Torbay and South Devon NHS Foundation Trust

JOB PLANNING POLICY
(MD24)

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Date of Issue:	June 2026	**Next Review Date:**	June 2028
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JLNC		16th May 2018	
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Links or overlaps with other policies:

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
2	June 2026	General review and updating of tariffs and SPA entitlement for new starters.	JLNC

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 accessibility of this policy, please contact **Equality, Diversity & Inclusion Team on** tsdft.diversityandinclusion@nhs.net

Rapid Equality Impact Assessment *(for use when writing policies and procedures)*

Policy Title (and number)	Job Planning	**Version and Date**	June 2026 v2
Policy Author	Medical Workforce Service		

An equality impact assessment (EIA) is a process designed to ensure that a policy, project or scheme does not discriminate or disadvantage people. EIAs also improve and promote equality. Consider the nature and extent of the impact, not the number of people affected.

EQUALITY ANALYSIS: How well do people from protected groups fare in relation to the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below)

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

Is it likely that the policy/procedure 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☐
Are the services outlined in the policy/procedure fully accessible[6]?	Yes ☐ No☐
Does the policy/procedure encourage individualised and person-centered care?	Yes ☐ No☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☐

If 'Yes', how will you mitigate this risk to ensure fair and equal access?

EXTERNAL FACTORS

Is the policy/procedure 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 the process of job planning in medical workforce

Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions?

Patients/Service Users	Trade Unions **X**	Protected Groups
Staff **X**	General Public	Other

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

Action	**Person responsible**	**Completion date**

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form		**Signature**	
Validated by (line manager)		**Signature**	

Contents

1. Policy Statement

1.1 Job planning for medical staff, specifically Consultants and SAS Doctors, (hereafter Doctors) is an annual, structured process involving a formal meeting between each doctor and their Clinical Service Lead with an Operational Manager attending if agreed.

1.2 A **job plan** is a forward-looking agreement outlining a clinician's duties, responsibilities, and objectives for the year ahead. It includes all aspects of their professional role, such as:

- Clinical activity
- Teaching and training
- Research
- Education
- Managerial or leadership responsibilities

2. Purpose

2.1 To value and reward the full range of work activities that doctors undertake for the Trust and to ensure that every job plan is fair and equitable.

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 The Trust requires a flexible medical workforce that can adapt to service demand while maintaining high standards of patient care. Job planning should reflect the complexity of healthcare delivery, balancing clinicians' individual goals with organisational priorities such as productivity, consistency, and safety. It also provides a collaborative opportunity for both the Trust and doctors to review working patterns, supporting effective service delivery alongside improved work–life balance.

3. Scope

3.1 This policy applies to all Consultant & SAS employed by Torbay & South Devon NHS Foundation Trust, 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.

5. Roles and Responsibilities

5.2 Medical Workforce

Responsibility for job planning includes overseeing its introduction, operation, and ongoing monitoring, as well as advising Clinical Service Leads, Operational Managers, and clinicians throughout the process. The Medical Workforce team is responsible for managing and maintaining the IT system used to record and store job plans.

5.3 Responsibility of the Joint Local Negotiating Committee (JLNC)

The JLNC will receive job plan reports, provided to the Job Planning Committee, for information and review at the quarterly JLNC meetings. They will be responsible for jointly reviewing the job planning policy with management.

5.4 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.

5.5 Responsibility of the Deputy Medical Directors (DMD)

Overseeing job planning in the areas of their responsibility. Areas of focus shall be:

- Meeting with the Associate Medical Directors (AMD) to discuss job planning issues
- Championing the use of team job planning across the organisation to ensure a consistent approach.

5.6 Responsibility of the Associate Medical Directors (AMD)

Overseeing job planning in their respective Care Groups. Areas of focus shall be:

- Ensuring that each doctor has a current Job Plan which is subject to annual review (or interim review as necessary)
- Meet with the Clinical Service Leads to discuss specialty specific issues and agree parameters for job planning
- Support the team job planning process
- Undertaking the job plans of the Clinical Service Leads
- Ensure there is a consistent approach to job planning across their Care Group

5.7 Responsibility of the Clinical Service Leads (CSL)

Ensure AMDs are aware of service priorities related to job planning.

- Lead team job-planning discussions or delegate as appropriate, supported by the Operational Manager.
- Work with the Operational Manager to review draft job plans before individual meetings.
- Ensure doctors have adequate time to address any issues arising during job planning.
- Apply consistency across the team in how job-planning activities are recorded and ensure interim reviews occur when working arrangements change.
- Release doctors to participate in job planning within their core SPA time.
- Collaborate with AMDs and Operational Managers to develop service and team objectives.
- Work jointly with AMDs and Operational Managers to resolve issues identified during job planning.
- Escalate unresolved concerns from job-planning discussions to the AMD promptly.

