The Consultant Contract

and

Job Planning for Emergency Medicine Consultants

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Key Points

- The 2003 consultant contract is time based
- The contract allows transparency and an ability to match work that you agree to do, to pay and to the resources you need to deliver the work
- The job plan should be based on a robust diary exercise
- It is vital that you have (at least) an annual job plan review and that you use your annual appraisal to feed into this
- You should not sign a contract without an agreed job plan
- Supporting resources should be agreed before agreeing a job plan
- This is a 10 PA contract. PAs over 10 are neither obligatory nor permanent
- Up to 10 PAs are pensionable
- A PA in normal working hours is 4 hours
- A PA outside normal working hours is usually 3 hours
- Scheduled work in premium time is not usually compulsory and compensation for such work is negotiable
- Time spent on emergency work includes travel time
- All activities related to direct clinical care should be identified
- If workload changes, ask for a job plan review
- There is specific provision for part time contracts.

1. INTRODUCTION

The 2003 Consultant Contract
This document will give Emergency Medicine consultants a broad overview of the principles of the 2003 contract together with specific advice appropriate for Emergency Medicine consultants. The objective is to enable Emergency Medicine consultants and thus their patients, to work within and benefit from the 2003 contract. In view of the differences in contract between each of the UK nations we have aimed to cover the general principles with details based on the English contract and then to highlight specific differences for other nations.

This document is based, with permission, upon the 2005 guidance published by the Association of Anaesthetists of Great Britain and Ireland. We gratefully acknowledge the generosity of the AAGBI in allowing us to benefit from their work.

The appended list of references and web links will allow members to access more complex and detailed information on various topics from other sources (see Appendix 6).

This document will also be available on the BMA website and will be updated as necessary to provide members with an ongoing and up to date source of reference.

The majority of consultants in England and Scotland have now transferred to the 2003 contract. All consultants appointed since 2003 have contracts on this basis. The contract identifies what consultants have agreed to do and the payment for those agreed activities. Although this is a national contract there are aspects that need local interpretation and several instances where a 'departmental' approach will be of benefit. For the first time, objectives for consultants and, importantly, the supporting resources necessary to deliver these objectives, are identified within the contract. A previous BMA survey suggested that a number of consultants did not have job plans. A thorough understanding of the new contract and the job planning process is thus important for all consultants to ensure a proper work-life balance.

Emergency Medicine Sub-committee
The British Medical Association maintains close relations with the College of Emergency Medicine through the EM subcommittee of the Central Consultants & Specialists Committee and the Professional Standards Committee (PSC) of CEM which both have cross representation between CEM and BMA.

This document is a result of close collaboration between BMA and CEM via these two committees.

Comments or suggestions may be addressed to either committee.

The Old (Pre-2003) Contract
Some Emergency Medicine consultants have chosen to remain on the pre-2003 contract, at least for the present. For these consultants may wish to read the BMA publication entitled:
"Controlling workload, maximising rewards – guidance for consultants -May 2003."

Professional Advice on Your Contract
The BMA publishes comprehensive advice on the 2003 and pre-2003 consultant contracts, with answers to 'frequently asked questions'. Some of this information is available to all, some is restricted to members.

NHS Employers also has a website which is worth visiting even though many areas are not agreed with the profession.

It is important to balance the professional organisation's views on contentious areas with those of NHS Employers. These views will be conflicting in some areas. Where this bears on your own job you should seek personal professional advice.

2. THE CONSULTANT CONTRACT

What is the contract?
A contract is a set of statements governing the agreement between you and your employer: what work you agree to perform, what facilities your employer agrees to make available for you to do this work, and what your employer agrees to reward you with for your work. It must be both fair and compatible with the law.

The consultant contract is not a single document. It has several components:

• The Statement of particulars (called the contract)

• The terms and conditions of service

• The job plan.

The Contract (Statement of Particulars)
This is usually a document that states your job title, your employing organisation and further details and ends with a place where you and your employer sign. It is negotiated nationally and should not be varied locally, except where your own particular circumstances have been inserted. Details of the contract for individual countries can be found on the BMA website.

The Terms and Conditions of Service
This is a set of rules describing how the contract operates in more detail. The rules are congruent with the statement of particulars.

Employers do not usually circulate these unless on request; you can find them on the Departments of Health websites. They are negotiated nationally, and should not be varied locally except where a collective agreement has been reached with the Local Negotiating Committee for medical and dental staff in your trust. Examples of such agreements might be to vary the provisions on additional programmed activities in the case of significant private practice, to confirm arrangements for fee paying services[1] or to agree appropriate places for supporting professional activities.

The Job Plan
This is your personal and detailed agreement about your work. The job plan is congruent with the terms and conditions of service. It will describe the purpose of your job, your work timetable, your objectives and the supporting resources, which should be allocated to help you achieve them. It should include any other personal agreements about the way you work.

[1] Previously referred to as “category 2 work” Fee Paying Services are services that are not part of Contractual or Consequential Services and not reasonably incidental to them, e.g. medico-legal work and writing police statements. Examples are now listed in schedule 10 of the English contract

Underlying Principles of the Contract
The contract is a professional contract that is, for the first time, clearly time based. This does not mean it promotes a strict "clock-watching" mentality, but it does give consultants a clear ability to resist escalations in working hours and to be properly rewarded for work they agree to do.

The "unit of currency" of the contract is the Programmed Activity (PA), and a consultant's work is expressed in numbers of PAs.

Each programmed activity (PA) worked between 7am and 7pm Monday to Friday, excluding bank holidays, is a period of 4 hours. Outside this time, one PA is normally 3 hours long. The whole-time contract is for ten PAs; consultants may agree to work fewer than ten (part-time) or more than ten (extra PAs).

3. JOB PLANNING PRINCIPLES

The 2003 contract is time based; the job plan should therefore be supported by a robust work diary.

Working time is divided into four components:

1. Direct Clinical Care (DCC)

2. Supporting Professional activities (SPA)

3. Additional NHS responsibilities

4. External duties.

The standard full time job plan comprises 10-programmed activities, generally 7.5 (30 Hours[2]) for direct clinical care and 2.5 (10 Hours[2]) for supporting professional activities.

Extra (sometimes described as additional) programmed activities may be agreed for direct clinical care, but these do not form part of the standard contract and above a total of10 PAs are not superannuable. In many areas of the country employers have a ceiling on the number of extra PAs, which they will agree to pay. In the event of this happening, consultants should not agree job plans that they know would involve working in excess of work paid for.

