

The Consultant Handbook

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Contents

Employment of consultants	5
The pre-2003 national consultant contract	7
The 2003 consultant contract	18
Terms and conditions of service common to the two contracts	35
Job planning	57
European Working Time Directive (EWTD)	64
Redundancy	68
Pensions	72
Clinical excellence awards (CEAs)	80
Private and independent practice	87
Working in the new NHS	103
Consultant appointments procedures	106
Disciplinary procedures and exclusions	113
Appraisal	121
General Medical Council (GMC)	131
Health	138
NHS reform – Darzi Next Stage Review	148
Workforce planning	150
Clinical academics	152
The clinical team	160
Clinicians in management	167
NHS structure	172
Health and hospital records	183
The British Medical Association (BMA)	190
Acronyms	195
Index	197

This handbook applies to consultants working in England only.

Employment of consultants

NHS Trusts

The vast majority of consultants working in the NHS in England are employed directly by Trusts, whether NHS Trusts, foundation trusts or primary care trusts (PCTs). Each Trust is entitled to determine its own contracts and terms of service for its employees, including consultants. However, very few NHS employers deviate significantly from national agreements and the Department of Health (DH) expects all NHS Trusts to offer the 2003 consultant contract to all consultants. It is possible, however, that the freedoms offered to foundation trusts may result in some future divergence from national terms of service. With extended plurality of healthcare providers in the NHS, it is also possible that consultants will increasingly work for alternative providers or indeed as independent contractors to the service. For consultants who are working in this way, or considering doing so, BMA Business Support offers a suite of guidance on areas such as business planning and tendering for contracts. This guidance for members can be accessed here:

www.bma.org.uk/about_bma/benefits_for_members/bma_business_support/index.jsp

Local and national negotiations

National NHS terms and conditions of service are negotiated through the Joint Negotiating Committee for senior hospital doctors (JNC(S)). The committee normally meets twice a year to discuss and negotiate issues surrounding changes and/or additions to the national contracts. It includes representatives from the BMA, the DH and NHS Employers. Because of the autonomy NHS employers have for determining their own contracts, the BMA has worked hard to ensure that medical staff have appropriate local negotiating machinery in Trusts to complement the national structures. The role of these local negotiating committees (LNCs) is to ensure that national terms and conditions of service are applied, to provide a formal mechanism to negotiate any proposed changes to local contractual arrangements and to negotiate around any local flexibilities that exist in national agreements. The overwhelming majority of Trusts have an LNC consisting of doctors elected by their colleagues to negotiate with Trust management.

Where LNCs have been set up according to BMA guidelines they are formally accredited by the Association. This means that they receive advice and support from BMA staff, and their members receive training in negotiating skills and are protected by trade union law.

It is vital that members of the Association who are considering appointment to a particular Trust request information on the terms and conditions of service that will apply. For advice and information on consultant terms and conditions of service, contact *askBMA*.

Consultant contracts

The following four sections of the handbook deal with contracts and the terms and conditions of service for NHS employed consultants. There are two distinct employment contracts in England, but there are some common terms of service, therefore, the handbook has been divided up as follows:

- the pre-2003 national consultant contract – a small number of consultants appointed before 1 November 2003 retain this contract but it is not on offer to new appointments
- the 2003 consultant contract – the vast majority of consultants and all new appointments are employed under this contract
- terms and conditions of service common to the two contracts
- job planning – job planning has been a theoretical requirement since 1991 but the new consultant contract has placed more emphasis on it. There are common job plan themes for both contracts.

See page 152 for information about clinical academic contracts.

The pre-2003 national consultant contract

The current form of the 'old' pre-2003 national consultant employment contract was determined by an agreement in 1979 between the DH and the medical profession and was set out in the health circular PM(79)11, in which three types of consultant contract are defined: the whole-time contract, the maximum part-time contract, and the part-time contract. This contract has not been available to newly-appointed consultants since 31 October 2003.

Types of contract

Whole-time and maximum part-time contract holders have an identical contractual commitment to devote substantially the whole of their professional time to their NHS duties. Their contracts are termed professional in that they do not specify particular hours of work. However, a consultant enters into a job plan as part of the contract which sets out specific commitments that must be met (see page 57).

The work commitment of a consultant is considered to be the same whether the contract is whole-time or maximum part-time, that is, a 'full-time' commitment to NHS duties. However, there is a formal definition in the terms of service only in respect of the maximum part-time contract, which is defined as a minimum of 10 notional half days (NHDs) where an NHD is defined as being three and a half hours flexibly worked. Many contracts describe the commitment for whole-time and maximum part-time posts in terms of the number of NHDs. Because there is no difference between whole-time and maximum part-time appointments in this regard, ie a minimum of 10 NHDs, this could be misleading or inaccurate. It is recommended that contracts state either whole-time or maximum part-time rather than specifying the number of NHDs. The key difference between whole-time and maximum part-time contracts relates to the limitations placed upon private practice. (See 'Terms and conditions of service common to the two contracts' for further details.)

Whole-time contract holders are limited to deriving no more than the equivalent of 10 per cent of their gross NHS earnings from private practice. Maximum part-timers receive 10/11ths of the whole-time

salary, but are free to earn an unlimited income from private practice and 'category 3' work (see page 14). A detailed examination of the rules on private practice can be found on page 87.

With the agreement of their employer, whole-time or maximum part-time contract holders can voluntarily switch from one form to the other, although the workload commitment remains unaltered. Change from whole-time or maximum part-time to part-time again can only be with the agreement of the employer. The rules in relation to private practice income, as outlined above and described in detail on page 87, can require a whole-time consultant to move to a maximum part-time contract and limit his/her ability to revert to whole-time. In any event, consultants are advised to avoid any suggestion that they are exploiting the provisions to move between the different types of contract. Consultants may also enter into temporary, non-pensionable contracts to work additional NHDs. Maximum part-time consultants can also include up to 30 minutes of travelling time each way from their home (or private consulting rooms) to work in their NHD calculations.

Maximum part-time contract holders should also be aware that their service for pension purposes will be reduced. Part-time contract holders have a work commitment of between one and nine NHDs. Part-timers are paid 1/11th of the whole-time consultant salary for each NHD plus the same proportion of any distinction award or discretionary points held. Unlike whole-timers and maximum part-timers, there is no contractual obligation on part-timers to devote substantially the whole of their professional time to the NHS. There is, therefore, no limit on the private practice income a part-timer may earn. All NHDs up to a maximum of 11 will be counted towards pensionable service except those which are temporary additional NHDs (see page 10). The position of part-timers under the new contract is covered on page 30.

Fixed and flexible commitments

Under the pre-2003 contract, consultants' NHDs are divided between 'fixed' and 'flexible' commitments.

Fixed commitments

These are regular scheduled NHS activities. They are formally defined as those that substantially affect the use of other NHS resources, such as other staff or facilities. Examples of fixed commitments include operating lists and outpatient clinics. Some work may or may not be a fixed commitment depending on whether or not it is a regular scheduled activity. Fixed commitments should be fulfilled, except in an emergency or with local management's agreement, which should not be unreasonably withheld. Depending upon the type of contract consultants hold, along with several other factors, the number of fixed commitments should be as follows:

Whole-timers and maximum part-timers: normally between five and seven NHDs per week. Other part-timers, job-share contracts and honorary contract holders: normally at least half of the NHDs covered by the NHS contract.

In deciding upon the number of fixed commitments, all other components of the job plan must be taken into account. It is recognised that the 'normal' number of fixed commitments may be varied with the agreement of the consultant and the medical director in the light of all other factors that are covered by the job plan. If, for example, a consultant has onerous on-call rota commitments, with few junior staff, in a hard-pressed specialty, it would be appropriate to reduce the number of fixed commitments accordingly. Specialty also has a bearing on the number of fixed commitments in that in some specialties a higher number of fixed commitments may be more reasonable than in others. The type of hospital, number of sites, location of hospital and numbers of junior staff should also be taken into account.

Honorary contract holders: the number of fixed commitments is agreed by the consultant and the chief executive in consultation with

the dean or head of the academic department in respect of service commitments of university staff. NHS employers should be more flexible in the way in which NHS commitments are fulfilled by members of academic staff, and should be prepared to agree temporary variations to the number and timing of fixed commitments where necessary.

Flexible commitments

As well as setting out the consultant's fixed commitments, the consultant's job plan (see page 57) should also set out clearly the total number of hours spent each week on NHS duties, including non-fixed commitments – commonly referred to as 'flexible' commitments under the pre-2003 contract.

Temporary additional NHDs

In addition to their normal contractual duties, consultants may be contracted for temporary additional NHDs (defined as the equivalent of a period of three and a half hours flexibly worked). With regard to the number of temporary additional NHDs, the terms and conditions of service state that 'these should not normally exceed two, except in exceptional circumstances where work is being undertaken that is clearly in addition to normal duties agreed under the inclusive professional contract'. Additional NHDs are regularly paid to consultants who undertake:

- managerial work (eg as clinical or medical director)
 - additional clinical work (eg to cope with short-term demand or to cover work otherwise done by absent colleagues)
 - special responsibilities (eg as clinical tutor or audit coordinator).
- Contractual basis of and payment for any temporary additional NHDs
- temporary additional NHDs are not covered by the consultant's standard contract of employment, but form part of a separate contract
 - this separate contract is reviewable not less than annually and is terminable at three months' notice on either side
 - extra NHDs are each paid at the rate of 1/11th of the appropriate whole-time salary (including discretionary points or local clinical excellence awards (CEAs)). Where a consultant is in receipt of a

distinction award or national CEA, temporary additional NHDs will be calculated as if the consultant had reached point eight of the discretionary point pay scale or level nine of the local CEA scale.

- maximum part-timers' private practice rights are unaffected if they are contracted for temporary additional NHDs
- temporary additional NHDs are not pensionable. However, in the circumstances of a straightforward alteration to the job plan, for example where clinical NHDs are replaced, with those for managerial duties as a clinical director, and there is no difference in overall contractual commitment, there is no effect on pensions.



Information

- > [Terms and Conditions of Service, paragraph 14](#)
- > [AL\(MD\)5/98 Calculation of temporary additional notional half days](#)
- > [HC\(90\)16, Consultants' Contracts and Job Plans](#)

Intensity supplements scheme

Background

The intensity supplements scheme was introduced in November 2000 and still applies to consultants on the pre-2003 contract. The payments were introduced in recognition of the increasing volume and intensity of consultant workload, particularly in the out-of-hours period.

General features of the scheme

- Payments are in the form of annual pensionable salary supplements.
- The scheme is a contractual entitlement for all consultants on pre-2003 national terms and conditions of service (and by extension for those whose local contracts mirror the national terms).
- Clinical academic staff and locums are also eligible for payment.
- Payments can be withdrawn only where there is prima facie evidence that consultants are not complying with their agreed job plan.

Specific provisions

There are two types of supplement: a flat rate daytime intensity supplement and a banded out-of-hours supplement. Daytime intensity supplements are paid as follows:

- the payment is made to all consultants, but delayed for two years after the first appointment to a consultant post. On the second anniversary of appointment a consultant would qualify for 50 per cent of the payment and after three years receive the full payment
- whole-timers and maximum part-timers receive the full supplement. Part-timers receive the appropriate NHD proportion of the payment. Clinical academic staff receive a proportion of the payment according to the formula used for the payment of distinction awards. In addition to the daytime supplement, consultants may qualify for an out-of-hours supplement in one of three bands, paid as follows:
- the appropriate supplement is determined by completion of a questionnaire assessing the level of intensity by such factors as rota commitments, frequency of telephone calls and recall, or late working both when on call and when not on call. The questionnaire has a fixed scoring system which indicates the appropriate banding without the need for the exercise of any judgement by the employer
- irrespective of their type of contract, consultants receive whichever level of payment is indicated by the scoring system (ie there are no part payments).



Information

> AL (MD) 5/2000, NHS Executive, November 2000

Category 1 and 2 work

There are three categories of work for consultants working under the pre-2003 terms and conditions of service. Diagnosis, treatment or prevention of illness of NHS patients and related examinations and reports are known as category 1 work and this will form the basis of a consultant's contract with their Trust. Examinations and reports not regarded as part of NHS contractual duties can command a fee. These services are described as category 2 work under the old contract. Category 2 work should not be confused with private practice (see page 87) or category 3 work (see overleaf).

A report on a patient not under observation or treatment at the hospital, often for a third party, which may involve a special

examination, is category 2 work, in which case a fee may be charged. (If the patient is under observation or treatment at the hospital, reports for a third party not requiring a special examination are usually category 1 work.) Examples of category 2 work include medical examinations for life insurance purposes, and reports and examinations for coroners. BMA guidance schedules on fees for part-time medical services are available from askBMA and on the askBMA section of the BMA website www.bma.org.uk

Charges for the use of hospital facilities

Where consultants use NHS services, accommodation or facilities in carrying out category 2 work, a reasonable fee is payable to the hospital as payment for hospital costs. Trusts may now determine the level of charges for using their facilities. However, a sum is not payable to the employer when undertaking coroners' post mortems, as special provisions apply. The CCSC does not regard secretarial and other office support as services for the purpose of the rule. It is the view of the CCSC that where the consultant who has been requested to provide the report requires an investigation from another department headed by a consultant, for example a radiology department, the radiologist would also be entitled to charge a fee, a proportion of which would be due to the employer for the use of NHS facilities. In this case, the first consultant would not be required to pay the employer a proportion of the fee unless the first consultant had used NHS facilities. The two consultants should charge the client separately for their services, but it is considered good practice for the first consultant to inform the client/patient in advance that a report from another department will be required and that there will be a separate bill.



Information

- > Terms and Conditions of Service, paragraphs 30-38
- > The Walden Report on 'The Review of Category 2', Department of Health
- > PM (81) 30B, paragraph 34

Category 3 work

Category 3 work is a term coined by the CCSC to describe extra work undertaken on NHS patients by separate arrangement outside the principal contract of employment. An example of category 3 work is work under the waiting list initiative. The position on the treatment of the category 3 earnings of whole-time consultants is as follows. Patients treated under such arrangements remain NHS patients and should continue to be treated as such. However, such work is under a separate contract, and is not subject to the terms and conditions of service of hospital medical and dental staff. Any income will count against the 10 per cent limit even though there is no private arrangement between doctor and patient and the patient remains an NHS patient. This does not include the situation where the employer and the practitioner have entered into a separate contract for an additional NHD to undertake work which is not part of their contractual duties. Consultants carrying out this type of work should ensure in each case that the work is covered either by NHS medical indemnity, by another employer's indemnity or by their defence body, taking out additional cover if necessary (see page 52). Consultants are also advised to ensure that they have proper contracts in place for this work.



Information

- > [Terms and Conditions of Service, paragraphs 42-43](#)
- > [AL\(MD\)4/94 – Treatment of Earnings from Work outside the Principal Contract of Employment](#)

Domiciliary visits

(See page 28 for arrangements under the 2003 contract)

Definition

Where medically necessary, the services of specialists may be provided at the home of the patient. A domiciliary consultation is defined as a visit to the patient's home, at the request of the general practitioner (GP) and normally in his or her company, to advise on the diagnosis or treatment of a patient who on medical grounds cannot attend hospital. The definition does not include:

- visits made at the consultant's own instigation to review the urgency of a proposed admission or to continue treatment initiated in hospital
- any visits for which separate fees are payable under the community health service.

Fees

Consultants are entitled to claim a fee at a standard rate for each domiciliary consultation they undertake, up to a maximum of 300 per year. These fees are pensionable (see page 72). Normally the payment is limited to an overall maximum of three consultation fees during any one illness. The standard rate of fee applies to a series of visits by a pathologist to carry out anti-coagulant therapy or to supervise treatment with cytotoxic drugs, and also to a series of visits jointly by a psychiatrist and an anaesthetist to administer electro-convulsive therapy.

Additional fees are payable at a lower intermediate rate for operative procedures (other than obstetrics which attracts the standard rate), for use of the consultant's own apparatus and for the administration of a general anaesthetic. Where a number of patients are seen at the same residence or institution in the course of one domiciliary visit, the first case attracts a fee at the standard rate, and up to three further cases may be remunerated at the intermediate rate.



Information

- > [Terms and Conditions of Service, paragraphs 140-154](#)
- > [RHB\(51\)11 – Specialist Service in the Patient's Home](#)
- > [BMA Fees Guidance Schedule 3: Miscellaneous work in the NHS](#)

Exceptional consultations

Consultants who are called in exceptionally for a special visit because of unusual experience or interest, and provide this service for a hospital managed by a different employer, should also be paid a fee by the visited hospital which covers any operative work or other procedures.



Information

- > Terms and Conditions of Service, paragraph 155
- > BMA Fees Guidance Schedule 3: Miscellaneous work in the NHS

Family planning in hospitals

(See page 28 for the situation under the 2003 contract)

The provision of family planning services in hospitals does not form part of consultants' contractual duties, but is the subject of separate arrangements between consultants and their employers. Consultants (normally general surgeons, gynaecologists or urologists) are expected to reach agreement with the employer on the number of family planning cases to be accepted each year. They then receive remuneration on a per case basis at a rate reviewed annually by the Doctors and Dentists Review Body (DDRB). Anaesthetists, pathologists and radiologists need not enter into any special agreements but are entitled to a fee in respect of each family planning case in which they are involved.

A condition of participation in family planning arrangements is that there should be no reduction in consultants' responsibilities and volume of work under their main NHS contract. Subject to that, family planning work can be undertaken at any time. In practice, the budgets set for family planning work by Trusts have often been too low, or may be reduced during the year in order to make savings. In these circumstances pressure may be brought to bear on consultants to continue providing the service without remuneration. Consultants should not agree to do so, since these arrangements are the subject of a national agreement which explicitly recognises that the work is additional to consultants' NHS obligations and, as such, is separately remunerate.

The national agreement does allow that, in exceptional circumstances, family planning work could be included as part of a consultant's NHS contract. In this case the work would be assessed in NHDs and remunerated as part of the consultant's basic salary. However, individual arrangements of this kind may be made only with the agreement of the JNC(S) (see page 5).



Information

- > HP(PC)(76)20, Family Planning in Hospitals
- > 1974 Memorandum of Guidance of Family Planning Services (HSC(IS)32)
- > HN(89)9, Income Generation Initiative – Section 5 of the NHS Act 1977 EL(91)63
- > BMA Fees Guidance Schedule 4: Family planning

Lectures

The rate for lecture fees for consultants on the pre-2003 contract is reviewed annually by the DDRB.

Lectures to non-medical staff

When consultants give a lecture to nurses and non-medical staff, the fee is limited to the number of lectures authorised by the employer for the subject in question.

Lectures to medical staff

Consultants' fees for lectures on professional subjects to medical staff should be paid by the employer of the majority of the hospital staff who attend the lecture. Where this does not apply, the consultant's employer should pay the fee provided that the lecture forms part of a recognised programme of postgraduate education and that no other fee is received for the lecture. Fees are not payable for any lecture given during the course of consultants' clinical duties to teach other practitioners who are working under their clinical supervision. Where a fee is payable, travelling and subsistence expenses may be claimed (see page 112).



Information

- > Terms and Conditions of Service, paragraphs 165-166
- > BMA Fees Guidance Schedule 3: Miscellaneous work in the NHS

Transferring to the 2003 contract from the old contract

Consultants in post prior to 31 October 2003 have the option to transfer to the 2003 contract or retain their existing terms. Such consultants can choose to transfer to the new arrangements at any point in the future (see page 33 under the 2003 contract section for further details).

The 2003 consultant contract

Since 31 October 2003, the '2003 consultant contract' has been the only contract permissible for new NHS consultant posts, including locums. Consultants in post before 31 October 2003 had, and still have, the choice of moving on to the new terms and conditions of service or remaining on the previous contract. Consultants working as clinical directors, medical directors, or directors of public health are covered by this new contract.

The basic work commitment

The 2003 contract is based on a full-time work commitment of 10 programmed activities (PAs) per week, each having a timetabled value of four hours (or three hours if the PA is undertaken in premium time – see below). Each consultant must have a job plan that sets out the number of agreed PAs the consultant will undertake, plus a list of the duties he or she is expected to perform within those PAs. A key feature of the 2003 contract is that it provides a clear maximum commitment to the NHS, including work done while on call. Depending on the scheduling of work, this could mean a basic commitment of less than 40 hours, with no requirement to work in excess of this. Any additional work above 10 PAs will be by agreement and paid at the full appropriate rate. There are additional conditions applying to consultants wishing to undertake private practice (see page 87).



Information

> [Consultant contract 2003](#) (See also the section on 'Terms of service common to the two contracts')

The working week

A full-time consultant's job plan of 10 (or more) PAs will consist of work from any of the following categories as defined in the terms and conditions of service.

Direct clinical care (DCC): work directly relating to the prevention, diagnosis or treatment of illness that forms part of the services provided by the employing organisation under section 3(1) or section 5(1)(b) of the National Health Service Act 1977. This includes emergency duties

(including emergency work carried out during or arising from on call), operating sessions including pre-operative and post-operative care, ward rounds, outpatient activities, clinical diagnostic work, other patient treatment, public health duties, multidisciplinary meetings about direct patient care and administration directly related to the above (including but not limited to referrals and notes).

Supporting professional activities (SPA): activities that underpin DCC. This may include participation in training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities. Additional NHS responsibilities: special responsibilities (not undertaken by the generality of consultants in the employing organisation) which are agreed between a consultant and the employing organisation and which cannot be absorbed within the time that would normally be set aside for supporting professional activities. These include being a medical director, director of public health, clinical director or lead clinician, or acting as a Caldicott Guardian, clinical audit lead, clinical governance lead, undergraduate dean, postgraduate dean, clinical tutor or regional education adviser. This is not an exhaustive list.

External duties: duties not included in any of the three foregoing definitions and not included within the definition of fee-paying services or private professional services, but undertaken as part of the job plan by agreement between the consultant and employing organisation. These might include trade union duties, undertaking inspections for the Healthcare Commission, acting as an external member of an advisory appointments committee, undertaking assessments for the National Clinical Assessment Authority, reasonable quantities of work for the royal colleges in the interests of the wider NHS, reasonable quantities of work for a government department, or specified work for the General Medical Council (GMC). This list of activities is not exhaustive.

BMA guidance on additional duties can be found here:

www.bma.org.uk/employmentandcontracts/working_arrangements/job_planning/externalduties150307.jsp

The job plan will set out the number of PAs for each of the different types of activities above. It will also set out the duties the consultant is expected to perform within those PAs. See the job planning section on page 57 for more information on job plans.



Information

- > [Terms and Conditions of Service 2003, definitions](#)
- > [Job Planning: A Summary for Consultants new to the 2003 Contract in England and Northern Ireland, CCSC September 2004](#)

Balance of activities

The contract sets out that in a 10 PA job plan there will typically be an average of 7.5 PAs of DCC and 2.5 PAs of supporting professional activities. There is flexibility to agree a different balance of activities. For example, if a consultant has additional NHS responsibilities to carry out, such as being a clinical governance lead, they may reduce their DCC activities to fit this additional work into a 10 PA job. Alternatively, they may agree to undertake extra PAs in addition to the standard 10 per week.

It is recognised that part-time consultants need to devote proportionately more of their time to supporting professional activities, for example due to the need to participate in continuing professional development to the same extent as their full-time colleagues. The following table gives examples of the usual balance between DCC PAs and SPAs for part-time consultants:

Total programmed activities	Direct clinical care	Supporting professional activities
8	5.5	2.5
6	4	2



Information

- > [Consultant contract 2003, paragraph 7.3](#)
- > [Part-time and flexible working for consultants: An agreement between the BMA Central Consultants and Specialists Committee and the Department of Health for Consultants in England \(September 2003\)](#)

Emergency on-call work

The job plan should set out a consultant's duties and responsibilities in respect of emergency on-call work. Under the new contract, emergency work is recognised in three ways.

On-call availability supplement

Consultants on an on-call rota are paid an on-call availability supplement in addition to basic salary which recognises the inconvenience of being on a rota and the duty to participate in it. The level of supplement will depend upon the contribution to the rota and the nature of the response required for both full and part-time consultants. For determining which frequency band a consultant falls into, prospective cover should not be taken into account.

Number on on-call rota	Value of supplement as a percentage of full-time basic salary	
	Category A	Category B
High frequency: 1 – 4 consultants	8.0%	3.0%
Medium frequency	5.0%	2.0%
Low frequency	3.0%	1.0%

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.

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

The CCSC has produced guidance to help consultants and their managers determine which category applies to them. The guidance can be found here:

http://www.bma.org.uk/employmentandcontracts/working_arrangement_s/job_planning/Oncallsuppl.jsp

Consultants will always be paid the full value of an on-call supplement. If part-time consultants participate in the rota on the same basis and as frequently as their full-time colleagues, they will receive the same supplement as their colleagues. However, if they participate in the rota on a different basis they will receive the percentage supplement that a consultant on an equivalent rota would have received. For example, if a five PA part-time consultant was in category A for a rota with five other consultants, but only worked half the rota (1 in 12 on average), they would receive a supplement worth 3 per cent of a full-time salary (based on their own pay threshold). They would not get half of a 5 per cent supplement.



Information

> [Terms and Conditions of Service 2003, schedule 16](#)

The on-call availability supplement recognises the inconvenience of being available while on call. It does not recognise the work actually done while on call. The new contract explicitly takes account of the work done by allocating an appropriate number of PAs within the weekly job plan.

For many consultants, there will be a predictable amount of emergency work arising from on-call duties (operating lists, ward rounds, administration etc). The consultant and the employer should monitor the number of hours worked over the period of the rota and calculate the average number of PAs of emergency work done per week. Prospective cover should be factored into the calculation (see below). There is no limit on the amount of predictable on-call work that can be allocated to DCC PAs.

Some emergency work will also be unpredictable and the same approach to calculating average weekly PAs spent in this type of activity should be taken. Diary evidence will be key to calculating the PA allocation fairly. Allocations for unpredictable on-call work should not normally exceed an average of two PAs per week. If unpredictable

on-call work exceeds this level, a local agreement should be reached or the job plan and on-call commitment reviewed.

The allocation of emergency PAs should be reviewed and adjusted as necessary at the annual job plan review, or whenever the consultant or the employer believes that emergency workload has changed.

Definitions of emergency work (as set out in the terms and conditions of service): Predictable emergency work: this is emergency work that takes place at regular and predictable times, often as a consequence of a period of on-call work (eg post-take ward rounds). This should be programmed into the working week as scheduled PAs.

Unpredictable emergency work arising from on-call duties: this is work done while on call and associated directly with the consultant's on-call duties (except in so far as it takes place during a time for scheduled PAs), eg recall to hospital to operate on an emergency basis.



Information

> [Terms and Conditions of Service 2003, definitions and schedule 5](#)

Prospective cover

If a consultant covers colleagues' on-call duties when they are away on study leave and annual leave, this prospective cover should be taken into account when assessing workload for both types of emergency work (though not the consultant's on-call availability supplement). With six weeks' annual leave, on average two weeks' study leave and statutory days, consultants are likely to be covering nearly 10 weeks of each colleague's duties. This may mean a consultant's average out-of-hours workload is up to 24 per cent greater in the week and 18 per cent greater at weekends than that measured when nobody is on leave. In reality, consultants can do 52 weeks of on-call work in 42 weeks at the hospital.

Resident on call

There is no obligation for a consultant to be resident on call at night. Where a consultant agrees to be resident at night, the rate payable is for local agreement. The BMA believes that this should be substantially higher than standard or premium time rates.

The CCSC has produced guidance on shift working and resident on-call work for consultants which can be found here:

www.bma.org.uk/employmentandcontracts/working_arrangements/work_patterns/resoncall0109.jsp



Information

> [Terms and Conditions of Service 2003, schedule 8, paragraph 4](#)

Duty to be contactable

It is expected that while on call, the consultant must be easily contactable. However, it is possible for the consultant to agree with his/her employer not to be contactable for a period of time. The contract also sets out that the employer may, in exceptional circumstances only, ask a consultant who is not on an on-call rota to return to site for emergencies provided they are able to contact him/her.

Private practice and on-call work

Except in an emergency, private work and fee-paying services should not be undertaken while on call unless the consultant's rota frequency is one in four or more frequent and he or she is in category B for on-call supplements. Additionally, prior approval must be sought from the NHS employer.



Information

> [Terms and Conditions of Service, schedule 8, paragraphs 1 and 5](#)

Additional PAs

The consultant may agree with the employer to work more than the standard 10 PAs. There is no obligation on the consultant to work more than 10 PAs (but note the potential impact on pay progression

– below) and there is equally no obligation on the employer to offer more than 10 PAs. Where a consultant agrees to work extra PAs, these are payable at a rate of 10 per cent of basic pay, plus any discretionary points or local CEAs (see page 83). Where a consultant holds a distinction award (an A+, A or B award), extra PAs should be increased pro rata at the rate of eight discretionary points. Where a consultant holds a national CEA (level 9-12), the extra PAs should be uprated pro rata at the rate of nine CEAs. A separate contract should be agreed with the employer for any additional PAs. The additional contract can be set out in terms of a regular fixed number of PAs to be worked per week, or alternatively it could set out an annualised arrangement for a number of PAs to be worked per year.

Model APA contracts for consultants are available on the NHS Employers website here: www.nhsemployers.org

Private practice and extra PAs

There is no obligation for a consultant to undertake PAs in excess of the standard 10 per week, but one of the criteria for achieving progression through the pay thresholds is that consultants should accept an extra paid PA in the NHS, if offered, before doing private work. See page 89 in the private practice section for further details.

Premium time

The 2003 contract recognises the unsocial nature of work done at certain times of the week and defines the time after 7pm and before 7am during the week and any time during the weekend as 'premium time'. Non-emergency work cannot be scheduled during these times without the agreement of the consultant and there should be no detriment to pay progression or any other matter if a consultant refuses to undertake non-emergency work in premium time.

During premium time the length of a PA is reduced to three hours (rather than four) or, by agreement, the rate of pay for a four-hour PA increases to the equivalent of 'time-and-a-third'. A maximum of three PAs per week can be reduced in this way.

However, local arrangements can be negotiated if more than three premium time PAs per week on average need to be worked.



Information

> [Terms and Conditions of Service 2003, schedule 7](#)

Location of work

It is generally expected that PAs will be undertaken at the principal place of work, which must be set out in the consultant's individual contract. Other work locations must be set out in the job plan, and it is possible for a consultant to agree off-site working for some supporting professional activities. Indeed, It may be appropriate and helpful to both consultant and employer to agree that some SPAs are worked from home. There is also a clause in the 2003 contract which requires a consultant to work at any site with the employing organisation, including new sites.



Information

> [Consultant contract 2003, paragraph 4](#)

Travelling time

Travelling time between the principal place of work and other work sites is included as working time, and should be included within the category of work (eg DCC, SPA) for which the journey is necessary. Travel to and from work for NHS emergencies, and 'excess' travel, also count as working time.



Information

> [Terms and Conditions of Service 2003, schedule 12, paragraphs 10 and 11](#)

Pay elements

Pay thresholds for consultants appointed prior to November 2003
For consultants appointed prior to November 2003 (termed 'existing consultants' hereafter), pay progression arrangements are set out in schedule 13 of the terms and conditions of service. Basic pay depends on a consultant's 'seniority'. Seniority is calculated by combining

completed years as a consultant with the point on the salary scale when first appointed (on a scale of 1 to 5) and then adding any additional credited seniority. Additional seniority may be given if the consultant has any consultant-level experience gained outside the NHS, or if the consultant has undergone flexible training or dual qualification. The number of years of seniority determines the consultant's pay threshold on commencement and rate of progression through the thresholds. Progression through pay thresholds becomes possible on the anniversary of transfer to the new contract.

Pay thresholds for consultants appointed after 31 October 2003

Consultants appointed after 31 October 2003 are appointed to the bottom of the salary scale unless they have consultant-level experience gained outside the NHS or if they have participated in flexible training or undergone dual qualification. For consultants appointed after that date, schedule 14 applies. Progression through pay thresholds becomes possible on the anniversary of the date on which they started work under the new terms.

Information

> [Terms and Conditions of Service 2003, schedules 13 and 14](#)

Pay progression

The value of the thresholds is set out annually in a Pay Circular from NHS Employers. The first four pay thresholds are awarded at one-yearly intervals and the next three thresholds are awarded at five-yearly intervals; in effect it is a 19-year pay scale.

It is explicitly stated in the terms and conditions of service that it will be the norm for consultants to progress through the pay thresholds unless they have demonstrably failed in any one year to:

- take part in the appraisal process
- made reasonable efforts to meet job plan requirements
- take part in a job plan review and set personal objectives
- make every reasonable effort to meet personal objectives
- work towards any identified changes linked to the organisation's objectives

- take up an extra paid PA (if offered) if they want to work privately (see page 89)
- work in line with the contract's private practice standards (see page 87).

