and study/professional leave) and will be amended on an individual basis as necessary;
- Resources necessary for the work to be achieved.
- Ensure that service development, education, training and research are recognised and supported where appropriate and defined in a transparent, equitable way
- Ensure that the Trust delivers its corporate objectives and meets the requirements of the Trust Business plan

7.2 Each of the components of the job plan should be reviewed separately, with average weekly Programmed Activities being defined for each component. These components should then be brought together to determine the overall job plan commitment.

7.3 A job plan is described in Programmed Activities (PAs) each PA being 4 hours in duration and a full time contract being 10 PAs.

7.4 For Health and Well-being of our medical staff job plans should not consist of any more than 12 PAs in total. Any job plans above 12PAs will only be approved in exceptional circumstances.

7.5 Objectives

7.6 The agreement of objectives will be recorded on the job plan. Where possible clinical teams should meet and set objectives together, recognising that different roles are undertaken by different members of the team. Some objectives will be common to the team, others more specific to individuals.

7.7 Each clinician will have the following objectives:

- Individual Objectives
- Contribution to team objectives

8. Direct Clinical Care (DCC) Activities

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

8.2 Multidisciplinary Team (MDT) and Morbidity and Mortality (M&M) meetings that relate directly to patient care and/or treatment planning for specific patients should also be counted as DCC

time. Where MDT or M&M meetings have a mixed agenda (e.g. part clinically care based, part Divisional meeting), only the element relating to Direct patient care will count towards DCC time with the other element noted as a Supporting Professional Activity.

8.3 Any administration that is directly related to the above (including but not limited to referrals and notes) will also be allocated as DCC time. Clinical administration time should be proportionate to total DCC time. The PA allocation will vary according to the administrative requirements of particular role but will be broadly similar within specialties.

8.4 The following are examples of DCC PAs:

- Emergency work (actual work of all types while on call)
- Outpatient or other clinic (including resulting administrative work)
- Operating list (including pre and post-operative care)
- Ward rounds (formal with junior medical and other staff)
- Other patient referrals or treatment, or relative consultation
- Telephone, postal or email advice to patients, carers or professional colleagues about direct patient care.
- Multidisciplinary Team meetings (for direct patient care)
- Investigative, diagnostic or laboratory work (including diagnostic procedures, radiological procedures, interpretation of radiological, biochemical, microbiological or biophysical tests and any resulting administration)
- Public health duties
- Travelling time between sites, not to usual place of work
- Patient administration
- Support of junior doctors and non-medical colleagues in management of patients

8.5 Clinical sessions should include expected output (such as number of patients seen per session) appropriate to the speciality, averaged over multiple sessions as agreed with the team.

8.6 Where DCC administration is allocated within clinic time this should not be allocated elsewhere within the job plan. Where clinic time is shorter than 4 hours this should be reflected within the job plan.

9. On-Call Activities

9.1 On call is recognised in the job plan through an availability supplement and through DCC PAs allocated for predictable and unpredictable emergency work.

9.2 PAs for on call/emergency work should include both predictable and unpredictable emergency work and these should be programmed into the working week.

- Predictable emergency work is work that takes place at regular and predictable times, often as a consequence of a period of on-call work (e.g. post-take ward rounds, lists, etc.);
- Unpredictable emergency work is that which arises during the on-call period and is associated directly with the clinicians on-call duties (except in so far as it takes place during a time for scheduled Programmed Activities), e.g. recall to hospital to operate on an emergency basis.

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

9.4 **Prospective Cover for On Call -** Clinicians are expected to deputise for absent colleagues so far as is practicable, even if on occasions this would involve interchange of staff within the Trust, which includes:

- cross cover of in-patient beds (including the provision of support to junior doctors);
- on-call (in and out of hours).

Consideration of the need to cover planned absence should therefore be given when agreeing a job plan. Prospective cover will be recognised with PA allocations for DCC.

10. Supporting Professional Activities (SPA)

SPA is divided into Generic and Non-Generic activities.

10.1 **GENERIC SPAs** are activities that underpin appraisal and revalidation. It is expected that generic SPA time should be used for:

- Departmental training and educational meetings
- Mandatory training
- Audit/ quality improvement activity
- Personal medical education;
- Research; (if significant can be allocated as Additional SPA , if agreed and with funding)
- Clinical governance activities relating to your clinical role
- Self-directed learning;
- Clinical management:- this does not include formal clinical management roles such as Clinical Service Leads , which are classed as Additional NHS Responsibilities;
- Basic undergraduate and postgraduate teaching e.g. occasional tutorial
- Job planning;
- Preparation for and participation in appraisal and revalidation;
- Personal and professional administration Mortality & Morbidity meetings (element not related to DCC)

10.1.1 Clinicians must be able to demonstrate at their annual job plan meeting that they have achieved the expected outputs from their SPA time otherwise pay progression may be affected.

10.1.2 Clinicians have an obligation to attend key sessions (such as audit meetings, teaching sessions or clinical governance activities) and achieve any agreed percentages of attendance. These activities are included within SPA time allocations. Those not doing so without valid reason (e.g. leave, private practice registered in the job plan or urgent clinical care) may be expected to account for their absence.

