

Job planning as the operating agreement

What a job plan must accomplish

Miriam arrives at her review with a job plan that adds up neatly and a working life that does not. She is a composite Specialty Doctor in Wales, employed under the reformed national contract, with ten contracted sessions. Her timetable contains clinics, ward work, an allowance for on-call activity, professional development and teaching. During the past year she has also become the dependable contact for a second site. The service has added patients, the teaching programme has expanded, and correspondence now follows her into evenings. Nothing in the electronic total indicates that the job has changed.

A representative workload review suggests that the service is asking for approximately twelve sessions of work. Miriam does not begin by demanding that somebody approve the number twelve. She begins with a more useful question: which work does the organisation want her to undertake, and what arrangement will make that work deliverable? An increased contract is one possible answer. So are fewer clinical commitments, redistributed responsibilities, better support or a combination of changes. Her evidence describes a capacity problem; the meeting must turn that evidence into an operating decision.

The job plan is the bridge between the employment documents examined in Chapter 5 and the actual organisation of care. A contract may establish the general framework, while a job description explains the post. The job plan should make those descriptions usable: which duties occur, where they occur, how much time they require, what outcomes are sought and what support makes them possible. The joint NHS Employers and BMA job-planning guide describes a collaborative process linking individual contribution with service planning. It remains useful for that approach, although its older contractual detail must be read against the reader's operative terms. ^[33]

A timetable alone is insufficient. It can show a clinic on Tuesday without explaining its patient mix, administrative consequences or dependency on a functioning treatment room. An objectives form alone is also insufficient. It

can require improved access without identifying the appointments, staff or authority available. A complete agreement joins the two. The schedule supplies capacity; the objectives explain its intended use; the resource record states the conditions on which delivery depends. The review process tests whether those assumptions remain true.

This has consequences for both parties. The doctor should make a fair account of activity, use agreed time for its stated purpose and raise emerging problems. The manager should clarify priorities and respond when the proposed service exceeds the available capacity. Neither benefits from a document that conceals disagreement behind a signature. A plan that is achievable only because the doctor routinely works unrecorded evenings may appear affordable while carrying an undisclosed dependency. Once the doctor becomes ill, reduces hours or leaves, the dependency becomes visible as a service failure.

Job planning is therefore also a continuity exercise. Imagine the next suitably qualified doctor reading the agreement without access to the current doctor's goodwill or informal relationships. Could they identify the work, the escalation arrangements and the limits? Could a rota coordinator schedule the duties without asking the doctor to fill every gap personally? Could an appraiser understand the employment context without confusing the job plan with a regulatory assessment? If these questions are difficult, improve the description before negotiating its finer arithmetic.

The process should leave space for professional judgement. Patients do not arrive in equal units, and a safe service cannot specify every interruption in advance. The answer is to describe predictable commitments accurately and provide a sensible arrangement for variation. Flexibility works when both sides understand what may change and what must be reviewed. It becomes unreliable when it means that every new request is absorbed indefinitely. Miriam's aim is a plan that colleagues can operate during ordinary weeks and test during difficult ones, with a clear route for deciding what changes when demand exceeds the agreement.

Keep the agreement readable to the people who must implement it. A rota coordinator needs scheduling instructions, a clinical manager needs priorities and dependencies, and the doctor needs an accurate record of commitments. A plan written solely to satisfy a software field may serve none of them well. Use the required system, but attach a clear narrative where its categories cannot explain the work adequately.

Programmed activities sessions and annualisation

Start with the unit named in the applicable contract. Programmed activity, often shortened to PA, and session are not interchangeable accounting labels simply because both are used in medical employment. The Welsh Specialty Doctor terms updated in October 2024 describe a standard full-time plan of ten sessions, normally four hours each, with separate provisions for out-of-hours work. Northern Ireland's 2021 Specialty Doctor terms use ten programmed activities and the same ordinary four-hour timetable value. State the nation, grade and contractual version beside a calculation so that its assumptions can be checked. ^{[32][34]}

For an ordinary daytime activity valued at four hours per unit, the calculation is straightforward: divide recognised hours by four. A recurring two-hour meeting represents half a unit; four hours of clinical work represents one. This is an accounting conversion, not proof that every meeting deserves its requested duration. Establish the necessary work first. Equally, a four-hour label does not establish that a clinic ends within four hours. A timetable should reflect the work being commissioned, including what must happen before and after the visible patient contact.

Keep three quantities separate throughout the discussion: clock hours, contractual units and service outputs. Clock hours describe elapsed work. Contractual units recognise that work under the relevant terms. Outputs describe what the work produces. A clinic containing eight appointments may require a different amount of time from another eight-appointment clinic because the patient groups differ. An evening commitment may attract different contractual recognition from the same duration during ordinary hours. Collapsing all three quantities into one number makes comparisons look simpler while making their meaning less reliable.

Miriam's initial diary records time before converting it. Each entry identifies the activity, start and finish, whether it was already inside a scheduled commitment, and whether it displaced another duty. The entry for a forty-minute telephone discussion about an existing patient is counted once. If it occurred during time already allocated to clinical administration, it helps explain the use of that time rather than adding forty minutes to the weekly total. If it interrupted protected teaching preparation, it records a displacement that the plan must address. Chapter 7 develops the evidence method in detail.