The chief executive must agree that the consultant has met the criteria. Employers cannot introduce any new criteria and specifically, pay progression cannot be withheld or delayed on grounds of the employer's financial position. It is important that job planning ensures that consultants are supplied with adequate supporting resources to fulfil the objectives agreed in their job plans. See the job planning section for more details. There is a right of appeal against the chief executive's decision to withhold pay progression (see page 32).



Information

> [Terms and Conditions of Service 2003, schedules 13 and 14](#)

Fee-paying work

Fee-paying work (formerly called category 2 work – see page 12) is work that is not part of a consultant's contractual or consequential services, but is also not classed as private practice. This includes, for example, work required for life insurance purposes, work for the coroner and family planning work.

An underlying principle of the new contract is that consultants should not be paid twice for the work they do. A consultant undertaking fee-paying work can keep the fee due if they are doing the work in their own time, ie not in NHS PAs, or if they 'time-shift' so that their NHS work is unaffected, or if the work is, by agreement, only minimally disruptive to NHS activities. In all other circumstances the consultant should remit the fee to the employer.

In the same way, fees for domiciliary visits should only be kept if the consultant undertakes them in his or her own time, or if agreement is reached with the employer.

Relationship between private work, NHS work and fee-paying work
The 2003 contract clarifies the relationship between NHS work, private work and fee-paying work in that it sets out that a NHS consultant's first responsibility is to the NHS. Participation in private medical services or fee-paying services should not result in detriment to NHS patients or services or diminish the public resources available for the NHS. This relationship is set out clearly in schedule 9 of the TCS and in the 'Code of conduct on private practice' agreed between the DH and the CCSC as part of the consultant contract negotiations in 2003 (see page 87). Essentially, consultants should not schedule private work or fee-paying work at the same time as NHS activities, unless there has been a prior agreement with the NHS employer.



Information

- > [Terms and Conditions of Service 2003, schedules 9, 10 and 11](#)
- > [A Code of Conduct for Private Practice: Recommended Standards of Practice for NHS Consultants](#)
- > [Interface between NHS and private treatment: Guidance from the medical ethics department, BMA, February 2004](#)

Recruitment and retention allowances

In certain circumstances, employing organisations may pay consultants a recruitment or retention premium. These can be paid as a single sum, or on a recurrent basis for a time-limited period (typically up to four years). The value of the premium will normally not exceed 30 per cent of the normal starting salary for a consultant post. Employing organisations must demonstrate the need for the recruitment/retention premium.



Information

- > [Terms and Conditions of Service 2003, schedule 16, paragraphs 12-14](#)

Directors of public health supplements

Directors of public health are entitled to banded supplements (A-D) in addition to basic salary as set out annually in NHS Employers pay circulars. Eligibility for each band depends upon the populations served by the post and the weight of the post.



Information

> [Terms and Conditions of Service 2003, schedule 16, paragraph 16](#)

Responsibility allowances

The TCS also allows discretion for employing organisations to pay additional allowances/payments as necessary. Often employing organisations will use this provision to pay consultants for any additional responsibilities, such as being a clinical or medical director (see pages 168-71). Consultants are advised to contact the BMA pensions department if they have any queries about whether such payments should be pensionable.



Information

> [Terms and Conditions of Service 2003, schedule 16, paragraph 15](#)

Part-time contracts

Employers can offer part-time consultant contracts of between one and nine PAs per week. However, where consultants want to work part-time specifically to do private work, part-time contracts will normally be for no more than six PAs per week (although Trusts can agree to more PAs for part-timers locally). Employers are also able to offer annualised contracts where consultants wish to vary the number of PAs worked each week so that they can fit in other commitments, eg childcare, research, etc. Doctors requesting to work flexible patterns are entitled (with appropriate notice) to return to a regular pattern of work. The CCSC has published guidance for consultants who are interested in arranging their work in this annualised way. It can be accessed here: www.bma.org.uk/employmentandcontracts/working_arrangements/job_planning/Annualisationconsultants.jsp



Information

> Part-time and flexible working for consultants: An agreement between the BMA Central Consultants and Specialists Committee and the Department of Health for consultants in England (September 2003)

Locum appointments

Locum consultants are employed to cover annual, study or sick leave of consultants in substantive posts, and also to provide cover for temporary vacancies. The length of appointments can vary from a few weeks when covering leave to several months. The statutory maximum period for a consultant locum appointment is six months, which can be extended, upon satisfactory review by the employing body, for up to a further six months. Locums have no automatic entitlement to be appointed to the substantive post when it is filled, as all consultant appointments are subject to the statutory consultant appointment procedures.

Since 31 October 2003, all new consultant appointments, including locum appointments, must be under the 2003 contract. Except for the differences detailed below, all sections of the TCS apply to locum appointments.

Basic salary

Locums who have never held a substantive NHS consultant post will usually be first appointed at the bottom of the new salary scale, unless they have gained consultant level experience outside the NHS, in which case this should be taken into account when agreeing starting salary. Locums who hold a substantive consultant post and will continue to do so once the locum post comes to an end should be paid their existing pay threshold or rate of pay (including discretionary points, distinction awards or CEAs). Locums who do not currently hold a substantive consultant post but who have held one in the past (eg retired consultants) should be paid the equivalent of their most recent pay threshold or, if they have not previously been employed under the 2003 conditions, the rate of pay consistent with their calculated seniority.

Pay progression

A locum in post for a period of six months will become subject to the job planning process. When 12 months' service has been completed (continuous or cumulative), the employing organisation should assess whether the criteria for pay progression has been met. If part of the previous 12 months' service has been for one or more other NHS employing organisations, the current employer should seek assurance from previous employers as to whether the criteria have been fulfilled.

Job planning

A job plan for a locum post should have been agreed by the time the doctor takes up the post. An initial job plan review should take place three months into the post. Objectives should be agreed as part of the job planning process and locums should have the same access to resources, eg for administrative support and continuing professional development, as other consultants.



Information

> [Terms and Conditions of Service 2003, schedule 22](#)

Meditation and appeals processes

If there is a dispute over a job plan (see page 57) or a decision relating to pay progression, there is a process of mediation and appeal that can be followed. These processes are set out in schedule 4 of the terms and conditions of service.

Mediation

In the first instance, the consultant or the clinical manager should refer the dispute to the medical director (or another designated person if the medical director is one of the parties to the initial decision) in writing within two weeks of the disagreement arising, setting out the nature of the dispute. The other party should then set out their position on the matter. There will then be a meeting, usually set up within four weeks of the referral, involving the clinical manager, the consultant and the medical director. If agreement is not reached at the meeting, the medical director will take a decision or make a recommendation to the

chief executive of the employing organisation. The medical director must inform the consultant and clinical manager of the decision or recommendation in writing. Where the dispute is over pay progression, the chief executive should write with his/her decision to the consultant, medical director and clinical manager. If the consultant is not satisfied with the outcome, a formal appeal can be lodged.

Appeal

The consultant must lodge the appeal in writing to the chief executive within two weeks and the chief executive will then convene an appeal panel. The membership of the panel is a chairman nominated by the employer, a representative nominated by the consultant and a third independent member from a list approved by the BMA/BDA and the strategic health authority (SHA). The consultant can object on one occasion to the independent member who would then be replaced with an alternative representative. The parties to the dispute will submit written statements of case to the appeal panel one week before the hearing. The consultant can either present his or her own case at the hearing or he or she can be assisted by a representative, who may be a member of BMA Regional Services, but may not be someone acting in a professional legal capacity. The panel then makes a recommendation to the board of the employing organisation, usually within two weeks of the hearing. The recommendation will normally be accepted by the board.



Information

> [Terms and Conditions of Service 2003, schedule 4](#)

Transferring to the 2003 contract from the old contract

Consultants in post prior to 31 October 2003 who are still on the Pre-2003 contract have the option to transfer to the 2003 contract or retain their existing terms.



Information

> [Terms and Conditions of Service 2003, schedule 13, paragraphs 2 and 3](#)

Pay protection

Where consultants transferring to the new contract find that the combined total of their new basic pay and on call availability supplement will be less than the combined total of their existing basic pay and intensity supplement, pay protection will apply. Basic pay for these purposes does not include additional PAs, so any additional PAs paid under the new contract should be paid on top of the protected old salary. Pay protection is on a mark-time basis (ie until the new salary exceeds the salary at the point of transfer).



Information

> [Terms and Conditions of Service 2003, schedule 13, paragraph 11](#)

Terms and conditions of service common to the two contracts

The issues set out below are relevant to all NHS-employed consultants in England, whichever contract they hold. See the previous sections for issues specific to the pre-2003 and 2003 contracts.

Salaries

The DDRB reports each year to the Secretary of State, usually in January. The report is made public several weeks later, for implementation on 1 April of the same year. The DDRB's remit is strictly to advise the Prime Minister but its independence has been held as important by the BMA. Each year the DH (Department of Health and more recently, NHS Employers) and the BMA present written evidence to the DDRB in September, stating their case on appropriate remuneration for the forthcoming year, and this is supplemented by oral evidence in October. Current pay scales are published on the BMA website at www.bma.org.uk

The DDRB recommends salary increases for consultants and other doctors and recommends the value and number of distinction awards, discretionary points and CEAs. The Government then make a decision on the DDRB recommendations and when the increases are implemented they are issued in the form of Pay Circulars from NHS Employers. See page 153 for information about clinical academic salaries.



Information

> [BMA Guidance Note: Doctors' pay](#)

References are made throughout this section to paragraphs in the General Whitley Council (GWC) handbook. With the introduction of the Agenda for Change pay arrangement for non-medical staff in the NHS, the GWC has been replaced by an NHS Staff Council. At the time of writing, some sections of the GWC have been replaced by updated terms and conditions although not all. It is likely that this process will continue but for the time being, parts of the GWC continue to apply to consultants. Schedule 20 of the 2003 terms and conditions of service list the relevant sections.

Expenses and allowances

While the issues set out below are directly relevant to both contracts, the provisions for expenses set out in schedule 21 of the 2003 contract are labelled 'model provisions'. Local alternatives can be agreed which must be at least as favourable.



Information

> Consultant Contract 2003, paragraph 29 and Terms and Conditions of Service, schedule 21

Travel expenses

Consultants required to travel on NHS business are entitled to claim reimbursement of traveling expenses. This will be either the cost of public transport or a mileage allowance. It should be noted that part of the mileage allowance is taxable. Possession and use of a motor car is rarely a contractual requirement even for community-based staff. Consultants may be offered a crown or lease car.

Lease or crown cars

The crown car scheme for hospital doctors was introduced in 1990. In the 2003 contract, reference is made to lease cars as opposed to crown cars. A lease or crown car is a vehicle which is owned or contract-hired by an employing authority. Consultants are not entitled automatically to a crown car, but are offered one if the employer considers it economic or in the interests of the service to do so. Lease car schemes operate locally and can vary quite considerably. Trusts may also have their own schemes. Consultants should contact their employer's human resources department or LNC representative for further information. Consultants interested in crown cars should be aware that the scheme will be economically advantageous only to some individuals, depending on variables such as annual private and business mileage, size of car and the tax position. They are therefore advised to proceed with caution and should seek advice from askBMA and/or their accountant. A BMA guidance note is available at www.bma.org.uk

Mileage allowances for consultants not offered lease cars

Consultants not offered lease cars, who are required to use their own car on NHS business, are entitled to allowances at the standard rate unless they are classified as regular users. Standard and regular user mileage rates vary according to engine capacity. The mileage rate paid to regular users is lower than the standard rate but regular users are also paid a lump sum in equal monthly instalments regardless of the mileage covered.

Pending the outcome of the NHS Staff Council's review of mileage rates, NHS Employers is providing interim guidance on mileage allowances to all NHS organisations in England. The rates were adjusted with effect from 1 January 2008, as set out below:

- the 'regular user' mileage rate for staff travelling up to 9,000 miles per year on official business, in cars up to 1,000cc should be increased from 27 pence per mile to 29.7 pence per mile and after 9,000 miles per year from 16.2 pence per mile to 17.8 pence per mile
- the 'regular user' mileage rate for staff travelling up to 9,000 miles per year on official business, in cars between 1,001cc and 1,500cc should be increased from 33.5 pence per mile to 36.9 pence per mile and after 9,000 miles per year from 18.3 pence per mile to 20.1 pence per mile.

These increases apply to all staff in England receiving the allowances set out in Section 17 and Annex L of the NHS Terms and Conditions of Service Handbook and the relevant provisions in medical terms and conditions of service.

Hospital doctors who fulfil any of the following criteria are paid at regular user rates:

- travel an average of more than 3,500 miles a year on official business; or
- travel on average at least 1,250 miles a year on official business;

and

- i) necessarily use their cars an average of three days a week; or
 - ii) spend an average of at least 50 per cent of their time in travelling in the course of NHS business, (this time to include the duties performed during the visits)
- are classified as 'essential users' because they fulfil the following criteria:
 - i) travel on average at least 1,250 miles (other than normal travel between home or private practice premises and principal hospital) each year; and
 - ii) have ultimate clinical responsibility, or on-call responsibility normally controlled by a rota system, for the diagnosis and treatment of patients in hospital with emergency conditions which require them to be immediately available for recall; and
 - iii) are expected to be recalled to hospital in an emergency at an average rate of twice or more during a working week, the rate of emergency call out being averaged over the year but excluding periods of leave.

Classification as an essential user only results in access to the regular user category and has no other effect.

Mileage allowances for consultants who refuse a lease or crown car
Special provisions apply to those who refuse a lease or crown car.

Public transport rate

The public transport rate is payable when consultants use their private cars when travel by public transport would be more appropriate. This is rarely used.

Official journeys

The journeys listed below are classified as official business and mileage allowance may be claimed.

- Principal hospital (ie the hospital where the consultant's principal duties lie) and return to any destination, and travel between destinations, on official business.

- Home to any destination other than the principal hospital and return, on official business, subject to a maximum of the distance from the principal hospital to the place visited plus 10 miles in each direction or the actual mileage, whichever is the less.
- Home to principal hospital and return, when the consultant is called out in an emergency.
- Home to principal hospital and return, subject to a maximum of 10 miles in each direction, when consultants use their cars for subsequent official journeys, or where there is an acknowledged extensive liability to make emergency domiciliary visits.

Travelling time

In calculating the amount of time spent on NHS work for their job plans, all consultants should include the time spent travelling between hospitals. The pre-2003 contract says that the assessment of duties for maximum part-time and part-time consultants should also take into account travelling time between home or private practice premises and hospitals, up to half an hour each way.



Information

- > BMA Guidance Note: NHS official travel.
- > BMA Guidance Note Supplement: Current mileage rates
- > Advance Letter AL(MD)2/90 Personal Transport Arrangements.
- > Terms and Conditions of Service 2003, schedule 21
- > Terms and Conditions of Service, paragraphs 61, 275-308 (309 in Scotland)

Removal expenses

The provisions of the General Whitley Council (GWC) Conditions of Service apply to doctors' removal expenses. There is an entitlement to receive reimbursement in certain circumstances, for example if a consultant is required to move by the employing authority, but significant discretion is left to employers. Employers determine the scope and level of financial assistance to be offered to the prospective employee prior to the post being accepted. It is, therefore, the responsibility of the employer in negotiation with the doctor to

establish whether or not his/her current post satisfies the requirements of the new scheme.

Employers have been asked to ensure equity between different categories of staff, and should take into account both their own needs and the needs of the prospective employees. There may be considerable variation in expenses offered according to factors such as area and ease of recruitment in a particular specialty.

Consultants will need to be aware that expenses offered may vary, although the GWC scheme does indicate that expenses should be based on costs actually incurred. The LNC (see page 190) for the Trust should negotiate the removal expenses package and doctors should ensure that they are aware of the level of assistance which will be provided, the aspects of removal costs which will be reimbursed, and the upper limit of payment in normal circumstances before accepting a post. Advice should be sought on what is actually covered by the local scheme and not just the amounts reimbursed. In particular, consultants should note that employers may require that removal expenses are repaid in full or in part if they move to another employer. The extent to which the expenses must be repaid under these circumstances are at the employer's discretion, and may be dependent on the length of employment. Additionally, removal expenses in excess of a certain amount are taxable, and many employers set upper limits on the expenses payable in line with the tax threshold. A copy of the employer's removal expenses policy should be available from the employer.

Before accepting an appointment, consultants who have to move to take up that appointment should contact the new employer as early as possible to ascertain whether or not they are eligible for removal expenses. This has become even more important because of the discretion now given to employers to determine levels of expense and even eligibility. It is important that any negotiation of removal expenses takes place before the post is accepted. Confirmation of any agreement with an employer should be sought in writing. *askBMA* can give general advice and guidance to members on eligibility for

removal expenses. A BMA membership guidance note can also be found on the askBMA section of the BMA website: www.bma.org.uk



Information

- > General Whitley Council, section 26
- > BMA Guidance Note: Removal and associated expenses for NHS medical staff
- > Terms and Conditions of Service 2003, schedule 21, paragraph 62
- > Terms and Conditions of Service, paragraph 314

Telephones

Provision of telephones

It is normally a contractual requirement for consultants to be contactable by telephone. Employers should pay for the cost of installation and rental of telephones where it is essential for the efficiency of the service that the doctor should be on call outside normal working hours and the telephone is the only practicable method of communication with the doctor. In most cases the payment by employers of installation and rental costs is taxable.

Official business calls

Consultants may claim from the employer the cost of outgoing calls made on official business.

Mobile phones

Consultants may be able to negotiate with the employer the provision of a mobile phone or pager and/or subsequent outgoing NHS business calls. Where there is no clear Trust agreement on mobile phones the issue should be raised with the LNC to produce clear guidance for consultants.



Information

- > HC(PC)(79)3 Provision of Telephones for Medical and Dental Staff
- > Circular letter (6.3.87) from the NHS Procurement Directorate to all regional supplies officers regarding the Priority Telephone Fault Repair Service

Subsistence allowances

When consultants are required to be away from their main or regular place of work on employer's business, they may claim subsistence allowances in accordance with the GWC Conditions of Service. Subsistence allowances, which are payable in addition to travelling expenses, can be claimed for approved overnight stays, daytime meals and late night duties expenses. Situations where subsistence allowances may be payable include during periods of approved study leave and, at the discretion of the prospective employer, during a search for suitable permanent accommodation in a new area as part of removal expenses. Reimbursement should be claimed only for the expenses which consultants have actually incurred, up to a maximum of the appropriate allowance. Vouchers or receipts are required. Where the subsistence allowances have been exceeded, reimbursement of the excess costs is discretionary. Consultants are normally required to submit claims at intervals of not more than one month and as soon as convenient after the end of the period to which the claim relates. Consultants are advised to check whether GWC arrangements apply locally since some Trusts have introduced their own schemes. In any event, consultants are advised to check their entitlement before incurring expenditure.



Information

- > GWC Conditions of Service, section 22
- > Terms and Conditions of Service 2003, schedule 21, paragraphs 54-56
- > Terms and Conditions of Service, paragraphs 275-276 and 311

Annual leave

Consultants on the pre-2003 contract are entitled to six weeks' annual leave per year, with each leave year commencing at their incremental date or its anniversary for those at the top of their scale. Consultants on the 2003 contract are entitled to an additional one day of leave in April 2004-March 2005 and two extra days from April 2005 if they have been a consultant for seven or more years. It should be noted that this entitlement, as specified in contracts following nationally agreed terms and conditions of service, is not affected by the provisions of the European Working Time Directive (EWTD), which refers to a minimum statutory entitlement of four weeks per year.

In some cases, employers may have a standard leave year, for example commencing on 1 April for all employees, and this should be clearly specified in the contract of employment for the post. There is no agreed definition of how many days constitute a week. Some employers regard a week as seven days (to include weekends) giving 42 days per year; others include Saturdays but not Sundays, providing a six-day week, giving 36 days; others define a week as five weekdays, giving 30 days. Some employers add on statutory holidays to form part of the overall leave entitlement. As long as an employer's policy on the definition is clear and consistently applied, then any one of these options can be applied locally. Any proposals to change the definition or the standard leave year should be agreed locally.

The CCSC has produced guidance on calculating annual leave allowances which can be accessed here:

www.bma.org.uk/employmentandcontracts/leave/AnnualLeave070108.jsp

Consultants with substantive contracts may transfer up to five days of leave not taken in a leave year into the next leave year. Consultants must notify their employers in advance of taking annual leave. Arrangements to provide adequate cover must always be made and, although no permission is necessary to take leave for up to two days, approval may be withheld if cover arrangements for leave are not satisfactory (see page 51 for further details about cover during leave). It is in the interests of consultants, as well as essential for the service, that adequate cover arrangements for leave are arranged at unit level. It may be helpful to administer annual leave arrangements within clinical directorates (see page 169).

The CCSC has produced guidance for consultants covering for absent colleagues which can be accessed here:

www.bma.org.uk/employmentandcontracts/employmentcontracts/consultantscontracts/CCSCfaqs.jsp



Information

- > Terms and Conditions of Service 2003, schedule 18, paragraphs 1-4
- > Terms and Conditions of Service, paragraphs 205, 209, 211-213 and 215
- > GWC Conditions of Service, section 1
- > EC Working Time Regulations 1998

Public holidays

Consultants are entitled to 10 paid statutory and public holidays each year. These consist of eight public or bank holidays, plus two additional days' paid holiday as determined by the employer. The two additional days may be converted to annual leave, over and above the six-week entitlement, after agreement between the employer and local staff representatives. Consultants who are required to be on call on any of the above days are normally granted time off in lieu.

The CCSC has produced guidance for consultants on working on bank holidays which can be accessed here:

www.bma.org.uk/employmentandcontracts/employmentcontracts/consultantscontracts/CCSCfaqs.jsp

Study and professional leave

Consultants' study leave is mainly used to enable them to participate in continuing professional development (CPD). It therefore plays an important role in ensuring the highest standard of patient care, and consultants should be encouraged to take such leave. It is recommended in the terms and conditions of service that consultants should receive study leave with pay and expenses, within a maximum of 30 days in a period of three years. Employers may, at their discretion, grant study leave above the periods recommended with or without pay and expenses.

Both sets of terms of service make no distinction between professional leave and study leave, using the terms interchangeably. It is important to note, however, that the terms are discrete. The DH has clearly stated that professional leave is an allowance based on an individual's need, and has encouraged employers to release consultants for a range of

duties which are necessary for the broader benefit of the NHS, but which involve consultants being away from their employment base, citing the examples of advising the DH, participating in college duties or examining. Under the 2003 contract, such duties can be recognised as 'external duty' PAs (see page 19).

The day-to-day administration of study leave rests with the employing Trust, and there are considerable variations between Trusts in the way that study leave applications are dealt with. In practice, this is likely to mean that either a fixed amount of money will be set aside for each study leave application or that money will be allocated from a fixed pool of funds on a first come first served basis. Many employers have unrealistically low study leave budgets. Each consultant is now required by their royal college to attend CPD courses which help to maintain an acceptable standard of clinical skill. Under the GMC's 'Duties of a Doctor', consultants have a clear responsibility to keep up to date with current best practice. The royal colleges have highly developed programmes on CPD and colleges can provide details of the current CPD requirements in individual specialties.

There are a number of factors to be taken into account when considering study leave applications:

- once a study leave application is accepted then employers should pay all reasonable expenses associated with that period of leave
- the right of a consultant to take study leave should not depend on the employer's financial position. Employers should accept the natural consequences of granting study leave and pay all reasonable expenses associated with a period of approved study leave
- employers should not turn down study leave applications on non-educational, including financial, grounds
- the DH has said that it is unreasonable for employers to pre-determine the level of expenses which they are prepared to approve in connection with study leave applications
- study leave should not be used for inappropriate purposes, for example attending advisory appointments committees.

Where study leave claims are turned down or expenses not paid, consultants have a number of options open to them, including pursuing the issue of non-payment of expenses to the county court. Additionally, cases may be pursued as a formal grievance in accordance with the local grievance procedure (see page 54). In any event, consultants are advised to contact *askBMA* for advice and appropriate support. If a case were to be pursued in the county court, it would be judged on its individual merits rather than being subject to precedent.



Information

- > HC(79)10: Hospital Medical and Dental Staff: study leave
- > Terms and Conditions of Service 2003, schedule 18, paragraphs 9-16
- > Terms and Conditions of Service, paragraphs 250-254
- > HM(67)27, Professional and Study Leave for Medical and Dental Staff in the Hospital Service
- > HM(68)50, Hospital Medical and Dental Staff and Headquarters Medical Staff of Regional Hospital Boards
- > HC(79)10, Hospital Medical and Dental Staff: Study Leave
- > EL(95)53 Covering letter from NHSE Director of Human Resources (reference to professional leave)
- > EL(91)92, Postgraduate and Continuing Medical and Dental Education
- > EL(96)51, Postgraduate and Continuing Medical and Dental Education

Sick leave

The following information is based on the provisions of the national terms and conditions and GWC conditions. Procedure to be followed

Consultants should inform their employer immediately according to local arrangements if they are unable to work because of illness. If the illness lasts longer than three calendar days, a self-certificate must be submitted within the first seven days of absence. Further statements in the form of a medical certificate provided by another practitioner must be submitted for any absence extending beyond the first seven days. A statement submitted every seven days is normally sufficient, although the employer is entitled to ask for more frequent

statements. The employer may also insist that the consultant undergoes a medical examination conducted by its nominated practitioner.

Hospital admission

Consultants admitted to hospital must submit a doctor's statement on admission and discharge, or a self-certificate if absent for seven days or less.

Allowances

An allowance is paid during sick leave on a sliding scale according to length of service, with a minimum of one month's full pay and a maximum of six months' full pay and six months' half pay, although the employer has discretion to extend the application of the scale in exceptional cases. Most consultants are entitled by their previous service to the maximum allowance. The calculation takes account of any sick leave already taken in the 12 months immediately prior to the first day of absence.

Exclusions

An allowance is not normally paid in the following cases:

- accident due to active participation in sport as a professional
- contributory negligence
- once employment is terminated, for example because of permanent ill-health, resignation, old age or any other reason
- failure to observe the conditions of the scheme
- conduct prejudicial to recovery.



Information

- > [Terms and Conditions of Service 2003, schedule 18, paragraphs 18-30](#)
- > [Terms and Conditions of Service, paragraphs 225-244](#)
- > [GWC Conditions of Service, sections 1, 57 and 61](#)
- > [HC\(83\)8, Introduction of Statutory Sick Pay](#)

Income during sick leave

The allowance paid by the employer during absence on sick leave must

not result in consultants receiving more than their normal salary for the period. In practice, many employers pay the consultant as normal and make separate arrangements to claim back the statutory sick pay from the Inland Revenue, stating this element on the pay slip. Special arrangements for pay and sick leave entitlement exist in the case of a consultant receiving damages from a third party after an accident. Further advice is available from askBMA. Disputes are dealt with by local Inland Revenue offices (www.hmrc.gov.uk).

Private practice during sick leave

Consultants should be extremely cautious during sick leave with regard to the other activities they normally carry out. Some employers may regard the undertaking of private practice as a serious disciplinary offence. In certain circumstances, however, employers might allow a consultant to undertake private work, for example to facilitate a gradual return to work; consultants should always check with their employer before undertaking work while on sick leave and should seek advice from askBMA. Private practice is described in more detail on pages 87-102.

Illness during annual leave

Consultants who fall ill during annual leave and produce a statement to that effect are regarded as being on sick leave from the date of the statement and paid accordingly. The annual leave may then be taken at a later date. This does not apply if the consultant falls ill on a statutory or public holiday.

Help and advice for sick doctors

Details of services offering help and advice to sick doctors can be found in the chapter on health issues (see page 138).

Clinical academics

See page 157 for clinical academic staff.

Special leave

Special leave with or without pay may be granted at the discretion of the employer in accordance with paragraph 33, schedule 18 of the 2003 terms and conditions of service.

Leave for attendance as an expert witness

Leave for consultants attending court as expert witnesses is a contentious area, with some employers taking the view that this should be categorised as fee paying or category 2 work (see page 12), and consequently special leave with pay may be refused. However, it is arguable that it would be unreasonable for employers to object to consultants carrying out this work since it is part of the judicial process of the state. Consultants are entitled to time off with pay to attend court as professional witnesses, in connection with their own patients, because this is category 1 work (see page 12).

Leave for trade union duties and activities

The Trade Union and Labour Relations (Consolidation) Act 1992 places an obligation on employers to allow officials of recognised trade unions, which would include BMA local representatives and members of BMA accredited LNCs, to take reasonable time off with pay to undertake trade union duties during working hours. Special leave with pay is also available for consultants who attend meetings of the JNC(S) (see page 5), as one of the staff side bodies of the GWC. Under the Act, 'duties would be taken to refer to circumstances where an individual would be acting as a representative of the profession, either locally or nationally'. The Act also requires an employer to allow members of recognised trade unions to take reasonable time off, not necessarily with pay, for the purpose of taking part in trade union activity, such as BMA meetings. Such 'activity' would be attended in an individual capacity, and would not involve the representation of others.



Information

- > Terms and Conditions of Service 2003, schedule 18, paragraphs 33-34
- > Terms and Conditions of Service, paragraphs 260 and 262
- > GWC Conditions of Service, sections 3, 12 and 38
- > ACAS Code of Practice 3, Time off for Trade Union Duties and Activities
- > Trade Union and Labour Relations (Consolidation) Act 1992, sections 168-173

Sabbatical leave

There is no specific provision for consultants to be granted sabbatical leave although employers have the discretion to grant professional or study leave in the United Kingdom in excess of the recommended standards with or without pay and with or without expenses.

Additionally, employers are able to grant special leave without pay, for example, in respect of a long period of study abroad. Many employers have their own local policies for awarding sabbatical leave. Consultants are advised to contact *askBMA* to ascertain examples of good practice in respect of sabbatical leave within their region.



Information

- > [Terms and Conditions of Service 2003, schedule 18, paragraph 17](#)
- > [Terms and Conditions of Service, paragraph 252](#)
- > [GWC Conditions of Service, section 3](#)

Maternity, paternity and parental leave

Consultants, as other employees, have certain minimum statutory rights to maternity and parental (including paternity) leave and pay. In addition, under the terms and conditions of service, consultants can take advantage of more beneficial occupational arrangements. Entitlements under both the statutory and TCS schemes depend on certain qualifying conditions, and the application of, and interrelationship between the schemes, is a complicated area. Under the current TCS maternity leave scheme, consultants must have normally had 12 months' service with one or more NHS employer, with no break in service of more than three calendar months, at the 11th week before the expected week of confinement to qualify for maternity leave and pay. Notice of intention to return to work must normally be given at least 21 days before commencement of maternity leave, and failure to return to work for the same or another NHS employer for a period of three months may result in liability to repay some or all of the maternity pay. Maternity leave with pay under the current GWC scheme consists of 26 weeks' pay made up of eight weeks at full pay (less any statutory maternity pay or maternity allowance, including any dependents' allowances

receivable); 18 weeks' half pay (plus any SMP or MA, including any dependents' allowances receivable providing the total does not exceed full pay) and four weeks at the standard rate of SMP or maternity allowance. The maximum entitlement to leave is 52 weeks (including paid and unpaid). Consultants who do not qualify for maternity leave with pay as described will be entitled to 26 weeks' unpaid leave. Consultants should also consider entitlements to statutory maternity leave and pay. The schemes also cover areas including arrangements for employees who are incapable of carrying out all or part of their duties, and contractual entitlements during maternity leave.

In addition, the GWC introduced a set of principles on which to base locally negotiated schemes for parental, paternity, and adoption leave (among others) further to the implementation of the Maternity and Paternal Leave Regulations 1999. However, this section of GWC conditions of service, along with the current GWC scheme for maternity leave and pay is likely to be subject to further change. Consultants are strongly advised to consult *askBMA* for advice about their entitlements at the earliest opportunity. See page 157 for information about clinical academic staff.



Information

- > [GWC Conditions of Service, section 6](#)
- > [Maternity and Parental Leave Regulations 1999](#)
- > [BMA Guidance Note: Maternity leave \(for NHS medical staff\)](#)

Cover during leave

Arrangements must be made for consultants' duties to be covered for all forms of leave. Consultants are required by the terms and conditions of service to deputise for absent colleagues 'so far as is practicable', even where this involves interchange of staff between hospitals, and arrangements for deputising will usually be worked out among the staff concerned within the department.

When deputising is not practicable, it is the consultant's responsibility to inform the employer of the need for a locum. The engagement of the locum is then the responsibility of the employer. It is the view of the CCSC that a consultant's main on-call responsibility should be to ensure provision of cover rather than to actually provide it. Consultants should not be expected to take on cover for temporarily absent colleagues if the duties involved are unreasonable and beyond their competence. If the employing authority cannot provide adequate cover, it is the view of the CCSC that it is better for the service to be shut down, as it is clearly unfair and unsafe for patients if an incompetent service is provided. It is, however, the responsibility of the consultants going on leave to discuss any seriously ill patients with colleagues covering for their absence. It is then the covering doctor's responsibility to order such treatment as he or she considers clinically necessary in the light of the patient's changing condition.