10.1.3 SPA Allocation

Total Contracted PAs	**Generic SPA entitlement**
7 or more	**1.5**
6.9 - 4	**1.0**
Under 4	**Agreed on an individual basis**

10.1.4 One SPA may be worked flexibly with respect to timing and location if prior agreement has been reached with the Clinical Service Lead and recorded in the job plan.

10.1.5 NEW STARTERS: the SPA allowance will be as below for a period of 6 months unless they are a newly qualified Consultant/SAS (i.e. they have not previously held a post at this grade before either as a substantive or a locum) in which case the allowance will be for 12 months.

Total Contracted PAs	Generic SPA entitlement
7 or more	2.5
6.9 - 4	2.0
Under 4	Agreed on an individual basis

10.2 **NON-GENERIC SPAs**

10.2.1 Additional NHS Responsibilities (ANR) and External Duties (ED) categories of SPA time may be allocated for defined roles/ work as identified in Appendix 1. See also section 9 for further explanation.

10.2.2 Any such further SPA allocation must be specified in the job plan and agreed with the Clinical Service lead and Department/Service Manager and signed off by the Associate Medical Director. The SPA must be clearly defined and will be allocated to enable the doctor to deliver the Trust's objectives or to enable the Trust to fulfil its wider NHS responsibilities.

10.2.3 Reduction in direct clinical care commitment may be appropriate in the following situations; this will be dependent upon workload and negotiable at job plan review and agreed as above.

- Management Duties –Director of Medical Education, Deputy Medical Director, Associate Medical Director, Clinical Service Lead.
- Teaching – a major regular teaching commitment e.g. Post-graduate Medical School (funded or otherwise).

10.2.4 Where clinicians wish to reduce DCC time to take up a Trust wide role or external role this needs to be in discussion with their Speciality and agreed by the Clinical Service Lead and Department/Service Manager. Agreement will also need to be reached on the re-allocation of DCC time within the department. It may also be appropriate to agree with the Clinician the DCC/SPA allocation that they will return too.

10.2.5 Management responsibilities, including those for lead clinical roles will be defined and included within additional SPA allocation and must reflect the actual time spent undertaking the role. If the role occupies less than one hour per week it will not be remunerated separately. Roles occupying an hour or more a week will need to be remunerated within the job plan.

11. Additional NHS Responsibilities:

11.1 Examples include specialty lead clinician, audit and governance lead, college tutor, some additional teaching responsibilities and chairing Trust committees. Such responsibilities will have an associated job description, a formal process of competitive appointment or election where appropriate, and be defined in terms of additional pay as PA, or additional pay as a responsibility payment, or additional leave.

12. External Duties:

12.1 Examples include work undertaken for the GMC, Specialty Training Committee Chair BMA activities and ARCP panels. External duties are not included within the definition of Fee Paying Services or Private Professional Services. If these duties are ad hoc i.e. less that twice a year these should be within the existing job plan. Where this is a regular commitment it needs to be discussed and agreed in advance by the Clinical Service Lead and Service/Operations Manager and recognised with appropriate SPA allocation within the job plan.

12.2 If such activity is remunerated by an external body it should be defined in the Job Plan as an 'external duty' together with the funding source and an indication of how long this is expected to continue.

12.3 The nature of all additional NHS responsibilities/external duties should be discussed in advance with the Trust, as part of the job planning process. The Trust will adopt a pragmatic approach to the issue on an individual basis and in principle agree to support additional duties so long as:

- There is a demonstrable benefit to the individual, the Trust or the wider NHS;
- The impact on other clinical colleagues within the specialty/department is considered;
- Time to perform the additional NHS responsibility/external duties should be recorded separately in the job plan. In some instances it may be appropriate to agree that a responsibility exists and is recognised in the job plan, with associated objectives and supporting resources, for which the time may reasonably be contained within the generic SPA allocation. However, some additional NHS responsibilities/external duties can only be discharged when specific time is allocated outside generic SPAs and as such should be recorded separately.
- The impact on the service to patients must be considered.

13. Additional Programmed Activities (APA)

13.1 For full time contract holders, PAs above 10 per week are temporary. In this context, Additional Programmed Activities must be formally reviewed as part of the annual Job Plan review and may be reduced following the review subject to three months' notice on either side (which can be waived by mutual agreement). APAs may consist of DCC, SPA, Additional NHS Responsibilities and/or other External Duties and should be clearly identified as APAs on the job plan.

13.2 There is no obligation on clinicians to offer, or accept the offer of, an additional PA, except when they wish to perform Private Professional Services.

13.3 Any additional non-job planned work done at the request of the Trust should be remunerated on the basis of the Policy '*Remuneration for Additional Clinical Work*'. Once it is established that there is an on-going need for this work this must be incorporated into the job plan.

13.4 Any additional PAs in the job plan are not superannuable. Job Plans in excess of 12 PAs will only be approved in exceptional circumstances.

14. Rest & Meal Breaks

14.1 Rest and meal breaks are generally unpaid and are not included in Programmed Activities (PAs).

14.2 Job Plan schedules should reflect rest arrangements by specifying protected break times explicitly or describing flexible arrangements. Where the demands of the service make it difficult to schedule an appropriate meal-break, flexible local arrangements should be made which allow consultants to eat during a PA but do not impact on the effectiveness of the service.

