

Medical Job Planning Improvement Guide

A guide to improving consultant,
specialist, associate specialist
and specialty doctors job planning

Sharing learning from across organisations for
impactful change



Clinical forward

The NHS has been under enormous pressure over recent years and, as always, you have risen to the challenge in often difficult circumstances. We know we need to go further to improve services, by both reducing unwarranted variation and waste, and transforming pathways of care for the benefit of patients. If we increase our adoption of creative ideas and innovation and standardise practice, we can improve outcomes for patients and accelerate their access to care.

Although healthcare can be complex to deliver, getting it right for staff (reducing inefficiencies to free up time to see patients and improve their working day) will improve wellbeing and in turn operational and financial performance. Job Planning is a fundamental step to support this ambition.

The Job Planning Improvement Programme will use the NHS IMPACT improvement approach. We need to learn, scale and adopt from those organisations that do job planning well: where job planning is transparent, fair and aligned to the planning of services for patients. This will require a step change in culture, and organisational change to adopt standardised processes that link with business planning but are flexible and responsive to individual clinician changes in year.

By working together, we are committed in supporting you to ensure that [nationally 95% of job plans are signed off by 6th April 2026](#). We hope that this project will also help us all have a [clearer understanding of the contribution of wider ways of consultants, specialists, associate specialists and specialty doctors working in education, leadership and management](#), as well as [the impact new ways of working](#) introduced since 2019, such as new triage methodologies and virtual clinical sessions, [have on job plans](#).

We look forward to working with you.

Stella Vig, National Medical Director for Secondary Care
Michael Gregory, Regional Medical Director – North West
Michael Marsh, Regional Medical Director – South West
Hamish McLure, Regional Medical Director – North East and Yorkshire
Eddie Morris, Regional Medical Director – East of England

Jessica Sokolov, Regional Medical Director - Midlands
Chris Streather, Regional Medical Director - London
Chris Tibbs, Regional Medical Director - South East

Introduction: generating greater value for patients through improved planning

The NHS has set itself the ambition to become the fastest improving health system in the world. To achieve this bold ambition, we need to:

- continuously identify and define best practice to underpin consistent care standards
- create an infrastructure to spread & scale this best practice
- develop and spread improvement and operational capability across the NHS to underpin sustainable improvement

This medical job planning improvement guide is one way in which the NHS will work towards this ambition, supporting consultants, and specialist, associate specialist and specialty doctor (SAS doctors) to deliver more efficient and effective care. It is also an enabler for improvements in the following overarching metrics that Learning and Improvement Networks across the country are focused on:

- Elective: Increase percentage of patients waiting <18 weeks for their first appointment
- Urgent and Emergency Care: Reduce the proportion of beds occupied by long stay patients (7+ days)
- Mental Health: Reduce the average length of stay for adult mental health inpatients

This guide is also an important resource in exploring Clinical and Operational productivity opportunities identified in planning support tools provided to finance teams during the planning round.

Drawn from interviews with medical directors, this guide sets out how clinical and operational leads have improved medical job planning.

At the heart of this guide is the ambition to deliver better, safer care for patients and support clinical colleagues by sharing learning. Job planning is a professional as well as contractual obligation for consultants and employers. Job planning cycles were challenging during COVID with the workforce adapting and responding flexibly to difficult circumstances. We need to improve the job planning process to respond to changes in service delivery, support the work life balance of colleagues, standardise processes across organisations, and understand medical capacity to inform service planning for 2025/26.

Good job planning helps you deliver services more effectively for patients. It can increase productivity and efficiency gains with an alignment of the demands of the service with the clinical capacity to deliver it. Job planning supports staff and service development, applies a standardised, consistent, transparent and fair approach, and enables consultants, and SAS doctors to consider how to innovate and drive change within services.

Job planning needs to be an inclusive process, evidencing the staff value that all our doctors provide. To that end, this second iteration of the improvement guide includes a new section on job planning SAS doctors. It also includes supplementary guidance on annual leave and study leave. The guide does not change or override the contractual provisions for consultants, specialist, associate specialist or specialty doctors.

We want to understand how this guide works for you and your teams and how we can further develop and improve it to make it as useful as possible to support local improvement programmes. Our intention is that it will continue to be refined, developed and updated as we learn what works through your teams. Please share your thoughts on the guide and your ideas to include in it – [details on how to do this are at the end of this guide](#).

Thank you to the chief medical officers, medical directors & trusts who supported the development of this guide by sharing their learning and the approaches and processes they adopted to drive clinical and operational improvements.

“High quality job planning is the cornerstone of workforce design. It supports doctors to have a manageable work/life balance and provides the organisation with a workforce who can meet the challenges of demand. If we don’t understand our capacity, we can’t realise our potential”.

Hamish McLure, Regional Medical Director, North East and Yorkshire

“Regular, timely job planning should be done in a spirit of openness and collaboration, ensuring the sustainability of medical careers and for the services we work within. I see this as central to the recognition of our expertise and to the breadth of the work we do in the NHS”.