5.8 Responsibility of the Operational Manager

Provide annual clinical activity data and other relevant information to support the job-planning process.

- Work with the Clinical Service Lead (CSL) to keep an up-to-date record of all job plans in their area.
- Collaborate with the CSL and AMD to develop service and team objectives.
- Support team job planning and help ensure consistent application of activities across individual job plans.
- Submit change-of-circumstances forms to implement remuneration changes.

5.9 Ops Manager preparation in advance of job planning meetings

- Review the demand profile to understand service delivery needs for the coming year.
- Calculate the number of Programmed Activities (PAs) required to meet service demands.
- Align clinical capacity with the business plan.
- Ensure capacity is coordinated with other departments and related services.
- Identify service pressure points.
- Consider financial factors, such as the affordability of proposed job plans.
- Review workforce issues, including current or planned staffing gaps.
- Review the clinician's existing job plan and consider their aspirations.
- Draft a proposed job plan to discuss with the clinician during the meeting.

5.10 Responsibility of the doctor

- Participate annually in job planning (and interim reviews when needed) and support timely, accurate submission of job plans.
- Engage in team job-planning discussions.
- Ensure job plans include detailed Programmed Activity (PA) allocations, objectives, and outputs for both DCC and SPA work.
- Work within the framework of the agreed job plan.
- Request an interim job-plan review when personal circumstances or working patterns change.
- Inform the Clinical Manager and Operational Manager of any significant issues affecting their job plan.
- Consider how changes—such as increases in consultant numbers or alterations in clinical practice—may impact their workload (while recognising the Trust's duty not to undermine agreed duties).
- Review and verify individual and specialty clinical performance data.
- Is required to discuss taking on additional internal or external duties with the CSL, who must liaise with the Operational Manager and joint approval must be obtained.
- Declare any regular private practice activity within their job plan.
- Maintain an up-to-date job plan to support pay progression.

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

- Have a clear understanding of desired outcomes from the meeting.
- Identify personal objectives for the upcoming year.
- Be open about all internal and external work to enable realistic agreement.
- Consider colleagues' aspirations to support equitable team planning.
- Remain aware of wider clinical and corporate governance considerations.

6. Job Planning Process

6.1 Job planning for all 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 doctor, CSL, Operational Manager and AMD.

7. Team Based Job Plans

A team-based job-planning approach is recommended as the initial step. Team meetings bring together all doctors within the team, the CSL, and the Operational Manager **before** individual job-planning meetings.

The purpose is to:

- Discuss issues common to all team members.
- Agree a consistent approach across the team.
- Establish standard expectations around:
  - PAs allocated for clinical activities.
  - Average time required for clinical administration and on-call duties.
  - Allocation and distribution of SPA responsibilities.

Additional guidance is available in **Appendix 4**.

8. The Job Plan in Context

8.1 A job plan is a forward-looking agreement outlining a clinician's duties, responsibilities, and objectives for the coming year.

Effective job planning relies on partnership and should:

- Support safe, high-quality patient care and promote work-life balance.
- Enable compliance with CME, revalidation, appraisal, and other developmental responsibilities.
- Specify the clinical activity to be delivered over 12 months, including clinic/activity templates, and detail SPA activity with expected outputs and average time allocations, usually based on a 42-week working year, (to allow for annual and study/professional leave) and will be amended on an individual basis as necessary
- Recognise and support service development, education, training, and research in a transparent, equitable way
- Ensure alignment with Trust corporate objectives and the business plan.

8.2 Each component of the job plan should be reviewed separately, with average weekly PAs defined before being combined into the overall job plan.

8.3 Job plans are expressed in Programmed Activities (PAs), with each PA equalling 4 hours; a full-time contract is 10 PAs

8.4 To support staff wellbeing, job plans should not exceed 12 PAs, and any exception above this limit will only be approved in exceptional circumstances.

8.5 Objectives

8.5.1 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.

8.5.2 Each doctor will have the following objectives:
- Individual Objectives
- Contribution to team objectives

9 Direct Clinical Care (DCC) Activities

9.1 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.

9.2 **MDT (Multidisciplinary Team)** meetings and **M&M (Morbidity & Mortality)** meetings count as DCC when they relate directly to patient care or treatment planning. If meetings have mixed content, only the patient-care portion is DCC; the rest is recorded as SPA.

9.3 **Administrative tasks** directly related to DCC (e.g., referrals, clinical notes) are also counted as DCC. The amount of clinical administrative time should be proportionate to the clinician's overall DCC workload and broadly consistent within specialties.

9.4 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
- MDT 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 Resident Doctors and non-medical colleagues in management of patients

9.5 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.

9.6 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.

10 On-Call Activities

10.1 On-call duties are recognised in the job plan through an **availability supplement** and **DCC PAs** for both predictable and unpredictable emergency work and these should be programmed into the working week.

Predictable emergency work includes regular, scheduled activity resulting from on-call duties (e.g., post-take ward rounds, emergency lists).