[2] If any PA or part PA is worked in premium time (7pm-7am or at weekend), a PA is usually 3 hours not 4 hours

4. DIRECT CLINICAL CARE (DCC)

The Terms and Conditions of Service define Direct Clinical Care as “work directly relating to the prevention, diagnosis or treatment of illness”.

A number of types of work are listed as falling within this category:

- Emergency duties
- Operating sessions (including pre-operative and post-operative care) ward rounds
- Outpatient activities
- Clinical diagnostic work
- Other patient treatment
- Public health duties
- Multi-disciplinary meetings about direct patient care
- Administration directly related to the above (including but not limited to referrals and notes).

Some of these types of work such as operating sessions are not relevant to most Emergency Medicine Consultants most of whom have a working week based on departmental “shop floor” and other related clinical duties.

Of the categories above, clinical diagnostic work probably best describes the majority of an Emergency Medicine Consultant’s work. Examples of DCC:

- Clinical Diagnostic work – scheduled “Shop Floor” duties and unscheduled clinical work carried out during on-call, on an ad-hoc basis or as late finishes
- Ward rounds on CDU/Observation or Short Stay Wards
- Review clinics – outpatient clinics
- Multi-disciplinary meetings about direct patient care
- Administration related to patient care (e.g. referrals, notes, dictation, correspondence)
- Handling complaints
- Morbidity/mortality meetings
- Managing equipment and drugs in the ED
- Travel: to and from home for on-call work and between sites
- Other patient treatment, e.g. Intensive care or other subspecialty work.

In the new contract, for the first time, travel time can be counted when calculating on call emergency time. The total emergency episode time should be calculated as the time from the first telephone call relating to the episode to arriving home after the event. Travel time between hospitals within a Trust during the course of the working day, both for DCC and SPA, can also be counted.

5. SUPPORTING PROFESSIONAL ACTIVITY (SPA)

In the English and Scottish contracts, the time allowed for this should average 10 hours a week (2.5 PAs).

The 2003 contract states that for full time consultants the Job Plan will typically include an average of 7.5 Programmed Activities for Direct Clinical Care duties and 2.5 Programmed Activities for Supporting Professional Activities.

Here the “average” refers to the weekly time allocation for an individual consultant NOT to an average across a group of consultants. In other words some weeks could have fewer than 10 hours of SPA time and some weeks more provided that the average was 10 hours.

“Typically” means that this will be the default position although some consultants may require more SPA time (for example if undertaking a role such as clinical director). The College of Emergency Medicine advises that every consultant requires a minimum of 1PA for CPD and the requirements of revalidation.

There are a number of non-clinical requirements that every Emergency Department will have regardless of size and these may increase in larger departments. The College’s recommendations for these departmental non-clinical requirements are as follows:

Clinical Director	3PAs /week
Teaching organisation	2PAs /week (up to 4 in large teaching departments)
Educational support	1PA per four trainees/week
Clinical Governance lead	1PA/week
Contingency Planning lead	1PA/week
Emergency Care network duties	1PA/week

In addition Emergency Medicine consultants will need to participate in many other non-clinical activities including departmental administration and management, liaison with other specialties and departments, teaching and teaching preparation, service development and quality improvement work, audit and appraisal.

To fulfil these requirements, full time Emergency Medicine consultants should have a minimum of 2.5PAs for supporting professional activities.

In departments with four consultants or fewer, the departmental non-clinical requirements are such that each may need more than 2.5 PAs of SPA time to ensure a safe and quality service is delivered.

In unusual circumstances a consultant may wish to contract for fewer than 2.5 SPAs - but beware of the effect on appraisal and revalidation and on quality of care given to patients.

Examples of SPA

- Continuing professional development (i.e. all regular activity such as reading journals, attending regular professional or academic meetings etc.)
- Appraisal
- Teaching organization
- Training (e.g. of trainees, medical students)
- External teaching and education delivery (e.g. ATLS, APLS)
- Formal teaching and preparation (e.g. giving lectures, seminars)
- Audit and local clinical governance activity
- Clinical management
- Service development and quality improvement work
- Major incident planning
- Rota organization
- Job planning
- Research.

This list is by no means exhaustive.

6. ADDITIONAL NHS RESPONSIBILITIES

Some consultants may have additional NHS responsibilities that cannot be absorbed into the time normally set aside for SPAs. These should be recognised in the job plan and remunerated accordingly. It may be appropriate for them to replace some of the DCC Pas.

Examples:

- Medical director
- Clinical director
- Lead clinician
- Other official trust management roles
- Audit lead
- Clinical governance lead
- Risk management lead
- Teaching or research lead
- Subspecialty lead
- Project lead
- Equipment officer.

In many trusts, medical management positions are classified and remunerated separately to the consultant contract as a “responsibility payment”. These payments may in some circumstances be pensionable and advice should be sought as to whether this is beneficial or not for the individual concerned. This means that one would have a separate contract covering such work with a remuneration that might bear no relation to the consultant salary. This almost always applies to medical directors and sometimes to clinical director and some other posts.

Whichever type of contract a medical manager has, it is important to make sure that the duties of the medical manager, the supporting facilities and the remuneration for those duties are clearly specified.

7. EXTERNAL DUTIES

These activities are deemed to be for the greater good of the NHS. The DH recognises their value and has given implicit support for such activities.

"It remains, however, the policy of the Department of Health to encourage NHS organisations to release consultants for work that is necessary for the broader benefit of the NHS." *Consultant Contract Implementation Team (CCIT) update 14 January 2004*

Examples:

- Acting as an external member of an advisory appointments committee
- Work for other NHS bodies (e.g. Health Commission)
- College tutor
- Work for the General Medical Council or other national bodies
- NHS disciplinary procedures
- Regional advisor, deputy, programme director etc.
- Trades union activities (e.g. BMA)
- College work
- University roles.

If these activities are regular then allowance should be made for them within the Job Plan. Less regular activities may be better handled using paid special leave (*TCS schedule 18*), which simply replaces one's duties for the day in question.

Consultants should discuss their needs and the employer's usual way of handling them as soon as possible. Emergency Medicine consultants may be in a position to agree flexible elements to their workload so that their absence from the workplace is easier to cover.