Eddie Morris, Regional Medical Director, East of England

“A robust approach to individual and team job planning is one of the actions I have seen have significant impact in challenged services and services with challenged behaviour, but it is not always an easy task to undertake. Having clear support and expectations around this is a really positive step that I absolutely welcome”.

Jessica Sokolov, Regional Medical Director, Midlands

Using this guide and wider improvement activities

This guide provides some of the most impactful interventions that can support trust boards, medical directors, chief people officers and clinical and service managers and clinicians to improve care for patients and deliver more productive services. The high impact interventions and change ideas described should feed into your local improvement work, led by those closest to the point of care and supported by senior sponsorship, as you test, learn and adapt rapidly.

The guide will sit alongside regionally led, nationally supported medical job planning interventions and improvement analytics currently under development.

The overall improvement programme has 2 principal aims:

- to make care safer and improve patient experience by increasing the adoption of good practice
- to maximise the value of patients' and clinicians' time and the productivity of services by tackling waste and addressing poor processes

Key resources to support good job planning

This is an improvement guide, not a comprehensive guide to job planning. Links are included throughout to key resources to implement good practice, including:



[BMA and NHS Employers guidance \(2011\)](#)



[Consultant job planning guidance \(NHS England, 2017\)](#)



[E-job planning the clinical workforce: levels of attainment and meaningful use standards \(NHS England, 2019\)](#)



[Consultant Contract \(2003\): refer to for contractual terms and conditions](#)



[Terms and conditions and resources for the SAS contract 2021 | NHS Employers](#)

Tracking your 'level of attainment' for e-job planning to identify improvement opportunities

By documenting and digitising job plans using job planning software, hospitals can understand their workforce capacity better. If you also use e-rostering software, you can match your planned capacity to expected demand even better.

To support you to use this software to its fullest potential we have:

- set out 5 'levels of attainment' (LOA) for using e-job planning systems, underpinned by meaningful use standards which describe the processes and systems hospitals need to progress through the levels – these are [grounded in best practice job planning policy and processes](#)
- [developed a dashboard](#) which helps hospitals, systems and regions track their annual progress in advancing their LOA across different workforce groups
- identified [high impact actions and change ideas](#) drawn from the experiences of medical directors, aimed at advancing LOA for medical consultants and SAS doctors.

The levels of attainment and their associated meaningful use standards are:

- **chronological:** reflecting your progress towards implementing the most effective e-job planning systems
- **all-encompassing:** suited to all clinical workforce groups, while allowing nuances specific to each
- **meaningful:** setting standards for matching workforce capacity to demand
- **measurable:** enabling hospitals to self-assess their progress in implementing e-job planning and best practice job planning policy, and NHS England to identify lessons to share and target support

Level 0

No e-job planning: e-job planning software may be being procured or in place, but fewer than 90% of employees are fully accounted for on the system. Job plans may be in place (eg paper-based or Microsoft Excel) but are not recorded on dedicated e-job planning software.

Level 1

Basic individual e-job planning: the trust has procured e-job planning software and trained its staff to use it. Trust-wide policies detail the e-job planning process and its governance. At least 90% of employees have an active e-job plan.

Level 2

Advanced individual e-job planning: the trust allocates time and resources to e-job planning. The trust uses the full functionality of e-job planning software to include details of the agreed average output of planned activity. It maintains a fair and transparent culture around e-job planning.

Level 3

Team e-job planning: teams establish team e-job planning meetings that align team objectives to individual e-job plans and service needs, as defined through team capacity and demand analysis. Planned and delivered activity is reconciled at least quarterly using data from the trust's e-rostering system, with objectives annualised if this meets service needs. The trust ensures e-job planning is consistent between teams.

Level 4

Organisational e-job planning: there is board-level accountability for monitoring e-job planning across all workforce groups, ensuring audit and review. Individual and team objectives, departmental budgets and the trust's objectives are aligned, so it can respond dynamically to services' changing needs.

Roles and responsibilities

In high performing organisations **roles and responsibilities** are clearly delineated. The trust's board is responsible for ensuring the organisation is well-governed and the hospital's job planning policy, systems and procedures:

- provide a fair and transparent process for job planning all consultants, employed under the National Terms and Conditions
- consistently supports clinical staff across the hospital to provide the most productive, efficient and effective clinical care pathways for patients in each specialty
- are designed to meet educational, clinical and leadership objectives along with the organisation's strategic and financial objectives
- support meaningful conversations, and align service and individual objectives, which are mutually beneficial
- follow good practice shared by NHS England, NHS Employers and the BMA
- produce timely and accurate management reports to assure the board the above are in place and well managed

The chief medical officer is responsible for ensuring all required staff have an up to date and approved job plan designed to deliver the clinical demands of the services, via divisional directors.

The chief people officer is responsible for ensuring the policy is delivered fairly and transparently in accordance with employment law and the consultant, or SAS doctor's individual employment contract, and the policy aligns with good practice guidance from NHS Employers, the BMA and individual royal colleges.