Further guidance on this area can be found in the FAQs on the consultant section of the website here:

www.bma.org.uk/employmentandcontracts/employmentcontracts/consultantscontracts/CCSCfaqs.jsp



Information

- > Terms and Conditions of Service 2003, schedule 2, paragraph 3
- > Terms and Conditions of Service, paragraph 108

Medical indemnity

The NHS provides medical indemnity for its staff via the NHS indemnity scheme. The scheme ensures that employers bear the financial costs arising from claims for negligence against doctors carrying out work which falls strictly under their contract. Along with other NHS employed doctors, consultants and clinical academic staff are covered by NHS indemnity for the work they undertake under their NHS contracts. If a consultant is treating NHS patients under a contract with his or her employer (whether that is the main contract of employment or a separate contract issued specifically for dealing

with waiting list patients), the consultant is covered by NHS indemnity.

NHS indemnity scheme covers:

- work under NHS contracts including in non-NHS locations, eg independent sector treatment centres
- family planning work in hospitals (see page 16)
- hospital doctor locum work, whether through a locum agency or directly with the employer
- domiciliary visits (see page 14).

The NHS indemnity scheme does not necessarily cover:

- private practice work (see page 87)
- category 2 work, ie report for a third party where a fee may be charged (see page 12)
- ‘good Samaritan’ work, such as assisting at a traffic accident
- costs in GMC proceedings
- inter-hospital transfer
- category 3 work for a third party other than an employing authority, eg waiting list initiatives (see page 14).

Consultants should ensure in each case that the work is covered either by NHS indemnity or by another employer or by their defence body, taking out additional cover if necessary. Further information is in the BMA membership guidance note on NHS medical indemnity, available from askBMA or at www.bma.org.uk

Under the NHS indemnity scheme, employers being financially liable for the medical negligence of their staff, have the ultimate right to decide how the defence of any case is handled. Subject to this, doctors may be represented separately at their own cost in any case of alleged negligence, although if it is likely to increase their costs employers may not agree to this; additionally, the agreement of the plaintiff and the court needs to be obtained. Furthermore, the DH has stressed that, in representing doctors, employers should pay particular attention to any view expressed by the doctor concerned in respect of

any potentially damaging effect on professional reputation and to any point of principle or of wider application raised. In 1995 the National Health Service Litigation Authority was set up with the principal task of administering schemes to help NHS bodies pool the costs of any 'loss of or damage to property and liabilities to third parties for loss, damage or injury arising out of the carrying out of [their] functions'. The Clinical Negligence Scheme for Trusts (CNST) is one scheme via which member Trusts pay an annual contribution related to their size, the nature of their clinical work and in due course, the level of their claims. The vast majority of Trusts are members, however, membership of the CNST is voluntary so employers may have local arrangements. The NHSLA is increasingly implementing rigorous risk management guidelines for member Trusts which may bear significantly on clinical practice. Both the BMA and the DH advise that it is essential that all consultants retain some form of personal indemnity insurance to cover any non-NHS work as well as NHS indemnity cover. Consultants should consult the defence bodies to determine the degree of cover required and the schemes available.



Information

- > HSG(96)48 NHS Indemnity – Arrangements for Handling Clinical Negligence Claims Against NHS Staff
- > EL(95)40 Clinical Negligence Scheme for Trusts
- > BMA Guidance Note: NHS indemnity
- > The National Health Service Litigation Authority – Framework Document

Grievance procedures

Since October 2004 all employers have been legally required to have grievance procedures. Employers should have drawn up, in consultation with local staff representatives, procedures to enable employees to challenge an employer's decision which may adversely affect their terms and conditions of service. The procedure does not apply to settling differences relating to dismissal or any disciplinary matters; organisational change; or issues covered by the disputes procedure. The grievance procedure should be designed to provide a

speedy resolution of the grievance as close as possible to the source and regard should be given to good industrial relations practice. The procedures should provide for the reference of grievances to a person or body other than the employer, when both parties agree that this is appropriate.



Information

- > HSG(91)28 Settling individual employee grievances in respect of NHS conditions of service
- > ACAS Code of Practice 1 – Disciplinary and Grievance Procedures, 2003

Disputes procedures

The procedures for handling and resolving disputes that do not affect the terms and conditions of service are determined locally. These procedures should be drawn up following consultation with local staff representatives and be based upon the principles set out by the GWC:

- disputes should be resolved at the lowest possible level of management and as close as possible to the source of the dispute
- as far as possible, disputes should be settled locally without formal reference to a person or body outside the employing authority, though where relevant, advice can be sought from the joint secretaries of the appropriate Whitley Council
- disputes should be settled as speedily as possible.

The GWC further suggests that an employee should have the right to be represented.



Information

- > GWC Conditions of Service, section 42

Termination of employment

If the employer terminates the contract, three months' notice in writing must be given to the consultant. Likewise, consultants wishing to terminate their employment must also give the employer three months' notice. These notice arrangements can be altered subject to local written agreement.



Information

- > Terms and Conditions of Service 2003, schedule 18, paragraph 31
- > Terms and Conditions of Service, paragraph 196

Local contractual variations

Although Trusts have, since being established, had the power to offer amended or entirely different contracts, most Trusts have not introduced significant change. Nearly all existing contracts refer to the national terms and conditions and all NHS Trusts are now meant to employ new consultants only under the 2003 national contract. In the past, however, some Trusts have introduced flexibility by stating that the national terms and conditions will apply until such time as the Trust introduces its own terms and conditions. Given their extended freedoms, it is possible that foundation trusts in particular may seek to introduce some contractual variation in future. Newly appointed consultants should take great care to check if employers are seeking to introduce local variations to the national contract and seek advice from askBMA. References are made throughout this section to paragraphs in the GWC handbook. With the introduction of the Agenda for Change pay arrangement for non-medical staff in the NHS, the GWC has been replaced by an NHS Staff Council. At the time of writing, the GWC handbook was still in use, but is likely to be replaced by updated terms and conditions for doctors in the near future.

Job planning

A job plan is a detailed description of the duties and responsibilities of a consultant and of the supporting resources available to carry them out. Job planning has been a responsibility for all consultants in the NHS since 1991, but the 2003 consultant contract has placed a renewed emphasis on ensuring that job plans are accurate and up to date. A new job planning system has been developed that is based on a partnership approach between consultant and clinical manager.

Standards of best practice for job planning were agreed between the BMA and the DH in September 2003. However, these standards represented recommended guidance on best practice in relation to job planning, both for consultants on the 2003 contract and for those who remained on their existing contracts. The CCSC has produced extensive guidance on this issue for members – ‘Job planning: a summary for consultants new to the 2003 contract in England and Northern Ireland’ is available via askBMA and the BMA website at www.bma.org.uk. There is also job planning guidance for consultants choosing to remain on the pre-2003 contract in ‘Controlling workload, maximising rewards – guidance for consultants’, also available via askBMA and the BMA website. The BMA has also produced additional advice for clinical academic staff (see page 153).

In 2008 the CCSC published new job planning guidance specifically designed to help consultants make the most of SPA time and to get the best results from the objective setting part of job planning. The guidance can be found here:

www.bma.org.uk/employmentandcontracts/working_arrangements/job_planning/CCSCadvancedjobplanning090408.jsp



Information

- > Consultant Job Planning, Standards of Best Practice, an agreement between the BMA Central Consultants and Specialists Committee and the Department of Health for consultants in England
- > Terms and Conditions of Service 2003, schedule 3
- > HC(90)16, Consultants’ Contracts and Job Plans
- > Terms and Conditions of Service, paragraphs 30 and 61

The purpose of job planning

The purpose of the job planning process, as set out in the standards of best practice, is to enable consultants and employers to:

- better prioritise work and reduce excessive consultant workload
- agree how a consultant or consultant team can most effectively support the wider objectives of the service and meet the needs of patients
- agree how the NHS employer can best support a consultant in delivering these responsibilities
- provide the consultant with evidence for appraisal and revalidation
- comply with Working Time Regulations; and
- reward activity above the standard commitment via prospectively agreed additional PAs for those on the 2003 contract.

Job planning can therefore be of great benefit and the CCSC encourages all consultants to prepare for and participate actively in job planning on an annual basis. Additionally, for consultants on the 2003 contract, participation in the process will be a factor in informing pay progression (see page 32) and for all consultants, adherence to the principles of job planning will be a factor in decisions on CEAs.

The process of job planning

In general, the job planning meeting will take place between the individual consultant and their clinical manager (who will usually be the clinical director). The CCSC believes that, wherever possible, it is important that this discussion is between clinicians. In some instances it may be appropriate to have a 'team' job plan and even undertake the job planning process together as a team. There will be circumstances where generic issues relating to the job plan can be resolved at departmental or specialty level to ease the burden.

There is scope for collective agreement on this with the employing organisation through the LNC. There will, however, remain an important process of agreeing individual objectives and the necessary supporting resources. It is the clinical manager's responsibility to prepare a draft job plan and then to agree it with the consultant.

However, the consultant will inevitably be a key player in drawing up the initial job plan. In advance of any job planning meeting, the consultant should consider the following points:

- what is currently in the job plan (if there is one)
- what work is actually undertaken at the current time (this may well be different from the existing job plan)
- how the work that is currently undertaken fits into the contract's categories of work (eg for the new contract, what is direct clinical care, what is supporting professional activity)
- what the consultant would like to see changed in the future.

The consultant and the clinical manager should then discuss all elements of the consultant's current and future responsibilities and agree the job plan document. Where agreement cannot be reached, there are mediation and appeals processes that can be invoked (see page 32 for the 2003 contract and page 63 for the pre-2003 contract).

Format of job plans

2003 contract

There is no agreed national model of a job plan but the CCSC's advice 'Job planning: a summary for consultants new to the 2003 contract in England and Northern Ireland' contains a model for use by consultants and employers.

Pre-2003 contract

A model format for a job plan was included in the health circular HC(90)16. It distinguishes between the weekly timetable of fixed commitments in part A of the job plan and the total average number of hours spent each week in part B (ie including fixed and flexible commitments).

Job plan context

The job plan will outline the consultant's commitment to the NHS. It will normally include:

- a timetable of activities including duties such as out-patient clinics,

ward rounds, operating procedures, investigative work, administration, teaching, audit, management commitments, emergency visits

- a summary of the total number of PAs or NHDs of each type in the timetable
- the on-call arrangements (including the supplement category for the new contract and rota frequency)
- a description of additional responsibilities to the wider NHS and profession (including external duties)
- any arrangements for additional PAs or NHDs
- any details of regular private work carried out (see below)
- any agreed arrangements for carrying out regular fee-paying services
- a list of any agreed objectives (see below)
- a list of supporting resources necessary to achieve objectives (see below)
- any special agreements or arrangements regarding the operation/interpretation of the job plan
- the consultant's accountability arrangements.

A number of the above issues have been covered previously in detail in the relevant contract sections. Where this is not the case, further information is outlined below. Extensive guidance on the job planning process for the new consultant contract is available for BMA members in 'Job planning: a summary for consultants new to the 2003 contract' – available via *askBMA* and the BMA website at www.bma.org.uk

Objectives

The job plan should also include objectives. This is a contractual expectation for consultants on the 2003 contract but is anticipated for all consultants in the standards of best practice. Objectives could relate to quality, activity, outcomes, standards, service objectives, resource management, service development or team working. Personal objectives may also flow from discussions and agreement at the annual appraisal. Consultants on the 2003 contract will need to make every reasonable

effort to meet these objectives to achieve pay progression and so they must be appropriate, identified and, most importantly, agreed between the consultant and clinical manager. The CCSC believes that it is important that objectives are not set with significant factors outside the consultant's control, eg waiting list targets. Consultants have no obligation to sign up to objectives that are unreasonable. The CCSC supports good use of objectives. They provide focus for consultants' personal development and also for the service provision and development necessary to maintain a high quality standard of patient care

www.bma.org.uk/employmentandcontracts/working_arrangements/job_planning/CCSCadvancedjobplanning090408.jsp



Information

> Terms and Conditions of Service 2003, schedule 3, paragraphs 10-13

Private and fee-paying work

The job plan should normally include details of any private or fee-paying work undertaken by the consultant. Once again, under the 2003 contract, this is a contractual requirement. Consultants should identify any regular private commitments and provide information on the planned location, timing and the broad type of work that is being undertaken. The employer has no right to ask for financial details relating to private practice for consultants on the 2003 contract (see page 90 for consultants on the pre-2003 contract). Details are covered in the code of conduct for private practice (see page 87).



Information

> Terms and Conditions of Service 2003, schedule 9, paragraphs 3 and 4

Supporting resources

The job plan review should identify and agree the resources that the consultant needs to do the job properly. This gives the opportunity to make sure that the employer is formally aware of the supporting resources required, for example secretarial support, medical staff support, office space and information technology. Advice on

identifying and securing appropriate supporting resources can be found here:

www.bma.org.uk/employmentandcontracts/working_arrangements/job_planning/CCSCadvancedjobplanning090408.jsp

A lack of appropriate supporting resources could have an impact upon consultants meeting their objectives. It is therefore essential that the required resources are identified when job plans are agreed. For consultants on the 2003 contract, pay progression cannot be withheld if consultants have not met objectives for reasons beyond their control.



Information

> [Terms and Conditions of Service 2003, schedule 3, paragraphs 14-16](#)

Job plan review

Annual review

It is a contractual obligation for all consultants to have an annual job plan review. Information arising from annual appraisal could inform this process, and so consultants and employers may want to link the timing of the job plan review to the appraisal. The review should consider factors affecting the achievement of objectives, adequacy of resources, potential changes to duties or responsibilities, ways to improve workload management and planning of careers.

Interim review

The consultant or employer may request an interim review where duties or responsibilities or the employer's needs have changed during the year. This entitlement is formally provided for under the 2003 contract.



Information

> [Terms and Conditions of Service 2003, schedule 3, paragraphs 17-22](#)

> [Terms and Conditions of Service, paragraph 30d](#)

Disputes over job plans

2003 contract

The mediation and appeals process for job plan disputes is set out above in the contract section at page 32.

Pre-2003 contract

Where there are individual cases of disagreement, consultants are able to appeal to a special appeals panel established by their employer. The panel is chaired by the regional director of public health or a senior medical or dental officer of the employer. If either party to the dispute judges that it would be helpful, a medical or dental adviser acceptable to both parties is co-opted to the panel. The panel hears the case put before it and submits its advice to the employer, which then determines the appeal. If there are cases of widespread dispute or matters of principle, if the problem cannot be resolved at the local level, the terms of service contain a facility for referral of the matter to the JNC(S) (see page 5). Specific guidance on job plans for the following specialties has been drawn up by the royal colleges, the specialty subcommittees of the CCSC and specialty associations, and may be obtained from askBMA: Accident and Emergency (includes advice on part-time contracts), Anaesthetics (includes advice on part-time contracts), Clinical Radiology, Dentistry, Dermatology, General Medicine, Genito-Urinary Medicine, Geriatric Medicine, Nuclear Medicine, Obstetrics, Oncology, Ophthalmology, Orthopaedics, Paediatrics, Pathology, Psychiatry, Rheumatology and Rehabilitation, Surgery and Thoracic Medicine.



Information

- > [Consultant Job Planning, Standards of Best Practice, an agreement between the BMA Central Consultants and Specialists Committee and the Department of Health for consultants in England](#)
- > [Terms and Conditions of Service 2003, schedule 3](#)
- > [HC\(90\)16, Consultants' Contracts and Job Plans](#)
- > [Terms and Conditions of Service, paragraphs 30 and 61](#)

European Working Time Directive (EWTD)

All senior hospital doctors are covered by the EWTD, which is legislation designed to protect employees from working excessive hours. Employers are legally bound to implement the Directive and can be penalised by the Health and Safety Executive for noncompliance. A collective national agreement for senior hospital doctors for the implementation of the Directive was negotiated through the JNC(S), and came into force in November 1998.

The effect of the Directive is to limit working hours to 48 each week, with provision for compensatory rest periods. It must be noted that no suggested or agreed contractual arrangements can override the 48-hour limit; this must be taken into account in the drawing up of job plans. However, individuals do currently still retain the right to opt out of the 48-hour limit. In order that the legislation could be introduced sensibly, derogations were applied, the effects of which include that the 48-hour limit is calculated over an averaged reference period of 26 weeks, and that compensatory rest periods can be taken in lieu. It is recommended that in order to calculate entitlements to compensatory rest, doctors use a diary to monitor the total hours worked (including hours worked while on call) over a minimum period of four weeks.

The key aspects of the directive for consultants are:

- a limit of an average of 48 hours worked per week, over a reference period
- a limit of eight hours worked in every 24-hour period for night work
- a weekly rest period of 24 hours every week
- an entitlement to 11 hours consecutive rest per day
- an entitlement to a minimum 20-minute rest break where the working day is longer than six hours
- a requirement on the employer to keep records of hours worked.

The EWTD is currently under review and it is likely that changes will be made to the Directive in the coming years. However, currently resident on-call time does count as work and the opt-out remains for individuals. Members should check the BMA website for the latest news on how the Directive applies to doctors.

The CCSC published updated guidance on the EWTD for consultants in 2008. The guidance can be found here:

www.bma.org.uk/employmentandcontracts/working_arrangements/hours/ewtdguidance0408.jsp

See page 158 for information about clinical academic staff.



Information

- > Guidance on Implementing the EC Directive on Working Time for Senior Hospital Medical Staff, CCSC, March 1999
- > AL(MD)6/98, Implementation of the Working Time Regulations
- > EC Working Time Directive Regulations, October 1998

Compensatory rest

The Directive allows employers to exclude the provisions in relation to length of night work, daily rest, weekly rest and rest breaks if compensatory rest is provided. This means that where rest is delayed or interrupted by work, compensatory rest must be granted. However, there is flexibility about how and when compensatory rest is calculated. The entitlement to compensatory rest will be granted by the employer 'wherever possible' (Regulation 24, Working Time Regulations 1998).

The CCSC's view is that rest should be taken within a reasonable period and before returning to work. The Jaeger judgment in the European Court of Justice examined the provision of compensatory rest and stated that: 'equivalent periods of compensatory rest made up of a number of consecutive hours corresponding to the reduction applied and from which the worker must benefit before commencing the following period of work'.

The CCSC recommends that LNCs ensure that local agreements recognise the importance of ensuring rest is taken as soon as possible after a disruption to rest. The Directive is not aimed at providing extra periods of leave that consultants can accumulate over a period of time; it aims to ensure consultants are not tired when working.

The length of the rest period that should be taken is not clearly defined in the directive. In each situation the rest provided should make up for the rest missed; and, under the provisions of the Jaeger ruling, should be taken immediately after the end of the working period. The implications of the Jaeger ruling are that it will not be sufficient to aggregate the rest available to an individual over a period and assume that the minimum requirements have thus been met.

LNCs should discuss this with trust management but be mindful of the following factors:

- the length of disruption
- the nature of the disruption (did it require a return to the hospital or other significant disruption)
- the number of disruptions to a period of rest – if there are several then the rest might be assumed to be not a genuine period of rest.

Example local agreement on compensatory rest

The collective national agreement for senior hospital doctors, implementing the Working Time Regulations (1998), provides that where prescribed rest periods have been significantly interrupted, the doctor should take compensatory rest. This is not counted as annual leave. It is good practice for such compensatory rest to be taken immediately after the end of the working period. A doctor may commence work at a later time on the day following a significant interruption to rest, after notifying the responsible manager where work was to be performed. This provision is important for the maintenance of patient safety and shall not be taken as amending the doctor's rights under the Working Time Regulations. Any consultant having to take compensatory leave should ensure that colleagues are forewarned in order that appropriate cover arrangements can be arranged if necessary.

Doctors on part-time contracts are entitled to the same compensatory rest breaks as those doctors on whole-time contracts, as detailed above. It is therefore essential that doctors monitor their hours worked and their entitlements to compensatory rest.

The LNC will play an important role in implementing the agreement across employers. As well as putting individual entitlements in place, the LNC should encourage systematic review of job plans to ensure that they effectively limit the excessive hours that some doctors are working. LNCs may need to agree different arrangements for different grades of doctor, because an agreement for consultants may not suit, eg junior doctors working patterns.

Non-NHS work

With the changing nature of the NHS and increased plurality of provision, increasing numbers of consultants are working in a self employed contractor capacity. Derogation from Articles 3-6, 8 and 16 of the directive, which cover the 48 hour limit and other aspects, is possible for certain groups under Article 17 of the WTD. 'Persons with autonomous decision-taking powers' are one of these groups. The CCSC has sought legal advice on the definition of an autonomous worker. The advice received was that consultants' private practice work falls within the definition of 'managing executives or other persons with autonomous decision making powers'. Consultants undertaking private practice work could reasonably be regarded as either managing executives or persons with autonomous decision making powers or, if not, they could sign an opt-out agreement. The position is the same for consultants operating through the vehicle of a partnership or limited company. This is because, in practice, when working through either of these vehicles, the consultant retains autonomous decision making powers.

Redundancy

Introduction

It is still rare for medical staff to be made redundant, although there have been increasing numbers of redundancies. The increase in diversity of provision in the healthcare market may result in greater insecurity in the future. Redundancies can arise through a number of reasons including:

- the closure of a hospital, unit, or department within a hospital
- a reduction in the volume of work carried out by a hospital or unit
- a reorganisation within a hospital or unit resulting in the same work being carried out by fewer people, or by those with different experience or skills.

Consultation

When an employer identifies a potential redundancy situation there is a requirement on the employer to consult a recognised trade union representing the staff concerned (in the case of doctors this is almost certain to be the BMA). There is also a requirement to consult with any individuals potentially at risk of redundancy with a view to discussing the options available, such as alternative reorganisation proposals or possible alternative employment elsewhere.

Selection for redundancy

Once a redundancy situation has arisen an employer is required to draw up criteria, which are as objective as possible, to determine which staff should be made redundant. Firstly, an employer has to identify the group of staff from whom redundancies will be selected. This has to be done fairly. For example, if two departments in different hospitals are merging it would not be appropriate to select redundant staff from only one of those departments.

The following factors may be used in making selections for redundancy:

- skills, experience and qualifications
- standards of work performance
- attendance, fitness and health
- disciplinary record
- age.

These criteria are usually appropriate in any redundancy situation and must be agreed with the relevant recognised trade union, ie normally the BMA.

The BMA also believes that when a redundancy situation arises employers should offer staff the option of voluntary redundancy or voluntary early retirement, although some employers resist this for fear of losing their best staff.

Alternative employment

Once an employer has identified staff to be made redundant the employer is required to take all reasonable steps to find alternative employment for those staff. In reality this is not always easy. If suitable alternative employment is found then consultants may jeopardise their right to a redundancy payment if they unreasonably refuse to accept the offer of suitable alternative employment.

Appeal against redundancy

As with all dismissals consultants should have a right of appeal if they are made redundant. Consultants should be able to use appropriate Trust appeal machinery ensuring that the appeal is heard by individuals not previously involved in the redundancy selection. There may in addition be recourse to an employment tribunal if the process has not been handled fairly.

The transfer of undertakings regulations

A redundancy may be associated with the transfer of activity to a different provider of care. It may therefore be covered by the Transfer of Undertakings (Protection of Employment) Regulations 1981 ('TUPE'). In these circumstances, the Regulations provide that the Trust will have to demonstrate an 'economic, technical or organisational reason' for the redundancy.

Redundancy payments

Redundancy payments are payable to consultants who are made redundant either in accordance with specific Whitley Council agreements, or local Trust agreements. Under the GWC agreements (which is now contained in Section 16 of Agenda for Change), the amount of the redundancy payment is dependent on the consultant's reckonable service as at the date of termination. The consultant will receive one month's pay for each complete year of service up to a maximum of 24 years' reckonable service. The payment is subject to two years' continuous service with the present or a previous NHS Employer.

As an alternative a member who is eligible to retire from the NHS pension scheme (NHSPS) may choose to retire early without any actuarial reduction in their pension as an alternative to receiving the full lump sum payment. The consultant must have two years' continuous employment and have reached the minimum pension age. The employer will make a payment to the NHSPS to fund this, however, if the payment they are required to make is less than the lump sum payment the consultant would have received then the consultant is entitled to receive the balance of the lump sum payment.

Consultants will not be eligible for a redundancy payment in the following circumstances:

- they are dismissed for misconduct
- at the date of termination they have obtained suitable alternative employment with another or the same NHS employer
- they unreasonably refuse an offer of suitable alternative employment
- where employment is transferred to another public service employer who is not an NHS employer.

In a redundancy situation, doctors may not be required to work all their notice. They may be able to take the pension from all of their NHS posts, even if sessions at only one particular Trust are being made redundant. If pension is taken from all posts the doctor will be unable to continue in the NHSPS.

Returning to the NHS following redundancy

Doctors may be successful in rejoining NHS employment following redundancy retirement. In this case they will be unable to rejoin the NHSPS unless they were made redundant from one post but continued to remain a member of the NHSPS through a concurrent post. Additionally, the pension being received may be abated (reduced or removed) if the total of the NHS pension plus NHS income exceeds their pre-redundancy NHS income.



Information

- > General Whitley Council Conditions of Service: sections 45, Arrangements for Redundancy Payments and 46, Payment of Superannuation and Compensation Benefits on Premature Retirement
- > ACAS Advisory Booklet, Redundancy Handling, July 2004 (printed version), December 2004 (web version www.acas.org.uk)
- > Redundancy entitlement – statutory rights: a guide for employees (PL808), Department for Trade and Industry (www.dti.gov.uk/er/redundancy.htm)

Pensions

Occupational pension schemes

From 1 April 2008 the NHSPS was amended and a new NHSPS created alongside, for new joiners after this date. Current members of the amended NHSPS will be given the opportunity to switch to the new NHSPS during the 'choice exercise', due to commence in July 2009 in England, Wales and Northern Ireland and in April 2009 in Scotland. Most consultants are members of the amended NHSPS although some belong to other schemes such as the Universities' Superannuation Scheme, Principal Civil Service Pension Scheme, Medical Research Council Pension Scheme and Armed Forces Pension Scheme.

Although membership of these occupational pension schemes is voluntary, the BMA considers that they provide good pension benefits and recommends that consultants take financial advice before considering opting out of membership. The benefits of most of these various schemes are similar to the amended NHSPS, so this is described hereafter. Advice for clinical academics can be found on page 159.

Much of the information in this section relates to the amended NHSPS. Guidance on the New NHSPS can be found on the pensions pages of the BMA website (www.bma.org.uk).

Contribution rates

Since 1 April 2008 a new tiered contribution structure has been introduced. Consultants contribute between 6.5 and 8.5 per cent of pensionable income into the amended NHSPS, dependant on earnings. Contributions attract tax relief, and lower national insurance contributions, so the actual cost is less.

Pensionable income

This includes basic salary, distinction awards, discretionary points, CEAs, domiciliary consultation fees and London weighting allowance. Programmed activities are pensionable up to a maximum of 10 per week. Any programmed activities worked in excess of 10 will not be pensionable. Where a premium time programmed activity is included in the job plan then any agreed enhancement will also be pensionable.

Income which is not pensionable in the NHS scheme

This includes private income, category 2 and 3 work, NHDs beyond whole-time or maximum part-time (including temporary additional NHDs), or additional PAs above full time. Additional income from management posts is covered below under 'Clinical and medical directors'. It may be possible to pension this income in a personal pension scheme, and financial advice should be strongly considered.

Earnings cap

Since 1 April 2008 the earnings cap has been abolished in respect of future service. However, consultants who did not join the NHSPS until after 1 June 1989 are subject to the earnings cap in respect of service between joining and 1 April 2008. The cap for 2007/08 was £112,800 and, for those affected by the cap, it was not possible to pay contributions or earn benefits beyond the level of the cap. Consultants who purchased added years after 1 June 1989 should note that the added years purchase continues to be subject to the earnings cap even after 1 April 2008.

Pension

The amended NHSPS pension is calculated in the following way:

$$\text{Pension} = \text{scaled service (years)} \times \text{pensionable salary}$$

It is possible to achieve a maximum pension of 45/80ths.

Pensionable salary

This is the notional full-time salary (irrespective of whether the consultant is part time or full time), based on the best of the last three years of service before retirement. In most cases this will be the last 12 months.

Scaled service

If the consultant is full time this is the actual number of years (and days) worked. However, any part-time work is scaled down to its full-time equivalent. For instance, 11 years in a maximum part-time 10/11 contract would result in 10 years' scaled (pensionable) service.



Information

- > BMA Pensions Guidance Note: Salaried doctors
- > BMA Pensions Department website www.bma.org.uk

Lump sum

In addition to the pension, a lump sum (which is tax free within HMRC limits) is payable on retirement. This is usually three times the pension. It is less for married men with service before 1972 unless extra contributions have been paid to purchase the unreduced lump sum.

Since 1 April 2008 it has been possible to increase the lump sum from three times the pension. It is possible to access up to 25 per cent of the total pension value as a lump sum, by commuting pension to lump sum. £1 of pension can purchase an additional £12 of lump sum. Increasing the lump sum in this way means a reduced annual pension becomes payable.

Protection against inflation: index linking

The amended NHSPS pension is increased each year in line with the retail prices index (RPI). Increases are paid in April based on the movement in the RPI during the 12 months ending in the previous September.

Purchasing extra benefits

Up to 100 per cent of pensionable pay can be paid into pension schemes and attracts tax relief. The options available are as follows:

Unreduced lump sum

This is explained above.

Added years

Since 1 April 2008 this facility has been withdrawn. Existing contracts to purchase additional years of service will be honoured and those consultants making maximum added years purchases are still able to purchase the new Additional Pension Purchase facility, introduced on 1 April 2008 to replace added years. The added years facility enabled doctors to purchase additional years of service, and thereby receive an

extra indexed pension and an extra tax free lump sum, calculated in the same way as the basic amended NHSPS pension and lump sum. Added years also include important insurance cover, as the added years are usually credited in full in the event of ill-health retirement or death in service.

Additional Pension Purchase

Since 1 April 2008 this facility has been available for doctors to purchase additional annual pension in blocks of £250, up to a maximum of £5,000 additional pension. No additional lump sum is provided although the additional pension bought is taken into account when commuting pension for an increased lump sum.

Additional voluntary contributions (AVCs) and free standing additional voluntary contributions (FSAVCs)

These produce extra pension and a lump sum of up to 25 per cent of the fund value. The amount of extra pension will depend upon:

- the amount invested (up to 100% of salary, less contributions already made to an occupational pension or other pension plan)
- the success of the chosen investment fund
- the level of annuity (interest) rates prevailing at retirement.

Additional voluntary contributions (AVCs) are an arrangement offered by the NHSPS to allow members to save more for their retirement. They are arranged with external insurance companies who have been selected by the NHS Pension Agencies as AVC Providers to the NHS. Details of these providers can be obtained from the relevant pension agency, or from a factsheet available from askBMA. FSAVCs may be purchased from any company operating in this field. The advantage of an in-house arrangement, which all occupational pension schemes have, is that commission and administration charges may be lower than for FSAVCs. This is an important reason why FSAVCs are most unlikely to provide better value than AVCs.



Information

> [BMA Pensions Guidance Note: Improving benefits](#)

Retirement age

While there is now no compulsory retirement age for consultants employed in the NHS, consultants may retire and claim their pension and lump sum in full at any time from age 60. (The retirement age in the Universities Superannuation Scheme is age 65.) See below for the special arrangements relating to mental health officers (MHOs).

Early retirement

There are a number of early retirement options available:

Ill-health retirement

Since 1 April 2008 a new two-tier ill-health retirement process has been in place. Consultants may retire on ill-health grounds if they are permanently incapable of carrying out their NHS duties (Tier 1), or additionally, if they are permanently incapable of undertaking any regular work of similar nature and duration (Tier 2). Tier 1 retirement provides for accrued benefits to become payable (no reduction for early retirement but no enhancement either). Tier 2 retirement provides for an enhancement of 2/3 of prospective service to the normal retirement age of 60. A return to NHS work may be possible but benefits risk being affected.



Information

> [BMA Pensions Guidance Note: Ill-health retirement](#)

Redundancy; organisational change; interests of the service

These three options can involve a potential enhancement of pensionable service for doctors aged 50 or over. Such enhancement is due to be phased out by 2011 and is only available under the 'transitional protection' rules. In addition to enhanced pension benefits it is possible to receive a redundancy payment, depending on the level of enhancement received. Outside of the transitional protection rules a redundancy payment is payable (dependant on years of service). Alternatively, this payment can be used to access accrued benefits. See page 70.

Voluntary early retirement

Consultants may retire voluntarily from age 50 onwards with an actuarially reduced pension.



Information

> **BMA Pensions Guidance Note: Voluntary early retirement**

Mental health officer (MHO) status

Doctors who, before 1995, worked for the majority of their employment caring for mentally ill people may qualify for MHO status, which gives enhanced pension benefits in the form of doubled years of service after 20 years as an MHO and retirement at age 55 without actuarial reduction of pension.