8. ON-CALL AND OUT OF HOURS WORKING

Premium Time Working
Increasing numbers of Emergency Medicine Consultants are agreeing to work scheduled clinical sessions at the weekend or in the evening after 7pm (8pm in Scotland) (premium time). This is *not* on call work and should be included as part of scheduled Direct Clinical Care although other special provisions apply to this work.

On call is divided into two components:

1. Time spent working - unpredictable emergency work: e.g. dealing with telephone queries while on call or an unplanned return to work.

The College of Emergency Medicine has produced a statement on the role of the Emergency Medicine Consultant on call. This emphasises the professional nature of any decision to return to work for patient care, and the responsibility of the employing organisation to staff the Emergency Department and hospital as a whole to deal with predictable peaks in workload (see Appendix 5).

Unpredictable emergency work is subject to a “threshold” of two PAs per week. This is not a limit. It means that if the work in this category exceeds the threshold, then the employer has the right to seek to change working conditions so that the work does not exceed the threshold. However, if changes are not made with agreement, and the work continues, then the employer must recognise it in the job plan and pay for it as appropriate**.**

Time spent in hospital or travelling to/from emergencies should be noted in job planning diaries. The average amount of time taken should then be allocated to PAs. The effect of providing prospective cover for colleagues leave should be included within this allocation.

There is no automatic right to a “PA for on call” as this should reflect actual work done on average.

2. Time available – the on call supplement
This recognises the disruption to life of on call by way of a supplement to basic salary. This is based solely on the number of consultants on the on call rota and the characteristic nature of the response when on call.

Category A: this applies where the consultant is typically required to return immediately to site when called or has to undertake interventions with a similar level of complexity to those that would normally be carried out on site, such as telemedicine or complex telephone consultations. Most Emergency Medicine consultants will fall into category A due to the nature of EM on-call work.

Category B: this applies where the consultant can typically respond by giving telephone advice and/or by returning to work later.

Emergency Medicine consultants will normally be **Category A**, unless exceptional local circumstances are in place.

The requirement to provide prospective cover for leave does not affect the on call availability supplement. The rota frequency is defined by the number of consultants

sharing the rota without taking account of leave. Thus if 5 Consultants share an on call rota equally this is defined as a 1 in 5 rota and paid as such even though for much of the year each Consultant will be working 1 in 4 frequency due to leave of colleagues.

A rota of 1 in 4 or more frequent is defined as a high frequency rota and there is an obligation on the employer to “review at least annually the reasons for this rota and for its high frequency and take any practicable steps to reduce the need for high-frequency rotas of this kind.”

Part-time consultants will receive the appropriate percentage of the equivalent full-time salary, provided their responsibilities when on-call are the same as those of full-time consultants on the same rota.

Resident on call

The terms and conditions of service state “Where unusually a consultant is asked to be resident at the hospital or other place of work during his or her on-call period, appropriate arrangements may be agreed locally. A consultant will only be resident during an on-call period by mutual agreement”.

The effect of the working time directive and the legal judgments arising from this are that a traditional on call pattern with normal working the day before and after are no longer lawful and so in effect resident on call must take the form of a night shift.

The BMA would advocate a substantial premium on the current PA rate to recompense for the onerous nature of resident on-call/night shifts.

Higher PA rates for resident on call/ night shift working are quite specifically allowed for in the TCS by the phrase “*appropriate arrangements may be agreed locally*”.

Some Emergency Consultants have agreed working patterns that include a commitment to be on site overnight to respond for example to Trauma Calls but with a room provided on the understanding that they will go to bed at midnight and only respond to the needs of critically ill or injured patients. It may be appropriate to agree a lower PA rate for this style of working than for a full night shift on the shop floor.

9. EMERGENCY MEDICINE JOB PLANNING IN PRACTICE

Distribution of PAs
Within the standard 7.5PAs of Direct Clinical Care work for most EM consultants the bulk of the sessions will be allocated to shop floor duties (clinical diagnostic work). However within this at most 6PAs should be allocated to shopfloor work, within a 10 PA contract.

The nature of consultants' clinical work is such that there is an inevitable need for clinical administrative time to deal with matters arising from direct patient care. The College of Emergency Medicine Professional Standards Committee advises that for every 4 hours of shopfloor Direct Clinical Care there will be a need for one hour of clinical administrative work.

Team Job planning
For some Emergency Medicine consultants it may be appropriate to agree a job plan based on a fixed timetable of duties and responsibilities. However the increasing shift away from a command and control model of working towards a clinical manager or clinical decision maker model of working has led to a need for more consistent consultant clinical cover for the Emergency Department.

For many departments this has been achieved by adopting a team job plan for core clinical components. For example four consultants might agree that there will always be a consultant allocated to shopfloor work 9am to 5pm Monday to Friday and for one PA on Saturdays and Sundays regardless of annual or study leave. So instead of each consultant having a number of timetabled sessions to cover they have a shared commitment to cover these twelve PAs of DCC.

An individual's job plan might include a mix of team activities, and individual activities.

To calculate the effect of a team job plan the total shared PAs must not only be divided amongst the consultants but a prospective cover multiplier should be applied to allow for the effect of this.

Prospective cover
A Consultant has 6 weeks annual leave and 10 days of public holidays and statutory holidays, plus 10 days of professional and study leave. This equates to ten weeks of leave in a year and so they will be at work for 42 weeks of the year.

If a given activity is to be covered prospectively, the average weekly PAs must not only be divided amongst the consultants on the rota but an allowance for leave made by adding a factor of 10/42. (This is the same as multiplying by 52 and dividing by 42).

These calculations provide for the effect of covering for predictable leave.
Whilst Consultants have a professional and contractual responsibility to cover for the unpredictable absence of colleagues (such as sick leave) if this has the effect of increasing their work beyond the agreed job-plan then compensation must be arranged.

Similarly for predictable long term leave such as maternity or paternity leave, or for a vacant post the job plan should be reviewed unless a locum is appointed.

For example a group of six Consultants agree to work Direct Clinical care sessions valued at 5PAs a day Monday to Friday and 2 ½ PAs each day on Saturdays and Sundays – a total of 30 PAs a week. They agree that they will cover each others normal leave so that these commitments are covered every week. A one sixth share of 30 PAs would be 5 PAs but with prospective cover this increases to 6.2 PAs each per week.

Premium Time working

The College of Emergency Medicine supports the development of extended consultant presence in the Emergency Department with a goal of 16 hours a day shopfloor cover. However this requires careful consideration of the job plan and contractual arrangements.