Lessons learned

1. Set clear expectations for an **annual job planning cycle**, with targets and key milestones to be delivered on a quarterly basis.
2. Establish a **job planning committee**, which has oversight of job planning approaches, and can ensure they are transparent and fair across the organisation.
3. **Develop medical leadership in job planning** by providing training on key topics, such as HR approaches and finance / budget management, and ensure time is protected in job plans for training and job planning activities.
4. Ensure **operational teams understand the job planning approach**, follow good practice and can access regular training.
5. Set a clear expectation for **job planning data** to be reported to the organisation's board, and for this data to be triangulated with other information, including activities delivered and financial plans.

Roles and responsibilities

In high performing organisations clinical leads and colleagues in operational roles are **jointly responsible** for ensuring the totality of job plans meet the operational needs of their services and provide assurance that external duties and private practice do not impact unduly on service requirements. Job plans that meet these operational and service requirements are built on an understanding of:

- baseline activity and performance of the current service
- aspirations of the service and associated business plans
- agreed standards to provide the 'must do's'
- activity required in the year ahead
- capacity – for example theatre, procedure, ward round, outpatients and educational supervision
- if targets are being delivered
- the clinical team's development needs
- how to reduce unwarranted delivery variation between clinicians
- investment required for new service delivery
- individual and team resources
- the support required to deliver job plans
- workforce issues and existing gaps



Lessons learned

1. Implement an **annual job planning cycle**, with targets and key milestones to deliver on a quarterly basis.
2. Set the tone for good job planning conversations by being **clear and consistent on the purpose** of good job planning.
3. Build trust in the job planning process by **following good practice**.
4. Develop a clear and consistent approach to job planning **nomenclature and language** and a clear delineation between Direct Clinical Care activities and Supporting Professional Activities.
5. Establish a hospital wide **job planning committee**, which has oversight of job planning approaches, and can ensure they are transparent and fair across the organisation.
6. Develop **medical leadership in job planning by providing training** on key topics, such as HR approaches and finance / budget management, and ensure time is protected in job plans for training and job planning activities.
7. Ensure **operational teams have regular training** so they understand the job planning approach and how to apply good practice.
8. **Triangulate job planning data** with related information, including activities delivered and financial plans. This can ensure there is visibility of **planned versus delivered** activities and can be supported by implementing good e-rostering systems.
9. **Align the job planning approach with leave allowances**. This may require the consideration of annualisation where mutually agreed.
10. Develop your **service level planning**, including with the consultant body and wider MDT to align service demand to capacity.

Change ideas

How to implement the high impact interventions



Establish an annual cycle for job planning

Objective

Establish an annual cycle for job planning – underpinned by a trust board approved job planning policy – to deliver clear, robust and cyclical processes.

Metrics

- Percentage of consultants with a fully agreed job plan that is signed off by the end of the financial year.
- Percentage of SAS doctors with a fully agreed job plan that is signed off by the end of the financial year.
- Suite of process metrics and activities in [NHS England's consultant job planning guidance](#) is reviewed on a quarterly basis.

Resources

Consider the following when developing the job planning policy:

National employment contracts:

- [The Consultant Contract \(2003 and pre-2003\)](#)
- [Terms and conditions of service for specialist grade \(England\) 2021 | NHS Employers](#)
- [Terms and conditions of service for specialty doctors \(England\) 2021 | NHS Employers](#)
- [Terms and Conditions of Service – Specialty Doctor \(England\) April 2008](#)
- [Terms and Conditions – Associate Specialist \(England\) April 2008](#)

National job planning guidance:

- [BMA and NHS Employers guidance \(2011\)](#)
- [NHS England Consultant job planning: a best practice guide \(2017\)](#)
- [NHS Employers](#) and [BMA websites](#) (a suite of job planning tools and templates)
- [NHS England Meaningful Use Standards and operational guidance](#)

Activities to consider

Good job planning processes and a successful annual cycle for job planning rely on the following systems and processes being in place and functioning effectively:

- a trust board approved local job planning policy
- e-job planning and e-rostering systems
- business planning processes with budgetary approval for pay spend changes

The following activities will help establish a robust job planning cycle:

- 1. review national employment contracts and job planning guidance, to ensure the job planning policy and processes are fit for purpose, comply with contractual provisions for consultants, and SAS doctors and are grounded in good practice**
- 2. engage the Joint Local Negotiating Committee in the development of the job planning policy and include clear mediation guidance in the policy**
- 3. create a governance structure to oversee how the medical consultant workforce can be optimised through the job planning process.** This will include:
 - trust board reporting with metrics
 - roles and responsibilities and training for all the roles involved in job planning
 - underpinning job plans with sound business planning and budgetary approval for pay spend changes
 - Key Performance Indicators (KPIs)
 - an annual job planning evaluation process for continuous improvement
 - clear quarterly gateways that are expected to be completed as part of the job planning cycle

Set the tone for good job planning conversations

Objective

Job planning conversations with consultants and SAS doctors are productive and informed by service requirements. They build trust in the process and create the right climate for effective job planning by adopting a partnership approach and maintaining good practice.