Information

> **BMA Pensions Guidance Note: Salaried doctors**

Clinical and medical directors

The pension position will depend upon the terms of the medical or clinical director's contract. If the contract involves extra NHDs or PAs beyond full time, these will not be pensionable. If the substantive contract is part time (fewer than nine NHDs or PAs), then the extra NHDs or PAs will be pensionable up to 10 PAs or 11 NHDs in total.

The medical/clinical director PAs or NHDs will also be pensionable if they simply replace pensionable clinical PAs or NHDs. If the contract provides for extra salary to take account of medical/clinical director responsibilities, but the doctor remains full time, then the medical/clinical director income is pensionable. The amended NHSPS pension and lump sum are based on pensionable income paid in the best of the last three years before retirement (see above). In negotiating a medical/clinical director contract, consultants should keep in mind that substantial pension benefits can accrue if medical/clinical director income is pensioned within three years of retirement, but that the contributions will have been wasted if this income finishes more than three years before retirement. See also Clinicians in management, page 167.



Information

> [BMA Pensions Guidance Note: Salaried doctors](#)

Working in the NHS after retirement

It is not normally possible to rejoin the amended NHSPS on returning to work after retirement. However, consultants retiring after 1 April 2008 but before the 'choice exercise' will be able to join the new NHSPS after a break of two years (subject to scheme rules of no more than 45 years' service being accrued overall). A break in service needs to be taken before returning to work in the NHS. Consultants who retire at the normal retirement age or who take voluntary early retirement with actuarial reduction or who have used their redundancy payment to fund for their accrued benefits will not be subject to any reduction of NHS pension (also known as abatement) on return to work in the NHS. For consultants retiring on health grounds and returning to NHS employment there is the possibility that some of their pension may be reduced depending on the level of post-retirement NHS earnings and the tier to which they had been allocated.

Personal pension plans (PPPs)

Consultants in the amended NHSPS can take out a PPP. If the consultant returns to work after retirement, the NHS income is not pensionable in the amended NHSPS and can therefore be pensioned in a PPP.

Injury benefits

The NHS injury benefits scheme provides benefits to any consultant who suffers a loss of earning ability due to an injury, illness or disease resulting from NHS duties. The maximum benefit, together with any NHS pension and state benefit which is payable, is 85 per cent of pay. In addition, it may be possible to make a claim for damages against the employer (see page 139). If this is successful there may be a consequent reduction in the NHS injury benefit payable. The scheme is currently under review.



Information

> [BMA Guidance Note: Injury benefits](#)

Further advice

The relevant NHS Pensions Agencies can provide estimates of benefits in advance of retirement and answer enquires about the amended NHSPS (the addresses and phone numbers are in all BMA pension guidance notes). Consultants can also access the pension pages in the BMA members' area of the BMA website. Guidance notes can also be obtained from the website, *askBMA* or the BMA pensions department at BMA House.

Clinical excellence awards (CEAs)

In August 2003, the DH published a framework for the CEA scheme to replace the previous distinction awards and discretionary points schemes. CEAs were awarded for the first time with effect from April 2004. The CCSC has published a suite of guidance on CEAs which is available here: www.bma.org.uk/employmentandcontracts/doctors_performance/awards/index.jsp

Distinction awards and discretionary points

Consultants with distinction awards or discretionary points retain them, subject to existing review provisions, and are eligible to apply for awards under the new scheme in the normal way. The value of distinction awards and discretionary points will continue to be updated in line with the recommendations of the DDRB. If a CEA is made, that will subsume the value of any discretionary points or distinction awards already held by the consultant.

Basis of awards

The CEA scheme is intended to recognise and reward those consultants who contribute most towards the delivery of safe and high quality care to patients and to the continuous improvement of NHS services including those who do so through their contribution to academic medicine. In particular, awards are made to consultants who:

- demonstrate sustained commitment to patient care and wellbeing or improving public health
- sustain high standards of both technical and clinical aspects of service while providing patient-focused care
- in their day-to-day practice demonstrate a sustained commitment to the values and goals of the NHS by participating actively in annual job planning, observing the private practice code of conduct and showing a commitment to achieving agreed service objectives
- through active participation in clinical governance contribute to continuous improvement in service organisation and delivery
- embrace the principles of evidence-based practice
- contribute to knowledge base through research and participate actively in research governance

- are recognised as excellent teachers and/or trainers and/or managers
- contribute to policy-making and planning in health and healthcare
- make an outstanding contribution to professional leadership.

Structure of the scheme

The scheme comprises local and national elements. The lower value local awards (levels 1-8) are made by Employer Based Awards Committees (EBACS). The higher value national awards (10-12) will be decided by the Advisory Committee on Clinical Excellence Awards (ACCEA) and its subcommittees. A level 9 award may be awarded by either the EBAC or the ACCEA, depending on the type of achievement being recognised. All awards under the new scheme are determined according to a common rationale and objectives. The eligibility and assessment criteria for all awards are set nationally and standard nomination forms for all levels of award along with guidance can be accessed from the ACCEA's website (www.advisorybodies.doh.gov.uk/accea/).

Eligibility

NHS consultants and NHS honorary consultants are eligible for awards provided that:

- they have completed at least one year's service at consultant level
- a satisfactory appraisal process has been signed off by employer(s) and consultant within the 12 months prior to the nomination process
- job plan and contractual obligations are fulfilled
- they have observed the private practice 'code of conduct'
- there are no adverse outcomes for the consultant following disciplinary action by employer or GMC or General Dental Council.

The scheme is meant to enable consultants whose contribution to the NHS is focused locally to be able to progress to the top level of higher awards. Some local agreements provide that consultants granted CEA(s) locally in one year would not normally be considered locally again the following year for further award(s).

How to apply

All eligible consultants can apply for CEAs using the ACCEA advice and the relevant forms which are available on the committee's website. National award applicants should check the timetable for the process on the ACCEA website. ACCEA has recently started to publish indicative timetables for the local awards round as well but you should check with your employer about the process in your trust. Citations can be sought from relevant professional bodies (such as royal colleges or the BMA) to support the application. Citations are required for applications for national awards but not necessarily for local awards. Consultants must ensure that their employer completes an assessment as part of the application process, including confirmation that an appraisal has taken place and that contractual duties have been fulfilled. Employers are also required to ensure that appropriate advice, secretarial support and IT resources are made available to all consultants to assist them in completing their application forms.

Values of awards

The values of the awards are reviewed each year by the DDRB and can be found on the BMA website.

www.bma.org.uk/employmentandcontracts/pay/index.jsp

All levels of award are pensionable and will be paid in addition to consultants' basic salaries. Awards will be annually up-rated, subject to the recommendations of the DDRB. CEAs for part-time consultants are paid on a pro rata basis.

The ACCEA advises that EBACs should comprise of between 10 and 15 members, including up to nine consultant members. In all cases, consultants should form at least 50 per cent of the membership of the committee. Employers, in consultation with their LNC, may decide that the committee should not contain members who are themselves eligible for awards. Where this proves to be impracticable, it is suggested that trusts and/or health authorities should combine to produce an adequate number of consultants to sit on EBACs. National awards will be made by the national ACCEA which will rely heavily upon advice received by its

regional subcommittees. This advice will be given particularly strong consideration for levels 9-11.

Numbers of awards

National awards

At a national level, the amount spent on CEAs is based on the historic spend on the distinction awards scheme, with the figure updated by the DDRB alongside other elements of pay and adjusted to take into account consultant expansion.

Local awards

Employers are required to award a minimum of 0.35 CEAs for each eligible consultant each year. Employers should also spend at least the amount previously spent on the discretionary points system. Employers cannot refuse to meet the minimum spend requirement for financial reasons. If, for justifiable reasons, an employer does not spend the minimum investment in any given year, that investment must be carried over and awarded in the next year.

As consultants move from discretionary points to CEAs, this will result in some awards being made with a value below that of a full CEA. The BMA has produced guidance on this for members which is available here:

www.bma.org.uk/employmentandcontracts/doctors_performance/awards/clinicalexcellenceawardsguide.jsp

EBACs can make awards which advance consultants by more than one level in one year. (For example, a consultant on level 2 could be awarded level 4.)

Assessment of awards

Decisions on all levels of award are based on the following criteria:

Area 1: Delivering a high quality service

- Evidence of outstanding commitment to achieving NHS service priorities and objectives including flexibility in adapting to changing priorities and demands.
- Evidence of practical application of high standards in the technical and clinical aspects of their service.
- The provision of patient-centred care, valued by patients and colleagues alike (or, in the case of public health, population-based service valued by stakeholders and colleagues alike).

Area 2: Developing a high quality service

- Evidence of active participation in clinical governance, leading to a major role in the continuous improvement and innovation in the organisation and delivery of services.
- Evidence of outstanding commitment to evidence-based practice, which is taken forward appropriately for the benefit of patients through clinical audit and/or other evaluative tools.
- Evidence of notable additions to the knowledge base of the NHS through research and discovery.
- Evidence of a strong commitment to patient safety, learning from error and promoting safer systems and clinical/research processes.
- Evidence of commitment to the development of effective multidisciplinary team working.

Area 3: Managing a high quality service

- Evidence of excellent contributions to policy-making and planning in health and healthcare, either at a local or national level.
- Evidence of excellent achievements in change management
- Evidence of managing a patient-centred service.

Area 4: Research, education and training

- Evidence of excellent achievements in research and development.
- Evidence of active participation in research governance.
- Evidence of excellent performance as an educator or trainer.

A consultant will not be expected to score highly in all four areas, even at the highest level of award, but an excellent record in the first will be expected if an application is to succeed.

Appeals against the process

Any consultant nominated for an award may seek a review of the process. The employer will set up a committee to consider appeals and that committee should be constituted differently from that which took the original decision, or which provided the original advice to the central committee. If a consultant has exhausted the local appeals process and still wishes to pursue their appeal to a higher level, they should contact the ACCEA secretariat.

Review and renewal criteria

Awards will be reviewed at five-yearly intervals to ensure that the consultant is continuing to fulfil the criteria for the award. It is expected that in the vast majority of cases, CEAs will be renewed throughout a consultant's career, although the review will have a range of options:

- straightforward renewal for a further period of five years where the criteria continue to be met
- renewal for a period of less than five years where there is a cause for concern but where the evidence suggests an ephemeral problem as the cause
- removal of the award or substitution of a lower award where the performance no longer merits the higher award with payment at the higher level continuing on a mark-time basis (ie the value of the higher award remains static while the lower award catches up through annual pay uplifts)
- in very extreme circumstances, removal of award and removal of payment. Awards made by the ACCEA and its subcommittees will be

reviewed by the committee which made the award. Local awards will be reviewed by LACs on an exception basis (eg where a contract of employment has been significantly altered). Where disciplinary or professional proceedings have upheld concerns or allegations about the consultant's conduct or performance, an employer can request a review. Employers will be expected to notify the ACCEA if an award holder is subject to disciplinary or professional fitness to practise proceedings.

Retirement of award holders

When a consultant retires, any CEAs he/she holds will cease to be paid with effect from the retirement date.

Openness and transparency

Analyses of the distribution of awards and the list of consultants receiving each level of national award and the principal reasons for the granting of an award are published by the ACCEA in an annual report. The BMA has worked with ACCEA to monitor awards at all levels, against the criteria for award, to ensure that:

- there is a fair distribution of awards between specialties
- there is a fair distribution of awards geographically
- there is a fair distribution of awards between types of hospital groups, such as female consultants and consultants from minority ethnic groups

Each trust should publish an annual report in line with the recommendations. Set out in the ACCEA's guide for employers which is available on their website.

The BMA is working with ACCEA on developing guidance on how part or all of application forms might be published with a view to increasing openness and to provide consultants with an opportunity to learn from successful and unsuccessful applications.

Private and independent practice

Introduction

This chapter sets out the position relating to private practice under national terms and conditions and other national agreements. The right to undertake private practice remains an essential part of the flexibility and freedom built into national contracts. For information on clinical academic staff, see page 154.

Definition of private practice

Private practice is defined for consultants and other hospital doctors in both sets of terms and conditions of service as 'the diagnosis or treatment of patients by private arrangement'. A private patient is defined in the NHS Acts as a patient who gives (or for whom is given) an undertaking to pay charges for accommodation and services.

Code of conduct on private practice

As part of the 2003 contract negotiations, a new code of conduct for private practice was agreed. The aim of the code was to minimise the risk of a conflict of interest arising between a consultant's private practice and their NHS commitments. While part of the 2003 negotiations, the standards of best practice are designed to apply to all consultants working in the NHS, whatever their contractual arrangements. Adherence to the standards in the code forms part of the eligibility criteria for clinical excellence awards. The code also states that consultants should conform to any local guidelines. Consultants are, therefore, advised to contact their LNC for advice on any local arrangements that may apply.

Disclosure of information

The code says that consultants should disclose details of private commitments, including planning, timing, location and broad type of activity as part of the job planning process.

Scheduling of work

Programmed NHS commitments should take precedence over private work and private commitments should not be scheduled during times that a consultant is scheduled to be working for the NHS. Private commitments should be rearranged if there is regular disruption to

NHS work and private work should not stop a consultant from being able to attend NHS emergencies when on call. However, the code recognises that there will be circumstances when a consultant may need to provide emergency private care when working for the NHS.

Private care in the NHS

With the agreement of the employer, some private work may be undertaken alongside NHS duties provided there is no disruption to NHS services, although private patients should normally be seen separately. Consultants can only see private patients in NHS facilities with the employer's agreement. The employer can determine the use of staff, facilities and equipment and any relevant charges.

Information to patients

Consultants should not, while on NHS duty, initiate discussion about providing private services to NHS patients.

Private patients to NHS lists

The code says that, where a patient chooses to change from private to NHS status, they should not be treated any differently because of their former private status and should join the NHS waiting list at the same point as if the consultation or treatment was an NHS service.



Information

> [A Code of Conduct for Private Practice: Recommended Standards of Practice for NHS Consultants, An agreement between the BMA Central Consultants and Specialists Committee and the Department of Health for consultants in England](#)

NHS contractual provisions: 2003 contract

NHS work and private practice

In addition to the code of conduct, the 2003 terms and conditions of service also contain contractual provisions dealing with the relationship between NHS and private activity. The terms of service cover much the same ground as the code of conduct and state that:

- consultants should inform the employer of any regular private commitments which should be noted in the job plan
- NHS commitments take precedence over private work and there should be no significant risk of NHS commitments disrupting private work
- consultants should not undertake private work while on call for the NHS apart from in cases of emergency or, with the agreement of the employer, when on a high frequency and low intensity rota
- the consultant can only use NHS facilities and staff for private work with the employer's agreement
- private patients should normally be seen separately from scheduled NHS patients
- consultants should not initiate discussions about private practice and should only provide agreed information when approached by a patient.



Information

> [Terms and Conditions of Service 2003, schedules 8 and 9](#)

Additional PAs and pay progression

Under the 2003 contract, there is no obligation for a consultant to undertake PAs in excess of the standard 10 per week. However, one of the criteria for achieving progression through the pay thresholds is that consultants should accept an extra paid programmed activity in the NHS, if offered, before doing private work. The following points should be borne in mind:

- if consultants are already working 11 PAs (or equivalent) there is no requirement to undertake any more work
- 11 PAs could easily be fewer than 44 hours if some work is in premium time
- a consultant could decline an offer of an extra PA and still work privately, but with risk to NHS pay progression for that year
- any additional PAs offered must be offered equitably between all consultants in that specialty; if a colleague takes up those sessions there would be no detriment to pay progression for the other consultants.

Where a consultant intends to work privately, the matter should be discussed with the clinical manager. The employing organisation may then offer the consultant the option of undertaking up to one extra PA per week, which is paid. The consultant may choose either to accept or reject the offer. If rejected, the employing organisation is entitled to withhold pay progression for that year only. Additional PAs can be offered on a fixed basis or a mutually agreed annualised basis. Where possible, the offer should be made at the annual job plan review and should be no fewer than three months in advance of the start of the proposed extra PAs, or six months in advance where the consultant would need to reschedule external commitments. There is a three-month minimum notice period for termination of the additional PAs on both sides. Transitional provisions are in place for former maximum part-time consultants until the end of March 2005 where fewer additional PAs need to be worked per week in order to satisfy the pay progression criteria.



Information

> [Terms and Conditions of Service 2003, schedule 6](#)

NHS contractual provisions: pre-2003 contract

Under the pre-2003 national terms of service, whole-time consultants (see pages 3-4) may undertake private practice subject to certain contractual restrictions, including a strict limitation on private practice income. The gross earnings from private practice of whole-time consultants for any financial year beginning 6 April must not exceed 10 per cent of gross NHS salary. Maximum part-time consultants can do unlimited private practice, subject to the requirement that they devote substantially the whole of their professional time to their NHS duties, but only receive 10/11ths of whole-time NHS salary. Gross NHS salary is taken to include any discretionary points, distinction award or CEA payable, but not other NHS earnings such as fees for domiciliary visits. Some employers have offered whole-time contracts with no limit on private practice earnings, sometimes with a condition that private work will take place on NHS premises.

Whole-time consultants may practise privately in their own NHS hospitals or elsewhere, provided that significant amounts of time are not spent travelling to or from private commitments. Any rights to practise privately, whether as whole-time or maximum part-time employees, do not allow consultants to diminish the level of service given to their NHS patients. Consultants must give priority to their NHS work at all times, subject only to their ethical obligations to all their patients when emergencies arise.

Whole-time consultants must certify to their employer at the end of each financial year that they have not exceeded the 10 per cent limit. While employers have the explicit right to call for the production of fully audited accounts to support certificates of earnings, this is rarely exercised. However, if a certificate is requested and not provided within three months, the employer has the right to regard this as evidence that private practice earnings are in excess of the 10 per cent limit.

Consultants lose their whole-time status if they exceed the limit in two consecutive years beginning 6 April, and cannot show by the following 1 April that they have taken effective steps to reduce their private commitments. They will automatically be re-graded to maximum part time and paid 10/11ths of the gross whole-time salary. After such compulsory re-grading, consultants may return to whole-time status only after a further two years in which their private earnings do not exceed the 10 per cent limit. Employers cannot count part-years on a pro rata basis. When consultants take up appointments on dates other than 6 April, the employer can only begin assessing compliance with the limit from the following 6 April.

It would, however, be contrary to the spirit of the agreement if consultants were to regard themselves as having three years' automatic grace in which to flout the limit before being re-graded. Similarly, deliberate repeated compliance only at the three-year stage is regarded as an abuse of the system. If consultants know in advance that their private earnings are likely to exceed the limit, and that they have no intention of reducing them, they should make this clear to their

employers and seek to be re-graded. Consultants who have concerns about any aspect of their private work are advised to contact askBMA in the first instance. If it is found that you need direct representation locally you will be referred to staff working from a BMA Centre or to the BMA private practice committee.



Information

- > [Terms and Conditions of Service, paragraphs 40-43](#)
- > [PM\(79\)11, Contracts of Consultants and other Senior Hospital Medical and Dental Staff](#)

Definition of private practice income

Income from private practice and category 3 work (see page 14) counts towards the 10 per cent limit under the pre-2003 contract. However, consultants may receive fees and payments in addition to their NHS salaries and discretionary points or merit awards which are quite separate from private practice income. In order to fully understand the definition of private practice income, it is important to identify those fees and payments which are not income derived from, or are classified as being separate to, private practice, and which do not, therefore, count towards the 10 per cent limit. These are:

- fees for category 2 work, for example, medico-legal work, insurance reports (see pages 12 and 28)
- fees for family planning services arranged by the employer (see page 16)
- fees for domiciliary visits (see page 15)
- fees for exceptional consultations in hospitals managed by a different employer (see page 15)
- fees for lectures to hospital staff (see page 17)
- fees for examinations and reports in connection with the routine screening of employees of health and local authorities carried out by radiologists and pathologists outside their contractual arrangements
- earnings from temporary additional NHDs (see page 10)
- fees under the collaborative arrangements.

Private practice in the NHS

Access to private beds

Under the NHS and Community Care Act 1990 Trusts may make pay beds available to those staff who are entitled to admit their own patients to the hospital for NHS treatment, ie to the hospital's consultant staff. Trusts may also offer patients 'amenity beds' for which a charge is made, or another category of private bed for which the patient pays but does not make a private arrangement for treatment with a consultant. In neither of these cases may the consultant charge any fees.

NHS charges for private practice

The Health and Medicines Act 1988 provides for Trusts to set their own charges on what they consider to be the appropriate commercial basis.

Involvement of other specialties

When patients are admitted privately, the primary consultant should explain to the patient that the professional services of an anaesthetist and the opinion of a pathologist or radiologist may also be required and that fees will be payable for these services. It is essential that colleagues in the diagnostic specialties are properly involved in the treatment of private patients, so that a personal service may be expected. Problems have arisen in the past over the practice of arranging the investigations of private patients through the NHS rather than privately. This practice developed for the historical reason that, until the contract changed in 1979, most pathologists and radiologists held whole-time contracts and therefore were not entitled to undertake any private practice. However, the guidance set out in the 1986 handbook *Management of private practice in health service hospitals in England and Wales*, sometimes referred to as 'The Green Book' (see page 95) helped to clarify the position where the general rule is that private patients should remain private throughout the whole treatment episode, although they do have the right to change their status between an NHS and private patient at any stage of their treatment.

Junior staff

Training grade and non-consultant career grade doctors are required to assist the consultants to whom they are responsible with the treatment of their private patients within an NHS hospital in the same way as their NHS patients. The charge paid by private patients to the hospital covers the whole cost of hospital treatment including the salaries of nurses and all medical staff other than consultants. Junior doctors, when on duty, should not be required to leave their main site of employment to attend to private patients, except for agreed training purposes. Training grade doctors may undertake additional duties outside their contractual hours if they wish, which may include assisting in private cases either in the NHS or in a private hospital. While many consultants will offer training grade doctors payment for such work, training grade doctors should seek advice from a medical defence organisation about the indemnity position for undertaking fee paid work outside the NHS.

Non-consultant medical staff

Practitioners, such as associate specialists, who do not have their own beds, may treat the private patients of a consultant on a private basis, but only by special arrangement when the consultant concerned, the practitioner's supervising consultant and the private patient have agreed. In practice there are difficulties for non-consultant medical staff to establish their own practices as private insurance companies are unlikely to recognise them as specialists. Most require membership of the specialist register.



Information

- > Section 65 of the NHS Act 1977 (as amended) – Authorised Accommodation for Private Patients
- > Section 63 of the NHS Act 1977 – Amenity Beds
- > Section 23 of the NHS and Community Care Act 1990
- > Management of Private Practice in Health Service Hospitals in England and Wales, 1986
- > Health and Medicines Act 1988
- > HC(89)9, Determination of Charges for Private Patients and Overseas Visitors

> Private practice and junior doctors, BMA Junior Doctors Committee, June 1999

The Green Book

Guidance exists on the management of private practice in the NHS, although having been published in 1986, it is now out of date in many respects. The guidance describes the procedure for authorising pay beds, the application of charges, practical aspects affecting income from private patients and, most importantly, the principles to be followed in conducting private practice in the NHS:

- that the provision of services for private patients does not significantly prejudice non-paying patients
- generally, early private consultations should not lead to earlier NHS admission
- common waiting lists should be used for urgently and seriously ill patients
- normally, access to diagnostic and treatment facilities should be governed by clinical considerations
- standards of clinical care and services should be the same for all patients
- single rooms should not be held vacant for potential private use longer than the usual time between NHS patient admissions.

Much of this guidance is confirmed in the code of conduct on private practice. Some employers have in addition drawn up their own guidelines on the management of private practice in consultation with the profession, a move the CCSC welcomes and encourages. Procedures for identifying private patients are described in the Green Book and it is essential that consultants are aware of the procedures adopted in the hospital in which they work. The guidance and code of conduct also stress that it is the responsibility of consultants themselves to ensure that their private patients are identified as such. A private patient officer should be appointed at hospitals where private patients are treated, and, if consultants require advice on the procedure to be adopted, then this officer should be contacted.



Information

> Management of Private Practice in Health Service Hospitals in England and Wales, 1986

Private prescriptions in the NHS

The Green Book clarifies that patients receiving NHS services should not be charged. The terms 'service' in the National Health Service Act 1977 generally covers any services and where there is a definition of service(s) it is prefixed, for example with the word medical or pharmaceutical.

Despite this, patients may receive private prescriptions. In such cases it would be possible for a consultant to charge an NHS patient a fee for issuing a private prescription. However, it is important that the patient understands the reason for the prescription being private and that a practitioner should not write a private prescription when the patient is entitled to an NHS one. Private prescriptions can be written for a number of reasons, for example, the prescribing of a drug which has restricted availability, for example because of doubts about clinical efficacy. The consultant may consider that there is a chance the patient could benefit from the medication but it would not be funded by the NHS. Where a drug is unlicensed the doctor would have to take full clinical and legal responsibility for the prescription.

In cases where a private prescription has been issued, both an employer and a doctor can charge the NHS patient a separate fee, the employer for the cost of the drug prescribed and the doctor for the issuing of the prescription. The Health and Medicines Act 1988 provides for NHS employers to set their own charges for private prescriptions on what they consider to be the appropriate commercial basis. The writing and issuing of a private prescription to any patient by a doctor does not form a written undertaking that the patient has become a private patient. A doctor cannot write an NHS prescription for a private patient unless it is for a separate condition than that for which the patient was admitted. Advice on undertaking private practice while on sick leave from the NHS can be found on page 48.



Information

- > Private Prescriptions in the NHS and prescribing Responsibility, CCSC June 2000
- > Letter, 18 February 2000 from N Cullen, NHSE, to J Woodcock, CCSC Secretariat
- > Letter, 22 September 1999 from V Jones, NHSE, to J Woodcock, CCSC Secretariat
- > Health and Medicines Act 1988

Trusts' contracts with third parties

Trusts may enter into contracts with outside bodies to provide medical services to those bodies, a common example being the provision of pathology services to a local private hospital. Such arrangements are often referred to as 'section 58 arrangements', although section 58 of the NHS Act 1977 has been subsumed into the broader provisions of section 7 of the Health and Medicines Act 1988.

If the arrangements made by the Trust involve consultants then, under the pre-2003 terms and conditions of service, the prior agreement of the consultants should be obtained. It is then for the consultants to negotiate directly with the third party in respect of their professional fees, which will count as private earnings for the purposes of the 10 per cent limit or alternatively, the consultants and the employer may agree that the work forms part of the NHS workload. Concerns have arisen in some parts of the country regarding the practice of private health insurers agreeing fees, for example for pathology and radiology services, directly with hospitals. The BMA has raised this matter with the insurers and private hospital groups involved, expressing concern that the practice undermines the key principle of independence of consultant practice. Radiologists and pathologists who share the BMA concern are advised to act collectively and insist upon undertaking their own billing, if they do not do so already.



Information

- > Terms and Conditions of Service, paragraph 31
- > Health and Medicines Act 1988, section 7

> Management of Private Practice in Health Service Hospitals in England and Wales

Medical indemnity

Consultants should note that the NHS indemnity scheme (see page 52) does not cover private work, either in the NHS or in private hospitals, although different arrangements apply to category 3 work (see page 14). Consultants should ensure that they have appropriate indemnity with a medical defence body to cover them for private practice.

Indemnity for private prescribing will depend on the individual circumstances. For example, when consultants charge for their signature on forms for driving licences they would still be covered by NHS indemnity because the charge is purely for the signature. However, in the case of drugs such as Viagra they would not be covered, because the doctor has issued a prescription for a patient that the NHS had not judged viable for receiving that treatment. Consultants should seek advice from their medical defence organisation.

Private patients

It is important to note that in private practice, a direct contractual relationship exists between the doctor and patient, and not normally the doctor and insurer. While practitioners are, therefore, entitled to treat any patient privately, regardless of whether or not they have obtained specialist recognition for a particular insurance company, they would have an obligation to inform the patient at the outset that their insurer may not reimburse the full costs of treatment. Consultants should note that health insurance companies have widely differing policies and that patients might not be fully aware of all the restrictions that apply. It is the responsibility of patients to ensure that they have adequate medical insurance to cover the costs of treatment and fees charged by specialists, which will vary from case to case, depending upon the time spent and complexity of individual procedures. Patients are responsible for meeting any shortfall between the fees levied by consultants and the costs reimbursed by their insurer. The BMA encourages consultants to forewarn patients at the earliest opportunity

of the likely level of charges for treatment and to ensure that such charges are reasonable and transparent.

Private medical insurance companies: specialist recognition

Private hospitals and provident associations/insurance companies employ the concept of 'specialist recognition' to determine either who may practise from their hospital or who may treat their subscribers. Recognition is usually granted to individuals who hold, or have held, a substantive consultant post in the NHS or to those who hold a certificate of completion of training (CCT). Insurers and private hospitals have the right to grant discretionary recognition to anyone they see fit to do so. This decision may take account of an individual's clinical abilities, experience, references where appropriate and how they see these factors fitting into their own selection criteria which are often not published.

All substantive NHS consultants should automatically be entitled to specialist recognition by insurers and while a small number of other practitioners may have also obtained recognition, on an individual basis, insurers are becoming increasingly firmer in this criterion's application. Consultants should contact askBMA in the first instance if they have any concerns regarding restrictions of their admitting rights.

Independent hospitals

Medical advisory committee (MAC)

Most private hospitals have a MAC or consultation by the hospital management on all medical matters including, for example, any request for admitting rights. The MAC has a crucial role in the maintenance of medical standards at private hospitals and the BMA firmly supports the existence of strong and effective committees in all private hospitals. The BMA envisages an increasing role for MACs under clinical governance and in handling complaints. Increasingly, the hospital groups expect consultants to sign up to a set of complaints and disciplinary procedures.

Admitting rights

As indicated above, arrangements for admitting rights at a private hospital are a matter between the consultant and the hospital concerned. The arrangements are not always the subject of a contract or written agreement in the case of surgeons and anaesthetists, nor are there financial arrangements between the consultant and the hospital unless the consultant is renting consulting rooms at the hospital.



Information

> *Good Medical Practice, GMC, third edition 2001*

Fees for private medical work

From 1989 until 1994, the BMA produced guidelines on fees for private medical services. However, in 1994 the Government accepted the sole recommendation in the Monopoly and Mergers Commission's report into the supply of private medical services to prohibit the publication of the BMA Private Consultant Guidelines because, in its view, a complex monopoly existed which materially benefited consultants who used the suggested fees set out in the document. Since this date the BMA has been unable to offer advice to consultants on reasonable levels of fees for private medical treatment and procedures.

While some provident associations and insurers publish benefit level schedules setting out the maximum they are prepared to pay for a particular episode of treatment, consultants should remember that they are free to determine the actual level of fee for treating patients privately, whether or not the patients are insured with a particular company. In attempting to establish their own fees, consultants are advised to consult with colleagues in the same field and to seek information on the benefit maxima paid by the main insurance companies.



Information

> *Section 65 of the NHS Act 1977 (as amended) – The Treatment of Private In-Patients, and Out-Patients in NHS Hospitals*
> *Terms and Conditions of Service, paragraphs 32, 33, 37 and 40*

Fee-paid work

The arrangements under which NHS consultants may carry out fee-paid work, such as reports for insurance companies and medico-legal work are covered on pages 12-13 for those on the pre-2003 contract and on page 28 for those on the 2003 contract. As noted above, the BMA has limited opportunities to suggest fees for such work undertaken by consultants. However, certain organisations set fees for such work and the BMA has also been able to agree fees with other organisations, such as some government departments. These are set out in the BMA fees guidance schedules available from askBMA or via the BMA website www.bma.org.uk



Information

> BMA Guidance Note: Fees for part-time medical services

Working as a medical expert

New Civil Procedure rules were introduced in 1999 to implement the Woolf report, whose aims were to deal more justly with civil claims, to reduce the delay in civil claims being resolved, and to reduce the expense of civil claims.

For the parties and their lawyers it is hoped to achieve this by:

- insisting on greater cooperation between the parties
- enabling earlier settlements by cooperation and information exchange
- giving the court significant powers to manage a case.

In addition, cases are expedited by allocating them to a 'track' according to their value, as follows:

- small claims track (up to £1,000) allows very limited costs, restricts pre-trial steps
- fast track claims (£1,000-£10,000 but £1,000 if personal injury) requires cost to be proportionate to the claim, allows only fixed costs for a trial, has a short timetable, limits expert numbers
- multi-track claims (over £10,000 or some complex lower value cases).