A weekly plan is convenient when the work repeats. It is less satisfactory when activities occur monthly, seasonally or across a long rota cycle. Annualisation can make those patterns visible, but it requires an agreed denominator. Do not start by assuming that every doctor delivers ordinary

scheduled activity during the same number of weeks. Leave, public holidays, study arrangements, rotation, part-time patterns and duties continuing during other absences affect the calculation. A national leave entitlement, a local planning assumption and an actual record of attendance answer different questions.

Consider a purely illustrative daytime teaching programme. The employer wants twenty workshops in a planning year. Each requires one hour of delivery and two hours for preparation, assessment and follow-up. The annual requirement is sixty hours. If the agreed planning model distributes that activity over forty delivery weeks, it represents one and a half hours per delivery week, or 0.375 of a four-hour unit. The result should normally be scheduled in usable blocks, perhaps three hours every fortnight. Nothing in the arithmetic establishes that forty weeks is a national entitlement or that teaching must be divided into small fragments.

The same calculation can be reversed to test a proposal. Suppose sixty hours have been allocated but the programme expands to thirty workshops with unchanged preparation requirements. The requirement becomes ninety hours, leaving a thirty-hour difference. A discussion about efficiency should then identify what would actually reduce that requirement. Reusing a well-designed introduction might save preparation time; assessing more learners might increase follow-up. Merely leaving the annual allocation unchanged does not create efficiency. It leaves either a smaller programme, incomplete work or additional time to be accounted for.

Separate fixed events from average allowances. A monthly committee has dates that must fit the calendar even if its annual total produces a modest weekly average. A doctor cannot attend a two-hour meeting on Wednesday by using thirty minutes on each of four unrelated days. Likewise, averaging on-call activity does not make the demand evenly distributed. The annual view is a budget; the calendar is a feasibility test. Both are needed when sessions are distributed irregularly or several organisations make demands on the same doctor.

Prospective cover needs explicit treatment. If the rota is designed for colleagues to cover planned absence, show how that changes each participant's frequency, activity and available elective capacity. Do not count cover within the rota and then add the same cover again as an independent workload. Conversely, do not calculate a nominal one-in-six commitment from six names if vacancies or known absences produce a materially more frequent actual pattern. The relevant contractual approach controls payment and recognition, while the operational record should show what the service genuinely expects.

Annualisation must not become a debt system in which every cancelled clinic is automatically owed again. Record why a session did not occur and what work was undertaken instead. A hospital cancellation, an agreed professional activity, sickness, annual leave and a doctor's failure to attend are different circumstances. They require different treatment under the applicable arrangements. The useful question is whether the agreed plan was delivered or appropriately varied, not whether a spreadsheet can recover every theoretical slot. Keep prospective capacity planning separate from retrospective attendance investigation.

Before accepting an annual total, ask whether the calculation has counted each hour once, applied the correct time category, made the delivery-week assumption explicit and included the calendar constraints. Retain the arithmetic with the agreement. Another reviewer should be able to reproduce the answer from the same assumptions, and a change in those assumptions should reveal exactly which part of the plan needs reconsideration.

Round only at the agreed stage. Rounding every small activity upwards can inflate a total, while rounding each downwards can erase meaningful work. Retain minutes in the working calculation and show how the final allocation was reached. This makes negotiation more transparent without pretending that the diary measures every task with laboratory precision.

Direct clinical care

Direct clinical care should describe the complete work of caring for patients rather than only the portion visible to appointment systems. The Welsh contractual definition expressly includes patient-related administration and multidisciplinary meetings about direct patient care.^[32] The practical implication is substantial. A service that counts the consultation but not the resulting decision, prescription, referral or communication has measured only part of the work it commissioned. The task may be completed at a desk or by telephone; its connection to care matters more than the room in which it occurs.

Take a clinic lasting four hours on the appointment template. Before it begins, the doctor reviews referrals, investigations and previous decisions. During the clinic, interpretation, examination and discussion generate further actions. Afterwards, results may arrive, letters need checking and other professionals request clarification. Some of that work can sensibly occur within the four-hour block. Some may require a separate period. The job-planning question is not whether every administrative task attracts an

extra allowance, but whether the whole clinical episode is realistically contained in the time already allocated.

Miriam samples several clinics rather than selecting the worst afternoon. She distinguishes preparation, scheduled contact, same-day completion and later follow-up. The sample shows that the existing clinic blocks include most preparation and immediate documentation, but subsequent results and correspondence require a further four hours each week. She checks that the same work has not already been recorded under her general clinical administration allowance. Her proposal is then precise: the present allowance is insufficient by a defined amount under the current patient mix, and the service must decide how to address the difference.

One response might be to reduce the number of booked appointments while retaining the block. Another might be to provide administrative support that genuinely removes non-clinical tasks. A third might be to create a separate clinical administration session. These options have different effects on access, staffing and the doctor's schedule. The most useful evidence allows them to be compared. A statement that the doctor is simply too busy leaves the manager with little basis for choosing; a statement that all correspondence requires medical time ignores opportunities to improve the process.

Patient complexity should be described with care. Avoid presenting complexity as an unchallengeable personal judgement. Identify the features that affect work: multiple decisions, interpreter involvement, cognitive or communication needs, coordination across services, medication reconciliation or substantial records to review. Use anonymised categories rather than identifiable stories in the job-planning record. A case-mix description can explain why a clinic's capacity differs from another without implying that one doctor's patients are uniquely difficult or that another colleague's workload is less valuable.