Resources

- [NHS England consultant job planning guide](#)
- [NHS England Meaningful Use Standards](#)

*‘The job planning conversation should be relational, not transactional.’
(Associate Medical Director)*

*‘You need to build trust in the job planning process by maintaining good practice and inviting staff to be part of the conversation.’
(Medical Director)*

Activities to consider

Meaningful conversations between colleagues are an important element of the job planning process, to align both service and individual objectives. Job planning is more valuable when it is grounded in informed conversations on service requirements, and the capacity required to meet expected clinical and non-clinical demand. Although job planning and medical appraisal inform each other, they should be separate processes.

When preparing for job planning conversations with consultants and SAS doctors about their job plans:

1. **be clear and consistent on the purpose and benefits of job planning** and take a partnership approach
2. **be clear on the process that will be followed**
3. **understand the total volume of programmed activities required to meet the clinical and non-clinical demands of the service (capacity and demand planning):** the senior clinical leads with support from the operations, workforce (business partnering) and finance teams should meet to discuss budget setting and activity planning, and to understand what it costs to run the service and the volume of programmed activities required to meet clinical and non-clinical demand. This meeting should include a wider discussion about educational needs and any proposed changes in service, location, staff numbers or skill mix and potential impact of any hospital or national objectives or initiatives. The output of this process should be available ahead of individual job planning processes. Use consistent job planning language.

Use consistent job planning language

Objective

Use clear & consistent language for job planning & establish agreed activities within the job planning categories to ensure there is transparency & fairness in job planning across the organisation.

Metrics

Local tracking metrics include:

- number of job plans with clearly delineated job planning activities. These may be categorised as shown in the classification table below
- Use of standardised templates for activities for example OPD and theatres
- regular reporting on DCC: SPA: ANR: on call activities

Level 1 activity	Category	DCC	SPA	ANR	ED	Other	On-call
Level 2 activity	Activity	Standard lists (PAs / Hrs)					%
Level 3 activity	Specific detailed activity	Bespoke (for example, colorectal list at site)					

Resources

- [Outpatient services: a clinical and operational improvement guide](#)
- [Theatres, surgery and perioperative care: a clinical and operational improvement guide](#)

Activities to consider

When establishing a clear and consistent language for job planning:

1. **Identify direct clinical care (DCC) activities** such as clinics, procedure lists & theatre lists, under grouped headings. More detailed descriptions – such as location, modality & sub-specialty information – can be detailed within bespoke Level 3 descriptors. It is important to include activities such as Advice & Guidance, triage, multidisciplinary teams (MDTs) & other DCC admin requirements in this category. The time taken to deliver these activities should be regularly reviewed to ensure appropriate Programmed Activity (PA) allocation
2. Be clear on what constitutes **Supporting Professional Activities (SPAs) & ensure this is appropriately recognised within the job plan**. This includes training, education, service development, non-clinical admin, & audit & research. Again, it is helpful to agree group headings & fair & transparent tariffs across relevant workforce groups, for example, continuing professional development (CPD) & core SPA allocation. The Academy of Medical Royal Colleges estimates that 1.5 SPAs per week are the minimum for a consultant's CPD for revalidation purposes. Additional SPAs may be funded in line with the consultant contract. Educational supervision & clinical supervision should be fully recognised & provided for within job plans
3. Be clear on what constitutes **External Duties (ED) & Additional NHS Responsibilities (ANR)**. EDs are for external roles delivered within working hours (for example, research, guest lecturers) while ANRs are delivered within working hours & paid by the substantive employer (for example, Clinical Advisory Groups, Integrated Care Board work & committees, mental health first aider, Freedom to Speak Up Guardian, union representatives & training programme directors). Where EDs are commissioned, it is important to ensure there are appropriate recharge mechanisms in place. Equally where core NHS business is commissioned, this is classified as ANR & is at the cost of the employer
4. Clarify your approach to **Additional Programmed Activities (APA)**. These can be agreed over & above the standard contract, reviewed annually & can be ended with 3 months' notice
5. Remember that **Additional to Contract (ATC)** is a non contractual term. While ATC PAs may be included in job plans to recognise discretionary work that is done 'above & beyond' & without remuneration, such as voluntary research, **they should not be used to deliver NHS activities**.

Establish a job planning committee

Objective

Establish a job planning committee to provide assurance to the board on the outputs of job planning the clinical workforce. The committee will review all aspects of performance, including financial, risks affecting job planning delivery, mitigating actions, job plan sign off rates, & consistency & monitoring issues. The purpose of this committee is not to sign off or change individual job plans & does not override the contractual sign off process of job plans between the consultant and their clinical manager.