There are various implications for experts, including medical experts, as described below:

- the court is given a duty to restrict expert evidence to that which is 'reasonably required to resolve the proceedings'. No expert can be called, or report put in evidence, without the court's permissions. Expert evidence is normally to be by written report. In the fast track, no expert is to give evidence at trial unless it is necessary 'in the interests of justice'. The parties to a case are encouraged where possible to appoint a joint expert
- parties are encouraged to appoint an expert jointly
- experts are encouraged to collaborate to clarify issues
- there is greater emphasis that the duty of an expert is to help the court on matters within their expertise and that this duty overrides any obligation to the instructing or paying person/solicitor
- the court sets tighter limits on the fees that are recoverable for expert witnesses
- cases are expedited by the setting of tight timetables – late expert reports may be thrown out.

The new procedure rules also set requirements for the contents of medical reports, give detailed advice on the role of the expert in court, and fees and expenses. The BMA is currently working with the Civil Justice Council and other bodies to examine in detail the role and accreditation of experts.



Information

- > [BMA Guidance for Medical Experts \(October 2007\)](#)
- > [BMA Membership Guidance Note on professional witness work and court reporting \(July 2005\)](#)
- > [BMA Guidance on contracts \(September 2008\)](#) [BMA Expert Witness Guidance \(October 2007\)](#)

Working in the new NHS

In recent years, the way that NHS funded care has been provided in England has changed significantly. Many of these changes have centred around the increased use of the private sector in delivering NHS services. The BMA is concerned about the impact this may have on existing NHS providers and the consequent impact that could have on patient care and the livelihoods of NHS staff. It is important that consultants who continued to work as NHS employees are aware of their responsibility in helping their Trust remain competitive and attractive to patients.

For other consultants, Patient Choice offers opportunities to work in different ways. Some may look to work as employees of new providers whilst others may set up their own physicians' organisations to provide NHS-funded (as well as privately-funded) care. Some consultants will probably want to keep their options open by maintaining NHS employment while at the same time contracting for some services separately.

The CCSC is aware that some consultants are willing to explore some of the new possibilities and has published detailed guidance on the scenarios that are likely to develop and the broad issues that consultants need to consider in this new, business orientated environment. The guidance can be accessed here:

www.bma.org.uk/healthcare_policy/nhs_system_reform/WorkinginnewsJanuary2006.jsp

More specialised and detailed guidance on setting up businesses, tendering and other such activities is available here:

www.bma.org.uk/about_bma/benefits_for_members/bma_business_support/index.jsp

Sometimes, as a result of the changes, you may find that some of your work is being outsourced. The BMA does not approve of this outsourcing but this will not stop it happening and you need to consider how best to protect your interests. There is a possibility that as a result of a transfer of work, you could risk losing certain benefits of NHS employment such as your pension. To avoid this happening the BMA

has agreed a process with the DH called 'Retention of Employment' (RoE). If some of your work is going to be outsourced, you should read the CCSC RoE guidance and contact your local IRO as soon as possible. The guidance is available here:

www.bma.org.uk/employmentandcontracts/employmentcontracts/consultantscontracts/ROEGuidance071008.jsp

At the time of writing, the retention of employment module was under review by the DH. All consultants considering this model are strongly advised to contact the BMA for advice.

Consultants working in competition with NHS employers

As a result of NHS reforms increasing numbers of consultants are carrying out paid work which could be viewed as competing with their main (NHS) employer. Some Trusts are beginning to develop policies to govern how such arrangements are dealt with and LNCs should always be involved where this happens. The law in this area is, at the time of writing, untested and unclear in some areas and it is possible that in certain circumstances, consultants who carry out paid work that has been commissioned in competition with their main NHS employer there may breach the implied duty of fidelity that applies to all employment contracts. However, the consultant contract does not exclude competition or limit the consultant from undertaking private practice (ie those services defined as 'Private Professional Services') on behalf of other parties (NHS employers or otherwise) even if this means that the consultant is carrying out private practice on behalf of competing organisations. For this reason, the CCSC believes that consultants should be able to carry out this type of work. The position is less clear where the consultant's private practice work includes managerial or strategic advice for third parties (or for their own businesses). Therefore, all consultants spending even a small proportion of time on strategic management duties are advised to proceed with some caution.

The CCSC advises that consultants in this situation should provide their NHS employer with a full declaration of outside business interests in

accordance with Paragraph 1 of Schedule 12 of the Consultant Contract. The CCSC has published guidance on this area which can be accessed here: www.bma.org.uk/healthcare_policy/nhs_system_reform/ConWorkCompNHSEmployers.jsp?page=1

If your Trust seeks to restrict your non-NHS work, you should refer them to this guidance and contact your local IRO who will support you in discussions with your Trust. You should also inform your LNC of any difficulties you experience.

Consultant appointments procedures

The NHS (Appointment of Consultants) Regulations 1996

Consultants carry ultimate clinical responsibility for every patient seen in hospital under their care. The public is therefore entitled to expect that all consultants will have reached the highest standards of skill and knowledge, and this is guaranteed by means of a statutory appointments procedure laid down in regulations for NHS Trusts, PCTs and SHAs. The regulations do not, however, apply to foundation trusts. The regulations and accompanying good practice guidance (as applies to England only) were amended most recently in 2004.

Planning and advertising a consultant post

Employers should normally begin planning for a consultant appointment well before the post is to be filled. They should consider service needs, continuing educational requirements, teaching, training and supervision of junior staff, research and audit, and should take account of the views of local consultants, who should be involved in drawing up the job description. It is good practice to plan the timetable for the whole process at the outset, so that all involved – staff, colleges, faculties, universities, advisory appointments committee (AAC) members and potential applicants – know the timetable for appointment. The timetable should be confirmed after prospective AAC members have been contacted.

College and faculty regional advisers must be allowed to comment on the draft job description, and should be allowed to do so at the earliest opportunity. Where there is a disagreement, the matter will be referred to the president of the college. This will not, however, prevent an employer advertising the post. Where the job involves significant teaching commitments of undergraduates, it is also good practice to forward the job description for comment to the dean of the medical school.

As well as details of the post and proposed job plan, the job description should include the selection criteria that will be applied. Once the job description has been agreed, it cannot be changed,

nor challenged by a member of the AAC (other than over a technical error). The job description, together with selection criteria, should be made available to all applicants. The NHS guidance states that it should form part of a general information package which should include a list of the relevant terms and conditions of service, including pay and any local terms of service.

Candidates for consultant posts should always request details of the terms and conditions of service from the Trust in advance of the appointment committee. Advice may also be sought from askBMA, and from the chairman of the Trust's LNC, which should have been involved in negotiating local variations to contracts.

All posts must be advertised (unless a statutory exemption applies: see page 110). Whole-time posts must also be available to part-timers, and all posts must be open to job-sharers. Appointments to a consultant post in the NHS are governed by a statutory instrument, which specifies the procedure to be followed and the membership of the AAC.

Eligibility for appointment

From 1 January 1997 it is a legal requirement for all doctors to be on the GMC's specialist register before they can take up a consultant appointment (see page 150 for the specialist register). However, trainees may explore the possibility of post-CCT careers as soon as it is apparent that a CCT will be awarded in the near future. Consequently, specialist registrars will be able to apply for a consultant appointment provided the expected date of award of their CCT (or recognised equivalent, if outside the UK) falls no more than six months after the date of interview for the consultant post. There will be some other instances (for example, when considering applicants trained outside the UK) where an AAC may choose to interview a candidate prior to specialist register entry although, in these circumstances, it will wish to be satisfied that subsequent specialist register entry is likely.

Membership of advisory appointments committees (NHS employers)

The employer must constitute an AAC as follows.

Core members:

- a lay member (often the chair of the Trust or another non-executive director)
- an external professional assessor, appointed after consultation with the relevant college or faculty
- the chief executive of the appointing body (or a board level executive or associate director)
- the medical or dental director of the Trust (or person who acts in a similar capacity at that hospital) or the relevant director of public health for public health appointments
- a consultant from the Trust, who, if available, should be from the relevant speciality. The committee cannot transact any business in the absence of any core member.

Additional members:

- in the case of appointments to units which have either teaching or research commitments or both, the committee must also include a professional member nominated after consultation with the relevant university
- in cases where the teaching/research commitment does not require an additional professional member, the chair should ensure that any interests of the university are represented by one of the other members of the committee
- any other members the Trust may consider appropriate providing that the committee shall have a majority of professional members and a majority of local members (ie employed by the Trust).

The provisions applying to appointments by health authorities differ only slightly from those in Trusts.

Release of consultants for AACs

Trusts should make every effort to release medical and dental practitioners to attend as members of AACs and should give a clear explanation of the reasons to the recruiting Trust if this is not possible.

Training

All members of AACs should have received appropriate training. This should cover all aspects of the appointments process and concentrate on those areas where difficulties may arise:

- equal opportunities; and
- matters which should not be discussed at the interview other than in exceptional circumstances.

It is the responsibility of the nominating body (eg Trust, royal college or faculty) to ensure that such training has been provided.

Procedure of AACs

All members of the AAC should receive copies of all the applications, together with the job descriptions and selection criteria, and should have the opportunity to contribute to the shortlist. It is the chairman's responsibility to ensure that all members are content with the final shortlist.

Applicants may be given the opportunity to visit the Trust before interview, and such visits are a vital source of information about the hospital and the post. It is increasingly common for Trusts to request candidates during these visits to make formal presentations to medical staff or members of the Trust board. Nonetheless, the NHSE guidance is quite clear that pre-interview visits do not form part of the selection process and must not influence the outcome. Canvassing for support of any application is prohibited. The procedure adopted by the AAC is a matter for decision by the committee itself, subject to the statutory provisions and current employment legislation. The proceedings are confidential, but records will be retained by the employing body for a minimum of five years in case of discrimination claims in an employment tribunal (see the section on discrimination below). Individual members may also be questioned about their reasons for accepting or rejecting candidates.

The committee's role is to make a recommendation to the Trust about which, if any, candidates are suitable for appointment. In practice, it is

usual to recommend only one name, and the Trust will have delegated to the AAC the power to offer the post to the chosen candidate, though the appointment will formally be made by the Trust. NHSE guidance states that 'successful candidates should be formally offered posts in writing within two working days of the decision to appoint'.

The committee may not put forward the name of a candidate without interview, nor may the Trust appoint a candidate who has not been recommended by the AAC. Furthermore, an appointment must not be confirmed until the appropriate pre-appointment checks have been made.



Information

> [Department of Health Circular HSC 2002/008](#)

Exemptions from the statutory procedure

Several categories of post are exempt from the requirement to hold an AAC. In some cases the employer must seek the approval of the Secretary of State to invoke an exemption. The exemptions are:

- a consultant, working for the Health Protection Agency, the Defence Medical Services or a university, transferred to an NHS post in which the duties are substantially the same as those performed for the Agency, the Defence Medical Services or the university
- a doctor who has been appointed to a hospice post which is equivalent to an NHS consultant post
- a doctor who has retired as a consultant and returns to work for the same employer and specialty as the one he or she filled prior to retirement
- a doctor filling a fixed-term consultant post via the New Consultant Entry Scheme (who will instead be interviewed by a panel comprising of a non-executive member, a medical representative from the employer/WDC, and a representative from NHS Professionals). In some circumstances, eg agreed grade assimilations, or health problems requiring a move to lighter duties, the Secretary of State may approve an exemption from the requirement to advertise a consultant post.

Discrimination and fairness

There is strong emphasis throughout the DH's good practice guidance on the need for employers to ensure that their procedures are seen to be fair. The chairman of the AAC has an important role to play in ensuring that members act fairly in accordance with the Sex Discrimination Act, the Race Relations Act, the Equal Opportunities Commission and the Commission for Racial Equality Codes of Practice, the Code of Good Practice on the Employment of Disabled People and the employing body's equal opportunities policy. In addition it should be noted that:

- all members of AACs should have received training in the shortlisting and selection of applicants by interview, with specific regard to the use of fair and non-discriminatory interviewing and selection techniques. Members should also have received appropriate training in the application of equal opportunities legislation
- members of AACs are advised to keep a record of the proceedings, as they can subsequently be questioned by the courts or employment tribunals on the reasons for accepting or rejecting a particular candidate. The employing body will retain records for a minimum of five years
- decisions on the suitability of candidates should relate to the agreed selection criteria and should rely on facts rather than impressions. Questions should not relate to candidates' personal circumstances
- members of the AAC who have a connection with any candidate should declare the fact and take care not to show a bias
- comments on references should be limited to the written remarks and third party comment or hearsay should be excluded
- the employing body is required to carry out ethnic and gender monitoring of applicants, shortlisted and successful candidates, usually by means of a tear-off slip on the application form
- the DH asks employing bodies to see that no AAC consists wholly of men or wholly of women and that if possible the composition of the AAC reflects that of the local population and workplace.



Information

> The NHS (Appointment of Consultant) Amendment Regulations 2004 (Statutory Instrument No 3365) attaching Direction to NHS Trusts and

- Good Practice Guidance (Revised 2004)
- > HSG(96)24, The NHS (Appointment of Consultant) Regulations 1996 (Statutory Instrument No 701) attaching Direction to NHS trusts and Good Practice Guidance (Annex A)

Fees and expenses

Applicants

Doctors who are currently employed under the national terms and conditions of service (be they consultants or specialist registrars seeking a first consultant appointment) are entitled to have their expenses reimbursed by the prospective employing authority at the appropriate rate. This may include pre-interview visits, providing the applicant is subsequently shortlisted. Consultants who are not on national terms and conditions of service should check with the Trust concerned that these expenses will be reimbursed.

Members of AACs

College assessors are entitled to a fee for participation in an AAC and other members are entitled to reimbursement of travel and subsistence expenses. The NHSE's guidance implies that Trusts may fix local terms for these allowances. It is, therefore, advisable to check with the Trust that the fee will be at the agreed national rate, and that first class travel and subsistence will be fully reimbursed.



Information

- > Terms and Conditions of Service, paragraph 313
- > Terms and Conditions of Service, appendix IV paragraph 3(ii)
- > Terms and Conditions of Service 2003, schedule 11
- > BMA Fees Guidance Schedule 3: Miscellaneous work in the NHS

Indemnity

It may be unwise for a member of an AAC to rely on any implied indemnity from the Trust for whom the appointment is being made. Alternatively, members of such an AAC who are not employed by the Trust should seek a written express indemnity from the Trust covering them for all legal costs and awards arising out of their role on the committee.

Disciplinary procedures and exclusions

Consultants facing disciplinary action are advised to seek help from askBMA at the earliest opportunity.

The BMA, the BDA and the DH completed negotiations on new rules governing disciplinary procedures and exclusions (suspensions) for NHS employers in February 2005. These arrangements, which came into effect from June 2005, are set out in the following parts:

- action when a concern arises
- restriction of practice and exclusion of practitioners from work
- conduct hearings and dismissal
- procedures for dealing with issues of capability
- handling concerns about a practitioner's health.

Additional advice for clinical academic staff can be found on page 154.

Action when a concern arises

Where a concern about a consultant has been raised, it must be registered with the chief executive who will appoint a case manager. In cases involving clinical directors and consultants this will be the medical director. The case manager, in consultation with the human resources directorate and the National Clinical Assessment Service (NCAS – formerly the National Clinic Assessment Authority), must consider whether the concern can be resolved without resort to formal disciplinary procedures. Where an informal route is chosen the NCAS can still be involved until the problem is resolved.

The NCAS provides a support service to health authorities, PCTs and hospital and community Trusts faced with concerns over the performance of an individual doctor. The service also provides support to the employers of hospital and community dentists about whom there are performance concerns.

If a more formal route is necessary, the medical director must appoint a case investigator who will be responsible for ensuring that a senior medical or dental staff member is involved where there is a question of clinical judgement, that confidentiality safeguards are in place, that sufficient evidence is gathered prior to the decision to convene a panel

and that a written record of the investigation is kept. The case investigator will not decide what action should be taken or whether the employee should be excluded from work and may not be a member of any disciplinary or appeal panel relating to the case. If it is decided that an investigation will be undertaken, the consultant concerned must be informed in writing by the case manager. The consultant must be given access to any correspondence relating to the case, together with a list of the people that the case investigator will interview and should have the opportunity to put their view of events to the case investigator.

At any stage of this process – or subsequent disciplinary action – the practitioner may be accompanied in any interview or hearing by a companion. In addition to statutory rights under the Employment Relations Act 1999, the companion may be another employee of the NHS Trust; an official or lay representative of the BMA, BDA or defence organisation; or a friend, partner or spouse. The companion may be legally qualified but he or she will not be acting in a legal capacity.

The case investigator should complete the investigation within four weeks of appointment and submit their report to the case manager within a further five days which should clarify whether:

- there is a case of misconduct that should be put to a conduct panel
- there are concerns about the practitioner's health that should be considered by the NHS employer's occupational health service
- there are concerns about the practitioner's performance that should be further explored by the NCAS
- restrictions on practice or exclusion from work should be considered
- there are serious concerns that should be referred to the GMC or GDC
- there are intractable problems and the matter should be put before a capability panel
- no further action is needed.

The name of the consultant should not be released to the press or public in relation to any investigation or hearing.

Restriction of practice and exclusion from work

Occasionally, employers may consider it necessary to exclude/suspend a consultant from duty in order to assist the process of an investigation and/or to protect the interests of patients, the consultant and other staff.

Key features of exclusion from work:

- an initial 'immediate' exclusion of no more than two weeks if warranted
- notification of the NCAS before formal exclusion
- formal exclusion (if necessary) for periods up to four weeks
- advice on the case management plan from the NCAS
- appointment of a board member to monitor the exclusion and subsequent action
- referral to NCAS for formal assessment, if part of case management plan
- active review to decide renewal or cessation of exclusion
- a right to return to work if review not carried out
- performance reporting on the management of the case
- programme for return to work if not referred to disciplinary procedures or performance assessment.

A consultant should only be excluded where there are:

- allegations of misconduct
- serious dysfunctions in the operation of a clinical service
- lack of capability or poor performance of sufficient seriousness that it is warranted to protect patients; or
- the presence of the practitioner is likely to hinder the investigation.

The employer should consider whether the consultant could continue in or (in cases of an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case. The consultant should be informed by letter of the details and terms of the exclusion, the reasons for it and what further action the Trust is taking. If the investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the case manager must lift the exclusion.

Conditions of the exclusion:

- the practitioner should only be excluded from the premises where absolutely necessary
- exclusions should usually be on full pay provided that the practitioner remains available for work and seeks the consent of the case manager if they wish to undertake voluntary or paid work
- the practitioner must inform the Trust of his other employers in case they deem it necessary to inform the other employers of the exclusion.

The employer must review the exclusion after each four-week period. After three exclusions, the NCAS must be called in. Normally there should be a maximum limit of six months exclusion, except for those cases involving criminal investigations of the practitioner concerned. There must be formal arrangements for the return to work of the consultant once the exclusion has ended, these arrangements will establish whether there are any changes or restrictions to the consultant's job plan.

Guidance on conduct hearings and disciplinary procedures

Every NHS employer should have a code of conduct or staff rules which will set out acceptable standards of conduct and behaviour expected of all its employees. Breaches of these rules are considered to be 'misconduct'.

Examples of misconduct:

- a refusal to comply with reasonable requirements of the employer (including failure to fulfil contractual obligations)
- an infringement of the employer's disciplinary rules including conduct that contravenes the standard of professional behaviour required by doctors and dentists by their regulatory body
- the commission of criminal offences outside the place of work which may, in particular circumstances, amount to misconduct
- wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care or patient safety, or create serious dysfunction to the effective running of a service.

If the alleged misconduct relates to matters of a professional nature, appropriate professional advice should be sought by the case investigator. Where such a case proceeds to a hearing under the employer's conduct procedures the panel must include a member who is medically qualified. If the investigation establishes the need for police involvement in the case, the Trust investigation should only proceed in respect to those aspects of the case which are not being dealt with by the police.

The employer, in conjunction with the NCAS, will decide the most appropriate way forward. Consultants who feel that their case has been wrongly classified as misconduct can use the employer's grievance procedure and/or make representations to the designated board member. Many smaller employers such as PCTs, may need to work in collaboration with other local NHS employers in order to provide sufficient personnel to follow the agreed procedures.

Procedures for dealing with issues of capability

Capability procedures apply where an employer considers that there has been a clear failure by a consultant to deliver an adequate standard of care, or standard of management, through lack of knowledge, ability or consistently poor performance. Before capability issues are considered by a panel, the matter must be referred to the NCAS which will provide advice to the Trust on whether the matter raises questions about the consultant's capability as an individual or whether there are other matters that need to be addressed.

If a case covers both conduct and capability issues, the Trust, in consultation with the NCAS, must determine the most appropriate way forward although such cases should usually be combined under a capability hearing.

The pre-hearing process

Once the case investigator has produced his/her report, the consultant will have 10 working days to comment in writing on the report. The case manager will then decide what further action is necessary, taking

into account any comments that the consultant has made and the advice of the NCAS. The case manager will also need to consider with the medical director and head of human resources whether the issues of capability can be resolved through local action (such as retraining, counselling, performance review). If this action is not practicable for any reason the matter must be referred to the NCAS for it to consider whether an assessment should be carried out and to provide assistance in drawing up an action plan. The case manager will immediately inform the consultant concerned of the decision and normally within 10 working days of receiving the practitioner's comments.

The NCAS and the employer will draw up an action plan designed to enable the consultant to remedy any lack of capability that has been identified. The Trust has a responsibility to the action plan (which has to be agreed by the Trust and the practitioner before it can be actioned). In rare circumstances the NCAS may decide that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the case manager must make a decision, based upon the completed investigation report and informed by the NCAS advice, whether the case should be determined under the capability procedure. If so, a panel hearing will be necessary.

The case manager must notify the practitioner in writing of the decision to arrange a capability hearing. This notification should be made at least 20 working days before the hearing. All parties must exchange any documentation no later than 10 working days before the hearing. Either party can request a postponement. Employers retain the right, after a reasonable period to proceed with the hearing in the practitioner's absence. Witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the capability hearing. If evidence is contested and the witness is unable or unwilling to attend, the panel should reduce the weight given to the evidence.

The hearing framework

The capability hearing will normally be chaired by an executive director of the employer. The panel should comprise a total of three people,

normally two members of the Trust board. At least one member of the panel must be a medical or dental practitioner who is not employed by the Trust. The panel must seek specialty specific medical advice. The consultant concerned may raise an objection to the choice of any panel member. The consultant and his or her adviser is entitled to be present at all stages during the hearing, The decision of the panel should be communicated to the parties as soon as possible and normally within five working days. The panel will have the power to make a range of decisions including:

- that no action is required
- an oral agreement that there must be an improvement in clinical performance within a specified timescale
- a written warning that there must be an improvement in clinical performance within a specified timescale
- final written warning that there must be an improvement in clinical performance
- termination of contract.

Appeals procedures in capability cases

Where a consultant disagrees with the outcome of a capability hearing he/she will have recourse to appeal. The appeal panel, having taken specialist advice where appropriate, will need to establish whether the Trust's procedures have been adhered to and that the panel acted fairly and reasonably in reaching their decision. It can also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing although it cannot rehear the entire case.

It is important to remember that a dismissed consultant will in all cases be potentially able to take their case to an employment tribunal if he/she is unhappy with the result of these procedures. Membership of the appeal panel includes an independent chairman (trained in legal aspects of appeals) from an approved pool, the chairman (or other non-executive director) of the employing organisation, a medically qualified member (or dentally qualified if appropriate) from outside the employing organisation and in the case of clinical academics a further panel

member may be appointed in accordance with any protocol agreed between the employer and the university.

Handling concerns about a practitioner's health

The principle for dealing with consultants with health problems is that, wherever possible and consistent with reasonable public protection, they should be treated, rehabilitated or re-trained and kept in employment, rather than be lost from the NHS. Wherever possible the employer should attempt to continue to employ the consultant provided this does not place patients or colleagues at risk.

The Occupational Health Service (OHS) should ensure that the employer considers what reasonable adjustments could be made to their workplace conditions or other arrangements to support the consultant's return to work. Where retirement due to ill-health is necessary, it should be approached in a reasonable and considerate manner, in line with NHS Pensions Agency advice. However, it is important that the issues relating to conduct or capability that have arisen are resolved, using the agreed procedures where appropriate.

Where OHS involvement is required, the occupational physician should agree a course of action with the practitioner and send his/her recommendations to the medical director and a meeting should be convened with the director of human resources, the medical director or case manager, the practitioner and case worker from the OHS to agree a timetable of action and rehabilitation. Unless the concern relates solely to the health of the practitioner, procedures set out in earlier chapters of this guidance should be followed as appropriate.



Information

- > HSC 2003/012 High Professional Standards in the Modern NHS; a framework for the initial handling of concerns about doctors and dentists in the NHS
- > Maintaining High Professional Standards in the Modern NHS (Department of Health 2005)

Appraisal

Introduction

The development of clinical governance in the NHS and proposals by the GMC for the revalidation of doctors has underlined the need for a comprehensive annual appraisal scheme for medical and dental staff. This chapter summarises and supplements the agreed guidance on the national model appraisal scheme for consultant staff in the NHS. Similar principles apply to appraisal for consultants working in the private sector and this issue is covered briefly below.

Appraisal is a contractual requirement for consultants on the 2003 contract and must be carried out annually. All consultants should participate fully and positively in the appraisal process. In addition, chief executives are required to indicate in the CEAs application process whether a consultant has participated in the appraisal process during a particular year.

Definition and aims of appraisal

Appraisal should be a professional process of constructive dialogue, in which the consultant has a formal structured opportunity to reflect on his or her work and to consider how his or her effectiveness might be improved. For the employer, it is an opportunity to give consultants feedback on their performance, to chart their continuing progress and to identify development needs. Appraisal is a forward-looking process essential for the development and educational needs of an individual. It is not the primary aim of appraisal to scrutinise doctors to see if they are performing poorly but rather to help them consolidate and improve on good performance. However, it can help to recognise, at an early stage, developing poor performance or ill-health, which may affect practice.

The CCSC advises that, although the appraisal may refer to the job plan, the two should be dealt with separately. Time allocated for appraisal should not be spent on job plan work and vice versa. The completed appraisal should inform the job plan by assessing the need for increased or enhanced resources to the working environment that would enable fulfilment of job plans. The aims and objectives of the appraisal scheme are to enable NHS employers and consultants to:

- regularly review an individual's work and performance, using relevant and appropriate comparative performance data from local, regional and national sources
- optimise the use of skills and resources in seeking to achieve the delivery of service priorities
- consider the consultant's contribution to the quality and improvement of services and priorities delivered locally
- set out personal and professional development needs and agree plans for these to be met
- identify the need for the working environment to be adequately resourced to enable any service objectives in the agreed job plan review to be met
- provide an opportunity for consultants to discuss and seek support for their participation in activities for the wider NHS
- use the annual appraisal process and associated documentation to meet the requirements for GMC revalidation.

Appraisal process and content

Chief executives are accountable to their board for the appraisal process and must ensure that appraisers are properly trained to carry out this role and are in a position to undertake appraisal of clinical performance, service delivery and management issues. In most cases, this will be the appropriate clinical director (see below for detail). The content of appraisal is based on the core headings set out in the GMC's *Good Medical Practice* together with relevant management issues including the consultant's contribution to the organisation and delivery of local services and priorities. The GMC's core headings are: good clinical care; maintaining good medical practice; relationships with patients; working with colleagues; teaching and training; probity and health.

Who undertakes the appraisal

For the purposes of GMC revalidation, a consultant on the medical or dental register must undertake the appraisal. The chief executive will nominate the appropriate person competent to undertake appraisal across the broad range of headings within the appraisal scheme. The chief executive must ensure that the appraiser is properly trained and in

a position to undertake this role and, where appropriate, the interlinked process of job plan review. The appraiser will be able to cover clinical aspects and matters relating to service delivery, and will usually be the clinical director, if this is appropriate to the management arrangements of the employer. Where there is a recognised incompatibility between proposed appraiser and appraisee the chief executive will be responsible for nominating a suitable alternative. This decision will be final. In circumstances where the clinical director is not on the register, the medical director, having first consulted the clinical director, should conduct the appraisal or select a suitable lead consultant or other appropriate consultant to do so. In these circumstances, the clinical director will be fully consulted before the appraisal meeting takes place and will undertake the subsequent job plan review. The clinical director will also ensure that the appraiser and appraisee are aware of and consider all relevant issues at the appraisal meeting. This may be best achieved through an agreed contribution to the appraisal meeting and outcome report.

If the doctor being appraised is a clinical director, then normally the medical director or suitable consultant nominated by the chief executive would conduct the appraisal. The medical director will be appraised for his/her clinical work by a suitable consultant nominated by the chief executive (excluding any consultant appraised by the medical director in that year).

In some small NHS employers it may not be possible to identify a suitable appraiser to conduct the professional aspects of the appraisal where specialist knowledge is essential. In these instances, two or more employers might collaborate to ensure that an appraiser is available to contribute to the appraisal process.

Preparation

The consultant being appraised should prepare for the appraisal by identifying those issues which he or she wishes to raise with the appraiser and prepare a personal development plan. Consultants should also consider whether the appraiser has adequate professional

knowledge to appraise their work and whether some element of peer review is required (see below). The appraiser should prepare a workload summary with the consultant being appraised to inform the appraisal and the job plan review. It will be necessary for early discussion to take place on what data is relevant and will be required. This will include data on patient workload, teaching, management and any pertinent internal and external comparative information. The summary should highlight any significant changes which might have arisen over the previous 12 months and which require discussion. This should be supplemented by any information generated as part of the regular monitoring of organisational performance undertaken by the employer.

Appraisees should also submit any other data that is considered relevant to the appraisal. This must include sufficient relevant data relating to other work carried out external to the employer (eg in private practice and in commercial healthcare industries). In advance of the appraisal meeting, the appraiser should gather the relevant information as specified above and consult in confidence and where appropriate, the medical director, other clinical directors/lead consultants and members of the immediate care team. The information and paperwork to be used in the appraisal meeting should be shared between the appraiser and the appraisee at least two weeks in advance to allow for adequate preparation for the meeting and validation of supporting information. Adequate time must be allocated in lieu of other duties for the preparation and appraisal meeting.

Scheme content

Clinical performance

This focuses on all clinical aspects of the consultant's work including data on activity undertaken outside the immediate NHS employer.

This should include:

- clinical activity with reference to data generated by audit, outcomes data, and recorded complications. This should permit discussion of factors influencing activity, including the availability of resources and facilities

- concerns raised by clinical complaints that have been investigated. If there are any urgent and serious matters that have been raised by complaints made but that have not yet fully been investigated, these should be noted. The appraisal should not attempt to investigate any matters that are properly the business of other procedures, eg disciplinary
- continuing professional development, including the updating of relevant clinical skills and knowledge through continuing medical education
- the use and development of any relevant clinical guidelines
- risk management and adherence to agreed clinical governance policies of the Trust and suggestions for further developments in the field of clinical governance
- professional relationships with patients, colleagues and team working.

Teaching and research activities

Review of the quantity and quality of teaching activity to junior medical staff, medical undergraduates, non-medical health professionals, and postgraduate teaching activity, with consideration of feedback from those being taught. Where appropriate to the professional practice of the doctor being appraised, review of any research activity in the preceding year, ensuring that all necessary procedures including ethical approval have been followed.

Personal and organisational effectiveness

This includes, for example, relationships and communications with colleagues and patients; the contribution made to the organisation and development of services, the delivery of service outcomes, management activities including the management and supervision of staff and identification of the resources needed to improve personal effectiveness. This will include 360° profiling with regard to respect for patients and working with colleagues.

Other matters

Discussion of any other matters which either the appraiser or the consultant being appraised may wish to raise, such as the consultant's

general health and wellbeing. The CCSC advises that consultants should note whether all aspects outlined above have been covered, that an opportunity has been given to raise matters of concern, and that the appraisal has not strayed from its remit.

Peer review

The assessment of some of the more specialist aspects of a consultant's clinical performance is best carried out by peers who are fully acquainted with the relevant areas of expertise and knowledge. Where it is apparent that peer review is an essential component of appraisal, the appraiser and the appraisee should plan this into the timetable in advance of the appraisal interview. If, during the appraisal, it becomes apparent that more detailed discussion and examination of any aspect would be helpful and important, either the appraiser or the appraisee should be able to request internal or external peer review. This should normally be completed within one month and a further meeting scheduled as soon as possible thereafter (but no longer than one month) to complete the appraisal process.

As a matter of routine, the results of any other peer review or external review carried out involving the consultant or the consultant's team (eg by an educational body, a professional body, or the Healthcare Commission or similar bodies) will need to be considered at the next appraisal meeting. This will not prevent the employer from following its normal processes in dealing with external reviews.

Outcomes of appraisal

The maximum benefit from the appraisal process can only be realised where there is openness between the appraisee and appraiser. The appraisal should identify individual needs which will be addressed through the personal development plan. The plan will also provide the basis for a review with specialty teams of their working practices, resource needs and clinical governance issues. All records must be held on a secure basis and access/use must comply fully with the requirements of the Data Protection Act.