Multidisciplinary work requires the same discipline. A patient-focused meeting may involve reviewing records beforehand, contributing decisions during the discussion and completing actions afterwards. The meeting's duration captures only its central portion. Agree which preparation is necessary and which actions belong to which professional. If everyone spends an hour reproducing the same summary, redesign may be more useful than multiplying allowances. If the doctor must make a clinical decision based on material that is unavailable until the meeting, apparent efficiency through reduced attendance may instead weaken the quality of care.

Handover belongs in the account of clinical work. A service change can increase handover demand without adding a clinic or ward round. Moving care between sites, extending opening hours or adding an evening doctor can introduce new transitions. Describe the information that must pass, the people involved and the time needed for questions. An electronic list may support the process but does not necessarily replace discussion where decisions or risks remain uncertain. The job plan should fit the actual handover arrangement rather than assuming that it occurs effortlessly between scheduled blocks.

Distinguish predictable emergency work from genuinely unpredictable demand. A regular morning review following an admission period can be scheduled even though the patients' diagnoses are unknown. An unplanned overnight recall has a different pattern. Calling both emergencies does not mean that neither can be anticipated. Examine when the work occurs and how frequently it recurs. If an urgent advice function generates a substantial workload every afternoon, the service may need a scheduled duty rather than an assumption that it will fit between other commitments.

Supervision during clinical care can be particularly difficult to classify. A doctor overseeing another clinician's patient decisions may be providing direct clinical work, whereas a planned educational review has a different purpose. Record the activity accurately before assigning the local category. Do not count the same hour as both a full clinic and an additional hour of supervision merely because both occur together. Instead, show how supervision affects the clinic's capacity and what dedicated time is required outside it. The aim is a credible account of the combined task.

Finally, agree the boundary of follow-up responsibility when the doctor is absent. A well-planned clinic includes arrangements for results, urgent messages and pending decisions that arrive later. If the system sends everything to one doctor's personal queue, reduced hours or leave may expose an unsafe dependence. The remedy may involve team coverage and routing rather than extra individual sessions. Job planning works best when it identifies the service design behind the workload as well as the doctor's share of it.

When a process is redesigned, measure whether work has moved rather than disappeared. Digital dictation might reduce transcription delay while leaving clinical checking unchanged. An electronic referral form might save administrative handling while requiring more medical information. Review the workflow after implementation and compare the whole episode, including follow-up. A technology change should alter the calculation when its actual effect on workload is properly understood.

Supporting professional activities

Supporting professional activities sustain the quality of the clinical service over time. They include the work of maintaining capability, examining practice and developing the people and systems around care. Their value is often less visible than a completed clinic because the output may be better judgement, a safer process or a competent colleague. That does not make the time optional. The GMC requires doctors to keep knowledge and skills current and to engage with relevant professional development and quality assurance. Those responsibilities need a practicable place in a working life.

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Under Schedule 4 paragraph 5 of the October 2024 Welsh Specialty Doctor terms, the job plan includes a minimum of one SPA session designated for job planning and meeting appraisal and revalidation requirements. ^[32] That minimum is not the complete requirement for every role. The BMA's SAS SPA guidance distinguishes core requirements from further teaching, research and management work, and identifies the Welsh good-practice recommendation of around twenty per cent of a basic full-time commitment. This recommendation should not be presented as an automatic UK-wide entitlement. The applicable contract and agreed duties establish the individual arrangement. ^[36]

Build the proposal from functions. What professional maintenance does this doctor need for this scope of practice? Which teaching responsibilities are commissioned? What quality work is expected? Is there a defined educational supervision role? Which activities are occasional, and which recur throughout the year? A list that simply says CPD, appraisal and audit can hide considerable variation. A better account explains the work, the intended use of time and the evidence that it happened, without turning every hour of learning into a miniature performance report.

Personal development is not confined to attending courses. Reading, discussion with peers, reviewing a difficult decision, practising a skill and examining a changed guideline may all be useful. The important distinction is between purposeful development and the accumulation of certificates. A doctor planning to extend a procedure may need supervised practice; a doctor maintaining a stable scope may need a different pattern. The job plan should make the proposed activity possible, while the appraisal conversation examines its relevance and learning. Neither process benefits from a universal points quota invented for administrative convenience.

Protected time also requires an operational meaning. If a doctor is listed as doing SPA work but remains the default contact for every routine clinical query, the allocation may exist only on paper. Agree who covers foreseeable

clinical demand and which exceptional circumstances justify interruption. An interrupted session need not automatically become a grievance, but repeated interruption is evidence that the arrangement does not work. Record the displaced activity and agree how it will be recovered or reprioritised. Otherwise, the clinical schedule appears fully delivered while professional maintenance moves into personal time.

Teaching illustrates why delivery time alone is inadequate. A one-hour session may require selecting appropriate material, adapting it to the learners, arranging a suitable setting and responding to questions afterwards. The first delivery may require more preparation than a repeat. Supervising a learner with additional needs can alter the workload further. A proportionate plan recognises these differences. It does not assume that every lecture needs a fixed multiplier, but it also does not assume that knowledge becomes a usable educational session without preparation.