Metrics to be tracked by the committee

Process metrics:

- number of e-job plans approved & signed off by the clinical line manager
- number of appeals outstanding, with timescale & reasons
- number of different roles who attended training & development sessions
- an on-call supplement audit
- a payroll reconciliation audit with ongoing monitoring (job planned versus paid)

Performance metrics by specialty:

- DCC / SPA ratio
- premium pay spend

Resources

- [E-job planning the clinical workforce: levels of attainment and meaningful use standards \(NHS England, 2019\)](#)
- [Consultant job planning guidance \(NHS England, 2017\)](#)

Activities to consider

When establishing a job planning committee:

1. Create terms of reference for the committee outlining specific duties including:

- overseeing the development & delivery of the trust's job planning commitment
- regularly reviewing & monitoring job planning sign off rates, taking action to address where these are low
- regularly reviewing & monitoring bank, agency & waiting list initiative spend in relation to the clinical workforce & taking action where required
- Reviewing & approving policies & procedures that fall within the remit of the committee
- identifying fair & transparent processes & consistency within job planning. Each job plan & service may be different & therefore the role of the committee is not simply to identify inconsistencies between job plans but to identify where that inconsistency is unwarranted or unfair

2. Carefully consider the committee's membership. This should include all roles responsible for ensuring the trust's job planning policy & procedures are implemented effectively to provide optimum patient experience and outcomes, & there are fair and transparent workforce terms and conditions. Suggested membership includes:

- medical director (or associate) (chair)
- chief operating officer (vice chair)
- chief people officer
- divisional / clinical directors / senior medical clinical leads
- divisional general managers
- temporary staffing lead
- professional leads (for example, AHP, nurse, healthcare scientist, pharmacist)
- member of the Local Negotiating Committee (LNC)
- medical staffing lead

3. Consider how the committee & job planning processes can support staff wishing to work more flexibly, including Less Than Full Time, those undertaking 'retire & return' & those in peri-retirement

4. Oversight of job plans over 10 Programmed Activities. Employers should consider removing PA thresholds to allow those who wish to, to undertake job plans in excess of 10 PAs (& 12 PAs where relevant opt-outs are voluntarily entered into), provided working patterns remain safe. These job plans should be reviewed regularly.

Objective	Activities to consider
Medical leaders are developed so the job planning process is effective, collaborative, consistent, appropriate, professional and follows good practice.	To develop medical leadership: Protect time for job planning and associated training: • medical directors should consider how best to resource protected time for those responsible for job planning. This should be delineated, appropriately remunerated and reflected in the local job planning policy • ensure those responsible for job planning have protected time to undertake job planning and training activities. This should be reflected in the job planning and study leave policy • clinical service leads should have time allocated in their job plans to undertake individual job plan reviews on an annual basis Provide access to training and track attendance: • clinical service leads should attend local training, which will cover the specifics of job planning within their organisation and how best to lead the department, taking into consideration the range of activities the consultant body undertakes. Specific training should be considered for clinical leads on the complexities of the consultant contract (annual leave over a compressed working week, out of hours activities, on-call). This may also include other topics, such as understanding the departmental budget and service plan
Metrics	
Attendance rates at local job planning training sessions	

Support operational teams in understanding the job planning cycles

Objective

Operational teams have the required support and training. They understand how to support good practice job planning in their organisation and, where appropriate, are included in job planning discussions.

Metrics

Attendance rates at local job planning training sessions.

'The job planning process is completed by the most competent person, who has completed the necessary training, not the most senior team lead just because it has historically been part of their job description.'

(Associate Medical Director for Workforce)

Activities to consider

Operational managers need to understand the core requirements of job planning and how to use the outputs to plan services.

To support upskilling, provide:

1. regular job planning training for newly appointed leads
2. formal and informal training, with peer support and 1:1 coaching on the more complex aspects of job planning, including how to link the job planning cycle to the hospital's business planning timetable.
This can help align consultant and organisational objectives

Understand job planning data in a wider context

Objective

Job planning data is considered alongside other key data points such as delivered activities, and finances / budgets, to ensure services continue to meet patients' needs.

Resources

- [Meaningful Use Standards – E job planning the clinical workforce \(2019\)](#)
- E-job planning [technical](#) specifications

'You need one dedicated person, sat on the same corridor, who can analyse your data, tell the story behind it and take on an objective role in discussions.'

(Deputy Medical Director)

Activities to consider

1. Establish a **regular review of performance data** with finance, clinical, operational and human resources teams, who undertake a service-level review at least quarterly to enable capacity and demand matching.
2. **Gain the support of analytics and operational intelligence** teams.
3. Consider **system as well as hospital level data**. Collaboration at a system level can facilitate more efficient care delivery, improve the interface between primary and secondary care and, where mutually agreed, can support more flexible, efficient deployment of the clinical workforce so activities and job plans are not wedded to site.
4. **Ensure e-job plans, ledgers, roster templates and electronic staff records automatically reconcile**, to improve efficiency and consistency across them. This should also be considered when procuring and implementing an e-job planning system.

Recommended performance data:

- job planning data, including sign off rates, DCC / SPA ratio
- planned versus delivered sessions
- expected versus actual demand
- planned versus actual budget
- premium pay spend, including locum spend and Waiting List Initiative spend

Objective

Job plans may be annualised where mutually agreed and where it supports the clinical workforce and employers to provide services in different patterns. This can address seasonal demand patterns or enable staff to work compressed or annualised hours.