The 2003 Contract England specifically allows for work to be scheduled outside the traditional normal working week and places a slightly enhanced value on such work if it occurs in premium time. Premium time is defined as any time which falls outside 7am to 7pm Monday to Friday or any time on Saturday Sunday or a Public Holiday.

The enhanced rate for premium time working equates to time and a third – either by counting 3 hours per PA, or by paying an enhanced rate for a 4 hour PA. The same rate applies to unscheduled work that falls in premium time. *Consultant Contract - Schedule 7*[3]

The contract gives consultants the right to refuse to undertake non-emergency scheduled work in premium time. As Emergency Medicine "by its nature involves dealing routinely with emergency cases" any regular programmed work is defined as non-emergency work for these purposes. *Consultant Contract Schedule 3*[4] *and Definitions*[5].

This puts Emergency Medicine consultants in the unusual position of being able to refuse such work. However if they do agree it, the rate remains at time and a third - unless there are more than three PAs a week on average of premium time working (including unscheduled work done whilst on call). If this applies then the TCS gives the flexibility for the employing organisation and the consultants to "agree appropriate arrangements". *Consultant Contract Schedule 7*[3]*.*

Resident on call or Night shift working is also premium time working but is covered by other specific provisions – see above.

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[3] Schedule 7 Paragraph 6: The foregoing provisions are designed to cover situations where work in Premium Time is up to the equivalent of three Programmed Activities per week on average. Where work during Premium Time exceeds this average, the employing organisation and the consultant will agree appropriate arrangements.

[4] Schedule 3 Paragraph 6: Non emergency work after 7pm and before 7am during weekdays or at weekends will only be scheduled by mutual agreement between the consultant and his or her clinical manager. Consultants will have the right to refuse non-emergency work at such times. Should they do so, there will be no detriment in relation to pay progression or any other matter.

[5] Definitions – Emergency Work: For the purposes of Schedule 3, paragraph 6, non emergency work shall be regarded as including the regular, programmed work of consultants whose specialty by its nature involves dealing routinely with emergency cases, e.g. A&E consultants.

If a Consultant is employed specifically to work a pattern that includes premium time working, or resident on call then they may have an implicit or explicit contractual commitment to continue such a pattern and so the special provisions of the contract that allow them to refuse to accept these sessions may not apply. A Consultant should take individual advice before agreeing any such contract.

Public Holidays

A Consultant is entitled to "eight public holidays and two statutory holidays or days in lieu thereof." As being on call for a public holiday cannot be construed as a days leave, a consultant on call from home is entitled to a day in lieu. The contract further allows "*In addition*, a consultant who in the course of his or her duty was required to be present in hospital or other place of work between the hours of midnight and 9am on statutory or public holidays should receive a day off in lieu." This means that the consultant on call for a Sunday night before a public holiday Monday can only claim a day in lieu if they have to go in to work after Midnight and before 9am.
Working scheduled sessions by agreement on a public holiday does not automatically give rise to any greater entitlement to time in lieu than simply being on call from home. However as premium time working a consultant does not normally have to agree to work such scheduled sessions.

Extended Hours cover – how late should we go?

There is an inherent conflict between the benefits to patients from having their care directly supervised by a Consultant in Emergency Medicine and the sustainability of career long anti-social hours working arrangements. We must also be aware of our responsibility to maintain the attractiveness of the specialty of Emergency Medicine as a career so that it continues to attract the brightest and the best of the doctors in training. If EM is the only specialty with significant scheduled out of hours consultant working this may influence career choices away from EM. Patient care will not be best served by the out of hours presence of less than excellent EM doctors.

Despite this, provided the overall working pattern and rewards are reasonable, extended consultant shopfloor presence should be supported. The more consultants who share the cover, the greater the extended hours presence that can be sustained.

As a guide, it may be considered reasonable to agree extended hours evening cover on a Monday to Friday basis as follows:

Number of Consultants	Weekday evening cover up to		Weekend cover each day Saturday and Sunday
6	6pm	AND	8 hours (e.g. 12pm to 8pm)
8	8pm	AND	12 hours (e.g. 8am to 2pm & 2pm to 8pm)
10	10pm	AND	16 hours (e.g. 8am to 4pm & 4pm to MN)
12	12 MN	AND	20 hours (e.g. 8am to 6pm & 2pm to MN)

Enhanced Rates for Premium Time Working
For existing Consultants, the various exclusions and clauses above allow for the possibility of agreeing enhanced rates equivalent to better than 3 hours per PA for new job plans that include premium time working. These rates should be negotiated with local employing organisations by the Consultants concerned via their LNC as any rates agree set a precedent for other specialties and for future job plans (Local Negotiating Committee of the BMA). Neither the BMA nor the College can recommend specific rates for local negotiation but we would encourage you to consider examples of successful strategies that have been adopted elsewhere.

Higher rates
Some EM consultants have agreed rates of 2 Hours per PA on Saturdays and Sundays for scheduled DCC PAs.

Covering for missing juniors
Some LNCs have negotiated significantly enhanced rates for providing emergency on site out of hours cover when a resident junior or middle grade doctor has called in sick at short notice and no locum can be found in time.

Reduced DCC totals
Some EM Consultants have successfully argued that the high intensity nature of premium time working is such that their job plan should include fewer then the standard 7.5 PAs of DCC with consequently more SPA time.

Flexible time and location of SPA time
Some EM Consultants have agreed arrangements whereby some of their SPA time (e.g. CPD) can be worked at home and at a time of their own choosing.

Unscheduled on call work
Some EM Consultants have agreed a job plan whereby they will received one PA for work done whilst on call even if the actual work falls below three hours each per week on average.

Travelling Time
If out of hours work was to be done as unscheduled on call work, travelling time would be included as DCC. By substituting scheduled sessions some EM consultants have agreed a standard half hour each way of travelling time built into their weekend DCC PAs.

Additional PAs
Regardless of whether the scheduled premium time working is at “standard” 3 hours per PA or an enhanced rate, consultants may agree that these sessions are remunerated by additional PAs above 10 rather than by displacing day time working.

Block rate
Rather than calculating an hourly rate some EM consultants have negotiated arrangements whereby in return for covering certain hours at weekends, during evenings and on public holidays, they will receive additional PAs. For example one group of eight Consultants has agreed to work a basic 10 PAs over 4 days a week between 8am and 6pm and additionally to cover 6pm to 8.30pm Monday to Friday, 8am to 4pm on Saturday and Sunday and Public Holidays plus on call with prospective cover for an extra 2 PAs of DCC. At contract rates this would be 1.28

PAs each but by including public holidays and work done whilst on call a payment of 2 PAs was agreed.