For a formal supervision role, identify learner numbers and expectations. Scheduled meetings, observation, feedback, reports and liaison with an educational organisation can each create work. Daily clinical advice should be considered alongside the clinical timetable, so that it is neither lost nor counted twice. If a supervisor is asked to take an additional learner, the discussion should address capacity before the appointment is treated as complete. A signature accepting the role should be supported by a reasonable prospect of delivering what the learner has been promised.

Quality improvement can also be understated. The visible presentation may follow weeks of defining a problem, obtaining data, testing a change and reviewing the result. A useful allocation states what scale of project is expected and what assistance is available. A small service evaluation conducted with accessible data is different from a project requiring new data collection across several organisations. The doctor can be accountable for agreed contributions without being made solely responsible for every dependency. Chapter 12 returns to how evidence of this work can be retained proportionately.

Research needs its own clarity. Reading research to inform practice is different from recruiting participants, acting as an investigator or managing a study. A broad research label does not establish funding, permissions or the required governance. Where a formal research role is intended, define its commitments and obtain the relevant institutional arrangements before assuming that general SPA time can absorb it. A doctor can have a worthwhile research ambition without an immediate funded role, but aspiration and commissioned activity should be recorded separately.

Less-than-full-time work makes these distinctions particularly important. Some clinical commitments reduce broadly with hours; some professional requirements contain a fixed component. A doctor working six sessions may still need a meaningful appraisal conversation, mandatory training relevant to their role and sufficient development to maintain a safe scope. It is therefore unhelpful to copy a full-time plan and mechanically reduce every supporting activity by forty per cent. Examine the actual duties and requirements, then agree an allocation that is compatible with the reduced working pattern and applicable terms.

Consider a composite doctor, Helen, who reduces her clinical commitment but retains responsibility for supervising two learners. The number of clinics falls, but the agreed supervision duties do not. If the employer expects that role to continue unchanged, the time should be considered on that basis. Alternatively, learner allocation could reduce. The unworkable compromise is to retain the full educational obligation while reducing its time merely because the doctor's overall contract is smaller. That arrangement transfers the cost of the decision to either the supervisor's personal time or the learners' support.

Miriam's proposal separates her professional-maintenance and teaching programme from her cross-site leadership responsibility. This makes the negotiation clearer: reducing leadership duties would not remove the need to maintain clinical capability, and completing mandatory training would not deliver the teaching programme. The resulting SPA record contains a small number of understandable commitments, usable periods in the calendar and an agreed review of interruptions. It treats development as part of maintaining a professional service, while leaving room to test whether particular activities are useful and proportionate.

Additional responsibilities and external duties

Some responsibilities are substantial enough to require an explicit place beyond the ordinary pattern of clinical care and supporting activity. A doctor may lead a service, coordinate governance across sites, act as an educational lead, manage a workforce programme or hold an agreed external appointment. These duties should be described by what they require, not merely by their title. The Welsh terms distinguish additional NHS responsibilities and agreed external duties from other categories.^[32] The practical question is whether the proposed time, authority and organisational support match the responsibility being accepted.

Miriam's second-site work began as occasional advice. It now includes preparing for a monthly operational meeting, reviewing a recurring safety

issue and coordinating actions with another team. Calling her the site lead does not explain whether she is expected to recommend changes, approve them or deliver them. She therefore asks for a short role description before discussing the allocation. It identifies the purpose, reporting relationship, decisions within her remit and the route for matters requiring another person's authority. Her job plan can then attach time to a defined function.

Time should include the work between meetings. A committee membership may involve reading papers, consulting colleagues, preparing an item and following up decisions. A clinical leadership role may require responding to matters that do not wait for the next scheduled meeting. Distinguish recurring demand from exceptional events and describe how priorities will be handled. A nominal session every month is unlikely to explain an ongoing operational remit unless the work has been deliberately limited and another person holds responsibility between those sessions.

Authority needs equal attention. If a doctor is asked to reduce a backlog, can they change booking rules, request data, alter staff deployment or propose additional capacity? If their role is advisory, who receives the advice and decides what to do? If a decision requires funding, who can approve it? A useful job-plan objective might concern producing an options paper and presenting it to the authorised group. It should not quietly turn that advisory task into a guarantee that a whole service outcome will be achieved.

External work should be agreed prospectively wherever practicable. A Royal College role, examining commitment or national advisory appointment may benefit the wider profession and the employer, but the calendar still has to work. Identify the expected meetings, preparation, travel and notice arrangements. Clarify whether the appointment is undertaken within agreed employment time, through professional leave, under a secondment or as a separate commitment. The label external does not answer the funding, cover or accountability questions. Recording the arrangement protects both the clinical service and the external body from incompatible expectations.

Where more than one employer is involved, avoid creating two complete accounts of the same hours. Show which organisation holds each commitment, who pays for it and how the interfaces are managed. One employer may release time that another funds, or the doctor may have separate contracts. The relevant documents should make that visible. A shared diary alone cannot resolve conflicting priorities when both organisations expect attendance at the same time. Named contacts and a

process for resolving clashes are more useful than a general promise to remain flexible.