Appraisal meetings should be conducted in private and the key points of the discussion and outcome must be fully documented and copies held by the appraiser and appraisee. Both parties must complete and sign the appraisal summary document and send a copy, in confidence to the chief executive, medical director and clinical director (if not the appraiser). For the chief executive, this will also include information relating to service objectives which will inform the job plan review. There will be occasions where a follow-up meeting is required before the next annual appraisal and clinical directors should ensure that the opportunity to do this is available.

Where there is disagreement, which cannot be resolved at the meeting, this should be recorded and a meeting should take place in the presence of the medical director to discuss the specific points of disagreement.

Where it becomes apparent during the appraisal process that there is a potentially serious performance issue which requires further discussion or examination, the matter must be referred by the appraiser immediately to the medical director and chief executive to take appropriate action. This may, for example, include referral to any support arrangements that may be in place.

The clinical director will be responsible for ensuring any necessary action arising from the appraisal is taken (or the medical director, in the case of clinical directors). If the agreed appraiser is not the appraisee's clinical or medical director, the appraiser will be responsible for submitting to the clinical or medical director the details of any action considered to be necessary. The clinical and medical directors will be accountable to the chief executive for the outcome of the appraisal process. The chief executive should also ensure the necessary links exist between the appraisal process and other Trust processes concerned with clinical governance, quality and risk management and the achievement of service priorities. In discharging this accountability, the chief executive and medical director will have confidential access to any documentation used in the appraisal process. In these circumstances, the individual concerned will be informed.

The chief executive should submit an annual report on the process and operation of the appraisal scheme to the board. This information will be shared and discussed with the medical staff committee or its equivalent and the LNC. The annual report must not refer, explicitly or implicitly, to any individuals who have been appraised. The report will highlight any employer-wide issues and action arising out of the appraisal process, eg educational developments, service needs.

Serious issues relating to poor performance

Serious issues relating to poor performance will most often arise outside the appraisal process and must be addressed at that time. It is not acceptable to delay dealing with such issues until the next scheduled appraisal. Such concerns should be dealt with in accordance with the normal agreed employer procedures. This may include the chief executive feeling it necessary to inform the board in a closed session. In the event of serious concerns being identified during an appraisal, they should be dealt with in the same way. The appraisal will then be suspended until the identified problems have been resolved.

Personal development plan

As an outcome of the appraisal, key development objectives for the following year and subsequent years should be set. These objectives may cover any aspect of the appraisal such as personal development needs, training goals and organisational issues, CME and CPD, eg acquisition/consolidation of new skills and techniques.

The medical director and chief executive must review the personal development plan to ensure that key areas have been covered, for example, that training is being provided to enable a consultant to introduce a new clinical technique and to identify any employer-wide issues which might be addressed on an organisation basis. This might include clinical audit priorities.

Revalidation

After some years on hold during the Shipman Inquiry, plans to introduce revalidation were set in motion again in early 2007 by the chief medical

officer's report 'Trust, assurance and safety: the regulation of health professionals'.

Revalidation will be required for doctors to demonstrate their continuing fitness to practise and will be separated into two processes; relicensure and recertification. Relicensure will be overseen by the GMC and all doctors wishing to practise in the UK will require a licence to practise which will need to be renewed every five years. In terms of recertification, all doctors on the specialist and GP registers will need to demonstrate that they meet the standards that apply to their medical speciality. These standards will be set by the medical royal colleges and their specialist societies and approved by the GMC. It is envisaged that a new, standard appraisal module will be used to gather the information for revalidation. At the time of writing, proposals to introduce revalidation were not sufficiently developed to provide more detailed information.

The CCSC has produced a document setting out how it believes enhanced job-planning and appraisal can be used to deliver revalidation with minimum extra burden on doctors. It can be accessed here: www.bma.org.uk/employmentandcontracts/doctors_performance/1_appraisal/Usingjobplanning0408.jsp

Consultants working in more than one Trust

Employing organisations must agree on a 'lead' employer for the appraisal. Agreement will also include: appropriate discussion prior to the appraisal between clinical directors to ensure key issues are considered, systems for accessing and sharing data; and arrangements for action arising out of the appraisal.

Clinical academics

As recommended by the Follett report, consultants with substantive university appointments or NHS consultants with major academic duties should undergo joint appraisal in respect of their complete range of NHS and university duties (either with one appraiser for each component, or a single joint appraiser if properly qualified for

this task). Separate documentation is available for the clinical academic appraisal scheme. In addition to those noted above, for clinical academics a copy of the appraisal summary document will be sent, in confidence, to the nominated university representative.

Appraisal in private practice

Alongside the likely GMC revalidation requirements, doctors working in the private sector will also be required by the Healthcare Commission to renew their practising privileges every two years under the National Minimum Care Standards. Appraisal is seen as the gateway to both processes and the BMA, alongside the Independent Healthcare Forum and supported by the DH, has produced advice on this issue, available on the BMA website: www.bma.org.uk

Doctors employed by the NHS and who also work privately, are recommended to participate in 'whole practice appraisal' within their NHS appraisal, to cover all elements of their practice. Appraisal should take place in the NHS, using NHS appraisal forms together with data provided from private hospitals. Separate advice for consultants practising entirely in the private sector is also available on the BMA website.



Information

- > GMC Continuing Professional Development for Doctors (guidance issued in April 2004)
- > Further Guidance for Appraisal for Consultants in Public Health Medicine, Department of Health, November 2002
- > Clinical Academic Staff (Consultants) Appraisal Scheme, Department of Health, July 2002
- > Annual Appraisal for Consultants AL(MD) 6/00 and AL(MD)5/01 (further guidance)
- > An agreement between the British Medical Association and the Independent Healthcare Forum, October 2004
- > Medical Revalidation; principles and next step. A Report of the Chief Medical Officer for England's Working Group, July 2008

General Medical Council (GMC)

Introduction

The GMC is the regulatory body of the medical profession and is established as such by Act of Parliament. The GMC declares that its purpose is 'to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine'. To this end, the GMC controls entry to the medical register and determines the principles and values that underpin good medical practice. Where a doctor fails to meet the standards it has set the GMC acts 'to protect patients from harm – if necessary, by removing the doctor from the register and removing their right to practise medicine'.

The GMC exercises its powers by determining whether individuals should be registered as doctors in the UK and setting the educational standards for medical schools. The GMC's *Good Medical Practice* guidance sets out a doctor's professional obligations and duties, and advises on standards of good clinical care, professional relationships with colleagues, matters of probity and doctors' health.

The GMC does not deal with general complaints and can only take action when a doctor's fitness to practise is called into question.

Broadly it can act in the following circumstances:

- when a doctor has been convicted of a criminal offence
- when there is an allegation of serious professional misconduct that is likely to call into question a doctor continuing in medical practice
- when a doctor's professional performance may be seriously deficient, whether or not it is covered by specific GMC guidance
- when a doctor with health problems continues to practice while unfit.

The GMC's procedures are only activated when a case is referred to the Council. Convictions of doctors are usually reported directly by the police. Complaints can be made by individual doctors, members of the public, or employing or other public authorities. However, the CCSC advises that consultants should in most cases bring concerns about colleagues to the attention of their medical director in the first instance. The GMC has produced guidance for doctors and other healthcare

professionals on referring a doctor to the GMC which is available on its website (www.gmc-uk.org/concerns/making_a_complaint/index.asp).

It is a duty of a doctor under *Good Medical Practice* to explain any concerns about a doctor's fitness to practise that may be putting patients at risk, to an appropriate person from the employing authority, such as the medical director. If there are either no local procedures, or they do not resolve the problem satisfactorily the concerns should be passed to the GMC. Doctors are advised to discuss any concerns with an impartial colleague or their defence body. The GMC can also give advice and, before a referral is made, any concerns can be discussed with one of its caseworkers. It can be contacted on **0845 357 0022** or on practise@gmc-uk.org

The National Clinical Assessment Service (NCAS) (www.ncas.npsa.nhs.uk) can advise Trusts on:

- the handling of concerns
- the professional performance of individual doctors
- effective local systems for handling poor performance.

The GMC has previously taken action in circumstances where a doctor has:

- made serious or repeated mistakes in diagnosing or treating a patient's condition
- not examined patients properly or responded to reasonable requests for treatment
- misused information about patients
- treated patients without obtaining their informed consent
- behaved dishonestly in financial matters, with patients or in research
- made sexual advances towards patients
- misused alcohol or drugs.

The GMC can normally only consider complaints within five years of the incidents that are the reason for the complaint.

Fitness to practise

GMC procedures are divided into two separate stages: 'Investigation' and 'Adjudication'. In the investigation stage, the GMC investigates cases to assess the need for referral for adjudication. At the end of the investigation by the GMC of allegations against a doctor, the case will be considered by two senior GMC staff known as case examiners (one medical and one non-medical). They can:

- conclude the case with no further action
- issue a warning (which will be disclosed to a doctor's employer, where 'there has been significant departure from 'good medical practice' or there is 'cause for concern following assessment but a restriction on the doctor's registration is not necessary')
- refer the case to a fitness to practise (FTP) panel
- agree undertakings.

The adjudication stage consists of a hearing of those cases that have been referred to a fitness to practise panel. At any stage of the investigation the GMC may refer the doctor to an Interim Orders Panel (IOP). An IOP can suspend or restrict a doctor's practice while the investigation continues. Fitness to practise panels hear evidence and decide whether a doctor's fitness to practise is impaired.

From May 2008, the GMC introduced a provision for the use of the civil standard of proof (the balance of probabilities) at fitness to practise panel hearings when panelists are making decisions on disputed facts. Previously the GMC used the criminal standard of proof (beyond reasonable doubt). The requirement to move to the civil standard of proof was a result of the Shipman inquiry and the Government's subsequent white paper, *Trust, assurance and safety: the regulation of health professionals in the 21st century* published in February 2007. The balance of probabilities, as applied in the civil standard of proof, means that the tribunal need only be satisfied that the alleged facts are more likely than not to have happened. The criminal standard of proof of 'beyond reasonable doubt' meant that the tribunal had to be sure that the case was proven.

Panel hearings are the final stage of the GMC's procedures following a complaint against a doctor. Panels of three to five medical and non-medical members are appointed by the GMC. In addition to the chairman, who is not necessarily medically qualified, there must be at least one medical and one non-medical member on each panel. A legal assessor sits with each panel and advises on points of law and fact.

Once the panel has heard the evidence, it must consider three matters: whether the facts alleged have been found proved; whether, on the basis of the facts found proved, the doctor's fitness to practise is impaired; and if so, whether any action should be taken against the doctor's registration. The application of the standard of proof applies only to the first of these questions.

In deciding on the appropriate sanction, which could be from taking no action to erasing the doctor from the Medical Register, the panel must have regard to the Indicative Sanctions Guidance. Doctors have a right to appeal to the High Court against any decision by a panel to restrict or remove their registration. The Council for Healthcare Regulatory Excellence (CHRE) may also appeal against certain decisions if they consider the decision was too lenient.

Office of the Health Professions Adjudicator (OHPA)

At the time of writing, the Health and Social Care Bill – medical regulation, introduced on the back of the *Trust, assurance and safety white paper* – is making its way through the parliamentary process. Subject to parliamentary approval, the Bill will legislate for the creation of the Office of the Health Professions Adjudicator (OHPA). This new body is expected to take over the adjudication of fitness to practise cases from the GMC. This will result in the separation of the adjudication of cases from their investigation and prosecution. The Bill proposes that OHPA's fitness to practise panels can be chaired by a lay person or by a professionally qualified member. OHPA is expected to be fully operational by 2011.

Handling of local concerns

The Health and Social Care Bill proposes the creation of GMC affiliates to be based at SHA level. The role of the GMC affiliate will be to lead regional medical regulation support teams.

The Bill will also enable regulations to require all organisations in England, Wales and Scotland employing doctors to appoint or nominate a 'responsible officer' with responsibilities relating to the regulation of doctors. It is envisaged that responsible officers will address concerns about doctors, oversee local revalidation processes and be a central point for holding and sharing information on complaints and concerns about doctors. It is as yet unclear how the responsible officer will liaise and interact with GMC affiliates.

In addition, the Bill proposes a system of recording concerns about a doctors' conduct or practice locally. 'Recorded concerns' will track patterns of misconduct and behaviour over time and place.

Council for Healthcare Regulatory Excellence (CHRE)

CHRE looks at the final stage decisions made by the regulators on professionals' fitness to practise. If the CHRE considers that a decision fails to protect the public interest, it has the power to investigate that decision. If the CHRE considers the decision too lenient, and there is no other effective means of protecting the public, it can refer it to the High Court (or its equivalent throughout the UK).

Constitution of the GMC Council

As part of the reform programme, the GMC, with Government agreement, has lifted restrictions on a lay majority on the Council to make provision to have equal numbers of lay members and professional members on the governing body. In June 2008 the GMC advertised for 12 lay members and 12 medical members to join the Council body.

Duties of a doctor

The GMC sets out the duties of a doctor registered with the Council:

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:

- make the care of your patient your first concern
- protect and promote the health of patients and the public
- provide a good standard of practice and care
- keep your professional knowledge and skills up to date
- recognise and work within the limits of your competence
- work with colleagues in the ways that best serve patients' interests
- treat patients as individuals and respect their dignity
- treat patients politely and considerately
- respect patients' right to confidentiality
- work in partnership with patients
- listen to patients and respond to their concerns and preferences
- give patients the information they want or need in a way they can understand
- respect patients' right to reach decisions with you about their treatment and care
- support patients in caring for themselves to improve and maintain their health
- be honest and open and act with integrity act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
- never discriminate unfairly against patients or colleagues
- never abuse your patients' trust in you or the public's trust in the profession

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Good Medical Practice

The Council published the most recent edition of *Good Medical Practice* in 2006. The guidance sets out the principles and values on which good practice is founded and standards of competence, care and conduct expected of doctors in all aspects of their professional work. *Good Medical Practice* sets broad standards on clinical care; teaching, training and appraisal; relationships with patients; dealing with problems in professional practice; working with colleagues; probity and health.



Information

- > Good Medical Practice, GMC, 2006
- > GMC website: www.gmc-uk.org
- > CHRE website: www.chre.org.uk

Health

Introduction

The role of the NHS as an employer in maintaining the good health of its doctors and other employees has often been overlooked or downplayed. Doctors and other healthcare professionals are particularly exposed to work-related injury and stress, the impact of which can be dramatic. In extreme cases, health problems can lead to self-harm or suicide or patients being put at risk.

Procedures and legislation are in place, both at a local level in Trusts and nationally, to prevent ill-health where possible, and to assist doctors for whom impaired health has become a source of concern. These are set out below. Advice is also given on dealing with misuse of alcohol and other drugs.

Doctors in hospitals are also particularly exposed to risks arising directly from their working environment. These include exposure to pathogens, blood-borne viruses and other dangerous substances, radiation, and personal violence. Increasingly stress induced by workload or by workplace bullying or harassment is a cause of ill-health. Poor performance for reasons other than ill-health is dealt with in the chapter on Disciplinary procedures (see page 113). Health issues are also dealt with in 'Maintaining high professional standards in the modern NHS', covered in the section on Disciplinary procedures.



Information

> [The Management of Health, Safety and Welfare Issues for NHS Staff, new edition 2005, NHS Employers](#)

Management responsibilities

All employers have legal obligations under the Health and Safety at Work Act 1974 to protect the health of their employees, contractors and members of the public. This includes dealing with work-related stress or violence in the workplace. All employers should prepare and publish a statement of their safety policy and the organisation and arrangements for implementing it. The National Audit Office report A

safer place to work, estimated the cost of work-related accidents in English Trusts to be about £173 million in 2001-02.

The Management of Health and Safety Regulations 1999 emphasise a risk management approach which requires employers to identify hazards and assess risks, develop appropriate measures to eliminate or minimise risk and record their findings. Such work would not just reduce accidents but also release additional money for healthcare. For example, the Health and Safety Commission has reported that one Trust saw the cost of manual handling injuries fall from £800,000 in 1993 to £10,000 in 2001. Consultants should also note that the EC Working Time Regulations (see page 64) are a health and safety measure.

Concerns about the failure of employers to fulfill their health and safety obligations should be raised with the employer in the first place and, if not resolved, may be reported to the Health and Safety Inspectorate. All employers are required to report serious accidents, incidents or injuries under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995. It is worth noting that the Health and Safety Executive has reported wide variations between the best and worst performers, that re-organisations have often left Trusts with out-of-date policies and that more effort across all Trusts will be required if the health service is to meet the targets for accident/ill-health reductions that have been set by the NHS.

Consultants may have a case for a personal injury claim if their physical or mental health has suffered from adverse working conditions, which their employer knew or ought to have known were potentially harmful and did nothing to alleviate the problem. The NHS injury benefits scheme can also protect income where this is reduced either permanently or temporarily as a direct result of work-related illness or injury. Details of rights and responsibilities under health and safety legislation are available to BMA members from *askBMA* in the first instance.

Occupational health services

All NHS employers must ensure that their staff have access to confidential occupational health services, including a consultant in occupational health medicine. Where the occupational health team is made up of an occupational health nurse and/or non-consultant occupational health physicians, managers are obliged to ensure that there is access to and advice from a consultant. The DH has provided a national policy lead on occupational health issues for some years through *The management of health, safety and welfare issues for NHS staff* (1998) and *The effective management of health and safety services in the NHS* (2001). In 2004, the DH circulated a draft of the first NHS Occupational Health and Safety Strategy for England, which set out its vision for a safer, healthier NHS.

The strategy was developed in response to The National Audit Office report *A safer place to work* (2003). The responsibility for encouraging the implementation of good occupational health and safety policy across the NHS has now been transferred to the NHS Employers organisation, which will act in an advocacy and advisory role to NHS senior managers.

Through their occupational health services, NHS employers should protect the health of their staff from physical and environmental health hazards arising from their work or conditions of work; reduce risks at work which lead to ill-health, staff absence and accidents, and help management to protect patients, visitors and others from staff who may represent a hazard, such as from infectious disease.

The functions of an occupational health service are to advise employees and employers about the interaction between health and work, to maximise the beneficial effects of this interaction and to minimise the adverse effects. It should be noted that occupational health is primarily a preventative and not a treatment service, but much of the output of an effective occupational health service is directly or indirectly therapeutic to organisations and the individuals employed by them.



Information

- > HSC 98(64) Management of Health, Safety and Welfare Issues for NHS Staff
- > The Effective Management of Health and Safety Services in the NHS, Department of Health, 2001

Personal injury claims

Consultants may have a case for a personal injury claim if their physical or mental health has suffered from adverse working conditions which their employer knew or ought to have known were potentially harmful and did nothing to alleviate the problem. Consultants who feel that a personal injury claim may be justified should contact *askBMA* in the first instance for advice.



Information

- > BMA, Pursuing Civil Claims for Damages for Personal Injuries

Work-related stress

The Health and Safety Executive (HSE) has identified work-related stress as a serious and increasing problem and has stated that half a million people in the UK believe that stress at work has made them ill. While stress itself is hard to identify, the HSE has noted that 'a convincing body of research shows that... there is a clear link between poor work organisation and subsequent ill health'. The executive has also noted that medical practitioners are among the groups in which high rates of work-related mental illness have been reported.

The seriousness with which the HSE takes the problem was highlighted by its serving of an improvement notice on West Dorset General Hospitals NHS Trust. It subsequently worked closely with the Trust in ensuring that risks were thoroughly assessed and action taken. The executive has issued guidance on dealing with stress and has been working on standards for the management of work-related stress on which they consulted during the summer of 2004. The standards were launched in November 2004 and propose a number of 'states to be achieved' including:

- the organisation provides employees with adequate and achievable demands in relation to the agreed hours of work
- where possible, employees have control over their pace of work
- the organisation has policies and procedures in place to adequately support employees
- the organisation ensures that, as far as possible, the different requirements it places upon employees are compatible.

The HSE has produced an example of a stress policy which is available on its website. Employees are advised to raise issues of concern with their safety representative, line manager or occupational health service.



Information

> Health and Safety Executive website, www.hse.gov.uk/stress and www.hse.gov.uk/healthservices/index.htm

Violence against doctors

The British Crime Survey has reported that doctors and nurses are among those most at risk of threats and assaults in the workplace. A BMA report, *Violence at work, the experience of UK doctors* reported that a third of hospital doctors had experienced some form of violence in the workplace in the previous year and that doctors working in A&E, psychiatry and obstetrics and gynaecology were even more likely to have experienced violence. The paper also noted that the under-reporting of incidents was a widespread problem.

The paper recommended training for doctors on the management of potentially violent situations, partnerships with other relevant local agencies (such as the police) and raising awareness of patients' responsibilities and acceptable behaviour. Doctors are advised and encouraged to report violent incidents and, through their LNC, to ensure that Trust managements put in place protocols for recording such incidents and effective strategies for dealing with the problem. The HSE has also produced guidance on the assessment and management of violence against staff in the healthcare sector.



Information

- > Health and Safety Executive website, www.hse.gov.uk/violence/index.htm
- > BMA, Violence at work, the experience of UK doctors www.bma.org.uk/employmentandcontracts/morale_motivation/violence08.jsp

The misuse of alcohol and other drugs

The misuse of alcohol and other drugs is a major threat to health, family, livelihood and potentially, in the case of doctors, a threat to patients. The problems are widespread, a 1998 BMA report suggesting that some one in 15 doctors in the UK may suffer from some form of dependence, and noting that two-thirds of all cases referred to the GMC health procedures involve the misuse of alcohol and other drugs. Although it is widely perceived that those affected are predominantly male and approaching retirement, specialist units with experience of treating doctors note that both female and male doctors of all ages are affected. Doctors who misuse alcohol are often at the same time involved in misuse of other drugs, and doctors whose primary problem appears to be alcohol may also be misusing hypnotics, anxiolytics, opioids or amphetamines.

Guidance from the GMC in *Duties of a doctor* is explicit in the responsibility that doctors have to prevent any risk to patients arising from their own ill-health or that of their colleagues. There are additional responsibilities under health and safety regulations which impose duties on all individuals regarding their own health and safety and that of their colleagues.

Once in treatment, medical practitioners do remarkably well, and early recognition and treatment considerably increase the chance of successful rehabilitation. To facilitate this, the BMA recommends that every employing authority must have a well-publicised drug and alcohol policy. Such a policy must include an acknowledgement that organisations within the health service exist to provide high standards of healthcare and such high standards should also be available to

employees of these organisations. Policies should provide for involvement of occupational health services, appropriate sick leave, access to treatment services and retention of employment when the employee cooperates. Policies should be supportive rather than punitive. Advice on responsibilities for their own health and that of colleagues should be included in any induction programme. Given below under Sources of professional advice is a list of organisations which are able to provide further advice and counselling.



Information

> **Taking Alcohol and Other Drugs out of the NHS Workplace**,
Department of Health, 2001

Transmission of infection

In March 2007 the DH published *Health clearance for tuberculosis, hepatitis B, hepatitis C and HIV: New healthcare workers*. This aims to clarify the position on testing for blood-borne viruses for NHS staff.

The guidance recommends that, on appointment, all new healthcare workers should have standard healthcare clearance checks. All new workers should have checks for tuberculosis disease/immunity and be offered hepatitis B immunisation, with post-immunisation testing of response and the offer of tests for hepatitis C and HIV. It states that where a new member of staff's duties include performing exposure-prone procedures (EPPs), additional healthcare clearance should also be obtained before confirmation of an appointment. This includes being non-infection for:

- HIV (antibody negative)
- hepatitis B (surface antigen negative, or if positive e-antigen negative with a viral load of 10 genome equivalents/ml or less; and
- hepatitis C (antibody negative or, if positive, negative for hepatitis C RNA).

The DH guidance does not recommend mandatory large-scale screening of healthcare workers for blood-borne viruses. It instead recommends that only the following groups of staff should be tested:

- healthcare workers who are new to the NHS
- healthcare workers moving to a post that involves EPPs (where workers have not undertaken EPPs before); and
- returning healthcare workers.

There is further BMA guidance on this at

www.bma.org.uk/employmentandcontracts/3_occupational_health/BBVguidance.jsp

Healthcare associated infections (HCAs)

Reducing HCAs has been a high-profile area of DH policy in recent years, with a particular focus on MRSA and *C. difficile*, particularly following some significant public failings in certain NHS Trusts. In January 2008, the DH published 'Clean, safe care: reducing infections and saving lives'. This document sets out a number of further actions aimed at tackling HCAs, such as:

- introducing screening for MRSA for all elective admissions by March 2009
- annual infection control inspections of all acute Trusts using teams of specialist inspectors
- a new regulator – the Care Quality Commission – to be set up in 2009 with the power to impose fines on poor performers
- 5,000 matrons in place in the NHS by May 2008
- a new bare-below-the-elbows dress code for hospitals; and
- every hospital to have undergone a deep clean by March 2008.

With regard to the bare-below-the-elbows policy, CCSC guidance on hospital dress and uniform codes can be found at

www.bma.org.uk/employmentandcontracts/working_arrangements/CCSCdresscode051207.jsp

Sources of professional advice

BMA Counselling is a service available 24/7 and allows doctors to speak to a team of fully-qualified counsellors. Any issue causing distress or difficulty can be discussed including:

- workplace problems

- exam pressures
- stress and anxiety
- loss of confidence
- personal and relationship difficulties
- alcohol and drug misuse
- bereavement
- debt and other financial concerns.

The telephone number for the BMA counselling service is 08459 200169. All calls are charged at local rates.

The **Doctors for Doctors** Unit is run by the BMA and offers doctors in distress or difficulty the option of speaking in confidence to another doctor. Our team of doctor-advisers work with you to gain insight into your problems, supporting and helping you to move on by adopting a holistic approach to your situation. A wide range of concerns are dealt with including doctors who have been referred to the GMC, bullying at work, mental health issues and alcohol problems. The Doctors for Doctors service is completely confidential and is not linked to any other internal or external agencies. Simply call 08459 200169 and ask for a doctor-adviser.

Please visit www.bma.org.uk/doctors_health/index.jsp

Other sources of advice

The Sick Doctors Trust provides a proactive service for doctors with addiction problems, and provides a 24-hour advice and intervention service. Facilitates admission to appropriate treatment centres and introduction to support groups. The telephone number is 0870 444 5163 and the website is www.sick-doctors-trust.co.uk

The British Doctors and Dentists Group is a support group of recovering medical and dental drug and alcohol misusers, and can be contacted on 020 7487 4445.

The Sick Doctor Scheme of the Association of Anaesthetists is available to all anaesthetists and can be contacted via the association on 020 7631 1650.

British International Doctors Association has a health counselling panel, which can advise in particular those with problems where cultural or linguistic factors are prominent. The telephone number is 0161 456 7828 and the address is ODA House, 316A Buxton Road, Great Moor, Stockport, SK2 7DD.

The Doctors' Support Network is a self help group for doctors who are currently suffering from or have suffered from a serious mental health problem. The telephone number is 07071 223372 and the website is www.dsn.org.uk

NHS reform – Darzi Next Stage Review

The NHS Next Stage Review, 'Our NHS, Our Future', was announced in July 2007 and is a wide-ranging review of the NHS in England, both at a local and national level, to ensure that a properly resourced NHS is clinically led, patient-centred and locally accountable. The aim of the NHS Next Stage Review is to build on the progress made in delivering the vision set out in the NHS Plan and the Government's reform agenda. As part of that process, both national and local working groups were set up to form the basis of Lord Darzi's final report in July 2008 on the future of the NHS in England. The national groups were:

- quality improvement
- innovation
- primary and community care strategy
- workforce – planning, education and training
- leadership.

Within each SHA, local working groups were also set up to develop improved models of care across eight broad areas:

- maternity and newborn care
- children's health
- planned care
- mental health
- staying healthy
- long-term conditions
- acute care
- end-of-life care.

In October 2007, Lord Darzi published a first interim report. This interim report was informed by discussions held with staff in NHS organisations, representatives of stakeholder groups and feedback from the deliberative events for patients and the public held at SHA level. This report emphasised the four principles that underpin Lord Darzi's vision for a world-class NHS. These are that it should be fair, personalised, effective and safe. In addition to national measures being put in place to embed these principles, the SHA clinical pathway groups considered them as part of their work.

On 9 May 2008, Lord Darzi published a second interim report 'Leading Local Change' in advance of publication of the first SHA 'vision' for healthcare. The eight local working groups in each SHA formed the basis for each SHA vision. The report sets out '...five pledges to the public and staff on how the NHS will handle changes to services' and which '...PCTs will have a duty to have regard to...', as follows:

Change will always be to the benefit of patients. This means that change will improve the quality of care that patients receive – whether in terms of clinical outcomes, experiences, or safety.

Change will be clinically driven. We will ensure that change is to the benefit of patients by making sure that it is always led by clinicians and based on the best available clinical evidence.

All change will be locally-led. Meeting the challenge of being a universal service means the NHS must meet the different needs of everyone. Universal is not the same as uniform. Different places have different and changing needs – and local needs are best met by local solutions.

You will be involved. The local NHS will involve patients, carers, the public and other key partners. Those affected by proposed changes will have the chance to have their say and offer their contribution. NHS organisations will work openly and collaboratively.

You will see the difference first. Existing services will not be withdrawn until new and better services are available to patients so they can see the difference.

More information on how the BMA has fed into this process can be found here: www.bma.org.uk/healthcare_policy/darzi_review/index.jsp

Lord Darzi's final report High Quality Care for all was published in June 2008 and can be accessed on the DH website. Its main thrust is putting quality at the heart of NHS care and includes plans to:

- strengthen the involvement of clinicians in decision-making at every level of the NHS
- systematically measure and publish information about the quality of care 'from the frontline up'
- develop an NHS constitution.

Workforce planning

At the time of writing, workforce planning in the NHS is undergoing radical change as part of Lord Darzi's review of the NHS. The national working group on workforce planning, education and training was tasked with developing a long-term strategy to ensure that the NHS has the right clinical workforce available. The 2008 Tooke report which was commissioned following 2007's chaotic introduction of reforms to medical training (Modernising Medical Careers), highlighted the fact that workforce policy objectives must be integrated with training and service objectives. It also suggested that medical workforce advisory machinery should be revised and enhanced.

The national group recognised this and Lord Darzi's final report, published in June 2008, announced the establishment at both national and regional (SHA) level of an independent advisory, non-departmental public body, Medical Education England (MEE), to advise the Department of Health on the education and training of doctors, dentists, pharmacists and healthcare scientists. MEE and other advisory bodies, supported by a Centre of Excellence, will oversee a new devolved system of workforce planning for the NHS.

The specialist register

On successful completion of speciality training, doctors are currently awarded a certificate of completion of training (CCT), allowing them to practise across Europe as recognised 'specialists'. The Postgraduate Medical Education and Training Board (PMETB) recommends CCT holders for inclusion on the specialist register, administered by the GMC. PMETB was established by the General and Special Medical Practice (Education and Qualifications) Order on 4 April 2003 to develop a single, unifying framework for postgraduate medical education (PGME) and training across the UK. PMETB has a duty to establish, maintain, and develop standards and requirements relating to postgraduate medical education and training in the UK. The board is made up of 16 medical and eight lay members with observers from the UK health departments.

The specialist register includes the names of all CCT holders together with those of other eligible specialists, and shows their specialty and, if requested, any particular field of expertise within it. Eligible specialists are defined as:

- European Economic Area nationals holding recognised specialist qualifications
- other overseas nationals holding specialist qualifications that are deemed equivalent to the CCT
- doctors who have followed academic or research training paths, resulting in a level of knowledge and skill consistent with NHS consultant practice in that specialty.

Those who were consultants in the NHS before 31 December 1996 were automatically transferred to the specialist register.

Clinical academics

Contracts

(See pages 7 and 18 for NHS consultants)

Clinical academic consultants may be employed under one of two possible types of contract.

Honorary contracts

The consultant is employed by a medical or dental school, or by the MRC (usually through the university) and has an honorary (unpaid) appointment with a Trust.

A and B contracts

The consultant is employed either:

- jointly on a full-time basis. Doctors are employed on a full-time basis by the NHS with sessions subsumed to the university and work done in these sessions directed by the university; or
- on a part-time basis with both a medical and dental school or MRC and a Trust (in which case the consultant will be treated as part time by both the university and the NHS employer).

Like their NHS colleagues, clinical academics may be employed under the 'new' 2003 consultant contract, or under the pre-2003 contract if employed prior to October 2003.



Information

- > Terms and Conditions of Service, paragraphs 78 and 81
- > Terms and Conditions of Service 2003, schedule 23
- > Honorary Consultant Contract (England), an agreement between the BMA, BDA, Universities and Colleges Employers Association (UCEA) and the Department of Health for Clinical Academic Consultants in England, December 2003
- > Consultant Clinical Academic Substantive Contract Suggested Clauses (England), December 2003
- > Guidance Notes For the Employment of Consultant Clinical Academics (England), Guidance agreed between the BMA, BDA, UCEA and Department of Health, December 2003

Pay

(See page 35)

Although not formally part of the DDRB process, clinical academic salaries are updated every year in line with the implemented recommendation of the DDRB applicable to NHS hospital medical staff. Clinical academics who experience problems in being awarded the annual DDRB recommendation should contact *askBMA* for advice.