14.3 Consultants and SAS Doctors are responsible for ensuring that they take appropriate breaks to comply with the European Working Time Directive where they are working continuously for 6 hours or more.

15. Travelling Time

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

15.2 If travelling from home to a location other than the base of work additional time in the job plan will only be required where the time from home to the location is longer than home to base.

16. Private Professional Services (Practice)

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

16.2 All private professional services must be arranged and undertaken within the requirements of the Private Practice Code of Conduct. This requires that providing services for private patients should not prejudice NHS patients' interests or disrupt NHS services.

16.3 In line with the Code of Conduct for Private Practice the Trust will insist that private practice is not undertaken during scheduled Trust PAs without the prior agreement of the Clinical Service Lead. The Trust will only agree to this where time-shifting arrangements are formally agreed or where the income for the work is passed to the Trust.

16.4 In some circumstances the Trust may at its discretion allow some private practice to be undertaken alongside a clinician's scheduled NHS duties, provided that they are satisfied that there will be no disruption to NHS services. In these circumstances, the clinicians should ensure that any private services are provided with the explicit knowledge and agreement, in writing, of the Clinical Service Lead and Department/Service Manager and that there is no detriment to the quality or timeliness of services for NHS patients.

16.5 Consultants (including those less than full time) wishing to perform private work are expected to offer one additional PA to the Trust. If the Trust takes advantage of this offer any work will be remunerated at standard rate. If the clinician declines to undertake the additional PA and continues to undertake the proposed private work, the individual will not be entitled to receive pay progression during the year in question. Where it is agreed that no additional PA is required the Clinician may undertake private practice without jeopardising pay progression.

16.6 The Trust will endeavour to give reasonable notice i.e. no fewer than three months in advance of the start of the proposed extra Programmed Activities. There will be a minimum notice period of three months for termination (on either side) of these additional activities.

16.7 Where the Trust wishes to reschedule a clinician's activity to a time when they have private activity scheduled, the Trust will seek to achieve this by discussion and agreement. Where this is not possible the Trust will give no less than three months' notice to allow the clinician to make arrangements to re-schedule their private professional services, starting from the date of resolution of any job planning appeals processes.

16.8 It is recognised that occasionally a private patient may suddenly deteriorate and require view by their doctor. If this occurs during an NHS PA the doctor must ensure that the NHS patients being cared for are safe prior to leaving the hospital. The doctor will make their selves available at a mutually agreed time for additional NHS work up to the same duration without additional payment. This also applies if a doctor provides emergency care to an NHS patient outsider of their scheduled DCC time (where the circumstances are not covered by another policy e.g. acting down) this should be paid back by the Trust.

16.9 Subject to the following provisions, a consultant will not undertake Private Professional Services or Fee Paying Services when on on-call duty. The exceptions to this rule are where:

- The consultant's rota frequency is 1 in 4 or more frequent, his or her on-call duties have been assessed as falling within the category B described in Schedule 16, and the employing organisation has given prior approval for undertaking specified Private professional Services or Fee Paying Services;
- The consultant has to provide emergency treatment or essential continuing treatment for a private patient. If the consultant finds that such work regularly impacts on his or her NHS commitments, he or she will make alternative arrangements to provide emergency cover for private patients.

17. Fee Paying Services

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

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

18. Time Allocation of Types of Work

18.1 For work within the job plan the hours considered to be within the normal working day will be 7am to 7pm, Monday to Friday.

18.2 If a consultant has PAs in premium time, this is recognised as time and a third. Alternatively a PA is considered to be 3 hours long rather than 4 hours in standard time.

18.3 Where weekend work is timetabled in the job plan remuneration or time in lieu for working under 4 hours of actual work National Terms and Conditions apply i.e. 1.33:1.

Else if 4 or more hours are timetabled in the same weekend, time in lieu or remuneration at 1.5:1 would apply for all hours worked up to 8 hours and 2:1 for any hours worked in excess of 8 hours (see Table and examples below).

Table - Weekend Working - Remuneration or Time in Lieu
(Scheduled Job Plan PAs worked between 7.00 pm Friday – 7.00 am Monday)

Hours Worked Over Single Weekend	Remuneration or Time in Lieu
Less than 4	All Hours worked * 1.33
4 to 8 inclusive	All Hours worked * 1.5
In excess of 8 hours	First 8 hours worked *1.5 **plus** Hours worked in excess of 8 * 2

Example 1 **3 hours worked Saturday**
Calculation = 3 hours ** 1.333
= 4 hours (1PA) payable

Example 2 **10 hours worked Saturday**
Calculation = (8 hours * 1.5 = 12 hours) + (2 hours * 2 = 4 hours)
= 16 hours (4PAs) payable

Example 3 **4 hours worked Saturday and 6 hours worked Sunday (10 in total)**
Calculation = (8 hours * 1.5 = 12 hours) + (2 hours * 2 = 4 hours)
= 16 hours (4PAs) payable

Example 4 **10 hours worked Saturday and 8 hours worked Sunday (18 in total)**
(8 hours * 1.5 = 12 hours) + (10 hours * 2 = 20 hours)
= 32 hours (8PAs) payable)

18.4 Remuneration or time in lieu will be as agreed by the Clinical Service Lead and Operational Service Manager. Where possible within the constraints of the department there should be flexibility to allow some adjustment to week-by-week working patterns.