Unpredictable emergency work includes unplanned activity arising during on-call periods, such as returning to the hospital to operate or provide urgent care.

10.2 The number of PAs allocated for on-call duties is based on the **actual work undertaken**, including telephone advice, travel time, ward rounds linked to on-call, and on-site emergency interventions.

10.3 **Prospective Cover for On Call**

Clinicians are expected to provide cover for absent colleagues where practicable, even if on occasions this would involve interchange of staff within the Trust, which includes:

- Cross-covering inpatient beds and supporting resident doctors.
- Providing on-call cover both in and out of hours.

Consideration of the need to cover planned absence should therefore be given when agreeing a job plan.

11 Supporting Professional Activities (SPA)

SPA is divided into Generic and Non-Generic activities.

11.1 GENERIC SPAs

Are activities that underpin appraisal and revalidation. 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 M&M meetings (element not related to DCC)

11.2 Clinicians must demonstrate that they have achieved the expected outputs from their SPA time otherwise pay progression may be affected.

11.3 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.

11.4 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

11.6 New Starters

11.6.1 New Consultants and Specialty and Specialist (SAS) doctors joining the Trust will be allocated additional Supporting Professional Activity (SPA) time for a period of six months, as detailed at 11.6.4.

11.6.2 This additional SPA time is intended to support induction and orientation within the department, attendance at the Trust's New Consultant and SAS Development Programme, and the development of the skills and knowledge required to undertake additional NHS responsibilities.

11.6.3 Towards the end of the six-month period, a review discussion will take place between the individual, Clinical Service Lead, and operational manager. This discussion will determine whether the individual will undertake Additional NHS Responsibilities, in line with service and/or Trust needs, or whether the additional SPA time should be reallocated to Direct Clinical Care (DCC).

11.6.4

Total Contracted PAs	Generic SPA entitlement
7 or more	2.5
6.9 - 4	1.5
Under 4	Agreed on an individual basis

11.7 Non-Generic SPA

11.7.1 Additional NHS Responsibilities (ANR) and External Duties (ED) may be allocated SPA time for defined roles (as listed in Appendix 1). See also section 12 and 13 for further explanation.

Any additional SPA allocation must:

- Be clearly specified in the job plan.
- Be agreed with the CSL and Operational Manager.
- Be authorised by the AMD.
- Be clearly defined and explicitly linked to delivering Trust objectives or wider NHS responsibilities.

11.8 Situations where DCC may be reduced

Reductions in DCC time may be negotiated and agreed where workload supports this, such as for:

- **Management duties** — e.g., Director of Medical Education, Deputy Medical Director, Associate Medical Director, Clinical Service Lead.
- **Significant teaching commitments** — e.g. postgraduate medical education roles (funded or otherwise).

11.8.1 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 CSL and Operational Manager prior to applying for the role. 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.

11.9 Management Responsibilities within SPA

Management responsibilities, including those for lead clinical roles must be defined and included within additional SPA allocation:

- SPA allocation must reflect the **actual time spent** on the role.
- Roles requiring **less than one hour per week** will *not* be remunerated separately.
- Roles requiring **one hour or more per week** must be remunerated within the job plan.

12 Additional NHS Responsibilities (ANR)

ANR roles include responsibilities such as:

- Specialty Clinical Lead
- Appraiser
- Educational Supervisor
- Pastoral Tutor
- Audit and governance lead
- College tutor
- Certain additional teaching commitments
- Chairing Trust committees

These roles come with:

- A defined job description
- A formal appointment or election process (where applicable)
- Defined remuneration, which may be:
  - Additional PA allocation
  - A responsibility payment
  - Additional leave

Clinicians must **discuss and agree** undertaking these roles with the CSL and Operational Manager **before applying**.

13 External Duties (ED)

13.1 Examples include work undertaken for the GMC, Specialty Training Committee Chair, BMA activities and ARCP panels.

- EDs are **not** classed as Fee-Paying Services or Private Professional Services.
- **Ad hoc duties** (less than twice a year) should be undertaken within the **existing job plan**.
- **Regular commitments** must be discussed and agreed in advance with the **CSL** and **Operational Manager** and recognised with **appropriate SPA allocation**.

13.2 If an external duty is remunerated by an external body, it must be defined in the job plan as an ‘external duty’ including the funding source and the expected duration.

13.3 All ANR and ED activities must be discussed with the Trust in advance. Support will generally be given where:

- The activity provides a **clear benefit** to the individual doctor, the Trust, or the wider NHS.
- The **impact on colleagues** within the specialty/department is properly considered.
- Time required for ANR/ED is **explicitly recorded** in the job plan.
  - Some roles may be delivered within **generic SPA time** if appropriate and achievable.
  - Others require **additional SPA allocation** outside generic SPAs.
- The **impact on patient services** is considered.