Job planning

(See page 57)

The BMA has produced detailed guidance on the integrated job planning process for clinical academics on the 2003 contract in England which is available separately. In broad summary:

- clinical academics will have a commitment to the university/academic employer and the NHS employer. This will typically be five PAs of academic work and five PAs of NHS work, although these proportions can be varied according to the needs of the job (for example, 6:4, 3:7)
- within the NHS commitment, there should be a typical ratio of three direct clinical care PAs to one supporting PA. Supporting PAs can include teaching and research activities if agreed with the NHS employer
- the integrated job plan should be agreed between the academic employer, NHS employer(s) and the clinical academic staff member
- additional PAs can be agreed with either employer, according to the needs of the job. Consultants might find it useful to keep a workload diary for a reasonable period in order to argue for additional PAs
- a key feature of the 2003 contract is flexibility. Consultants may decide to annualise their job plan rather than keep a weekly or fortnightly timetable, so that attendance at conferences, exam periods or research projects can be incorporated into the job plan more easily.

Many of the principles of job planning can and should be applied to the pre-2003 contract.



Information

> [The Clinical Academic Consultant Contract \(England\) 2003, BMA Advice on Integrated Job Planning](#)

Appraisal

(See page 121)

Appraisal is separate from, but informs, the job planning process. As with job planning for clinical academics, the appraisal process should include input from both employers as well as the clinical academic. Further information on the appraisal process for clinical academic staff is available on the BMA website.



Information

> [Clinical academic staff \(consultants\) appraisal scheme 2002](#)

Disciplinary procedures

(See page 113)

Clinical academic staff are subject to the newly-agreed NHS procedures for issues arising from their NHS employment, and applicable university procedures for university activities, which will be determined by each institution, usually in line with model statutes. The Health Department and Universities and Colleges Employers Association have agreed guidance and a protocol that outline the management of disciplinary procedures as they apply to clinical academics, which is available from the DH website (www.dh.gov.uk).



Information

> [Maintaining high professional standards in the modern NHS, guidance on clinical academics](#)

Private practice and spare professional capacity

(See page 87)

The rules that apply to clinical academic staff in this regard are potentially complex because of the myriad possible combinations of arrangements that could apply, ie partial or total remittance of private income to the university department, shared arrangements among a number of interested parties, or income being retained by the individual. If in doubt it is recommended that you contact *askBMA* for further advice. That said, in general terms, the arrangements applicable in the NHS apply, apart from cases where it is an expectation of academic

employment that some private practice is carried out. Where this is the case, this should be clearly identified in the integrated job plan, and should not affect pay progression. It should be noted that private practice in this context is only the diagnosis and treatment of patients by private arrangement, and does not apply to any other activities, for example, writing text books.

Clinical excellence awards (CEAs), distinction awards and discretionary points

(See page 80)

Clinical academic staff are eligible for CEAs, distinction awards and discretionary points. The proportion of the award that they receive is determined according to how much of the work in their job plan is of benefit to the NHS, as outlined below.

Pre-2003 contract, discretionary points and distinction awards

Paragraphs 81 and 82 of pre-2003 terms and conditions refer – clinical academics are eligible for distinction awards and discretionary points according to the average time per week for which they are engaged in clinical work per week as follows.

Average number of hours of clinical work per week	Proportion of award
21 or more	Full amount
17.5 or more but less than 21	80%
14 or more but less than 17.5	65%
10.5 or more but less than 14	50%
7 or more but less than 10.5	35%
3.5 or more but less than 7	25%
An assessable amount but less than 3.5hours	15%

2003 contract, discretionary points and distinction awards

Average number of PAs work per week of benefit to the NHS	Proportion of award
5 PAs	100%
4 PAs	80%
3 PAs	60%
2 PAs	40%
1 PA	20%
An assessable amount but less than 1 PA	15%

Consultants on pre-2003 contract who receive CEAs

The entitlement to full eligibility for an award will be based on five PAs (or equivalent) in the jointly agreed job plan being devoted to activities beneficial to the NHS including teaching and clinical research.

Average number of hours of per week	Proportion of award
20 or more	100%
16 or more but less than 20	80%
12 or more but less than 16	60%
8 or more but less than 12	40%
4 or more but less than 8	20%
An assessable amount but less than 4 hours	15%

Consultants on 2003 contract who receive CEAs

The entitlement to full eligibility for an award will be based on five PAs (or equivalent) in the jointly agreed job plan being devoted to activities beneficial to the NHS including teaching and clinical research.

Average number of PAs per week	Proportion of award
5 PAs	100%
4 PAs	80%
3 PAs	60%
2 PAs	40%
1 PA	20%
An assessable amount but less than 1 PA	15%

Sick leave

(See page 46)

Honorary contract holders are subject to the arrangements in force at the employing authority (university/MRC). Previous continuous service within the NHS does not normally count towards continuous service for sick leave purposes in university contracts. A and B contract holders are subject to NHS sick leave entitlements.

Maternity and parental leave

(See page 50)

Honorary contract holders are subject to the maternity and parental leave provisions laid down by individual universities. Previous continuous service within the NHS does not normally count towards continuous service for maternity and parental leave purposes in university contracts. However, there is reciprocity when moving from the university to the NHS as the main employer.

Doctors who since 20 April 1983 have held honorary NHS contracts in academic posts may, on their return to the NHS, count service under that honorary contract when assessing their eligibility for maternity/parental leave and pay. A and B contract holders are subject to NHS maternity leave entitlements.

European Working Time Directive (EWTB)

(See page 64)

All clinical academics are covered by the EWTB. At the present time, clinical academics are not included under the terms of the senior hospital doctors' agreement on working time. This is because they are employed by universities who hold responsibility for applying these regulations.

University employers have refused to implement the terms of the Directive under regulation 21 (the derogation applied for senior hospital doctors). They have taken the view that clinical academics have control over the hours they work and are therefore not entitled to receive rest periods or to have restrictions placed upon their average hours worked per week. The BMA continues to challenge this view and promote the application of the senior hospital doctors' agreement. Clinical academics undertake similar duties to their NHS colleagues and have an obligation to provide continuity of care for patients throughout the entire working week, regardless of other teaching and research commitments.

Removal expenses

(See page 34)

There is no national policy for provision of removal expenses for clinical academics by university employers. Individual universities may provide some reimbursement. On consideration of a new contract of employment, clinical academics are advised to raise this matter with the university and to seek information from askBMA on any agreements reached within the university with other clinical academic employees.

Pensions

(See page 72)

All clinical academics have the option of joining either the NHSPS or the University Superannuation Scheme which at the time of writing are broadly comparable in terms of the benefits they provide. Clinical academics would lose two years' pension rights if they ever transfer back from the University Superannuation Scheme to NHSPS. Further details are available on both schemes from *askBMA* and information on moving between NHS and university appointments can be found here: www.bma.org.uk/employmentandcontracts/pensions/superannuation_scheme/index.jsp

The clinical team

Consultant responsibility

Only a consultant or a principal in general practice can accept ultimate medical responsibility in NHS units and the development of new working patterns and increased multidisciplinary working should not alter this basic principle. Consultants must nonetheless work constructively within multi-disciplinary teams and respect the skills and contributions of their colleagues. They should delegate responsibilities (to both medical and non-medically qualified staff) when they believe it is in the best interests of the patient and are sure of the competence of the staff in question. In the case of referral to non-medically qualified health workers, consultants should ensure that such staff are accountable to a statutory regulatory body, and that a medical practitioner retains overall responsibility for the management of the patient.

Except in clearly defined circumstances, such as direct access to accident and emergency departments and GUM clinics, access to secondary care provided by consultants has traditionally been through a general practitioner, acting in a gatekeeper role. More recently there have been nurse referrals from community screening programmes or integrated services such as diabetes programmes. Such referrals are normally on behalf of the patient's GP and follow agreed protocols. The traditional pattern is also increasingly being challenged with further developments such as:

- moves to increase provision in primary care and community settings, such as through the proposed 'polyclinics'
- walk-in health centres and NHS Direct
- widened prescribing rights for new groups of health professionals
- independent sector treatment centres and greater diversity of providers
- proposals to extend clinical autonomy to staff and associate specialists and some doctors in training.

In order to ensure the proper continuity of medical responsibility for patients, the CCSC advises consultants to insist, wherever possible, on referrals coming from a named medical source (with the patient's consent), including referrals made under Choose and Book. The

CCSC also advises consultants always to inform the patient's GP of advice given or treatment proposed, as recommended by the GMC, and on which the CCSC has issued guidance jointly with the BMA General Practitioners Committee (www.bma.org.uk/ap.nsf/Content/improvecommunication?OpenDocument&Highlight=2,improving,communication). Where nurse referrals are accepted under local protocols, these protocols should be drawn up with medical input. The CCSC's guidance on access to secondary care offers consultants a detailed commentary on the way that traditional referral patterns are changing and advice on what steps to take if they have concerns about the ways that referrals to secondary care are being made.

In the day-to-day performance of their duties, consultants take responsibility for their own practice and many will routinely fulfil the role of team leader. The clinical team may include a number of other grades of doctor for which the consultant is responsible. The GMC issued guidance on the teaching and supervisory responsibilities of doctors in *The doctor as teacher* in 1999. It states that:

- all doctors have a professional obligation to contribute to the education and training of other doctors, medical students and non-medical healthcare professionals on the team
- every doctor should be prepared to oversee the work of less experienced colleagues, and must make sure that students and junior doctors are properly supervised
- teaching skills are not necessarily innate, but can be learned. Those who accept special responsibility for teaching should take steps to ensure that they develop and maintain the skills of a competent teacher
- doctors are expected to be honest and objective when assessing those they have supervised or trained. Patients may otherwise be put at risk.

In a joint publication with the Postgraduate Medical Education and Training Board (PMETB), *Principles of Good Medical Education and Training*, published in 2005, the GMC added that:

- doctors with responsibilities for teaching, training and providing CPD

should gain and develop appropriate knowledge, skills, attitudes and behaviours

- there should be adequate training and support for anyone who provides education, training and CPD
- students and doctors should have appropriate teaching and learning resources, such as libraries, computing equipment and teaching rooms. These resources should be regularly reviewed and assessed
- professionals providing effective medical education, training and CPD need time to do so. Those responsible for programmes should make appropriate arrangements for time to be set aside for the students and trainees. There should be adequate resources, including time where teachers cannot be called away to see patients, to support assessment and appraisal.

A general overview of the role of doctors as teachers is provided by the paper of the same name produced by the BMA Board of Science and Education published in September 2006, which is available on the BMA website: www.bma.org.uk/careers/training_trainers/doctorsas_teachers.jsp



Information

- > Improving communication, the exchange of information and patient care. Suggested guidelines for secondary care doctors and GPs, October 2007
- > CCSC Guidance, Access to Secondary Care, January 2000
- > NHS Primary Care Walk-in Centres HSC 1999/116
- > GMC, Good Medical Practice 2001, Third Edition
- > GMC, The Doctor as Teacher, 1999
- > Towards Tomorrow: The Future Role of the Consultant (CCSC 1996)

Specialist doctors

Until the agreement reached between the BMA and NHSE Employers on the specialty doctor contract in 2008, there were essentially two types of pre-CCT specialty doctors: associate specialists and staff grade doctors. Associate specialists are senior hospital doctors, responsible to named consultants. The associate specialist grade is a career grade and, for

those employed under national agreements, appointments are subject to a year's probationary period, and may be held until retirement.

Associate specialists are appointments established for those doctors committed to a career in the hospital service who have been unable to complete higher professional training or who, having completed it, are unable or do not wish to accept the full responsibility of a consultant appointment. The positions were originally personal appointments but Trusts advertise for and recruit associate specialists directly.

In making an appointment to the associate specialist grade, employers were advised to seek advice from the relevant royal college or faculty. Employers had to be sure that there was a clear service need which could not be met more appropriately by the creation of a consultant post, and bear in mind the need to develop a consultant-based service, overall responsibility for patient care, consultant cover, and provision of teaching for juniors.

The staff grade was a non-training career grade intended to provide a career in hospital medicine for doctors who did not wish, or were unable to train for, consultant status. Staff doctors exercised an intermediate level of clinical responsibility and worked to a named consultant. Their commitments related solely to service requirements and they did not have continuous 24-hour responsibility for their patients.

Following representations by the BMA and other organisations, the Postgraduate Medical Education and Training Board (PMETB) established a mechanism for assessing the experience of doctors who had not been able to complete their specialist training, but who had worked as associate specialists and staff grades for a number of years, in order to ascertain their eligibility to be on the specialist register. The process was established under Article 14 of General and Specialist Medical Practice (Medical Education, Training and Qualifications) Order 2003. The BMA has produced guidance for applicants available on its website: www.bma.org.uk/careers/training_trainers/postgraduate/PMETBguidance.jsp

When granting access to the specialist register through Article 14 of the Order, the PMETB undertake an assessment of a doctor's specialist qualifications, training and experience when compared with:

- the requirements of training in a UK training specialty (ie a specialty in which a CCT is currently awarded); or
- the standards for a newly qualified consultant in the NHS in a non-UK training specialty.

Having been granted a Certificate of Eligibility for Specialist Registration, holders may apply, if they wish for consultant posts. In practice, however, as the business case for a new consultant post may require the abolition of the doctor's current post, and taking part in open competition for the new consultant post, this option is not always taken.



Information

- > [Guidance for PMETB Applicants, BMA, February 2006](#)
- > [BMA Guidance Note: The associate specialist grade](#)
- > [HSG\(91\)18 The associate specialist grade](#)
- > [EL\(91\)150 Delegation of procedures for appointment to the associate specialist grade in the medical specialties](#)
- > [EL \(97\)25 A working draft to develop a Quality Framework for HCHS](#)
- > [Medical and Dental Staffing \(Annex 2\)](#)
- > [BMA Guidance Note: The staff grade](#)
- > [AL\(MD\)4/97 Terms and Conditions of Service for the Staff Grade](#)
- > [HC\(88\)58 – The New Hospital Staff Grade](#)

Clinical assistants

Clinical assistants are appointed under paragraph 94 of the Terms and Conditions of Service of Hospital Medical and Dental Staff. Clinical assistant posts are part-time hospital posts that were initially intended for general practitioners who wished to work in a hospital. In theory, there were limits on the number of notional half days for which clinical assistants can be appointed – no more than five for non-GP clinical assistants, and no more than nine for others. However, in practice these restrictions are now rarely enforced. Doctors in the grade are

particularly vulnerable in that there are no clearly defined terms and conditions of service nor security of tenure. The BMA recommends that doctors working under paragraph 94 beyond these limits take steps to negotiate alternative arrangements, such as a staff grade contract, and would encourage them to contact BMA Regional Services for assistance and support.

There is evidence of clinical assistants undertaking significant clinical responsibility. The requirement to be responsible to a named consultant is not stipulated in paragraph 94, but nevertheless should be clearly stated in the contract of employment. Failure to ensure this can lead to difficulties.

Hospital practitioners

The hospital practitioner grade is available to GPs who wish to work in hospitals for up to five notional half days a week as part of a hospital team headed by a consultant. The grade is open only to principals in general practice who have been fully registered for a minimum of four years and have two years' whole-time hospital experience in the relevant specialty, or an appropriate specialist diploma, or the equivalent experience.

Non-standard grade doctors

From 1997 the restrictions on the proportion of doctors in the associate specialist, staff grade and clinical assistant grades were replaced with overall targets for the proportion of such doctors to consultants incorporated into each Trust's medical staffing plan. Any concerns that a Trust is deviating from these targets should be raised initially through the LNC.

This policy has not, as hoped, prevented Trusts from attempting to circumvent the remaining workforce planning mechanisms by inventing new grades with non-standard terms and conditions of service. Doctors employed in such irregular posts are not subject to the national terms and conditions of service which apply to regular posts, and may well be employed on poorer terms. In particular, they frequently face restrictions

on continuing professional development which do not apply to recognised grades.

Training grades

As indicated above, the GMC states that all doctors have a professional obligation to contribute to the education and training of other doctors in their team and must make sure that junior doctors are properly supervised. In addition to these general requirements, some consultants have a formal role in providing clinical or educational supervision for doctors in training, either at employer level or regionally.

Clinicians in management

Introduction

The GMC's *Management for doctors* (February 2006) describes management as 'getting things done well through and with people, creating an environment in which people can perform as individuals and yet cooperate towards achieving group goals, and removing obstacles to such performance'.

Consultants are clearly expected to play their part in managing their organisations, not least to ensure that medical matters are given proper priority in the Trust's decision-making process. Since the Griffiths Report in 1985, this has largely been through formal management structures. NHS Trusts and foundation trusts are required to appoint a medical director to their board and most have also established a framework of clinical directorates or divisions led by a clinical director who is normally, but not always, a doctor. Some Trusts use other terms to describe medical managers who carry out similar roles, such as clinical lead or lead clinician.

The GMC had previously produced guidance for doctors as managers entitled *Management in health care: the role of doctors*. This was reviewed and superseded by *Management for Doctors* in February 2006. This guidance applies to all doctors not just to those with formal management responsibilities. It states that 'all practising doctors are responsible for the use of resources; many will also lead teams or be involved in the supervision of colleagues; and most will work in managed systems, whether in the NHS or in the independent, military, prison or other sectors. Doctors have responsibilities to their patients, employers and those who contract their services. This means that doctors are both managers and are managed'. The DH formally recognised the important roles of clinicians as managers and leaders in final report of the *NHS Next Stage Review, High Quality Care for All* (June 2008).

Remuneration

There is little, if any, national guidance on the pay and conditions of medical managers. The BMA has sought support for improved pay from the DDRB but it decided that they were outside its remit.

The CCSC Medical Managers Subcommittee's survey of medical manager remuneration published in March 2005 revealed a wide variety of ways in which medical managers were paid for their management work and the amounts received. Medical managers are advised to consult the survey as a source of general information on remuneration and seek advice from askBMA on negotiating the best possible deal for themselves. A further survey on the workload and remuneration of medical managers in primary care was published in May 2007. Many respondents comment that the current level of remuneration did not reflect the level of responsibility, the increasing workload and the expanded role expected as a manager in primary care. It also indicated significant differences within this group of medical managers but also from medical managers in secondary care.

A further survey of the workload of medical managers in secondary care was issued in June 2008 and the results are due to be discussed by the Medical Managers Subcommittee in the early autumn with a view to publishing them later in 2008.

Guidance on superannuation for clinical and medical directors can be found at page 77.

Medical directors

The Medical Managers Subcommittee thoroughly revised the BMA's previous guidance on the role of medical directors. This was published in May 2007 and sent to all medical directors. The guidance highlights and gives more details on the areas summarised below. The guidance is available from askBMA and on the website:

www.bma.org.uk/medicalmanagers

The areas of responsibility of a medical director can be summarised as being:

Corporate responsibilities

Giving professional advice; training; business planning; strategic planning; co-trustee of donated funds.

Professional responsibilities

Recruitment and selection; health performance and conduct; clinical excellence awards; job plans; continuing professional development; consultant induction; management and development; clinical outcomes; quality-clinical governance.

Management responsibilities

Risk management; workforce planning; clinical practice development; succession planning; research and development; teaching; external relationships and liaison.

Medical directors must maintain appropriate continuing professional development to ensure smooth transition back to clinical practice on relinquishing the post.

Clinical directorates

Under a system of clinical directorates, management responsibility is decentralised and devolved from unit to sub-unit level (the directorate). The role of clinical directorates within Trusts may be different and the position of individual clinical directors within the overall management structure may vary from Trust to Trust. Clinical directors will normally work closely with a business manager, finance manager and probably a senior nurse manager in a management team. They will often have a range of functions as set out below.

Strategy

Clinical directors have a strategic management role regarding the directorate's position in relation to others in the Trust, primary care groups and health authorities. The scale of this role is determined locally.

It should be supported through the provision of adequate resources.

Budget

The extent to which responsibility for budgetary management is devolved varies significantly. Some clinical directors negotiate and agree the budget in relation to throughput and workload and will be held accountable for control of the budget and potentially for any under or overspending. Others may have little real control of the budget although they will receive regular financial statements.

Clinical governance

Clinical directors are likely to be closely involved in quality assurance initiatives, often leading on clinical audit programmes, risk management and the investigation of clinical incidents. Particularly in bigger Trusts, clinical directors will often be responsible for initial investigation of any concerns about the health or performance of colleagues in the directorate.

Clinical directors have a key role in the consultant appraisal process (see page 122 for further details).

Human resources

Clinical directors negotiate the distribution of work through the directorate via staff job plans; there is usually a responsibility for coordinating annual leave, study leave, cover during leave, on-call rotas, disciplinary procedures, the training of juniors and the management of non-consultant career grade contracts as appropriate. With the introduction of the 2003 consultant contract, there has been greater emphasis on job planning and a key role for clinical directors.

Other important points include:

- clinicians and the clinical director have a joint responsibility to ensure that the work of the directorate is successfully carried out
- clinical directors must have the confidence of the consultants within the directorate
- clinical directors who relinquish clinical programmed activities (PAs) in

order to carry out their managerial duties must seek to ensure that they have the right to have such PAs reinstated when they step down from being clinical director

- clinical directors must be able to call upon support from other services within the Trust when carrying out management functions, and should be given adequate training and secretarial and office support to carry out their job.



Information

- > Guidance for Developing the Role of Medical Directors (May 2007)
- > HC(85)9, Health Services Management (1) Consultants and General Practitioners in General Management; (2) Unit Medical Representatives with General Management Duties.
- > The Roles and responsibilities of the clinical director (BAMM 2003)

NHS structure

Introduction

Since the introduction of the *NHS Plan* in 2000, the NHS has continued to come under substantial review. A number of new policy initiatives have profoundly changed the health service framework and the ways in which services are provided in the UK. All current policy initiatives need to be set within the context of a move towards a mixed economy where provision is becoming increasingly pluralistic.

The NHS in England: the operating framework for 2007/08 sets out the current Government's prioritised plan to build a 'patient-led' system driven by local priorities with a continuation of reforms designed to build 'a self-improving' NHS. The Government hopes that the reforms will create an NHS 'characterised by free choice across a wide range of providers, competing on quality, as money follows the patient'.

The white paper *Our Health, Our Care, Our Say* (January 2006) sets out the Government's vision for delivering more effective healthcare services outside the hospital setting. The health service is perpetually being reviewed but currently consists of the following components.

NHS organisations

The Department of Health (DH)

The DH is responsible for formulating health and social care policy across England. It negotiates and allocates resources for healthcare, as well as setting national standards for all components of the NHS. It additionally drives modernisation across all areas of the NHS, social care and public health.

NHS Institute for Innovation and Improvement

The Institute superseded the NHS Modernisation Agency in 2005. It supports the development and spreading of new ideas by providing practical guidance on implementation. The Institute is particularly interested in new ways of working and new technology.

NHS Employers

Set up by the DH in 2004, NHS Employers has the responsibility for workforce and employment issues on behalf of NHS organisations in England. NHS Employers is responsible for pay negotiations, planning and workforce, productivity, HR policy and practice, and promoting the NHS as an employer in relation to all organisations within the NHS in England. It represents employers' views and supports them through advice, guidance and information.

Special health authorities

There are currently 12 special health authorities in England. They are independent institutions (although subject to ministerial direction) which provide a service to the whole of England in a specific aspect of healthcare. The special authorities are:

- Health Protection Agency – responsible for reducing the impact of infections, poisons, diseases and chemical and radiation hazards in England and Wales
- The Mental Health Act Commission
- NHS Blood and Transport
- National Institute for Health and Clinical Excellence
- National Patient Safety Agency
- National Treatment Agency aims to increase the availability, capacity and effectiveness of treatment for drug misuse in England
- NHS Appointments Commission
- NHS Litigation Authority
- NHS Business Services Authority
- NHS Professionals provides the NHS with locum staff including consultants
- The Health and Social Care Information Centre
- The NHS Institute for Innovation and Improvement.

Strategic health authorities (SHAs)

In 2006 the number of SHAs was reduced from 28 to 10. SHAs manage the NHS locally and are a key link between the Department of Health and the NHS. Their functions include:

- creating a coherent strategic framework for the local provision of healthcare and developing plans for future provision
- managing the performance of local healthcare providers, including agreeing annual performance plans and implementing national priorities locally
- increasing the capacity of the local health service.

SHAs develop over-arching strategies for workforce development and capital investment. They also foster partnerships with non-NHS bodies, universities and further education institutions.

Primary care trusts (PCTs)

PCTs are responsible for meeting the needs of local communities by running primary and community services and commissioning secondary care. There are 152 PCTs (reconfigured in 2006 from 303) and they control 80 per cent of the NHS budget. They perform three main functions:

- to improve the health of the local community – they do this by assessing their health population's needs and working with a variety of local providers to develop a service to meet those needs
- to develop and ensure the provision of all primary and community health services – they do this by managing, integrating and ensuring the quality of all medical, dental, pharmaceutical and optical primary and community services
- to commission hospital care – either singly or in partnership with other organisations.

Commissioning can be delivered in partnership with general practice. Practice-based commissioning is a Government reform designed to give GP practices greater control over how the NHS provides services for patients. PCTs continue to be legally responsible for the contracting, but practices can keep up to 70 per cent of savings to reinvest in premises, equipment or other services. The policy is in-line with the Government's aim to devolve responsibility locally and increase patient choice.

A number of PCTs are teaching Trusts. They offer health professionals clinical posts that involve teaching, research or development and provide activities which are focused on learning and development. After the 2006 reconfiguration, teaching PCTs did not automatically keep their teaching status but had to seek approval from their SHA.

NHS Trusts

There are three main types of NHS Trust:

- acute Trusts – these provide medical and surgical care and are usually centred on a teaching or district general hospital. Some are attached to universities, while others are regional or national centres providing specialised care. Acute Trusts employ most of the NHS workforce
- mental health Trusts – these provide health and social care in primary, secondary and community settings for people with mental health problems. They provide a range of services including psychological therapy and specialist medical and training services
- ambulance Trusts – in 2006, many of the 32 ambulance Trusts merged to create 11 new organisations.

Some Trusts provide a combination of these services. The healthcare provided by NHS Trusts is commissioned by PCTs and set out in service level agreements between organisations. NHS Trusts are legally obliged to achieve minimum quality standards, deliver national as well as local priorities and break even financially. They are largely self-governing and are run by their own Trust boards, although SHAs manage their performance. The Government intends that all NHS Trusts will eventually become foundation trusts.

Foundation trusts

Foundation trusts were established in 2004 as NHS Trusts which have greater financial and operational freedoms. They are independent public benefit organisations and local people can influence their running by contributing to their trust boards. However, they also remain subject to the standards, performance ratings and regulation of the wider NHS and are accountable to Parliament. At the time of writing there were 92 foundation trusts. Foundation trusts can:

- retain any financial surpluses, eg from land sales, and borrow capital from both the public and private sectors
- establish private companies
- have control over how they fulfill their obligation to achieve the national targets and standards which are followed by the wider NHS
- vary staff appointment and remuneration outside of nationally agreed terms and conditions of service
- be exempt from directions of the Secretary of State
- be exempt from performance management by SHAs and the DH.

Care trusts

At the time of writing there were 12 care trusts in England. Care trusts are designed to provide and commission integrated health and social care within a single organisation. They may be based on either a PCT or an NHS Trust.

Children's trusts

It is intended that most areas will have children's trusts by 2008. They will integrate the planning and commissioning of children's services within a single organisation as outlined in the Government's 2004 green paper, *Every Child Matters*.

Managed clinical networks

Clinical networks are partnerships of all organisations and professionals involved in commissioning, planning and providing a particular service in a geographical area. They are managed by multidisciplinary teams and aim to ensure all staff with whom a patient has contact are working to the same protocols and policies. Networks are now well developed in cancer care and there are currently 34 cancer care networks.

The NHS Confederation brings together all these organisations that make up the NHS. It aims to influence policy, provide networking opportunities, represent the views of its members and promote the NHS (www.nhsconfed.org).

The regulatory framework

The Healthcare Commission

The Healthcare Commission acts as an independent inspection body in England for both the NHS (including foundation trusts) and independent healthcare. It is independent of the Government and reports to Parliament. Its functions include:

- assessing the performance of health services across England, according to standards set out by the DH, and publishing regular ratings and an annual report on healthcare in England
- identifying how effectively public funds are being used in all healthcare institutions
- investigating serious failures in healthcare services and coordinating inspections to minimise disruptions
- developing an independent second stage for complaints relating to healthcare provision which cannot be resolved locally
- coordinating inspections with other organisations to minimise the disruption to healthcare.

The current Health and Social Care Bill will, subject to Parliamentary approval, pave the way for the establishment of the Care Quality Commission. From April 2009, the new Commission will take over the functions for the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission. The Care Quality Commission will be responsible for regulating services across the health and social care sectors. The Government envisage that the new Commission will provide a more consistent approach to regulation across health and adult social care.

Monitor

Monitor is the foundation trusts' regulator, responsible for authorising, monitoring and regulating such trusts. Once foundation trusts are established, they are monitored to ensure that they comply with the requirements of their terms of authorisation. Inspection of the performance of a foundation trust against healthcare standards is carried out by the Healthcare Commission. Monitor has powers to intervene in the running of a foundation trust in the event of failings

in its healthcare standards or other aspects of its activities, which amount to a significant breach in the terms of its authorisation.

National Institute for Clinical Excellence

The National Institute for Clinical Excellence is a special health authority established to promote clinical excellence and effective use of NHS resources. It provides evidence-based national guidance on medicines, treatments and care for patients, carers and healthcare professionals (www.nice.org.uk).



Information

- > Pocket Guide: The NHS in England 2007/8 (NHS Confederation, 2004)
- > The NHS Plan (Department of Health, 2000)
- > The NHS Improvement Plan (Department of Health, 2004)
- > PCTs: An Unfinished Agenda (Institute for Public Policy Research, 2004)
- > NHS Plc: The Privatisation of Our Health Care (A Pollock, 2004)
- > NHS Gateway website: www.nhs.uk/
- > Department of Health website: www.dh.gov.uk/Home/fs/en
- > NHS Employers' Organisation website: www.nhsconfed.org/ourpriorities/employers_organisation.asp
- > Healthcare Commission website: www.healthcarecommission.org.uk
- > Our Health, Our Care, Our Say (Department of Health 2006)
- > The NHS in England: the operating framework for 2007/08 (Department of Health 2007)
- > Every Child Matters (Department of Health, 2005) www.everychildmatters.gov.uk/
- > NHS Choices website: www.nhs.uk
- > National Institute for Clinical Excellence website: www.nice.org.uk

Key initiatives

A number of key initiatives in healthcare provision have been proposed which could substantially alter the shape of the NHS in the future. Many of these have already been initiated to some degree, although development is still in progress.

Concordat with the private sector

This was drawn up in 2000 with the aim of establishing ‘a partnership approach that enables NHS patients in England to be treated free in the private and voluntary healthcare sector’. It was intended to enable the NHS to treat more patients more quickly by using spare private healthcare capacity.

Private finance initiatives

These are schemes which involve a public-private partnership between an NHS organisation and a private sector consortium that makes private capital available for health service projects. A private consortium will design, build, finance and operate a hospital, on the understanding that the NHS will effectively rent the hospital from them for a given number of years. The consortium is guaranteed a full return on costs, including interest on the capital borrowed, plus an element of profit. A significant programme of hospital building is currently being undertaken in the NHS under the PFI initiative.

Treatment centres

These are units established to provide intensive treatment programmes, often relating to a specific aspect of healthcare such as orthopaedic or ophthalmic surgery. Some are run by the NHS, but the majority are Independent Sector Treatment Centres (ISTCs) which are operated by private companies who have won tenders to provide services either locally or in national chains. Contracts for the first wave of ISTCs restricted the staff that could be employed to undertake work in treatment centres. In particular, staff who had worked in the NHS in the previous six months were not allowed to work in ISTCs. The BMA has objected to this ‘additionality’ restriction. There remain some outstanding concerns about the role of ISTCs, for example their financial

impact upon existing NHS establishments and in relation to the training of junior doctors.

Patient choice

This health policy articulates priorities to increase choice and responsiveness in order to 'create more personalised care while also promoting equity'. It is the Government's belief that such proposals will create choices for patients in all aspects of healthcare, including providing options for access to services, methods of treatment and timescales. It is intended that, by December 2005, patients will be given the choice of four or five different providers for elective care, one of which will be in the private sector.

Payment by results

Payment by results (PbR) is the name given to the system of reimbursement for providers introduced in phased fashion over the last four years. Under PbR, contracts are struck between commissioning bodies and providers on the basis of predicted levels of activity adjusted for casemix. By casemix, we mean the way in which different diagnoses and treatments together with their differential resource implications are taken into account.