The agreement

Regardless of the basis of any agreement, it should be explicit and in writing. If any arrangement is to be for a fixed term or if either party to agreement is to have the right to withdraw this and the notice period should be clear.

10. LEAVE

Annual Leave
Consultants are entitled to annual leave as follows:

Up to seven years' service and in Scotland: Six weeks

Seven Years or more (England only): Six weeks + 2 days.

Annual leave may be carried over subject to section 1 paragraph 10- 14 of the General Council Conditions of Service.

Consultants must seek formal permission to take leave. Up to two days' leave may be taken with notification but without formal permission. All trusts will have an agreed leave policy, which should be referred to.

Sickness during annual leave
If a consultant falls sick during annual leave and produces a statement to that effect he or she will be regarded as having been on sick leave from the date of the statement. Self-certificates can cover up to seven days' sickness.

Public Holidays
A consultant was entitled to ten days' public holidays or days in lieu thereof. (Ref: section 2 of General Council Terms of Service). An amendment to this has reduced this number to eight, but adds two days to the annual leave entitlement.

A consultant who, in the course of his or her duty was required to be present in the hospital or place of work between the hours of midnight and 9 am on a public or statutory holiday should receive a day off in lieu. This means that being on call the night before public holiday only gives rise to a day in lieu if you have to go in after midnight and before 9am. Being on call on a public holiday gives rise to a day in lieu regardless of whether you go in.

Professional and Study Leave
This includes:

- Study (usually but not exclusively or necessarily on a course or programme)
- Research
- Teaching
- Examining and taking examinations
- Visiting and attending professional conferences.

The recommended standard for consultants is leave with pay and expenses within a maximum of thirty days (including off duty days falling within the period) in any three-year period. Leave will normally be granted to the maximum extent. Emergency Medicine consultants may find it helpful to agree that for example teaching on advanced life support courses up to a certain limit is included within their SPA time as external teaching rather than having to be taken as Professional or Study Leave.

Any grant of leave is subject to the need to maintain NHS services.

Where a consultant is employed by more than one NHS organisation, leave must be approved by all these organisations.

During study leave with pay the consultant should not undertake any remunerative work without the special permission of the leave granting authority.

Unlike supporting activity, study leave facilitates absence for several days or even weeks at a stretch, where necessary. Therefore, study leave is a means of achieving professional activity goals in addition to (not in place of) supporting activity time.

Special Leave With or Without Pay
The provisions of Section 3 of the Terms and Conditions of Service will still apply. This leave is granted without formal restriction and some consultants find it useful in working for medical Royal Colleges or professional Associations.

Sabbaticals
A consultant may apply for sabbatical leave according to existing arrangements. Proposals for sabbatical leave should be made before annual appraisal and considered in the annual job plan review. There has been suggestion that new plans for sabbaticals may by proposed in 2005/6. Members should check arrangements in individual nations.

Sick Leave
A consultant is entitled to sick leave with pay where they are absent from work due to illness, injury or other disability.
Entitlement relates to their duration of NHS service. This may be extended at the employer's discretion.

Maternity Leave, Domestic, Personal and Care Relief
Consultants' rights are set out in section 3 and 6 of the General Council Term of Service (sections 6 & 7 Scotland).

11. PAY

The pay rates are well covered in the advice and documents available from the BMA and NHS Employers.

Seniority (Schedules 13 and 14)
You should consider whether you can claim extra seniority for previous service as an NHS consultant, experience at consultant level outside the NHS consultant system whether home or abroad, or to make allowance for training lengthened by flexible training or the need for dual qualifications.

Threshold progress (Schedule 15)
Progress through pay thresholds is not automatic, although the norm is or a consultant to progress as expected and the burden of proof is on the employer if they wish to defer advancement, should certain conditions have not been met. These conditions are closely associated with the job plan and agreed supporting resources.

Consultants should remain aware of the year of their pay threshold, since they will be at irregular intervals, particularly in the transitional period.

Pensions (Schedule 17)
The NHS pension scheme has recently been revised. Although you should take advice on your individual pension arrangements, the NHS Pension Scheme benefits are currently difficult to match in a private scheme.

Further advice is available from the SPPA in Scotland, the NHS Pensions agency in England and the BMA.

12. CLINICAL EXCELLENCE AWARDS

The Clinical Excellence Awards Scheme was agreed as a non-negotiated appendage to the 2003 contract in England. The scheme is designed to award excellence and not just hard work. Hours worked should be rewarded through PAs.

Excellence is assessed using a standard form covering 5 domains:

1. Delivering a high quality service
2. Developing a high quality service
3. Managing a high quality service
4. Research
5. Teaching & Training.

There are two elements:

Local awards: 1-9. Each trust must make, at least, 0.35 wards per eligible consultant available for consultants each year. In theory each consultant should gain an award every 3 years.

National awards: 9 (Bronze) (equivalent to local 9), 10 (Silver), 11 (Gold) and 12 (Platinum).

All consultants, from the first anniversary of their appointment as a consultant are eligible to apply. All applications must be electronic using the forms downloadable from the ACCEA web site, where full details of the process to be followed are provided.

Further details of example procedures can be found on the BMA website.

Any consultant who feels that the process is not fair or transparent is able to appeal, locally or nationally as appropriate, on the process used, but not on failure to award. Trusts bypassing the transparent process or misusing the scheme should be reported to the ACCEA and BMA.

DISCRETIONARY POINTS AND DISTINCTION AWARDS –

SCOTLAND
At the time of writing, the merit award system in Scotland is under review and is likely to change within the next few years. The current system has up to 8 discretionary points awarded at Trust level, and B, A, and A+ awards at national level (identical to the previous system operating throughout the United Kingdom). A survey in 2002 of Scottish consultants and academics revealed widespread dissatisfaction with the current system. The most popular of the proposed options would see abolition of the B award, with the funding redistributed to allow up to 10 discretionary points. This has not yet been agreed and discussions continue. The principal of no detriment to current award holders has been agreed.

The criteria for receiving an award are unchanged, and as elsewhere within the United Kingdom, Emergency Medicine consultants are under-represented at all levels of award.