14 Additional Programmed Activities (APA)

14.1 For full time doctors, PAs above 10 per week are temporary. In this context, APA's 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, ANR and/or other ED and should be clearly identified as APAs on the job plan.

14.2 Clinicians are not obliged to offer, or accept additional PAs, except if they wish to undertake Private Professional Services.

14.3 Any additional non-job planned work carried out at the Trust's request should be remunerated under 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.

14.4 Any additional PAs in the job plan are not superannuable (i.e., they do not count toward pension). Job plans exceeding12 PAs will only be approved in exceptional circumstances.

14.4 Notice Periods for Additional PAs

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

15 Rest & Meal Breaks

15.1 Rest and meal breaks are generally unpaid and are not included in Programmed Activities.

15.2 Whilst rest arrangements are not reflected in the electronic job plans, individuals should be provided with the opportunity to have appropriate breaks. 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.

15.2 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.

16 Travelling Time

16.1 Where doctors 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.

16.2 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.

17 Private Professional Services (Practice)

17.1 Regular private practice should be included in the job plan and schedule of PAs, including weekday evenings and weekends.

17.2 All private practice 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.

17.3 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 CSL. 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.

17.4 Doctors wishing to undertake private practice (including LTFT doctors) must **offer one additional PA** to the Trust.

- If the Trust accepts this PA it will be paid at standard rate.
- If the doctor declines to undertake the additional PA but continues private practice, they will not be entitled to pay progression that year.
- If the Trust agrees no additional PA is required, private practice can proceed without affecting pay progression.

17.5 Rescheduling of NHS Duties in Private Activity

If the Trust needs to move NHS work that clashes with scheduled private activity:

- It will seek agreement first.
- If agreement is not possible, the Trust will give **3 months' notice**, starting after any job-planning appeal is resolved.

17.6 Emergency Situations in Private Practice

If a private patient unexpectedly deteriorates during an NHS scheduled activity:

- The doctor must ensure NHS patients are safe before leaving.
- The doctor must make themselves available to provide **equivalent NHS time later**, without extra 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.

17.7 Private Practice while On Call

Consultants must not undertake private or fee-paying services when on call duty: The exceptions to this, as per Consultant National Terms and Conditions of Service Schedule 8 paragraph 5 are:

- The rota frequency is 1 in 4 or more frequent and the on-call category is Category B, (Schedule 16 of Consultant TCS) and the Trust has given prior approval.
- The Consultant must provide emergency or essential ongoing care for a private patient.

If private emergencies frequently disrupt NHS duties, the doctor must arrange alternative private cover.

18. Fee-Paying Services

18.1 Fee-paying services must be **included in the job plan** and scheduled PAs.

- They may only be undertaken during **DCC or SPA time** with **prior agreement** from the CSL and Operational Manager, and where **time-shifting arrangements** have been formally approved.
- When time-shifting is agreed, the doctor may retain the fees.
- These arrangements are subject to regular review and may be ended by either party with reasonable notice.

18.2 Doctors may also retain fees **without time-shifting** if:

- The impact on other NHS activities is **minimal**, and
- This is explicitly agreed in writing by the CSL.

- "Minimal impact" means no reduction in DCC activity levels and no adverse effect on efficient use of Trust resources.
- These arrangements will also be reviewed regularly.

19 Core & Premium Time & Weekend Working

19.1 For work within the job plan - the normal working day will be 7am to 7pm, Monday to Friday.

19.2 If a consultant has PAs in premium time, between 7pm and 7am, 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.

19.3 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.

19.4 The Trust has a local weekend remuneration agreement as follows:

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).

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

19.5 Remuneration or time in lieu will be as agreed by the CSL and Operational Service Manager. Within the constraints of the department there should be flexibility to allow some adjustment to week-by-week working patterns.

19.6 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.

19.7 The above enhanced remuneration for weekend working applies to all Consultants and SAS doctors employed as of 31 July 2019. They will not however apply to newly appointed Specialty

Doctors appointed after 1 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.

20 On Call Duties

20.1 Work resulting directly from on-call duties should be documented within the job plan. When performed 'out of hours' time will be recognised at premium rates.

20.2 For those 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.

21 SAS Doctors Working Hours Balance

21.1 As per the Trust's Charter for the Employment of SAS Doctors, SAS 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.

21.2 The Trust aims to maintain an appropriate balance between daytime and out-of-hours work. Out-of-hours activity should not exceed 60% of total working hours unless mutually agreed. The Trust is committed to reducing out-of-hours work towards a 40% limit, where practical and appropriate.

21.3 Arrangements are to be agreed at both an individual and team level.

21.4 The JLNC (Joint Local Negotiating Committee) will oversee these arrangements to ensure a fair and appropriate balance is maintained.