Metrics

Locally held metrics:

- all DCC activities delivered on a quarterly basis compared to planned activities
- additional PAs and / or Waiting List Initiative payments
- completed / signed off job plans

Resources

[BMA and NHS Employers 2011 guide on consultant job planning](#), sets out the best way to calculate annualisation, study and annual leave allowances. While the guide and exert below relate specifically to the consultant workforce, the outlined approach to annualisation is equally applicable to SAS doctors. The guide notes that:

‘Annualisation is an approach to job planning in which a consultant contracts with their employer to undertake a particular number of PAs or activities on an annual, rather than a weekly basis. Most consultants are used to carrying out at least part of their work on an annualised basis where the on-call commitment varies from week to week.

As with all aspects of job planning the decision on whether to annualise a job plan or not must be made by mutual agreement. At the outset, employer, consultants, should agree that activity relates to measurable outputs and that arrangements reflect the professional nature of the consultant or and consultants’ continuing responsibility for care as described in the GMC’s Good Medical Practice.

At the same time employers should clarify a consultant’s responsibilities when they are not scheduled to work, are not undertaking any other planned activity, on-call or when they are on leave, for example whether they are required to return to work in the event of an emergency.’

Service level job planning

Objective

Undertake service level job planning (also known as 'workload planning') to align capacity to service demand and ensure all colleagues understand the total demand on the services and how best to collectively meet this.

Metrics

At a local level, a team will monitor and track their collective performance to identify any variance from plan and agree mitigating actions to be implemented.

This will be led by the service leadership team and likely include team objectives, departmental budgets, performance indicators and other relevant metrics. For instance, success could mean a reduction in backlog, waiting lists and / or agency spend. Measures should also include specific job plan KPIs, such as planned versus delivered activity, as set out in the Meaningful Use Standards. It is good practice to monitor ongoing demand and capacity.

Resources

[ECIST Improvement Webinar Series - Job Planning \(youtube.com\)](#)

Activities to consider

The 4 domains to establish good service level job planning processes are below. These can help inform service level job plan discussions. Service level job planning does not mean that all colleagues have the same job plan. There may be variation in how the activities are delivered and shared among colleagues.

We recommend adopting the term 'service level planning' or 'workload planning' and shifting away from 'team-based job planning' to maintain the distinction between the contractual process of individual job planning between a consultant and their line manager, and the process of matching the team's capacity to service demand.

1. Demand and forecast activity

- Review previous demand & activity data, including backlog data
- Agree the service plan for the coming year, including commissioned services, planned delivery model & growth. This should also consider available resources & any resource constraints that have or may impact on activity, for example, bed capacity, clinic space, & wider MDT (for example, nursing) capacity

2. Capacity (Direct Clinical Care)

- Review establishment, including temporary staffing pay
- Match workforce availability to planned activities, including headroom & annualisation calculations

3. Leadership and Educational Portfolio (SPA and ANR)

- Set team objectives, linked to hospital objectives
- Agree team development plan
- Review performance, safety & patient outcome data

4. Ongoing monitoring

- Review agreed KPIs
- Establish regular meetings to review ongoing metrics, & consider whole specialty-line or separate medical & non-medical meetings
- Track Waiting List Initiative spend. Where capacity & demand are aligned, the need for WLIs is lower

Job planning SAS colleagues

Considerations for specialist, associate specialist and specialty doctor job planning





Specialist, associate specialist and specialty doctors, often referred to as SAS doctors, forms a significant portion of the medical workforce, with approximately 20% of the secondary care medical workforce being SAS doctors.

SAS doctors:

- Are a diverse group with a wide range of background, skills and experience, who are a vital part of the NHS workforce fulfilling the growing demands of NHS.
- Have portfolio careers with distinct roles.
- Have at least 4 years of postgraduate training, of which two is in a relevant speciality.
- Are highly valued clinicians with a range of experience, many being members and fellows of their relevant colleges, and many having extended leadership and management roles including in teaching and training.
- Can be employed on a variety of contractual terms - the 2008 specialty doctor contract (closed to new entrants), the 2008 associate specialist contract (closed to new entrants), the 2021 specialty doctor contract and the 2021 specialist grade contract.

The SAS charter for specialty and associate specialist doctors sets out the support available to SAS doctors and what they can expect from their employers. It includes recommendations around contracts, job planning, development, involvement in organisational structures and recruitment. First published in 2014, it is a joint document, agreed by the British Medical Association (BMA), the Academy of Medical Royal Colleges, Health Education England (now NHS England) and NHS Employers.

Specialty and Specialist Doctors have distinct roles and responsibilities, as shown on the next slide, with many being amongst the most senior doctors in the NHS.