An additional responsibility should also have an end or review point. Some roles are intended to last for a particular project; others continue until a new appointment is made. State how the role and its associated time will be reconsidered when the project finishes, funding ends or responsibilities change. If clinical activity is to resume, plan the transition rather than assuming immediate return to an old pattern. A doctor who has spent several years in a changed scope may need updated induction, equipment access or supervised refreshment before taking on particular work again.

The same care is needed when a title remains but the resources disappear. A leadership session removed from the timetable does not by itself tell colleagues that the doctor no longer holds the function. The employer should communicate any change in responsibility and identify who will receive outstanding matters. Otherwise, messages and expectations continue while the formal capacity has vanished. Miriam asks that any reduction in her cross-site role be accompanied by a clear handover, an updated contact route and a record of which decisions remain with the receiving manager.

This is also a useful test of recognition. A meaningful role provides an intelligible contribution, sufficient capacity and a fair account of results. A title can be welcome, but it cannot compensate indefinitely for work that remains undefined. Where the organisation values the contribution, the job plan should help make it sustainable and transferable rather than dependent on one doctor's willingness to remain continually available.

Objectives outcomes and organisational dependencies

An objective should enable a fair conversation about what was sought, what happened and why. It should not be a slogan that acquires a different meaning at the next review. Improve quality, support the department and demonstrate leadership are reasonable aspirations, but they do not establish a testable commitment. Translate them into work that the doctor can undertake, evidence that will illuminate the result and a date for considering progress. Keep the wording proportionate to the task; precision does not require an elaborate management vocabulary.

Begin with the difference between activity, output and outcome. Activity is what someone does, such as reviewing a sample of records. An output is what that work produces, such as an analysis and agreed action plan. An outcome is the subsequent effect, such as fewer incomplete handovers. Each can matter, but they should not be substituted for one another. Attending a meeting does not demonstrate that a process improved. Equally, an outcome

can fail to improve despite competent work if the organisation does not implement the agreed changes.

For example, an objective to reduce delayed clinical correspondence might begin with a baseline review. Miriam and the manager agree which letters are included, how delay is measured and which part of the pathway she can influence. The objective could require her to review the clinical approval process, test an amended workflow and report whether delays change over three months. Administrative staffing, software access and reporting support are named dependencies. This gives the doctor something deliverable without making her personally responsible for every stage between dictation and receipt.

The denominator matters as much as the target. A claim that ninety per cent of letters are completed promptly is meaningless unless the reader knows which letters were counted and when the clock started. A small sample may be appropriate for improvement, but its limits should be stated. An objective should discourage the selective exclusion of difficult cases simply to improve the figure. Where complexity or missing information affects completion, include that context in the review rather than allowing a superficially impressive percentage to conceal the underlying problem.

Use a short objective builder with six connected elements: the purpose, the doctor's contribution, the evidence, the dependencies, the review date and the response if assumptions change. In prose, this might read: Miriam will test a revised results-review process in the agreed clinic cohort, report completion and outstanding-action data at the September governance meeting, and propose changes after a three-month trial. The service manager will provide administrative cover and a monthly data extract. If the data extract is unavailable after the first month, both will review the method and timetable.

That final sentence is not an escape clause. It makes the agreement adaptable and creates an early action point. Without it, a failed dependency may remain unaddressed until the annual review, when the doctor is asked why an objective was not achieved. A timely record allows the organisation to provide an alternative, narrow the objective or accept a delay. The doctor remains responsible for raising the problem and doing the work that remains feasible. The manager remains responsible for decisions and resources within their remit.

Consider a less satisfactory objective: Miriam will reduce readmissions by twenty per cent. It may be motivated by a genuine service concern, but it attributes a complex outcome to one person without establishing case mix, baseline, measurement or authority. The improved objective might concern

reviewing a defined group of readmissions, identifying modifiable themes and testing one agreed change. A subsequent outcome measure can still be monitored. The difference is that the doctor's contribution is now explicit, while the organisation retains responsibility for the wider system in which the outcome occurs.

Clinical outcomes require particular care because the people most in need of care may have the poorest results. A crude target can create pressure to avoid difficult patients or transfer work elsewhere. Include balancing information where a proposed change could have unintended effects. If a service aims to shorten appointments, examine whether follow-up contacts, complaints or incomplete decisions increase. If it aims to reduce admissions, consider whether patients experience delayed access to necessary care. The objective should support better care, not merely a more favourable headline measure.

Development objectives should identify opportunity as well as intention. A doctor can agree to prepare for an observed procedure, complete relevant learning and seek feedback. They cannot create a training list, supervisor or suitable patient opportunities by determination alone. Name those dependencies and the person arranging them. If development is intended to support a future role, distinguish readiness evidence from a promise of appointment. A completed PDP objective can demonstrate progress without conferring a grade, a vacancy or entry to a regulatory register.

Miriam also has a leadership objective, but it is limited to her actual authority. She will bring a cross-site escalation proposal to the divisional group, consult specified teams and revise the document in response to feedback. The divisional manager will decide whether to adopt it and arrange implementation resources. The evidence includes the proposal, consultation record and decision. This avoids measuring Miriam's performance by whether a committee chooses to fund a change. It also avoids allowing the committee's decision to erase the quality of her contribution.