22 Flexible Working Arrangements

22.1 We recognise that colleagues work in different ways, and that face-to-face working is not always required. However, there are times when on-site presence is essential to support safe care, effective collaboration, and team functioning. Doctors are therefore expected to exercise professional judgement in balancing remote and on-site working, ensuring they attend in person when required to meet service and organisational need

22.2 Alternative work locations may be agreed, including for SPA activities. If an SPA is carried out away from the principal workplace, the doctor must remain contactable and able to return to the Trust in the event of an emergency. Only **one SPA** may be worked flexibly in this way.

22.3 There is an expectation that all agreed duties are fully delivered, including those scheduled as 'no fixed time', and that working arrangements support transparency of activity and availability. Doctors must ensure that their NHS commitments are prioritised and fulfilled in full, and that any external or private sector work does not conflict with, or detract from, these responsibilities.

22.3 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.

23 Mediation in Job Planning Disputes

23.1 **Informal resolution first:** Job planning disagreements should ideally be resolved informally before moving to mediation.

23.2 **Nature of mediation:** Mediation is a confidential, voluntary process led by a neutral mediator, aimed at helping both parties reach their own agreement, outside of the formal appeal procedure. Representatives (e.g., BMA reps, colleagues) do not attend mediation meetings.

23.3 **Starting mediation:** Either the doctor or the CSL can refer the dispute in writing to the DMD (or another designated person) within two weeks of the disagreement, outlining the issue and preferred outcome. 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.

23.4 **Mediation meetings:** A meeting is usually arranged within four weeks.
- Each party first meets **one-to-one** with the Mediator.
- A joint meeting with both parties follows to attempt to reach agreement.
- The mediator may gather extra information as needed.

23.5 **If agreement is reached:** The expectation is the job plan is signed off within 5 working days.

23.6 **If no agreement:** The mediator issues a written decision or recommendation to both parties.

23.7 **Appeal:** If the doctor is unhappy with the outcome, they may submit a formal written appeal to the CMO within two weeks, stating the disputed points, reasons for the appeal, and desired outcome.

23.8 **Team job plans:** For team-related disputes, the specialty should nominate a medical colleague to represent the team.

24 Appeals in Job Planning Disputes

25.1 This appeals process mirrors as far as possible that set out in the Terms and Conditions of Service for both Consultant and SAS doctors. A flow chart of the process is documented in Appendix 2. Separate Detailed Guidance is also available on Job Planning Mediation and Appeal Processes from the Medical Workforce Service.

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

25.3 A separate guidance document on the Job Planning Appeal Process is available.

26 The Appeal:

26.1 The appeal panel will consist of three members, ensuring a balanced representation:

- **Chair** nominated by the Trust
- **Panel member** nominated by the doctor(s)
- **Independent member** selected from the list approved by the BMA/BDA and NHS Employers (maintained by NHS England)

26.2 **The Panel Chair**: Medical Workforce will confirm the Chair of the panel. A senior person such as a DMD, CMO, Executive Director or Non-Executive Director of the Trust would normally undertake this role.

26.3 **Panel Member Nominated by the doctor(s**): The doctor(s) will nominate the second panel member. The JLNC may assist in identifying an appropriate nominee, or the doctor(s) may put forward their own choice.

26.4 **The Independent Third Panel Member**: The Medical Workforce Team is responsible for arranging the third panel member.

26.5 **Objections to the Independent Panel Member**

If the doctor(s) or management representative raises an objection to the independent panel member, the Chair will review the objection in good faith. Where necessary, an alternative representative will be provided. Objections must be submitted in writing with a clear explanation of the grounds, which will be retained on record.

26.6 **Role of Medical Workforce**

Medical Workforce will support the appeal panel by providing guidance on policy, process, and decision-making.

26.7 **Management Representatives**

Management representatives will normally be those involved in the mediation process and/or responsible for the service, typically the Clinical Service Lead and Operational Manager.

26.8 **Confirmation of Panel and Meeting Arrangements**

Medical Workforce will confirm the appeal panel membership and meeting date in writing to the doctor(s) and management representatives and will invite both parties to submit written statements of case.

26.9 **Submission of Written Statements**

Each party must submit their written statement of case to Medical Workforce no later than 7 calendar days before the appeal. These will be shared with the panel and with the opposing party. Verbal submissions will be heard at the meeting.

26.10 **Representation at the Appeal**

The doctor(s) may present their case personally or be accompanied by a work colleague, trade union representative, or professional organisation representative. Legal representatives acting in a professional capacity are not permitted.

26.11 **Management Case Presentation**

Management will present its case first, outlining the position regarding the job plan.

26.12 **Expert Advice**

Where required, the appeal panel may receive expert advice on matters specific to a specialty. Each party is responsible for arranging the attendance of their own expert witness. Unavailability of an expert will not ordinarily justify delaying or adjourning the appeal.

26.13 **Adjournments**

The Chair may adjourn the meeting to obtain expert advice or where an adjournment is judged necessary to ensure a fair and thorough hearing.