Joint guidance from the BMA and NHS Employers sets out that associate specialists and senior specialty doctors will “have acquired a high level of specialist knowledge and expertise and have the capacity and opportunity to work independently within agreed lines of responsibility and will also take a broader role in the organisation through other activities such as teaching and audit.”*

Specialty doctors, specialists and consultants – role comparison, adapted from The BMA Role Comparison table*

	Specialty doctor	Specialist	Consultant
Profile, Criteria and Experience	- Specialty doctors are a diverse group with different levels of knowledge, clinical skills, training, responsibilities and needs (both educational and career wise). They may be working towards joining a more senior grade e.g. specialist doctor. - Their experience ranges from a minimum of four years post-graduate experience to 20+ years.	- A senior and experienced clinician who can work autonomously to a level of defined competencies, as agreed within local clinical governance frameworks. - They shall have completed a minimum of 12 years' medical work (either continuous period or in aggregate) since obtaining a primary medical qualification, of which a minimum of six years should have been in a relevant specialty	- A senior and experienced clinician who works autonomously in one of the medical or surgical specialities and manages the delivery of care by other doctors (e.g. resident and some SAS doctors). - Consultants have completed full medical training in a specialised area of medicine and are listed on the GMC's specialist register.
Responsibilities	- Whilst a great portion of specialty doctors' time is directed towards patient care (clinical duties) and less to other clinical and non-clinical responsibilities required of a consultant or trainee, they too may fulfil additional responsibilities within their organisations as well as nationally. - At the top of the scale, specialty doctors may have increasing abilities to take decisions about patient care and carry responsibility	- Specialists serve as 'expert decision-makers' responsible for the full range of patient care within their specialised area, with the potential to work independently, including in on-call settings, if their competencies cover the breadth of presentations expected in their role. - Specialists, when working autonomously, can be the responsible named clinician. - The role will primarily focus on providing direct clinical care, meeting service delivery and improvement requirements, and they will manage the full range of presentations in their area of practice. - The role will be supported by suitable development opportunities including management roles and leadership responsibilities in teaching, academic research and service development. The details of the balance between clinical care and other elements of the role would be discussed during the job planning process. - They will be able to work as a member of a MDT (multi-disciplinary team), leading MDTs where appropriate i.e. clinical leads.	- Consultants serve as experts in their specialty and they accept responsibility for the care of patients referred to them, even when care is carried out by others, so it is a position of considerable responsibility. - The work of the consultant goes beyond caring for patients. A key aspect of the role is leading MDTs delivering care. This involves being able to take an overview of the care pathway and managing other team members accordingly.
Teaching	Speciality doctors may fulfil a wider role engaging in clinical and educational supervision, teaching and training, research and academic work, service development modernisation, audit, and committee/representative work.	Specialists are expected to be involved in delivering teaching and training of others (e.g. students and resident doctors) and in educational and clinical supervision.	Consultants are expected to be involved in the teaching and training and to contribute to their specialty field through research and leadership including educational and clinical supervision.
CPD	Required to actively engage in continued professional development activities (CPD) both internally and externally to their organisations and are encouraged to develop in provider, regional, national and college roles.		

SAS doctor job planning - contractual considerations

Under a remit from DHSC, NHS Employers and the BMA agreed changes to the specialty doctor contract and the introduction of a new specialist grade. These contracts* apply to new staff entering the SAS grades from 1 April 2021. SAS doctors on 2008 contracts and any other closed SAS contracts have the option to remain employed under their current contractual terms or transfer to these new grades. Changes to the 2021 contracts to be aware of when job planning are set out below.

Out of hours: Defined as any time that falls outside of the period 7am to 9pm Monday to Friday and any time on a Saturday or Sunday, or public holiday

On-call availability supplement: Introduction of Category A and Category B on-call availability supplement to bring in line with consultants.

Safeguards: Introduction of safeguards that allow work patterns to balance flexibility and support the health and wellbeing of SAS doctors:

- No more than 40% of working time should take place out of hours unless mutually agreed
- Where out of hours are more than 40%, the employer and doctor will work towards decreasing the percentage in out of hours until a limit of 40% is reached.
- Elective work should not normally be scheduled to finish later than 9 PM, unless mutually agreed.
- Maximum of 13 weekends a year
- Maximum of four consecutive nights (where at least 3 hours each night fall between 11pm and 6am) or long-day shifts
- A minimum period of 46 hours before and after transition between day and night shifts.

Annual leave: An additional day of annual leave after seven years in a SAS grade.

Professional or study leave: The SAS and consultant provisions for professional and study leave continue to align with (subject to the conditions set out in the contracts) leave normally being granted to the maximum extent consistent with maintaining essential services in accordance with the recommended standards. The recommended standard is leave with pay and expenses within a maximum of thirty days (including off-duty days falling within the period of leave) in any period of three years for professional purposes within the UK. The SAS 2021 notes the additional option of time off in lieu with expenses.

Temporary schedules: Removal of the temporary schedules and adoption of the common terms of the NHS Terms and Conditions of Service Handbook.