18.5 Work resulting directly from on-call duties should in all cases be brought `within the job plan'. When performed 'out of hours' time will be recognised at premium rates.

18.6 For consistency of PA allocation all work must be consistently and appropriately allocated e.g. outpatients clinic taking 4 hours, but generates 1 hour of patient directed administration, that hour must be allocated separately and appropriately; main theatre lists of 4 hours with 1 hour of pre and post-operative work would be recognised as such in the job plan. The same applies to clinics or lists scheduled over 3 hours.

18.7 For those Senior Medical Staff who work more than one on–call rota, the on-call supplement will be calculated as follows: Calculate the number of days or night's on-call over the two rotas over an appropriate time period e.g. 6 months or a year. This is then divided by the number of days in the observation period and reduced to a 1 in x rota and paid appropriately.

18.8 For the avoidance of doubt, the above enhanced remuneration for weekend working apply to all consultants and SAS doctors employed as at 31 July 2019. They will not however apply to newly appointed Specialty Doctors appointed after I August 2019 in circumstances where they work on middle tier rotas in tandem with doctors in training. These doctors will be paid the premium rates as per the 2008 TCS for Specialty Doctors.

18.9 As per the Trust's agreed Charter for the Employment of SAS Doctors, such doctors will be entitled to an appropriate balance between weekday daytime and "out of hours" work. For SAS doctors on a "full shift" system the total percentage of out of hours work should not be excessive and should provide a reasonable work/life balance.

18.10 The Trust recognises the importance of an appropriate balance between daytime and out of hours work which should not exceed 60% of the overall hours unless mutually agreed. Additionally, The Trust is committed to working towards a decrease in the percentage of total out of hours worked with the aim of achieving a limit of 40% where appropriate and practical. These arrangements shall be agreed on an individual and team basis and the JLNC will maintain an overview to ensure that an appropriate balance is maintained.

19 Local Contractual Flexibility

19.1 It is recognised that it is in the interests of the Trust and individual to have an element of flexibility in working arrangements. The scope for flexibility includes:

- How the hours are worked on a day-to-day basis.
- PAs can be worked in 0.25, 0.5 or 1 unit
- The number of PAs worked per week can vary.

19.2 Locations other than the principle place of work may be agreed. If locations other than the principle place of work are agreed for SPA activities, the Consultant should be available to be contacted at that agreed place in the event of an unpredictable emergency/event that might require contact being made with that Consultant and for them to return to the Trust. Only one SPA may be worked flexibly in this way

20 Mediation in Job Planning Disputes

20.1 Mediation is a process for resolving disputes, in which a neutral panel helps the parties agree a settlement outside the formal appeal procedure by helping them find their own resolution to disputes.

20.2 Disagreements regarding job planning should, where possible, be settled informally, resorting only to the mediation process where necessary.

20.3 In the first instance, the clinician or the Clinical Service Lead should refer the dispute to the Deputy Medical Director (or another designated person if the individual has already been involved in the job planning discussions) in writing within two weeks of the disagreement arising, setting out the nature of the dispute. The reasons for the dispute will be shared with the other party and they will be required to set out their position on the matter.

20.4 There will then be a meeting, usually set up within four weeks of the referral, which will be chaired by the Chief Medical Officer. Both parties will have an individual one to one meeting with the Deputy Medical Director (mediator) initially, so that their position or view is understood clearly. The parties will then be brought together for a face-to-face mediated meeting, the purpose of which will be to try to reach agreement.

20.5 Mediation is a confidential and voluntary process which brings together people who are experiencing problems with a work related relationship. As such no provision exists for a representative e.g. BMA rep/work colleague to attend the mediation meeting.

20.6 If the mediation succeeds and agreement is reached, the Mediator will arrange for the parties to proceed to sign off the job plan within 5 working days.

20.7 If agreement is not reached at the meeting, Deputy Medical Director will take a decision or make a recommendation on the matter. The Deputy Medical Director must inform the clinician and Clinical Service Lead of the decision or recommendation in writing.

20.8 If the clinician is not satisfied with the outcome of mediation, a formal appeal can be lodged.

20.9 In the case of disputes over team job plans, the speciality will be asked to identify a medical colleague to represent the team in the mediation process.

20.10 If the mediation fails to produce agreement and the clinician(s) are dissatisfied with the decision or recommendation(s) the clinician(s) may lodge a formal appeal. The appeal must be lodged in writing with the Chief Medical Officer within two weeks of receiving the Mediator's written outcome of the mediation process

21. Appeals in Job Planning Disputes (See Appendix 2)

21.1 This appeals process mirrors as far as possible that set out in the Terms and Conditions of Service for both Consultant and SAS doctors.

21.2 A formal appeal panel will be convened only where it has not been possible to resolve the disagreement using the mediation process.

21.3 The letter of appeal should set out the points in dispute and the reasons for the appeal, together with an indication of the desired outcome.