26.14 **Recommendation and Decision**

The Chair will submit the panel's written recommendation to the Trust Board, which will normally accept the recommendation. Copies will be sent to both parties at the same time. The Trust Board will make the final decision at the earliest available opportunity and will notify both parties in writing.

26.15 **Board Member Participation**

Any Board member involved in the mediation or appeal for a specific case must not take part in the Board's final decision on that case.

26.16 **Implementation**

No disputed element of the job plan will be implemented until the Trust Board decision is issued.

26.17 **Effective Date of Changes**

If the final decision results in a change to PA allocation, it will take effect from the date of the Trust Board's decision.

27. Training and Awareness

27.1 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. Any queries regarding this policy should be directed to the Medical Workforce Service.

27.2 The Medical Workforce team will 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	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.	7 or more PAs = 1.5 SPA 6.9 PAs to 4 PAs = 1SPA Under 4 PAs is by individual agreement

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	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	The level of time allocated will vary according to specialty and service requirements, typically ranging from 0.25 PA to a maximum of 2 PAs in exceptional circumstances. Allocated time must be proportionate to the scope and complexity of the role and agreed through the job planning process. There is an expectation that this time is demonstrably utilised to deliver the agreed responsibilities, with appropriate evidence of outputs. Delivery against these responsibilities will be reviewed through the Job Planning

Lead Role	Responsibility	Outcome	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.	Ensure all roles and responsibilities mentioned are effectively discharged	Review Group, and part of the formal job planning cycle.
Research Refers to principal investigator or Co-Investigator roles			The Trust recognises the importance of being research active in delivering best patient care. We recognise that time allocation, and the importance of delivering a research agenda may vary between specialities. Team based job planning to deliver research will be expected and any allocation over 0.25PA will be expected to have a separate funding stream allocated to this.
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.	1.5 PA

Lead Role	Responsibility	Outcome	Allocation
Champion of Resident Doctor Flexible Training	A Flexible Working Champion is a designated role, notably mandatory for Less Than Full Time (LTFT) trainee doctors/dentists in the NHS, tasked with advising, supporting, and promoting flexible working practices	implement flexible cultures, covering options like part-time,, flexitime, and home working to improve work-life balance.	0.5PA
Director of Cancer Services			2 PA
Director of Patient Safety			1 PA
Statutory Requirement or agreed in commissioning arrangements. **Specific Service Responsibilities**	E.g. Looked After Children, Safeguarding Named Doctor		0.25-1SPA dependent on size of the project/workload
Chief Clinical information Officer			To be determined according to the current requirements within the Organisation at the time of appointment.

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 – 4PA
Cancer & Clinical Support Services **Surgery** **Emergency Care & Medicine in Planned Care** **Medicine & Older People Care** **Families & Communities**			Dependent on Care Group

Role	Responsibility	Outcome
Clinical Service Leads MD24 Job Planning Policy	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

Clinical Service Leads	Allocation
Planned Care	2
General Surgery & Urology	2
Anaesthetics	2
Ophthalmology	2
Radiology	2
Orthopaedics	1
ICU	1
Breast Care	1
ENT	1
Oral & MaxFacs	1
Haematology Clinical Medicine	2 Includes 1PA for lead for Laboratory Medicine
Oncology & Radiotherapy	1.5 Includes 0.5 PA allocation national requirement for radiotherapy lead, this 0.5PA can be allocated separately within the speciality.
Upper GI Lead(If General Surgery CSL Colorectal)	0.5
Colorectal Lead (If General Surgery CSL UGI)	0.5
Microbiology	0.5
Histopathology	0.5
Chemical Pathology	0.5
Haematology Lab Medicine	As above

Medicine & Urgent Care	
Cardiology(inc. Coronary care)	1
Acute Medicine	1
Diabetes & Endocrinology	1
ED	2
Respiratory	1
Neurology	1
Healthcare of Older People	1
Rheumatology	1
Dermatology	1

Families & Communities	
Paediatrics	2
Obs & Gynaecology	1.5

Sub Speciality Leads
• Sub-specialty lead roles will be established where required to support service delivery, quality within specific areas of practice. • The remit and time allocation for these roles will be proportionate to the scope and complexity of the sub-specialty and agreed through the job planning process. • All roles will be subject to regular review and approval through the Job Planning Committee to ensure they remain aligned with organisational priorities and service need. • There is an expectation that the work undertaken within these roles is clearly evidenced, with demonstrable outputs and impact, and that this is

transparently reflected within job planning discussions.