Keep the number of objectives manageable. A long list can obscure priorities and create commitments that no one remembers commissioning. Separate continuing duties from a small number of particular developments for the coming year. A recurring clinic belongs in the schedule; a project to redesign its referral process may belong among the objectives. Mandatory responsibilities should not disappear simply because they are not selected as improvement objectives, but listing every normal duty as a target adds administration without necessarily improving accountability.

At review, record the result in language that preserves the distinction between effort, delivery and context. Completed as agreed, completed with a revised timetable, partly completed because of a documented dependency, and not completed despite available support are materially different findings. Discuss what evidence supports each conclusion. This record becomes useful for subsequent job planning, appraisal and, where relevant, pay progression. It should be sufficiently clear that those later processes do not have to reconstruct the circumstances from competing recollections.

On call premium time travel and cross site work

On-call arrangements contain several different quantities: how often the doctor is available, how much work occurs, when it occurs, how intense it becomes and what recovery is needed afterwards. A rota frequency cannot describe all of them. One-in-six availability may produce a relatively quiet advisory commitment in one service and repeated overnight attendance in another. Begin by describing the actual duty, including the sites covered, expected response, access to information and backup. Only then can its workload and contractual recognition be calculated sensibly.

Do not confuse payment for availability with recognition of work undertaken. A doctor may receive an on-call supplement while also having clinical work from that duty reflected in the job plan. The applicable terms explain the relationship. For a diary, separate telephone advice, record review, travel and attendance, and identify work already included in scheduled periods. Record consecutive interruptions as accurately as practicable. A succession of short calls may have modest aggregate duration but a substantial effect on sleep and next-day functioning; both facts are relevant to planning.

The out-of-hours boundary is not uniform across the UK. The Welsh Specialty Doctor terms updated in 2024 and the Scottish 2022 Specialty Doctor terms place the ordinary weekday boundary at 19:00. Northern Ireland's published 2021 Specialty Doctor terms use 21:00. Saturdays, Sundays and relevant holidays also require the applicable treatment.^{[32][35][34]} A calculation imported from another nation can therefore misvalue the same evening work. Older contracts must also be identified separately rather than assumed to follow a newer agreement because the doctor shares its rota.

For England, use the English Specialty Doctor or Specialist terms for the contract actually held, available through the NHS Employers links in the BMA's national contract directory. Record the weekday boundary, weekend treatment and applicable recognition mechanism from that document before

converting an evening rota. A Welsh amendment does not establish the English position.^[38]

Northern Ireland's 2021 Schedule 8 illustrates why the mechanism matters. For qualifying predictable out-of-hours work it provides, by agreement, a shorter timetable value for that PA or a reduction elsewhere; it also addresses enhanced payment and work only partly outside ordinary hours.^[34] Do not apply every mechanism simultaneously. Write down which arrangement has been agreed, show the relevant portion of time and check the resulting schedule. The clock may show four hours while the contractual recognition follows a different calculation; both quantities should remain visible.

For Miriam's Welsh illustration, the chosen planning arrangement recognises an average of three hours of qualifying out-of-hours emergency work as one session. This is an average, not a prediction that she will work exactly three hours in every week. A longer representative rota record is used because the initial four-week diary does not capture her full on-call cycle. The calculation includes work actually associated with the duty and excludes time already counted in scheduled daytime activity. Her availability supplement remains a separate payroll matter, outside the session total.^[32]

The next-day timetable must be examined alongside the payment calculation. If a doctor is repeatedly unable to obtain adequate rest, a larger allowance alone does not make the service safe. The GMC's concerns guidance requires doctors to act on risks arising from inadequate systems or resources through appropriate routes.^[37] An urgent fatigue or patient-safety issue needs an immediate operational response. The job-plan review then addresses recurrence, such as alternative cover, a different rota pattern or changes to next-day commitments. Recording the problem solely as unpaid time misses its clinical significance.

Cross-site work introduces another form of invisible demand. An appointment at one location may be followed by a meeting at another, but a timetable that places them back to back assumes instantaneous travel. Record the ordinary journey between work locations, the likely variation and any necessary preparation on arrival. Distinguish employment travel-time recognition from mileage reimbursement and tax treatment: those are separate questions. The proposed schedule must first be physically possible, whatever the eventual expenses decision. A payment for mileage cannot create time to complete the journey.

Group activities geographically where that improves the service. A cross-site leadership meeting and clinic on the same day may reduce repeated

travel, provided their timing and clinical dependencies fit. Remote attendance may remove a journey where the task can be done effectively and confidentiality is maintained. It may be unsuitable where direct examination, observation or local engagement is necessary. The decision should turn on the work rather than an assumption that remote participation is always equivalent or that physical attendance is always more valuable.

Travel also competes with recovery. A long drive after demanding on-call work creates a different risk from a routine daytime transfer. Agree the operational response to fatigue, including who can arrange alternative cover or transport where required. Do not turn a personal judgement about fitness to drive into an expectation that the doctor must independently solve every staffing consequence. The doctor should communicate the concern promptly; the service needs a practicable response. These arrangements belong in the wider rota and safety system as well as the individual's plan.

Finally, test the whole pattern over time. Look for clusters of nights, weekends, travel and early starts rather than judging each duty separately. Include commitments to other employers where relevant. A week that appears tolerable in isolation may recur within a demanding sequence. Conversely, an unusually busy week may not represent the normal pattern but still expose a need for contingency. The completed plan should describe expected work, the evidence used to estimate it and the trigger for a review when the actual pattern changes materially.