WALES

Clinical Excellence Awards

There is a commitment to Clinical Excellence Awards.

These will replace the discretionary points and distinction awards with a National scheme for England and Wales.

Commitment Awards

These will be available to all Consultants once they have reached the top of the incremental scale, who have demonstrated commitment to the service by satisfactory job plan review and appraisal.

13. REVALIDATION, APPRAISAL AND CONTINUING MEDICAL EDUCATION

Since 2001, the NHS and GMC have required that doctors undergo yearly appraisal. In the future satisfactory appraisal is expected to be a contributory basis to revalidation, without which we will be unable to practice. Within the appraisal process all aspects of medical practice and performance are examined. Individuals are required to keep and maintain up to date records in these areas. Time spent in this exercise is classified as Supporting Professional Activity.

While the new contract document says nothing specific about Continuing Medical Education, there is implicit reference in that it provides for study and professional leave and requires that doctors be registered with the GMC.

At present educational activities are given a value in CME Points.

Although some of these points will be acquired as a result of courses requiring study leave other will be acquired as a result of supporting activities. These points should be recorded in the appraisal document.

14. WORK DIARIES

Keeping a diary will help you get the best out of your job plan.

A diary does not have to be kept permanently - the important point is for it to be representative. This is usually interpreted as covering the same number of weeks as the relevant on call rota.

The diary should be kept according to the templates agreed between NHS Employers and the BMA. Sample Word documents are available on the NHS Employers and BMA websites.

15. PART TIME WORKING

It has been expressly stated that the implementation of the new contract should provide the necessary flexibility for those consultants who wish to work part time.

Basis of the contract
Trusts can offer part time contracts of between one and nine PAs.

For appointments after 1st Jan 2004, where the request to work part time is in order to undertake private practice the contract should normally not be for more than 6PAs in total. For existing consultants this restriction does not apply. Where a consultant wishes to work part time mainly for reasons other than private practice but still wishes to undertake some private work, they can be appointed to a contract of more than 6 PAs.

Flexible Career Scheme
Flexible contracts are available via NHS professionals for consultants wishing to work up to 50% of a full time contract. Up to 50% funding support is available, initially, for such appointments. These contracts are subject to the same terms as other part timers.

The Working Week
Although the division of PAs between DCC and SPAs will be seen broadly as pro rata it is recognised that part timers will need to devote proportionally more of their time to SPAs as they will need to participate to the same extent in CPD. The principle is that they must be able to undertake all the teaching, audit, and clinical governance activities required by the employer within the time allowed for SPAs.

DCC activities, as with full timers should not encroach on SPA time except in emergency situations.

Illustration:

Total PAs	DCC	SPA
8	5.5	2.5
6	4	2

Apart from their programmed activities a part time consultant should have no NHS commitment during the working week. Variations in the balance of activities will be the subject of agreement between the consultant and their employer. Consultants working part time will not be expected to carry the same workload as full time consultants.

Out of Hours Work
If a part timer participates in an on call rota they should receive the same supplement as a full timer on that rota. If they are on call, on a day that they do not normally work, time off in lieu or additional payment will be agreed.

Pay Progression
Some flexible trainees, because they spend longer in the training grades, may not be able to reach the top of the new consultant pay scale. They will, where necessary, have their progress through the thresholds adjusted so that they will reach the

threshold they would have attained if they had trained on a full time basis (extension of training by 2y = 2y seniority on appointment as a consultant).

Extra PAs and Spare professional capacity
Part timers wishing to undertake remunerated clinical work in their non-NHS time would be expected to offer up to one extra (paid) PA on top of their normal working week. All PAs up to 10 are pensionable.

Flexibility and Annualisation
The contract allows for both flexibility and annualisation of the consultant's PAs. Employers have a duty to make reasonable attempts to accommodate this. The employee has a right to return to a regular pattern of work.
Flexibility might include doing routine work outside normal hours.
Annualisation would allow employees to vary their weekly commitment, for example, during school holidays, making the time up in term time.

16. JOB PLAN REVIEW

Job planning is a dynamic process designed to match workload with clinical need. It is also your opportunity to improve your work/life balance as your needs and circumstances change.

It is a contractual obligation that you have an annual job plan review with your clinical manager. If your duties and responsibilities have changed significantly within the year you can make the case for an interim review.

In preparing for these you should have a clear idea whether the existing plan accurately reflects the work you do. A workload diary is vital for this.

You will also need information regarding Supporting Professional Activities undertaken as well as thoughts about future objectives, supporting resources and ways to develop both your service and your career. Information arising from your appraisal may help to inform this, should you wish; however the two processes are separate, having different methods and goals.

If a revised job plan is agreed you should confirm the arrangements and timescale for implementation with your medical manager.

Appeals
The job planning process should be in partnership with your manager, to seek mutual agreement. Should this not be possible then you have recourse to a process of mediation followed if necessary by formal appeal. Each Trust should have agreements with the LNC regarding the mediation and appeals process. When appeals panels are being constituted consultants may wish to nominate suitable lay members via their LNC.

Any consultant planning to go to mediation or appeal is advised to take advice from the LNC or the BMA beforehand.

A request for mediation must be made to the Medical Director within two weeks of failing to agree a job plan.

If mediation does not resolve your differences, you should lodge a formal appeal.

17. PRIVATE PRACTICE

A principle of the contract is that there should be no detriment to the NHS from any private practice. The job plan should include references to any regular private work you do. Regular private commitments should be recorded with details of location, timing and the general type of work you will be doing.

Provision of services for private patients should not prejudice the interests of NHS patients. Private commitments should not be scheduled during times when you are scheduled to be working in the NHS. Private commitments should not prevent you from being able to attend an NHS emergency while you are on call for the NHS.

The flexibility within the contract allows for private work to be done in your own time - on leave (not study leave) or when not otherwise scheduled to the NHS, by time shifting and where it causes minimal disruption to your NHS duties. There is no specific limit on the amount of private practice that can be undertaken as long as the above principles and the agreed job plan are adhered to.

Your trust has no right to ask for financial details of your private practice.

Fee paying services (Previously know as Category 2)
Fee Paying Services are services that are not part of Contractual or Consequential Services and not reasonably incidental to them e.g. medico-legal work. Fee Paying, schedule 10 refers to a list of this type of work.

In Scotland, Fee Paying Services are subject to local agreement.