External Duties	Current PA Allocation
Must be agreed in advance with CSL and Operational Manager and approved by AMD	
General Medical Council	By agreement up to max 0.5
Royal college work - Examiner & Peer Assessment	By agreement up to max 0.5
Trade Union Duties work involving local and national meetings, regular e-mail correspondence, and reading of related documentation in preparation for meetings, etc. 75% attendance at JLNC meetings.	By agreement up to max 0.5

Medical Education Roles

Role	Responsibility	SPA Allocation
College Tutor	Representing the Trust on the relevant NHSE Regional Committees. 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 and training issues within the appropriate school.	1 PA College Tutors in smaller specialties (e.g. under 15 Resident Doctors) are expected to provide Educational Supervision for up to 3 Resident Doctors.
Educational Supervisor	Responsible for one or more named Resident Doctors for all aspects of educational supervision. (often outside of Supervisors own specialty) (See HEE Education Roles and Responsibilities document).	0.25 PA per Resident Doctors per week

Role	Responsibility	SPA Allocation
	General teaching, lectures and tutorials for medical students and Resident 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 Resident Doctor, 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 additional NHSE tariff funding is applied to the Clinical Supervisor.

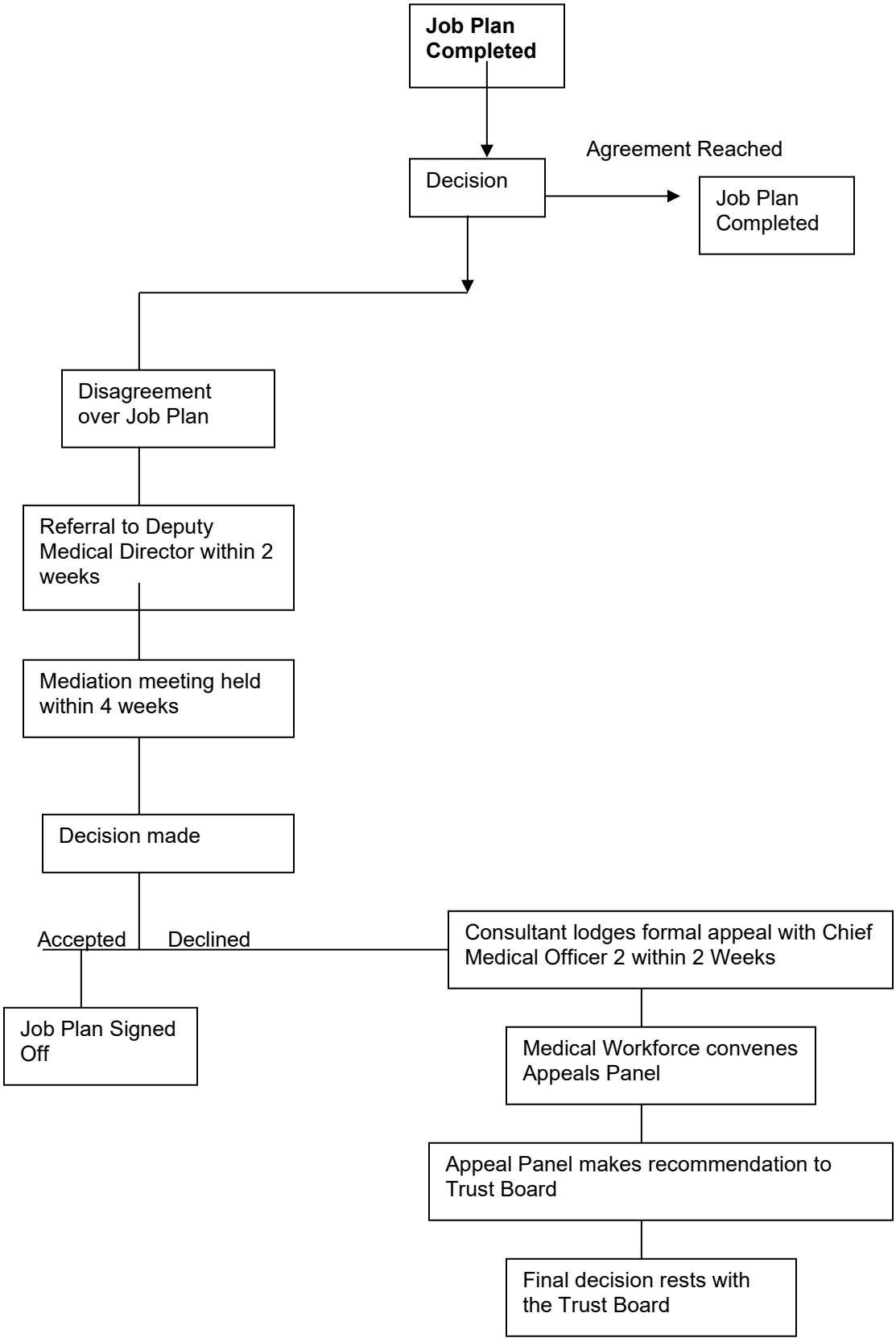
Role	Responsibility	SPA Allocation
	Liaises with the appropriate Educational Supervisor over trainee progression [SFT 2.2] Must ensure that all doctors and non-medical staff involved in training and assessment understand the requirements of the curriculum (foundation, specialty or GP) as it relates to a particular trainee [SFT 4.2	
Training Programme Director		Variable as paid by NHSE
Head of School, Associate Dean, Deputy Dean	Appointed by NHSE.	Variable as paid by NHSE
Director of Medical Education		2 PA
Associate Director of Medical Education for Support		1 PA
Associate Director of Medical Education for Quality		1 PA
SAS Advocate		0.5PA
SAS Tutor		1 PA
Trust Doctor lead		1PA
Pastoral Tutor		0.5PA
IMG Lead		1PA
SuppoRTT Champion		1PA
Clinical Leadership Mentor		0.5 PA