Test response expectations against geography as well. A doctor cannot promise immediate attendance at two distant sites simultaneously. The arrangement needs a first response at each location, a way to assess urgency and a named escalation route when demands conflict. These are service-design requirements, not questions that a session calculation can settle. If the employer changes the sites covered, revisit those arrangements even when the number of doctors on the rota and the nominal frequency remain unchanged.

The job planning meeting

Preparation should make the meeting easier to decide, not harder to read. Send a concise summary of the current agreement, the main discrepancy, the evidence and the proposed options. Keep detailed diary material available as an appendix or supporting record. The manager should be able to identify the decision before encountering every data point. Miriam's opening page states that her current ten-session plan cannot contain the documented work, identifies the recurring additional demand and offers two ways to restore a workable arrangement.

Agree an agenda that moves from facts to choices. First confirm the contract and present duties. Then examine the evidence of workload and any difference in interpretation. Next consider service priorities, the proposed allocation and supporting resources. Finish with objectives, scheduling, review and outstanding matters. This order reduces the risk of spending most of the meeting arguing about a preferred PA figure before either party has agreed what work the figure is intended to represent. It also makes misunderstandings easier to locate.

Use neutral, specific language. Miriam might say: my diary shows that results and correspondence regularly continue beyond the allocated period; I would like us to agree whether that work remains mine and, if so, how it will be accommodated. That wording does not surrender the concern. It directs attention to the decision. If the manager disputes the diary, ask which entries or assumptions are disputed and what further evidence would resolve the question. A general claim that everyone is busy does not answer a specific capacity calculation.

Listen for a different problem beneath an objection. A manager who says there is no funding may mean that increasing the contract is unavailable, not that the work is unnecessary. The next discussion can therefore examine what should stop, move or change. A doctor who rejects an additional session may be protecting health or another commitment, not denying the service need. The plan should make those constraints explicit so that a workable alternative can be considered. Neither party should have to conceal a legitimate constraint behind an argument about efficiency.

Where the proposed timetable contains competing priorities, test an ordinary difficult day. What happens if the clinic overruns before a leadership meeting? Who deals with an urgent result during SPA time? What happens when another site requests attendance? Practical examples often reveal ambiguity that a table conceals. Agree the usual priority, the person who can authorise a change and the treatment of displaced work. A general expectation of flexibility is more credible when the organisation has considered these foreseeable conflicts.

Close with an accurate record. State what has been agreed, what remains disputed, which evidence is still required and who will take each next action. Include dates. If only part of the plan is agreed, do not let a generic completion status suggest that every element has been accepted. The electronic system should reflect the substance of the discussion; it should not determine that substance by forcing a premature sign-off. Obtain advice if the system's options make it difficult to record the actual position.

Miriam's meeting ends with agreement on clinical administration and teaching, but not yet on the cross-site role. The record identifies the manager who will clarify that remit and the date for reconvening. The current disagreement is therefore contained and visible. Miriam leaves knowing what she should continue to deliver, what is being reconsidered and when a decision is expected. That is a more useful interim outcome than either a resentful signature or an undocumented promise to sort things out later.

Before leaving, read the summary back in ordinary language. We have agreed these clinical commitments, these supporting activities and these resources; we have not yet agreed the leadership remit; this person will provide the missing information by this date. The exercise can expose different interpretations while both parties are present. It is especially useful where several managers have contributed to the discussion or a decision requires approval elsewhere. If an authorised decision-maker is absent, distinguish a recommendation from approval. A draft allocation should not be presented to colleagues as operationally confirmed until the necessary agreement and implementation arrangements are in place.

Review mediation and appeal

A job plan should be reviewed when its assumptions change, not simply when a calendar reminder appears. The Welsh framework provides an annual review and interim review for significant changes.^[32] In practice, useful triggers include a new clinic, sustained growth in follow-up work, a changed rota, additional supervision, a health-related adjustment or a substantial leadership appointment. The request should explain what has changed and what decision is needed. It need not wait until the doctor can prove that every element of the existing plan has failed.

An interim review can be narrow. If a teaching programme doubles in size, the immediate question may concern that programme and its effect on the schedule. Reopening every aspect of the job can make a modest correction unnecessarily difficult. Equally, several apparently small changes may together justify a complete review. Use the evidence to determine the scale. A temporary arrangement should have a clear duration, because an unreviewed temporary duty can become a permanent expectation without the associated resources ever being agreed.

When discussion does not resolve the issue, identify the contractual route promptly. Mediation and appeal are specific processes, distinct from an informal conversation and potentially from a grievance. The applicable terms control who receives the request, the timescale, evidence requirements and effect of the outcome. Do not import consultant

procedures into an SAS dispute merely because a general webpage discusses both. A union or employment adviser can help establish the correct route and preserve deadlines while local resolution continues.

Wales provides a concrete example. Under Schedule 5 of the October 2024 Specialty Doctor terms, the written mediation referral is due within ten working days of the disagreement arising. A subsequent formal appeal must be lodged within ten working days of receiving the relevant decision. The schedule also addresses the status of disputed elements pending resolution.

^[32] These are Welsh contractual provisions, not a universal UK timetable. A doctor should record the event that starts each deadline and obtain advice immediately if its date or meaning is uncertain.