Spare professional capacity: Removal of the penalty for doctors not offering an additional PA to their employer. Replaced with a provision to strongly encourage doctors to initially offer additional hours of work to the service of the NHS via an NHS staff bank of their choice

* [Terms and conditions of service for specialist grade \(England\) 2021: SAS contract 2021](#)
[Terms and conditions of service for specialty doctors \(England\) 2021: SAS contract 2021](#)

Annual leave and study leave

Guidance to support job planning



Annual leave and study leave

Managing annual leave and study leave consistently and fairly across a team can sometimes be difficult. Added to this, working patterns including compressed hours, less than full time working or seasonal patterns can make it difficult to calculate leave entitlements. Leave audits shared with us demonstrate the challenges, with examples of activity delivery being impacted by the management of leave, and challenges for services and staff created by both under and over booking annual leave.

This section of The Improvement Guide shares high level guidance on developing a robust annual leave and study leave policy and good practice example policies approved by the Local Negotiating Committee.

Developing an annual leave and study leave policy

There should be a clear trust wide annual leave and study leave policy, approved by the Local Negotiating Committee, which sets outs:

- the approach to calculating annual leave, including examples where relevant for less than full-time employees or those working compressed or annualised hours
- the approach to requesting and arranging leave
- how bank holidays are managed
- the activities that are eligible for study leave.

To ensure business continuity and maintain on-call and service delivery cover, each service area should also agree and set out the maximum number of individuals who can be on leave at any one time and how swaps and cross-cover arrangements are organised.

The policies below have been approved by Local Negotiating Committees and can provide a good reference point when creating a robust leave policy.

- [Annual Leave Policy for Medical and Dental Consultants and SAS Doctors:](#) University Hospitals Dorset NHS FT
- [Job Planning Policy for Consultants and SAS Doctors:](#) Barts Health NHS Trust

Approaches to calculating leave

There is clear guidance on the BMA website on [study leave entitlements](#) and [annual leave](#), including possible methods for calculating leave, cover for leave, and details about working on public holidays.

The example policy from Barts Health NHS Trust set outs how to calculate leave in days. It states that *‘a week, for the purpose of annual leave entitlement, consists of whatever constitutes the consultant’s normal working week’* and clarifies that a week’s leave for a consultant who works a three-day week (whether less than full time or full time) entails three working days off. The policy includes a worked example of a consultant with a 30-day annual leave entitlement, with a working pattern of 10PAs spread over a three-day week. In the example the annual leave entitlement is expressed as $\frac{3}{5} \times 30 = 18$ days (6 weeks of taking 3 days per week).

Where it is difficult to account for leave in weeks or days, it can be useful to use one of the following approaches:

1. The job plan could be annualised, describing the number of PAs or activities that will be delivered over the year, rather than on a weekly basis; what remains is leave. Annualisation can give clinicians the flexibility to plan their annual leave and study leave in line with job plan delivery.
2. Leave could be calculated on a PA basis, reflecting the construct of the 2003 contract. For example, 6 weeks of annual leave based on an 11 PA contract is 66 PAs of leave entitlement.
3. Annual leave and study leave could be calculated in hours, pro rata’d according to the number of contracted PAs. The example policy from University Hospitals Dorset NHS FT provides a helpful example of this approach.

Requesting and arranging annual leave

Employers and consultants should take a flexible and pragmatic approach to planning annual leave to help ensure rotas are sustainable while also supporting work life balance and development. It is helpful to discuss leave prospectively as a team to plan for seasonal fluctuations and service variation and to ensure openness and fairness in allocating annual leave.

Where e-rostering is used, self-rostering against direct clinical care (DCC) activity can support work life balance and flexibility while also ensuring accuracy, fairness and transparency.

- Annual leave periods should reflect the proportion of DCC, supporting professional activities (SPA) or other commitments within the clinician's job plan. Particular care should be taken when leave is booked in single days to ensure that there is not a disproportionate effect on any one activity e.g. infrequent clinics, theatre lists or meetings. It is not acceptable to only book DCC as annual leave.

Additional resources

- BMA resources on annual leave: www.bma.org.uk/pay-and-contracts/leave
- BMA resources on study leave: <https://www.bma.org.uk/pay-and-contracts/leave/study-professional-and-special-leave/study-professional-and-special-leave>
- Joint BMA and NHS Employers job planning guidance (2011): www.nhsemployers.org/system/files/2021-11/Guide_to_consultant_job_planning%20July2011.pdf



More extensive guidance on job planning can be found on the websites of:

The BMA

- www.bma.org.uk

NHS Employers

- www.nhsemployers.org

The Hospital Consultants and Specialists Association

- www.hcsa.com

Please share your ideas and feedback with us

Thank you for engaging with this guide. While we have collected a wide range of improvement ideas, we want to gather your local improvement ideas for inclusion in an updated version of this guide early in 2025.

Please share your ideas and feedback with us. There are 2 ways you can do this:

- by emailing us at england.clinops@nhs.net
- by feeding back through your local Learning and Improvement Network. [Details on the networks are on the FutureNHS platform](#)