21.4 The Appeal:

21.4.1 Membership of Appeal Panel for Appeals**:**

- The appeal panel shall comprise three members, reflecting a balance of interests as follows:
  - A chair nominated by the Trust.
  - A panel member nominated by the clinician(s)
  - A third independent member from a list approved by the BMA/BDA and NHS Employers. (held by NHS England)

21.4.2 The Panel Chair**:** The Trust is responsible for nominating the Chair of the panel. A senior person such as the Chief Executive or Executive Director of the Trust would normally undertake this role.

21.4.3 Panel Member Nominated by the Clinician(s): The Clinician(s) is responsible for nominating the second panel member. The JLNC will assist the consultant(s) in choosing a s uitable panel member; alternatively the consultant(s) can nominate an individual of their own choice.

21.4.4 The Independent Third Panel Member: The Trust is responsible for arranging the third panel member.

21.4.5 In the event of an objection raised by the clinicians(s) to the independent third panel member, the Trust will consider the objection in good faith and if necessary arrange for an alternative. Any objection should be made in writing and supported by an explanation of the grounds of the objection, which will be kept on record.

21.5 The Medical HR Representative will confirm in writing to the appellant clinician(s) and Chief Medical Officer the membership of the appeal panel and meeting date, and will invite the parties to submit their written statements of case.

21.6 The parties to the appeal will submit their written statement of case to the Medical HR Representative who will submit it to the appeal panel and to the other party, to be received no later than one week before the appeal meeting. The appeal panel will hear verbal submissions on the day of the meeting.

21.7 The Clinician may present their own case in person, or be assisted by a work colleague or trade union or professional organisation representative, but legal representatives acting in a professional capacity are not permitted.

21.8 Management will then present its case explaining the position on the job plan.

21.9 Where the clinician, the Trust or the panel requires it, the appeals panel may hear additional expert advice on matters specific to a speciality. The clinician or Trust, as appropriate, shall be responsible for arranging the attendance of their expert witness. Unavailability of any such expert witness will not ordinarily be treated as sufficient reason (subject to the provisions in 25.6 below) for delaying or adjourning proceedings.

21.10 The Chair will have discretion to adjourn the meeting in order to call on expert advice where the panel requests such expert advice prior to making their decision, or for any reason in the Chair's opinion, would facilitate a full and fair hearing of the issues.

21.11 The appeal panel will make recommendations on the matter in dispute in writing to the Trust Board, normally within two weeks of the appeal having been heard. This recommendation will normally be accepted. The parties to the appeal will receive a copy of the recommendation when it is sent to the Trust Board.

21.12 The Trust Board will make the final decision at their first available opportunity (normally the next Board meeting) and will inform the parties in writing of their decision. Any Board Member involved in the mediation or appeals process for a particular case should not participate in the Trust Board's subsequent consideration of the appeal outcome for that particular case.

21.13 No disputed element of the job plan will be implemented until confirmed by the outcome of the appeals process.

22. Training and Awareness

22.1 Advice and support will be provided by the Medical Workforce team to support staff and managers in adhering to this policy and their understanding of dealing with job planning.

22.2 The Medical Workforce team will raise awareness of this policy through the publication of information on ICON and to advise staff of changes to the policy and ratification processes.

Appendix 1 – Supporting Professional Activities & Lead Roles Tariff

SPAs underpin direct clinical care and should be linked to clear objectives.

The Trust provides Generic SPAs for continuing professional development/revalidation purposes (See section 12.4).
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Generic SPA to Cover Core Requirements

Activity	Responsibility	Outcome	SPA Allocation
Continuous Professional Development (CPD) Preparation: re-licensing and revalidation General audit and research Clinical governance Appraisal Job planning Mandatory Training Clinical Supervision during DCC work Basic undergraduate and postgraduate teaching Mortality & Morbidity meetings (element not related to DCC) Other activities such as ad hoc clinical, management and educational meetings.	Educational meetings (lunch-time and evening) and associated paperwork e.g. applying for CPD certificates with records of educational meetings attended and CPD points Reading and other self-study, On-Line Learning/CPD Modules, Postgraduate Meetings, Peer Meetings (Specialty and Locality), External Training Events (lectures, courses, conferences, case presentations, journal clubs) Meeting requirements as set by the appropriate Royal College Meetings with representatives from pharmaceutical companies and keeping up to date with medicine developments Review of papers for journals Collation of information for appraisal folder and preparation of the paperwork Annual appraisal meeting Attendance at CEPOD/audit meetings	Maintain re-validation portfolio Attend minimum of 75% of educational meetings Undertake or supervise a minimum of 1 audit per annum Update/develop clinical protocols/guidelines for clinical role when requested or for service needs Appraisal for all junior reports Completion of junior doctor assessments Completed clinical supervisor training Job planning preparation and completing job planning paperwork. Annual job plan review with manager.	1.5 SPA

Additional SPAs as identified below will be allocated for clearly defined roles:

Additional NHS Responsibilities and External Duties

It is an expectation that the roles identified below will have an accompanying job description. Roles are as defined by this Organisation.