There is a basic principle within the contract that consultants should not be paid twice for the same work and that any extra-contractual work should not conflict with and should only cause minimal disruption to NHS duties. You and your trust can agree for category 2 and fee paying work to continue if it causes minimal disruption to the NHS work or you do it in your own time (either out of hours or by time shifting). It is essential that consultants ensure that there is no conflict between such work and their NHS work. Your LNC may have come to an agreement with your trust regarding this work.

18. ACADEMIC AND HONORARY CONTRACTS

Much of what is written above applies directly to the NHS work of Emergency Medicine consultants working in academic medicine but there are major differences to take into account the needs of academic employment, such as University and Research Council needs. For clinical academic staff, the new contract documentation comprises:

1. An honorary NHS contract, which applies many of the above principles to the clinical academic contract

2. Suggested clauses for insertion into the substantive academic contract, which incorporate the new NHS consultant rates of pay into the university/academic contract

3. Joint guidance (agreed by the university employers, department of health and the BMA), which explains in more detail the inter-relationship of the two contracts

4. Schedule in the NHS Terms and Conditions of Service that specifically outlines which of the NHS TCS apply to clinical academic employment.

As an alternative to the above, clinical academics may choose to contract on an "A+B" basis, where a substantive part-time contract is held with the NHS, and a further substantive part-time contract is held with the academic employer, which together are regarded as a whole. The clinical academic job plan should be discussed and agreed by the two employers and the individual concerned, according to Follett's principles (ref), where the onus is on the employers to resolve any conflicting demands on the academic's time.

NHS PAs
NHS academics will usually have a ratio of Direct Clinical Care to Supporting Professional Activities of 3:1. External duties and additional NHS responsibilities may be especially important to many clinical academics where they do work for the wider benefit of the NHS. NHS based teaching and research should also be recognised in the NHS component of the job plan.

University PAs
There is no prescribed content. This should be based on work diaries and job requirements. There should be an agreed allocation of PAs to university teaching, research and other activities.

The mediation and appeals process allows for additional panel membership to represent the interests of both employers in addition to those of the employee.

The BMA has produced advice on the clinical/academic integrated job plan. The Department of Health and CCIT have also produced guidance.

Contributing Authors

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The College of Emergency Medicine Professional Standards Committee

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APPENDIX 1

The 2003 Contract in Scotland
The Scottish contract is broadly similar to that in England. The transitional arrangements with regard to seniority and back pay were significantly different for those who transferred immediately, but now the contract has been introduced, the differences tend to be in minor areas, unlike the Welsh contract.

Salary scales – the basic salary scales published in 2003 are similar in Scotland and England, although not identical. The pay progression timescale is the same.

Programmed Activities (Scotland) – programmed activities are the same length, both at standard and premium times. However the times considered to be premium are slightly different, being 7pm - 7am in England and 8pm - 8am in Scotland. In Scotland, non-emergency work can be programmed (with agreement) on Saturday mornings (9am- 1pm) although work at this time would be premium rate. Non-emergency work may not be programmed on Saturdays in England.

Waiting List Initiatives (Scotland) – in England rates of pay for waiting list initiative work are negotiated locally, as under the previous contract. In Scotland the rates are made explicit in the terms and conditions, and are 3 times the hourly rate at point 20 on the seniority scale (£507 at 2003-04 rates). Alternatively, by agreement, consultants can receive twice the rate plus time off in lieu, or the standard rate plus twice the time off in lieu.

Mediation and Appeals– the process is broadly similar in England and Scotland. The differences include a role for the Divisional Chief Executive in Scotland, and a slight difference in the appeal panel make up.

Clinical Excellence/Merit Awards – as stated elsewhere, there are currently significant differences, with Scotland retaining the previous UK format. However this is under review at the time of writing.

In Scotland a number of issues have been left to local agreement and may vary from place to place. These issues include whether prospective cover is included, how resident on call will be reimbursed, if undertaken, and provision of cover for forms of leave not otherwise specified. As some of these have a significant impact on workload, leaving them to local agreement is not ideal - particularly as the trend for amalgamating hospitals is likely to continue in the future.

Emergency Medicine consultants should ensure that the Local Negotiating Committee is aware of their views and keeps them informed. Applicants for posts should establish what these agreements are for each post and not assume they are the same throughout Scotland.

APPENDIX 2

The 2003 Consultant contract in Wales
Main Amendments include:

- A basis 37.5 hour working week
- Session duration of 3-4 hours
- Typically 7 sessions of Direct Clinical Care
- Provision that one session of Supporting Professional Activities may take place at home or in the evening allowing uncontracted free time during the day. The Assembly Government has recognised the work undertaken by consultants at home e.g. preparing for teaching, research and CME
- No requirement to provide an extra session of time to the NHS in order to acquire the right to undertake private practice
- Existing unrecognised additional sessions for routine work to be entirely voluntary with no requirement for compulsory weekend or evening work
- A payment escalator for existing additional sessions
- Extra sessions requested by the Trust to be voluntary and locally negotiated, i.e. a time and price acceptable to both you and the Trust
- Payment at three times the sessional rate and a period of compensatory rest for consultants asked to be unexpectedly resident on-call
- In the event of a job-planning dispute, an initial conciliation procedure followed, if necessary, by a balanced and fair appeals procedure that will be binding on the Trust and the consultant
- A commitment award scheme to replace discretionary points, which will depend on achieving a satisfactory job plan. This is funded for 100% of consultants and will be achieved by nearly everyone
- Early enhancement to basic salary, by increasing incremental points
- Recognition of different patterns of work intensity, particularly later in a consultant's career
- A sabbatical scheme
- An intention by the NHS Trusts in Wales to improve working conditions for their consultant workforce
- A good package for part timers and academics particularly with openness about individualised job planning
- Flexibility and professionalism maintained as far as possible in the contract.

Job Planning (Wales)
This is an essential part of the process, it is mandatory, with annual review. It will confirm along with appraisal the Commitment Awards Scheme. The initial process will be subject to an external audit, conducted by the audit commission.

The Working Week (Wales)

- 10 sessions of 3-4 hours
- Average 37.5 hours per week
- Typically 7 Direct Clinical Care sessions
- 3 Supporting Professional Activities sessions
- Unrecognised additional work sessions
- Planned additional work sessions
- Waiting list initiative sessions
- Additional NHS Responsibilities
- On-call/Emergency work.