The case for mediation should be compact enough to understand. State the disputed element, the relevant contractual provision, the evidence, the proposed resolution and the consequences of the alternatives. Attach the current plan and the disputed proposal with clear dates. Include agreed facts as well as disagreements. A mediator should not have to infer the issue from a year of email exchanges. Where the disagreement concerns workload, the explanation should show how the time calculation was made and what happens operationally if the proposed allocation is insufficient.

Continue to separate immediate safety management from the employment dispute. A pending appeal does not make it appropriate to leave an urgent clinical risk unaddressed, nor does an urgent response necessarily settle the permanent contractual question. Record any temporary cover or variation accurately, seek advice about its status and use the appropriate safety reporting route when needed. The aim is to protect care while preserving a clear account of what has and has not been agreed. Avoid unilateral assumptions about either entitlement or obligation in a contested situation.

After resolution, check implementation. Does the revised timetable match the decision? Have payroll changes, responsibilities and cover arrangements been updated where required? Have colleagues been told about changes that affect them? A successful appeal or agreement is incomplete if the old workload continues informally. Retain the outcome and arrange a practical review after the new pattern has operated. Miriam's objective is not simply to win an argument about sessions. It is to establish a sustainable service arrangement that remains intelligible after the disagreement has ended.

Retain a short chronology rather than an indiscriminate archive. It should show the existing agreement, the date the issue was raised, substantive responses, the point of disagreement and each formal step. Preserve original

documents securely and avoid patient information in employment submissions unless specifically necessary and appropriately handled. An accurate chronology helps an adviser distinguish a continuing discussion from a missed procedural deadline. It also helps a new manager understand an unresolved issue without relying entirely on the account of either participant.

Worked complete job plan

Return to Miriam, the composite Welsh Specialty Doctor. This illustration uses the reformed Welsh terms updated in October 2024, a ten-session substantive commitment and ordinary daytime sessions valued at four hours. It is a planning example, not a model entitlement. On-call work is calculated separately at the agreed out-of-hours conversion described earlier. Actual dates, leave, rest and prospective-cover arrangements require the employer's calendar and rota; the following annual view concerns scheduled daytime delivery only.

The agreed allocation is six sessions of scheduled direct clinical care, two sessions of SPA, one session for additional cross-site leadership responsibilities and one session recognising average unpredictable on-call work. The total is ten. Scheduled daytime activity therefore occupies nine sessions, or thirty-six hours. The on-call allowance represents an average of three actual out-of-hours working hours in the chosen illustration. Thirty-nine actual working hours are therefore recognised as ten sessions; ten multiplied by four would give the wrong clock-hour total for this mixed pattern.

The six daytime clinical sessions comprise two clinic sessions, two ward sessions, one patient-focused MDT and follow-up session, and one clinical administration session. These total twenty-four hours. The two SPA sessions provide eight hours for the agreed professional-maintenance, teaching and quality programme. The leadership session provides four hours, including its agreed cross-site travel. The categories describe allocations, not a requirement to perform every component in an indivisible four-hour block. The calendar shows how the blocks and any smaller activities fit.

An illustrative daytime week places a clinic and clinical administration on Monday; ward work and the MDT on Tuesday; one SPA session and leadership on Wednesday; the second clinic and second ward session on Thursday; and the remaining SPA session on Friday morning. Friday afternoon is not silently available for another routine clinic. It is outside this daytime schedule, with the remaining contractual recognition allocated to

on-call work occurring elsewhere in the rota. Actual breaks, start times and travel are recorded in the detailed calendar.

For a deliberately simplified annual capacity illustration, the employer and doctor model forty weeks in which that complete daytime pattern is delivered. Six clinical sessions multiplied by forty gives 240 clinical sessions, or 960 hours. Two SPA sessions multiplied by forty gives eighty sessions, or 320 hours. One leadership session multiplied by forty gives forty sessions, or 160 hours. The scheduled daytime total is 360 sessions and 1,440 hours. Forty delivery weeks is an illustrative assumption, not a statement of leave entitlement. The on-call rota has its own annual calendar and is not multiplied by forty here.

The original workload evidence suggested twelve sessions because necessary additional correspondence consumed four ordinary hours and the expanded cross-site and teaching demand consumed another four. The agreed ten-session solution does not erase those eight hours. Clinic booking is revised to contain the documented follow-up requirement within the clinical allocation, part of the expanded teaching programme is reassigned, and the cross-site remit is narrowed to specified deliverables. The manager records who takes the displaced work and confirms that the receiving arrangements are operational before the revised pattern begins.

The objectives concern a defined correspondence improvement trial, delivery of the agreed teaching programme and a cross-site escalation proposal. Their resource record names administrative support, data access, teaching facilities and the manager responsible for decisions beyond Miriam's authority. An early review checks whether the changes actually remove the excess demand; the annual review remains scheduled. The completed agreement therefore contains a timetable, reproducible arithmetic, responsibilities, resources and a means of correction. Its success will be judged by whether the service and doctor can work to it in practice.

The October-to-September plan is reviewed in December. Site A hosts clinical work; Wednesday leadership includes Site B. The clinical manager reviews the plan and the divisional manager sponsors leadership. A six-person calendar records on-call dates and cover. The allocation is linked to those able to organise it.