Lead Role	Responsibility	Outcome	SPA Allocation
Appraiser	Appraiser of consultant colleagues and SAS doctors	Doing appraisals and associated paperwork	0.25 PA per 7 appraises or pro rata (to include training and support)
Service Development		Service Development work should be linked to the Business need of the Trust and agreed by Clinical Director and SDU Manager.	0.25 to 1 PA dependent on project. Time limited and reviewed annually
Clinical Governance Lead Clinical governance leads Specialty Lead Guidelines/ protocols/ procedures Organisational/departmental/personal clinical governance Management of departmental guidelines	Effective & up to date departmental clinical governance programme Development and management of departmental clinical guidelines review process Ensure all relevant guidelines are up to date and developed or adopted. Ensure all care bundles are developed and implemented Critical incident reviews Contribution to development of clinical protocols and guidelines Ensure departmental clinical dashboards are developed and reviewed and any areas of concerned escalated	75% attendance at Clinical Governance Accountability Group meetings Development and reporting for clinical governance framework Development and maintenance of clinical guidelines/protocols/care bundles Evidence of participation in clinical incident investigations and critical incident reviews Ensure > 90% of eligible patients are risk assessed for VTE Ensure all roles and responsibilities mentioned are effectively discharged	1 SPA per Operational Delivery Group 0.25 for larger specialities as defined in new operational structure 0.5 will be the minimum allocation for combined specialities or smaller specialities where there is a demonstrable need.

Lead Role	Responsibility	Outcome	SPA Allocation
	Ensure divisional risk register is reviewed and management as per risk management policy Ensure departmental clinical governance meetings are of high quality and occur monthly and cover the whole recommended range of clinical governance activities Ensure divisional clinical governance reporting framework is maintained and reported to CGAC 6 monthly Ensure departmental has a robust system for incident reporting and risk management Ensure complaints by departmental clinicians are handled in accordance with policy in a timely fashion and with lessons for learning implemented.		
Audit Lead	Directing and supporting audit projects Development and management of departmental audit plan Quality reviews Mortality paperwork Reviewing local and national audit data/reports and developing action plans Ensuring recommendations from action plans are discharged via appropriate divisional mechanisms/ structures/ committees Attendance at Clinical Audit & Effectiveness Committee	75% attendance at Clinical Audit & Effectiveness Committee. 80% completion rate of departmental audits in audit year including development of action plans and ensuring these are discharged Planning and management of trainee audits	0.5PA per Operational delivery group (dependent on new structure) and/or by directorate depending on intensity of work. Other clinicians as part of core CPD SPA

Lead Role	Responsibility	Outcome	SPA Allocation
Research Refers to principal investigator or Co-Investigator roles			Research Projects will need to be agreed in advance with clear objectives. 0.25-1SPA dependent on size of the project/workload
Guardian of Safe Working Hours	The guardian is responsible for protecting the safeguards outlined in the 2016 TCS for doctors and dentists in training.	The guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Board that doctors' working hours are safe.	1 PA
Director of Quality Improvement			3 PA
Director of Cancer Services			2 PA
Director of Patient Safety			1 PA
Statutory Requirement or agreed in commissioning arrangements. **Specific Service Responsibilities**	E.g. Infection Control Lead, Looked After Children, Safeguarding Named Doctor		0.25-1SPA dependent on size of the project/workload

Clinical Management Roles

It is acknowledged that some of the roles maybe recognised outside of a 10 PA contract.

Role	Responsibility	Outcome	SPA Allocation
Associate Medical Director			2 PA
Lead for: Medicine Emergency Dept. General Surgery Orthopaedics Ophthalmology Anaesthetics Obs & Gynae Paediatrics Radiology Lab Medicine ~~Head & Neck~~ removed and created Max-Facs 1PA and ENT 1PA	Department meetings and associated work Reading and disseminating management guidelines and policies Local specialty advisory committee membership Robust management of job planning with scrutiny and challenge of the process Ensure consultant engagement in departmental and Trust affairs Staff interviews, including short-listing Policy development Regional & Trust subcommittee duties, including meetings and preparation Reading and replying to emails about department and national/regional matters Membership of Departmental Management Teams Updating unit documentation and patient information Timely management of complaints, clinical incident investigations and critical incident reviews	Specialty specific lead objectives set annually by Medical Director/Director of Clinical Services 75% attendance at divisional meetings Attendance at interview panels Contribution to policy development Management of specialty job planning process and prospective job plans to be completed between Jan – March prior to the financial year Up to date correspondence and involvement in management matters Maintain compliant and safe rotas Timely complaints responses Ensure > 90% of eligible patients are risk assessed for VTE	2 PA

Role	Responsibility	Outcome	SPA Allocation
Lead for: • Gastro • Cardiology(inc. Coronary care) • Acute Physicians • Critical Care • ENT- Added • Max Facs- Added • Haematology- Added • Urology- Added	As Above and the following: • Responsible for On-call rota • Service Complexity • Headcount Complexity	As Above	1 PA
Lead For: • Diabetes & Endocrinology • Resp • Neuro • Healthcare of Older People • Upper GI (Only if Consultant is not the GS Lead) • Breast • Rheumatology • Pain • Oncology • Dermatology	Departmental meetings and associated work Reading and disseminating management guidelines and policies Local specialty advisory committee membership Robust management of job planning with scrutiny and challenge of the process Ensure consultant engagement in departmental and Trust affairs Staff interviews, including short-listing Policy development Regional & Trust subcommittee duties, including meetings and preparation Reading and replying to emails about department and national/regional matters	As Above	0.5 PA To include all Lead Roles in the speciality unless specified in commissioning arrangements or statutory roles.