APPENDIX 3

Supporting Resources

In order to ensure delivery of the objectives identified within the job plan, the resources required to do so must simultaneously be identified. It is the responsibility of directorate or Trust management to ensure these are provided. This is an important new opportunity, and should be considered carefully before agreeing a job plan. If lack of resources prevents objectives agreed at appraisal being achieved, pay progression should not be denied.

These resources might include:

Staffing Support

- Adequate staffing levels within department, to allow absence on CPD activities and other leave
- Resident trainee staff to cover on-call work
- Secretarial support (at least 1 wte secretary/2 wte consultants)
- Technical and IT support
- Managerial support
- Audit support staff.

Accommodation

- Office accommodation as recommended in HBN 26. This suggests that normally one office should be provided for every WTE consultant. The office should be located in a site that is accessible during the normal working day.
- Office space for supporting staff
- Secretarial office(s)
- Common room
- Teaching space
- Clinic space as required
- Appropriate space within ED for changing, rest and refreshment.

Equipment

- Up to date monitors and other resuscitation and other equipment, which comply with published standards and which are regularly serviced
- A dedicated computer for each consultant with access to an appropriate range of programmes and email/internet connection
- Software should be up to date
- Access to confidential telephone and fax facilities
- Access to equipment allowing suitable delivery of teaching, e.g. projectors, flip charts, power-point projector

- Adequate secure storage space, both for paperwork and personal belongings
- Secure locker space in theatre
- A constant supply of all sizes of appropriate clothing e.g. scrubs.

Other

- Funding for study leave
- Timely access to a full range of supporting services such as laboratory services, radiology
- Time allowed for administrative meetings within working hours (DCC)
- Access to up to date library services
- Car or bicycle parking, particularly out of hours, should provide for personal safety as well as protecting the vehicle.

APPENDIX 4

Implications of the Working Time Directive

The Working Time Regulations have applied to consultants' work since 1998. They are health and safety legislation, designed to protect you from being exploited by your employer.

In brief they set a limit, to be in place by 1st August 2009, of 48 hours work, on average, for an employee. This is averaged over a reference period, at present limited to 26 weeks. During the 48 hour week employees should be able to have 20mins break for every 6 hours, 11 hours every 24 and 48 hours every 14 days.

Consultants retain the right to "opt out" of the WTD but they cannot be forced to do so and any such opt out must not be signed at the time of agreeing the contract. The consultant "derogation" is one of the issues currently being reviewed by the EC and there is a proposal to remove this right.

The current position on compensatory rest is under dispute and open to review by the European Commission.

APPENDIX 5

Statement by the College of Emergency Medicine about the role of the Consultant in Emergency Medicine "On Call"

The College of Emergency Medicine is the professional body responsible for setting standards of clinical and professional practice in Emergency Medicine in the British Isles.

This statement outlines the view of the CEM on this matter.

Emergency Departments (ED) should have an Emergency Medicine (EM) Consultant on-call at all times.

The role of the on-call EM consultant* is to provide senior clinical leadership to the ED. This will consist of providing direct clinical care to individual patients, the supervision and support of doctors in training in EM and other specialties and a close working relationship with Departmental and Trust management teams to ensure safe systems and processes are in place for all patients attending with emergency and urgent conditions. A significant proportion of this work will require the consultant to be present within "normal" working hours, to enable engagement with other specialties and Trust management.

An on-call EM consultant may return to the ED to provide direct senior clinical input into selected, serious cases as well as providing telephone advice on clinical, medico-legal and ethical issues. It is also expected that the consultant should be kept informed of any significant departmental events that may represent clinical risk to individual or multiple patients, including excessive attendance numbers, unusual case mix or staffing issues.

Communications of this nature will normally be dealt with by telephone advice and support.

The on-call EM consultant will also provide required clinical leadership in the event of “Major Incident” activation.

When on-call, an EM consultant should not be recalled to hospital solely to deal with a build up of less serious cases, because of excessive waiting times for first assessment or because of potential breaches in the DH operational emergency access standard ("4 hour target").

Each ED and hospital as a whole should be staffed and resourced to a sufficient level to manage what are predictable peaks in workload, 24 hours a day, seven days a week. Where this has not been adequately addressed by a Trust, the on-call EM consultant must not be expected to make up for any deficit in staffing or other resource.

The decision whether to return to the ED or not, is one of a clinical, professional nature and should be a personal decision, made by the on-call EM consultant, in full possession of all relevant contemporaneous information. It is not appropriate for a

manager (clinical or non-clinical) nor for a clinician in another specialty, to make this decision.

Under the Working Time Directive, consultants, as with other workers, should have 11 hours uninterrupted rest in every 24-hour period. This is to ensure the health and safety of patients and of the consultant.

Where an EM consultant does have sleep interrupted either by a return to work or by a telephone call(s) while on-call, then arrangements must be in place to ensure that they can take any appropriate compensatory rest time as soon as is practical, after completion of the on-call period.

As a guide, compensatory rest time equates directly to time spent on telephone calls and any additional, rest-interrupting, work-related activity or to time spent on returning to the ED, measured from the point of first receipt of call necessitating the return, to the time of arrival back home.

Any such compensatory rest is disruptive to the day to day running of an ED and, for this reason, working arrangements should be organised to ensure that recall of the EM consultants is kept to a minimum.

**For the purpose of this document, the term "consultant" refers to that doctor, on the ED senior on-call rota, who has the responsibility to respond to any telephone calls for advice or to return to the ED for the specific reasons discussed in the document.*

Note: Supervision to trainees in Emergency Medicine of ST4 and above, can, normally, only be provided by a consultant who is on the specialist register in Emergency Medicine.

APPENDIX 6

Links to useful websites and documents

- Advisory Committee on Clinical Excellence Awards (ACCEA): http://www.dh.gov.uk/ab/ACCEA/index.htm
- British Medical Association: www.bma.org.uk
- The College of Emergency Medicine: www.collemergencymed.ac.uk
- Department of Health (England): www.dh.gov.uk
- Department of Health, Social Services and Public Safety (Northern Ireland): www.dhsspsni.gov.uk
- NHS Employers: www.nhsemployers.org
- NHS Scotland: www.show.scot.nhs.uk
- NHS Wales: www.wales.nhs.uk

Consultant Contract Information:

- England: www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/Modernisingpay/Consultantcontract/DH_4051508
- Scotland: www.paymodernisation.scot.nhs.uk/consultant/index.htm
- Wales: www.wales.nhs.uk/sites3/page.cfm?orgid=433&pid=3907