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) 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

Role	Responsibility	SPA Allocation
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 doctor will not be paid an additional fee, or – if paid a fee – the doctor must remit the fee to the employing organisation:

- Any work in relation to 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 planned 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 clinical duties
- Lectures and teaching that are not part of 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 doctor can retain any fee that is paid:

- Fee Paying Services carried out in their own time, or during annual or unpaid leave
- Fee Paying Services carried out during 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 their 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 their own time or during annual or unpaid leave
- Private Professional Services undertaken in other facilities during their own time or during annual or unpaid leave
- Lectures and teaching that are not part of their clinical duties and are undertaken in their own time or during annual or unpaid leave.

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

Appendix 4 – Team Job Planning

This guide offers a practical way to bring conversations about demand, capacity, workforce, training, personal development and service ambitions into one coherent process, where teams can use their collective experience to shape pathways, redesign roles, explore new models of care and highlight where investment is genuinely needed.

This approach is about strengthening shared ownership. It recognises that strategic planning is most effective when clinical, operational and analytical perspectives come together early, openly and with a shared purpose.

Step 1: Organise Service Planning Meeting

Each service must hold an initial planning meeting with all relevant multi-professional colleagues. This meeting is used to introduce the Trust's planning priorities, to provide an overview of performance expectations, and to review validated demand data from the previous year. It also ensures a shared understanding of job planning policy and service-level expectations. Time spent in this meeting is recognised as SPA activity.

Step 2: Establish Emergency Activity Requirements

Each specialty must calculate the full 52-week emergency service requirement, including out-of-hours cover and non-resident on-call activity. Prospective cover must be factored into the modelling so that periods of leave and absence are appropriately accounted for. A standardised rota should be developed and agreed across the Consultant and SAS workforce to ensure clarity regarding roles, responsibilities and workload distribution.

Step 3: Establish Elective Demand and Required DCC

Elective activity to be fully assessed using validated activity data. Patient-not-present activities such as triage, advice and guidance, MDT participation, administrative work and pre- or post-operative tasks must also be included. Services should use standardised clinic templates where appropriate to ensure clarity and consistency. The total DCC PAs required to deliver the elective service needs to be calculated as part of this step.

Step 4: Overlay Expected Changes to Demand

The service must incorporate projected changes in demand. This includes anticipated growth based on historical trends, the impact of the current waiting list or backlog, assumptions relating to sickness absence, and any requirements linked to performance standards. Services must also consider strategic aims such as technology-enabled changes that may affect activity patterns.

Step 5: Identify the Demand and Capacity Gap

A second service planning meeting should be held to review the outputs of Steps 2–4. During this meeting, services assess the total DCC requirement against the capacity available from consultants, SAS Doctors and other clinical contributors. Emergency PAs and elective PAs must be considered together to determine whether capacity is sufficient. Where a gap exists, the team will discuss potential approaches such as redesigning clinics, adjusting job plan allocations, implementing multidisciplinary models, or preparing a business case for additional staffing.

Step 6: Conduct SPA Planning

Services will undertake team-based SPA planning to ensure that supporting professional activities are equitably and appropriately allocated. This includes SPA time for supervision, teaching, appraisal, revalidation, service development, leadership roles, research, and trust-wide responsibilities. SPA responsibilities must be clearly defined, realistic and aligned with the overall service priorities.

Step 7: Agree Distribution of Demand

The team will then agree how the required activity will be distributed. This includes ensuring that workload expectations are realistic, that sessional activity levels align with specialty standards, and that individual circumstances and skill sets are considered. Decisions must be fair, transparent and grounded in the principle that all team members contribute appropriately to the service as a whole.

Step 8: Create Individual Job Plans

Based on the agreed allocation of activity, each job plan will be created following the Trusts policy.

Step 9: Establish an Annual Intelligent Roster

By following the steps above each service should be able to produce a full-year timetable that schedules 42 weeks of elective work and ensures emergency cover across all 52 weeks. The roster must include clear procedures for booking and managing annual leave, study leave, bank holidays and absences, and must minimise sessional cancellations to protect patient access. While the roster provides structure, it must remain flexible enough to allow colleagues to swap sessions when needed.