Role	Responsibility	Outcome	SPA Allocation
• Sexual Medicine	Membership of Departmental Management Teams Updating unit documentation and patient information Timely management of complaints, clinical incident investigations and critical incident reviews		
External Duties (must be agreed in advance with the Clinical Director and approved by the MD) GMC/Royal College work SCT chair NCAS Trade Union duties	Examiner Peer assessment GMC/Royal College activities NCAS BMA (including LNC) work involving local and national meetings, regular e-mail correspondence, and reading of related documentation in preparation for meetings, etc.	Defined per role 75% attendance at J/LNC meetings	By agreement up to max 0.5 These roles must be agreed by department and Clinical Service Lead before agreement

Medical Education Roles

Role	Responsibility	SPA Allocation
College Tutor	Representing the Trust on the relevant regional HEE Training Committee. Leading the Local Faculty Group in their specialty, and representing it on the Trust Education Board. Ensuring the delivery of the GMC/College curriculum within the Trust/Specialty. Monitoring the number and type of posts and their educational opportunities. Working with the Educational Supervisors and Programme Directors. Co-ordinate educator training programmes within the Department / Specialty. Ensure that induction process is in place in each Department / Specialty. Ensure that all trainees have a completed learning agreement with their Educational Supervisor. Provide support in the use of e-portfolios etc. Ensure systems are in place for each trainee to have an annual RITA/ARCP in their specialty. Provide specialty career advice. Provide advice on access to study leave opportunities. Support the regional HEE Quality Control arrangements and provide an annual report to the Local Trust Education Board / DME and/or training programme director Co-ordinating local recruitment issues within the appropriate school.	1 PA College Tutors in smaller specialties (e.g. under 15 trainees) are expected to provide Educational Supervision for up to 3 trainees.
Educational Supervisor	Responsible for one or more named trainees for all aspects of educational supervision. (often outside of Supervisors own specialty) (See HEE Education Roles and Responsibilities document).	0.25 PA per trainee per week

Role	Responsibility	SPA Allocation
	General teaching, lectures and tutorials for medical students and junior doctors Tutorials, problem based learning, in and out patient learning sessions May also include Audit/Project supervision & guidance Post graduate supervision of junior medical staff – formal timetabled sessions and support and advice as per foundation programme Writing presentations for unit teaching and other meetings Undergraduate teaching and examinations Foundation doctor teaching	Locally Employed Doctors (LEDs)- Although not in a training programme still require supervision and support. All LEDs not in a Deanery Funded Gap and are additional workforce will also need to receive 0.25PA for supervision. This funding will need to be accounted for by the department when they submit the business case for the post. The department will also be responsible for identifying the named supervisor within their department for the Trust Doctor.
Clinical Supervisor This is in reference to work undertaken in addition to ad-hoc supervision during DCC activity	Responsible for ARCP Ensuring safe clinical oversight of the trainee's day to day performance. Enables trainees to learn by taking responsibility for patient management within the context of clinical governance and patient safety Ensures that clinical care is valued for its learning opportunities; learning and teaching must be integrated into service provision Undertakes clinical supervision of a trainee, giving regular, appropriate feedback according to the stage and level of training, experience and expected competence of the trainee Undertakes assessment of trainees (or delegates as appropriate), has been trained in assessment and understands the generic relationship between learning and assessment [SFT 1.2]	0.10PA per Trainee for Named Clinical Supervisor (only 1 per trainee) for Foundation Trainees (FY1 & 2) and GPSTs ONLY. For all other doctors in training no tariff is applied to the Clinical Supervisor.

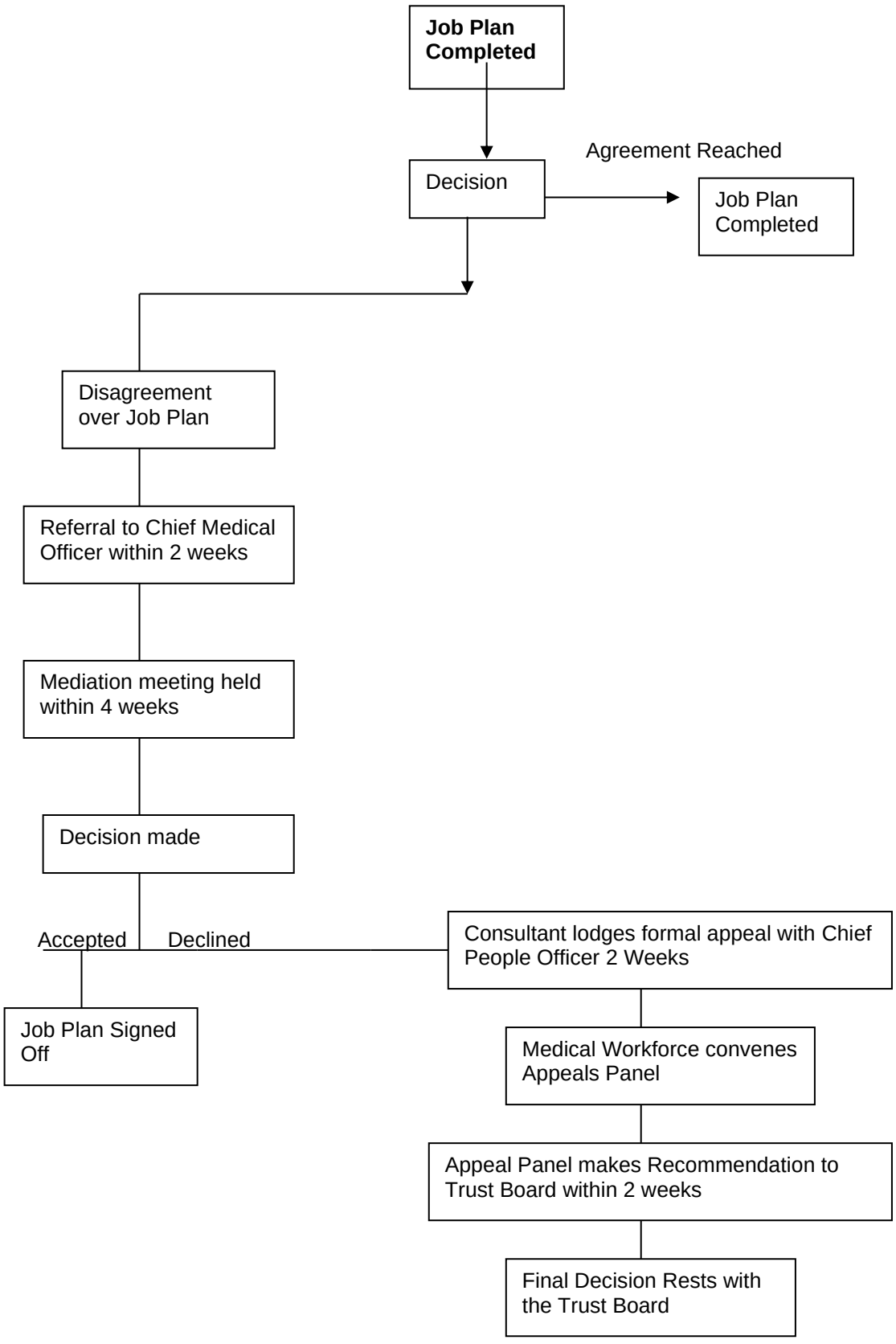
Role	Responsibility	SPA Allocation
	Liaises with the appropriate Educational Supervisor over trainee progression [SFT 2.2] Must ensure that all doctors and non-medical staff involved in training and assessment understand the requirements of the curriculum (foundation, specialty or GP) as it relates to a particular trainee [SFT 4.2]	
Foundation Programme Director		1 PA
Training Programme Director		Variable as paid by HEESW
Director of Medical Education		2 PA
QI Lead		1 PA
SAS Tutor		1 PA
Trust Doctor lead		1PA
Formal Teaching Role (Separate from departmental/specialty teaching)		Up to 0.5 PA Needs to be agreed in advance with DME & CD and reviewed annually.

Undergraduate Medical Education –

Role	Responsibility	SPA Allocation
Academic Tutor- Year 5		Total hours per student = 14 hours Training = 6 hours (one off payment paid in term 1) Example: 3 x yr 5 students = 42hrs plus 6 hours training = 48 hours
Academic Tutors- Years 3 and 4		Total hours per student = 8 hours Training = 6 hours (one off payment paid in term 1)

Role	Responsibility	SPA Allocation
		Example: 3 x Yr 3 students = 24hrs plus 6 hours training = 30 hours for the academic year. - 3x Year 3 academic tutees = 0.2PA per week for 42 weeks - 4x Year 3 academic tutees = 0.25PA per week for 42 weeks - 5x Year 3 academic tutees = 0.3PA per week for 42 weeks
Year 5 academic programme provider (teaching)		Dependent on number of hours and sessions in programme up to 0.5 PA (not always included in job plan if a low number of hours) Consultants are paid at £108 per hour through the SLA GPs are paid at £65 per hour to the Practice through the SLA GPs paid as a Visiting Specialist (VS) £53.41
Block/Speciality Lead (year 5) Pathway Lead and clinical reasoning (year 5)		0.25 PA (per student per block x 5 blocks – varies according to departments)
Associate Dean/Clinical Sub-Dean		1.5 PA (Exeter) and 2 PA (Plymouth)
Year 1 to 4 SSU Placement		Between 10-53 hours, depending on SSU type and group size
Pastoral Tutor		0.25 PA
SIM debriefing tutor		0.5 PA
Clinical Skills Lead		TBC – currently in development
Clinical Skills Tutor		Honorary contract
Clinical Teaching Fellow		FTE salary x 3 + acute medicine 0.6
SSU Lead		1 PA
Pathway Lead and clinical reasoning (year 5)		0.25 PA (per student per block x 5 blocks – varies according to departments)

Appendix 2 – Job Planning Mediation & Appeals Process



Appendix 3 – Principles Governing Receipt of Additional Fees

In the case of the following services, the clinician 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 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 the NHS time without the employer collecting the fee;
- Domiciliary consultations carried out during the Programmed Activities;
- Lectures and teaching during the course of the clinician's clinical duties;
- Lectures and teaching that are not part of the clinician's clinical duties, but are undertaken during the programmed activities.

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

Services for which the clinician can retain any fee that is paid:

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

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