PbR is predicated on a single price or tariff for a given activity regardless of where it is performed, the intention being to drive down costs as those with costs in excess of the tariff seek to bring them into line. A number of objectives have been claimed for PbR including all of the following:

- to provide a transparent, rules-based system for paying NHS providers
- to drive and reward sustained improvements in efficiency
- to support patient choice and encourage hospitals to respond to patient preferences
- to encourage plurality of provision
- to encourage activity for sustainable waiting time reductions
- to maintain and improve quality of care
- to encourage commissioners to provide effective care in the most appropriate settings.

Currently, the mandatory PbR tariff is payable for admitted patient care (elective, non-elective and emergency), outpatient attendances and accident and emergency attendances.

In February 2008, the Audit Commission published *The right result? Payment by results 2003-2007*, an analysis of the first four years of PbR. The main findings of the report were that PbR has improved the fairness and transparency of the payment system; that it has at most contributed towards an increase in activity and efficiency in elective care and; that the negative impact on quality feared by some had not materialised.

The Audit Commission set out four necessary steps for PbR:

- the information infrastructure needs to be strengthened, including diagnosis, procedure and casemix classifications
- the national tariff should be made more flexible
- it would be helpful to introduce some normative tariffs for selected HRGs
- separate funding streams for capital and quality, for example, as is the case internationally, should be considered.

Further information can be found here:

www.bma.org.uk/healthcare_policy/nhs_funding/pbr2008.jsp



Information

- > Pocket Guide: The NHS in England 2004/5 (NHS Confederation, 2004)
- > The NHS Plan (Department of Health, 2000)
- > For the Benefit of Patients: A Concordat with the Private and Voluntary Health Care Provider Sector (Department of Health, 2000)
- > Reforming NHS Financial Flows: Introducing Payment by Results (Department of Health, 2002)
- > Building on the Best: Choice, Responsiveness and Equity in the NHS (Department of Health, 2003)
- > BMA Response to Consultation Payment by Results (BMA, 2003)
- > The NHS Improvement Plan (Department of Health, 2004)
- > PCTs: An Unfinished Agenda (Institute for Public Policy Research, 2004)
- > Joining up the Jigsaw: Piecing Together Health Policy (NHS Confederation, 2004)

- > NHS Plc: The Privatisation of Our Health Care (A Pollock, 2004)
- > NHS Gateway website: www.nhs.uk/
- > Department of Health website: www.dh.gov.uk/Home/fs/en
- > NHS Employers' Organisation website:
www.nhsconfed.org/ourpriorities/employers_organisation.asp
- > Healthcare Commission website: www.healthcarecommission.org.uk

Health and hospital records

Health records

Doctors have always had the discretion to allow patients to see their health records and to share information where appropriate with the carers of children and incapacitated adults. Additionally, in recent years Acts of Parliament have given certain statutory rights of access to records. None of the legislation prevents doctors from informally showing patients their records or, bearing in mind duties of confidentiality, discussing relevant health issues with carers.

The implementation of data protection legislation in early 2000 changed patients' statutory rights of access to their health records. All manual and computerised health records about living people are accessible under the Data Protection Act 1998.

Doctors may wish to order, flag or highlight their records so as to ensure that, should the patient ultimately seek access, it will be straightforward to identify which the patient may see, and those where an exemption to the right of access applies. The appropriate health professional must be consulted about applications for access. In secondary care, this will normally be the consultant responsible for the clinical care of the patient. Consultants are advised to contact *askBMA* for guidance on the fee that they may charge for making records available.

Deceased patients

The Data Protection Act 1998 only covers the records of living patients. When the patient has died, the patient's personal representative and any person who may have a claim arising out of the patient's death has a right of access to information in the deceased's records necessary to fulfil that claim. These rights are set out in the Access to Health Records Act 1990 or Access to Health Records (Northern Ireland) Order 1993. The provisions and fees are slightly different from those in the Data Protection Act. Further information can be found in the BMA's guidance *Access to health records by patients* that is available at: www.bma.org.uk/ethics/health_records/AccessHealthRecords.jsp

Medical reports

The Access to Medical Reports Act 1988 (the Act) and Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 (the Order) give patients rights in respect of reports written about them for employment or insurance purposes.

They cover reports written by the applicant's GP or a specialist who has provided care, including an occupational health doctor. Reports written by an independent medical examiner are not covered by the Act or the Order. In the BMA's view, patients are entitled to access these reports under data protection legislation. Further information can be found here: www.bma.org.uk/ethics/health_records/index.jsp



Information

- > Medical Ethics Today: the BMA's handbook of ethics and law (2nd ed) (2004) www.bma.org.uk/ethics/MET2004.jsp
- > Data Protection Act 1998
www.opsi.gov.uk/Acts/Acts1998/ukpga_19980029_en_1
- > Good Medical Practice, General Medical Council, May 2006
www.gmc-uk.org/guidance/good_medical_practice/index.asp
- > Medical information & insurance: Joint guidelines from the British Medical Association and the Association of British Insurers, BMA, December 2002
www.bma.org.uk/ethics/health_records/MedicalInfoInsurance.jsp

Caldicott guardians

The Caldicott Committee was established by the chief medical officer to review all patient-identifiable information which passes from NHS organisations in England and Wales to other NHS or non-NHS bodies for purposes other than direct care, medical research, or where there is a statutory requirement for information. The purpose was to ensure that patient-identifiable information is only transferred for justified purposes and that only the minimum necessary information is transferred in each case. When the committee reported in 1997, one of its recommendations was that a senior person, preferably a health professional, should be nominated in each health organisation to act

as a guardian, responsible for safeguarding the confidentiality of patient information. The responsibility of this person is to ensure that the purposes for which patient information is used within an organisation are robustly justified, that the minimum necessary information is used in each case, and that good practice and security principles are adhered to.



Information

- > [Protecting and using patient information: a manual for Caldicott guardians, NHSE, 1999](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4068134)
- > [The Caldicott Guardian Manual 2006](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062722)

NHS IT

Choose and Book

Choose and Book is a national service, introduced in 2004, that combines electronic booking and a choice of place, date and time for first outpatient appointments. Its aim is that patients are able to choose their initial hospital appointment, and book it either on the spot in the surgery (in the consultation or with practice staff), later on the phone via the national appointment line (or in certain circumstances, by phoning the hospital), or via the internet at a time that is convenient to them. It is intended to help support the Government's patient choice policy of offering a choice of providers to patients requiring a first outpatient appointment. From April 2008, patients have been able to choose from any hospital that meets NHS standards.

NHS Care Records Service (CRS)

The NHS CRS will enable the sharing of electronic patient records across the NHS. The Summary Care Record is one part of the NHS CRS. It will provide a summary of key health information to support unscheduled care and will be accessed anywhere in England by NHS staff who are directly providing care to a patient.

Early Adopter Programme

The Summary Care Record is being introduced in the following early adopter areas – Bolton, Bury, Bradford and Airedale, Dorset and South Birmingham.

Patients in these areas will receive information about the changes. Members of the public who have concerns about this issue are advised to contact NHS Connecting for Health for further information: 0845 603 8510, or by emailing nhscaresrecords@nhs.net

Public Information Programme

In the Early Adopter sites, information was sent to every member of the public over the age of, or soon to reach, 16 years. The local media was used to raise awareness. Roadshows and information booths were also launched. The PCTs also worked with schools to raise awareness so those who are under 16 but Fraser competent and can make decisions about how their records are shared.

Consent model

Following the recommendations of the Ministerial Taskforce report, patients have 16 weeks from the start of the public information campaign to contact their practice with their sharing preferences. Patients are offered three choices:

Green – Summary Care Record (SCR) is shared with those providing direct care to the patient

Amber – SCR is created and stored centrally but not shared unless the patient gives their explicit consent or access is required by a court order or statute

Red – A blank SCR is created

The BMA has received assurances from the Department of Health and the Information Commissioner that uploading information on an implied consent basis meets the requirements of the Data Protection Act.

SCR Content

After the 16-week period a SCR is created unless patients have contacted the practice to state their preferences. Initially the SCR will only contain medications, adverse reactions and allergies. Work is being undertaken with the Early Adopters to establish how further clinical data such as major diagnoses should be added to the record. The Royal College of General Practitioners is developing standards to support GPs in their summary maintenance and its input into the content of the SCR.

Healthspace

Healthspace is an online personal area. Patients in the early adopter areas can access their SCR via an advanced Healthspace account offering additional security. Patients wishing to view their SCR via Healthspace will need to register, which involves filling in an application form and an interview with a registration agent.

The Independent Evaluation

The Independent Evaluation of the Early Adopter sites was conducted by University College London which reported its findings in May 2008. The report recommended that the consent model should be simplified. Previously it was based on 'implied consent'. It has now been suggested that a 'consent to view model' be used. With a 'consent to view model' the SCR would be uploaded on an implied consent basis but the record could only be viewed, at each consultation, with explicit consent. The 'consent to view' model has been successful in Scotland, Wales and Hampshire and could present a way forward in England. It would also help simplify matters for patients who cross the home country borders for treatment if the same consent model is adopted.

The recommendations are being considered by the Summary Care Record Advisory Group. In addition NHS Connecting for Health (CfH) working groups have been set up to consider four different work streams in more detail.

Freedom of Information Act

The Freedom of Information Act 2000, which came into force on 1 January 2005, gives the right of access to information held by public bodies. These include the DH, NHS Trusts and independent medical practitioners. The Information Commissioner's Office (ICO) is charged with the responsibility of implementing and enforcing the Act. The Act also requires that each public body produces and maintains a publication scheme which details the types of documents produced and held by the organisation and whether they are accessible to the public. Some NHS Trusts have already established such schemes.

Under the Act, an individual is able to make a request in writing to a public body for information. The body must comply with the request within 20 working days. If it fails to comply the Information Commissioner can be asked to intervene. Non-compliance could ultimately be regarded as contempt of court leading to an unlimited fine or imprisonment.

There are, however, 24 exemptions to access which are specified in the Act. They include for information relating to defence, international relations and national security. However, 16 of the exemptions are subject to the public interest test. This is a test used by public authorities to determine whether the public interest in withholding the information is greater than the public interest in disclosing it.

One of the exemptions subject to the public interest test is information provided in confidence. However, the ICO's guidance does state that it is 'fairly obvious' that information relating to appraisals would be kept confidential and that 'internal disciplinary matters would not normally be disclosed.' Nonetheless, the Information Commissioner specified in a press release on 1 January 2005 that 'information on hospital complaints and the performance of clinicians' would be considered an example of information which is likely to be 'routinely disclosed'. In addition, Trusts can release information even if it is incomplete or misleading. Consultants are, therefore, advised to attempt to persuade Trusts to pursue a well-

managed method of releasing information, such as through the publications schemes mentioned above.

It should be noted that the Data Protection Act does not protect consultants against the release of information on clinical performance or complaints. The Data Protection Act is designed 'to protect the private lives of individuals'. Hence, if a request is received for information to be released relating to an individual's 'private life' (eg details of the person's family life or personal finances) this information is likely to deserve protection under the terms of the Data Protection Act and hence would not normally be disclosed. However, if the information relates to an individual's 'non-private' life, for example if it concerns someone acting in an official or work capacity, this information would normally be disclosed.



Information

- > Freedom of Information Act – Guidance from the CCSC (April 2005)
- > Public Partners: www.foi-uk.org/
- > The UK Government's Official website for the Act: www.foi.gov.uk/
- > Information regarding the implementation of the Act by NHS bodies: www.foi.nhs.uk/
- > The Information Commissioner's Office website: www.informationcommissioner.gov.uk
- > The full text of the Freedom of Information Act 2000: www.legislation.hmso.gov.uk/acts/acts2000/20000036.htm

The British Medical Association (BMA)

The BMA is a voluntary association set up in 1832 'to promote the medical and allied sciences and for the maintenance of the honour and interests of the medical profession'. It is the professional association of doctors in the UK and is registered and certified as an independent trade union under employment legislation. The BMA has sole bargaining rights for all NHS doctors employed under national agreements, irrespective of whether or not they are members. It is also recognised by many employers of doctors practising in other fields. The BMA offers advice to members on contractual and professional matters via *askBMA* and provides individual and collective representation at a local level through BMA Regional Services. As a spokesperson for the medical profession to the public, the Government, employers, MPs and the media, the BMA addresses matters as wide ranging as medical ethics and the state of the NHS.

BMA divisions

The BMA divisions are the local branches of the Association, based on geographical areas, and cover all branches of practice. Every UK member of the BMA is automatically a member of one of 204 divisions. Each division should have a chairman, secretary and an executive committee including representatives of the branches of practice locally. Professional and administrative support to divisions is provided by BMA Regional Services.

Medical staff committees (MSCs)

Each NHS hospital Trust should have a MSC (or equivalent) consisting of all consultant and permanent staff and associate specialist doctors. Each MSC has a range of functions including providing professional advice to the Trust (including nominating members of audit, drug and manpower committees), monitoring local CEAs and electing representatives to a LNC. While not being formally part of the BMA, MSCs should also elect representatives to regional consultants and specialists committees and to the annual BMA seniors conference held in June each year.

Local negotiating committees (LNCs)

LNCs are now established in almost all NHS organisations which employ doctors. LNCs consist of local representatives of all grades of doctor

including consultants employed by the organisation who will meet regularly to identify issues for negotiation with local management and agree their objectives. They will meet with management representatives in a joint negotiating committee in order to conclude and monitor the application of local agreements and agree and monitor arrangements for the implementation of national agreements within the organisation. Professional and administrative support to LNCs is provided by BMA Regional Services.

Regional consultants and specialists committees (RCSCs)

The regional committees are the representative bodies for consultants in their region. They are the route by which consultants are represented at the BMA's CCSC and are one of the routes through which the central committee communicates to consultants. They are also a potential source of expert advice regionally for directors of public health, the deaneries, the regional ACCEA, SHAs and local authorities. Professional and administrative support to all BMA regional committees, including RCSCs, is provided by BMA Regional Services.

Central consultants and specialists committee (CCSC)

The CCSC is elected by and represents all consultants except those working in public and community health. It has sole negotiating rights with the DH for consultants employed under national agreements, and conducts negotiations with the newly formed employers' organisation, NHS Employers. It also develops policy and responds to consultation documents produced by government departments and other bodies on behalf of consultants. It is a standing committee of the BMA Council with full autonomy to deal with matters relating solely to senior hospital doctors.

Seniors conference

The conference of representatives of senior hospital medical staff consists of representatives from each medical staff committee along with the members of the CCSC. It debates motions presented to it by medical staff committees, RCSCs and CCSC subcommittees which guide the work of the CCSC in the following year.

BMA Council

The Council is the central executive committee as a trade union and the BMA's Board of Directors under company law. It is responsible for administering the affairs of the Association subject to the decisions of representative meetings. It has powers, in the interval between successive meetings of the representative body, to formulate and implement policies on any matter affecting the Association. Consultants are represented on council by at least four and not more than 12 voting members plus the Chair of the CCSC if/she is not a voting member of Council. Council members are elected from a single UK constituency. Half of BMA Council is elected biennially by postal ballot of the membership of the BMA. Council delegates its authority to seven major branch of practice committees including the CCSC. There are also committees for armed forces doctors (which has representatives of the medical reserves) and for private practice.

Annual representative meeting (ARM)

The ARM determines the policy of the BMA. The representatives are either elected by the BMA divisions or are appointed by branch of practice committees.

The Joint Medical Consultative Council

The Joint Medical Consultative Council was established in 1948 as the Joint Consultants Committee (JCC). It was set up by the medical royal colleges and the BMA, as a committee able to speak for the consultant body with one voice. In a review of its constitution in 2007, the Council agreed to modify its terms of reference and explicitly acknowledge changes to its constitution over a number of years, so that it was no longer a consultant committee. Nonetheless, consultants continue to predominate among its members.

The JMCC represents the medical profession in discussions with the DH on matters relating to the maintenance of standards of professional knowledge and skill in the hospital service, the encouragement of education and research, and to discuss with it the key medico-political issues of the day.

The members of the Council include the presidents of the royal colleges and their faculties and representatives of the main BMA branch of practice committees representing consultants, GPs, staff and associate specialist doctors, and trainees. Half of each quarterly meeting is devoted to discussions with the Department of Health led by the chief medical officer for England.

The Council also has a number of working groups on which its constituent bodies (and other organisations) are represented and through which it undertakes further work and seeks advice. The areas of work covered include independent healthcare, the GMC, NHS IT and liaison with the NHS Confederation.



Information

> www.jmcc-uk.org.uk/home.php

BMA advice and support

Each of the BMA branch of practice committees and conferences, as well as the ARM, are supported by a professional secretariat based in BMA House in London. The BMA also has a number of regional centres staffed by secretaries, employment advisers and industrial relations officers who provide support to regional and local committees and help and advice in disputes or negotiations with Trust management. The first point of contact for all individual queries is *askBMA* on 0300 123 123 3 or email support@bma.org.uk

The BMA can also provide specialist advice through its board of medical education, medical ethics committee and board of science. All these committees and the branches of practice are also assisted by the BMA's public affairs division, including its parliamentary unit. The BMA press office aims to maintain a high profile for the Association, the BMJ Publishing Group and the wider medical profession. It promotes positive news and features coverage of BMA activities and events and of the work of individual doctors and medical teams. The press office offers media training to members who have agreed to act as spokesmen and women, whether as members of national committees such as the CCSC

or as locally elected honorary public affairs secretaries. Individual members of the BMA who are facing media enquiries can seek help from the press office at any time by calling 020 7383 6254.



Information

- > [Your BMA – A full guide to membership benefits](#)
- > [Articles of the Association and Byelaws of the BMA \(2004\)](#)

Acronyms

AAC	Advisory Appointments Committee
ACCEA	Advisory Committee on Clinical Excellence Awards
AL	Advance Letter
AVC	Additional Voluntary Contribution
BMA	British Medical Association
CHRE	Council for Healthcare Regulatory Excellence
CCSC	Central Consultants and Specialists Committee
CCT	Certificate of Completion of Training
CEA	Clinical Excellence Award
CNST	Clinical Negligence Scheme for Trusts
CPD	Continuing Professional Development
CGWT	Care Group Workforce Teams
DCC	Direct Clinical Care
DDRB	Doctors and Dentists Review Body
DH	Department of Health
EC	European Commission
EL	Executive Letter
EPP	Exposure Prone Procedure
EWTD	European Working Time Directive
FSAVC	Free Standing Additional Voluntary Contribution
GDC	General Dental Council
GMC	General Medical Council
GP	General Practitioner
GWC	General Whitley Council
HA	Health Authority
HC	Health Circular
HIV	Human Immunodeficiency Virus
HMSO	Her Majesty's Stationery Office
HSC	Health Service Circular
HSE	Health and Safety Executive
HSG	Health Service Guideline
ICAS	Independent Complaints Advocacy Service
ICO	Information Commissioner's Officer
ISTC	Independent Sector Treatment Centre
JCC	Joint Consultants Committee
JNC(S)	Joint Negotiating Committee (Seniors)

LAC	Local Awards Committee
LNC	Local Negotiating Committee
MAC	Medical Advisory Committee
MHO	Mental Health Officer
MRC	Medical Research Council
MSC	Medical Staff Committee
NCAS	National Clinical Assessment Service
NCSSD	National Counselling Service for Sick Doctors
NHD	Notional Half Day
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NHSPS	National Health Service Pension Scheme
NICE	National Institute for Clinical Excellence
NPSA	National Patient Safety Agency
NWDB	National Workforce Development Board
PA	Programmed Activity
PCT	Primary Care Trust
PFI	Private Finance Initiative
PHLS	Public Health Laboratory Service
PMETB	Postgraduate Medical Education and Training Board
PPP	Personal Pension Plan
RCSC	Regional Consultants and Specialists Committee
SHA	Strategic Health Authority
SPA	Supporting Professional Activity
SpR	Specialist Registrar
STA	Specialist Training Authority
STI	Sexually Transmitted Infection
TCS	Terms and Conditions of Service
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
WDC	Workforce Development Confederation
WoNAB	Workforce Numbers Advisory Board
WWW	World Wide Web

Index

A

Acronyms	195-6
Additional voluntary contributions (AVCs)	75
Admitting rights (private hospitals)	99-100
Advisory appointments committees (AACs)	108
Advisory Committee on Clinical Excellence Awards, the	81
Alcohol, misuse of	143
Annual leave	42, 48
Annual representative meeting (ARM), the (of the British Medical Association)	192
Appeals procedures in capability cases	119
Appointment procedures, see Consultant appointments procedures	
Appraisal	121-30
Appraisal in private practice	130
Clinical academics	129
Consultants working in more than one Trust	129
Definition and aims	121
Outcomes	126
Peer review	126
Personal development plan	128
Preparation	123
Process and content	122
Revalidation	128-9
Scheme content	124
Serious issues relating to poor performance	128
Who undertakes the appraisal	122
Associate specialist grade, the	163

B

British Medical Association (BMA), the	190
Advice and support	193
Annual representative meeting (ARM)	192
Central consultants and specialists committee (CCSC)	191
Council	192
Divisions	190
Joint Medical Consultative Council	192
Local negotiating committees (LNCs)	190
Medical staff committees (MSCs)	190

Regional consultants and specialists committees (RCSCs)	191
Seniors conference	191
C	
Caldicott guardians	184
Capability, see Disciplinary procedures and exclusions	
Capability hearing framework	118-9
Category 1 work	12-3
Category 2 work	12-3, 28, 53
Category 3 work	14
Central consultants and specialists committee, the	191
Certificate of completion of training (CCT)	99, 147
Civil procedure rules (Woolf), effect of on working as a medical expert	101
Clinical academics	152-9
Appraisal	154
Clinical excellence awards (CEAs)	155-7
Contracts	152
Disciplinary procedures	154
Discretionary points	155-7
Distinction awards	155-7
European Working Time Directive (EWTD), the	158
Job planning	153
Maternity and parental leave	157
Pay	153
Pensions	159
Private practice and spare professional capacity	154
Removal expenses	158
Sick leave	157
Clinical assistants	164
Clinical directors	169-70
Pension	77
Clinical excellence awards (CEAs)	80-6
Appeals	85
Assessment of awards	84
Basis of awards	80
Distinction awards and discretionary points	80
Eligibility	81

How to apply	82
Local awards	83
National awards	83
Numbers of awards	83
Openness and transparency	86
Retirement of award holders	86
Review and renewal criteria	85
Structure of the scheme	81
Values of awards	82
Clinical governance	170
Clinical negligence and risk management	52-4
Clinical team	160-6
Clinical assistants	164
Consultant responsibility	160-2
Hospital practitioners	165
Non-standard grade doctors	165
Specialist doctors	162-3
Training grades	166
Clinicians in management	167-71
Clinical directorates	169-71
Medical directors	168-9
Remuneration	168
Commission for Health Improvement, see Healthcare Commission	177
Compensatory rest	65
Conduct hearings	116
Conflict of interest (between private practice and NHS commitments)	87
Consultant appointments procedures	106-12
Discrimination and fairness	111
Eligibility for appointment	107
Exemptions from the statutory procedure	110
Fees and expenses	112
Indemnity	112
Membership of advisory appointments committees	108
NHS (Appointment of Consultants) Regulations 1996	106
Planning and advertising a consultant post	106
Procedure of AACs	109

Release of consultants for AACs	108
Training	109
Consultant contracts	6
Consultant contract, 2003	18-34
Additional PAs	24
Balance of activities	20-3
Basic work commitment	18
Directors of public health supplements	30
Duty to be contactable	24
Emergency on-call work	21
Fee-paying work	28
Location of work	26
Locum appointments	31-2
Mediation and appeals processes	32-3
On-call availability supplement	21
Part-time contracts	30
Pay elements	26
Pay progression	27
Pay protection	34
Pay thresholds (new appointments)	27
Premium time	25
Private practice and extra PAs	25
Private practice and on-call work	24
Prospective cover	23
Recruitment and retention allowances	29
Resident on call	24
Responsibility allowances	30
Transferring to the 2003 contract from the old contract	17, 33
Travelling time	26
Working week	18-9
Consultant contract, pre-2003 national	7-17
Category 1 work	12-3
Category 2 work	12-3
Category 3 work	14
Charges for the use of hospital facilities	13
Domiciliary visits	14

Exceptional consultations	15
Family planning in hospitals	16
Fixed commitments	9
Flexible commitments	9
Intensity supplements scheme	11-2
Lectures	17
Temporary additional NHDs	10
Transferring to the 2003 contract from the old contract	17, 33
Types of contract	7
Consultant contracts: Local variations.	56
Consultant responsibility	160-2
Continuing professional development	44
Council (BMA)	192
Council for Healthcare Regulatory Excellence (CHRE)	135
Cover during leave	51-2
Crown or lease cars	36
D	
Darzi Next Stage Review	148
Deceased patients	183
Disciplinary procedures and exclusions	113-20
Action when a concern arises	113
Appeals procedures in capability cases	119
Clinical academics	154
Conduct hearings	116
Examples of misconduct.	116
Handling concerns about a practitioner's health	120
Hearing framework	118
Pre-hearing process	117-8
Procedures for dealing with issues of capability	117
Restriction of practice and exclusion from work	115-6
Discretionary points, see Clinical excellence awards (CEAs)	80-6, 155-7
Distinction awards, see Clinical excellence awards (CEAs)	80-6, 155-7
Divisions (of the BMA)	190
Domiciliary visits (definition of and fees for)	14, 28
Drugs, misuse of	143

E	
Early retirement	76
Employment of consultants	5-6
Consultant contracts	6
Local/national negotiations	5
NHS Trusts	5
European Working Time Directive (EWTD)	64-7, 158
Compensatory rest	65
Non-NHS work	67
Examples of misconduct	116
Exceptional consultations	15
Expenses (local alternatives)	36
Expert witness, leave for attendance as	49
F	
Family planning in hospitals	16, 53
Financial interest in private hospitals (GMC guidance)	131
Fixed commitments	9
Former maximum part-time consultants	8
Foundation trusts	175
Freedom of Information Act	188
Free standing additional voluntary contributions (FSAVCs)	75
G	
General Medical Council (GMC)	131-7
Constitution of the GMC Council	135
Council for Healthcare Regulatory Excellence (CHRE)	135
Duties of a doctor	136
Fitness to practise	133-4
Good Medical Practice	137
Handling of local concerns	135
Office of the Health Professions Adjudicator (OHPA)	134
Green Book, The	93, 95
Grievance procedures	54-5
H	
Handling concerns about a practitioner's health	120
Health	138-50
BMA Counselling	145-6

BMA BMA Doctors for Doctors Unit	146
British Doctors and Dentists Group, the	146
British International Doctors Association	147
Doctors' Support Network, the	147
Hepatitis B	144
Healthcare associated infections (HCAIs)	145
HIV/AIDS	144
Management responsibilities	138
Misuse of alcohol and other drugs	143
Occupational health services	140
Personal injury claims	141
Sick Doctor Scheme of the Association of Anaesthetists, The	147
Sick Doctors Trust, The	146
Sources of professional advice	145
Transmission of infection	144
Violence against doctors	142
Work-related stress	141
Health and hospital records	183-89
Caldicott guardians	184
Deceased patients	183
Freedom of Information Act	188
Health records	183
Medical reports	184
NHS IT	185-7
Health authorities, special.	173
Health authorities, strategic (SHAs)	173
Health records	183
Healthcare Commission	177
Hepatitis B	144
HIV/AIDS	144
Hospital practitioners	165
Hospital records	183-9
I	
Indemnity for membership of an advisory appointments committee	112
Indemnity for work in the NHS	52-4
Indemnity for work in the private sector	98

Independent hospitals	99
Infection, transmission of	144
Injury benefits	78-9
Intensity supplements	11-2
J	
Job planning	57-63
Appeal	32
Context	59-60
Disputes	63
Format (2003 contract)	59
Format (pre-2003 contract)	59
Mediation	32
Objectives	60-1
Private and fee-paying work	61
Process	58
Purpose	58
Review	62
Supporting resources	61-2
Job planning (locums)	32
Joint Consultants Committee (JCC)	192
Joint Medical Consultative Council	192
L	
Leave (annual)	42, 48
Leave (arrangements for cover during)	51-2
Leave (attendance as an expert witness)	49
Leave (maternity, paternity and parental)	50-1
Leave (public holidays)	44
Leave (sabbatical)	50
Leave (sickness)	46-8
Leave (sickness for clinical academics)	157
Leave (special)	48-9
Leave (study and professional)	44-6
Leave (trade union duties and activities)	49
Lectures	17
Local negotiating committees (LNCs)	190-1
Locum consultant appointments	31

Locums (job planning)	32
Locums (pay progression)	32
Locums (salary)	31
M	
Managed clinical networks	176
Management, clinicians in, see Clinicians in management	
Maternity, paternity and parental leave	50-1
Media, advice on dealing with	193-4
Medical directors	77, 168
Medical indemnity	52-4, 98
Medical reports	184
Medical staff committees (MSCs)	190
Medical workforce planning	150-1
Mental Health Act Commission	173, 177
Mental Health Officer status (with regard to pensions)	77
Mileage allowances	37-9
N	
National Clinical Assessment Service (NCAS)	113, 132
National Institute for Clinical Excellence	178
Negotiation of national terms and conditions of service – how conducted ..	5-6
NHS Employers	173
NHS Modernisation Agency	172
NHS official travel	38-9
NHS reform – Darzi Next Stage Review	148
NHS structure	172-82
Care trusts	176
Children's trusts	176
Concordat with the private sector	179
Department of Health (DH)	172
Foundation trusts	175
Healthcare Commission	177
Managed clinical networks	176
Monitor	177
National Institute for Clinical Excellence	178
NHS Employers	173
NHS Institute for Innovation and Improvement	172

NHS Trusts	175
Patient choice	180
Payment by results	180-1
Primary care trusts (PCTs)	174
Private finance initiatives	179
Special health authorities	173
Strategic health authorities (SHAs)	173
Treatment centres	179
NHS Trusts	175
Non-standard grade doctors	165
O	
Occupational health	140
Official travel for the NHS	38-9
Official journeys	38-9
P	
Parental leave	50-1
Part-time contracts	30-1
Paternity leave	50-1
Pay progression (locums)	32
Pay protection (transferring to 2003 contract from old contract)	34
Payment by results	180-1
Peer review	126
Pensions	72-9
Added years	74
Additional voluntary contributions (AVCs)	75
Clinical academics	159
Clinical and medical directors	77
Contribution rates	72
Earnings cap	73
Free standing additional voluntary contributions (FSAVCs)	75
Ill-health retirement	76
Income which is not pensionable in the NHS scheme	73
Injury benefits	78
Lump sum	74
Mental health officer (MHO) status	77
Occupational pension schemes (general background)	72

Pensionable income	72
Pensionable salary	73
Personal pension plans (PPPs)	78
Protection against inflation: index linking	74
Purchasing extra benefits	74
Redundancy; organisational change; interests of the service	76
Retirement age	76
Scaled service	73
Voluntary early retirement	77
Working in the NHS after retirement	78
Personal development plans	128
Personal misconduct	116-7
Primary care trusts (PCTs)	174
Private and independent practice	87-102
Access to private beds	93
Additional PAs and pay progression	89
Clinical academics and private practice	180
Code of conduct on private practice	87
Definition of private practice	87
Definition of private practice income	92
Disclosure of information	87
Fee-paid work	101
Fees for private medical work	100
Green Book, The	95
Independent hospitals	99
Information to patients	88
Involvement of other specialties	93
Junior staff	94
Medical advisory committee (MAC)	99
Medical indemnity	98
NHS charges for private practice	93
NHS contractual provisions: 2003 contract	88-90
NHS contractual provisions: pre-2003 contract	90-2
NHS work and private practice	88-9
Non-consultant medical staff	94
Private care in the NHS	88

Private medical insurance companies: specialist recognition	99
Private patients	98
Private patients to NHS lists	88
Private practice in the NHS	88
Private prescriptions in the NHS	96
Scheduling of work	87
Sick leave, private practice undertaken during	48
Trusts' contracts with third parties	87
Working as a medical expert	101-2
Private finance initiatives	179
Private medical insurance companies	99
Procedures for dealing with issues of capability	117
Professional leave	44-6
Public holidays	44
R	
Records	183-4
Redundancy	68-71
Alternative employment	69
Appeal against redundancy	69
Consultation	68
Redundancy payments	70
Returning to the NHS following redundancy	71
Selection for redundancy	68
Transfer of undertakings regulations	69
Regional consultants and specialists committees (RCSCs)	191
Removal expenses	39-41, 158
Representative and advisory machinery, see The British Medical Association (BMA)	
Restriction of practice and exclusion from work	115-6
Retirement age	76
Retirement, working in NHS after	78
Revalidation	128-9
Risk management and clinical negligence	52-4, 138-9
S	
Sabbatical leave	50
Salary (and the Doctors and Dentists Review Body)	35
Salary (clinical academics)	153

Salary (locums)	31
Seniors conference (BMA)	191
Serious professional misconduct or incompetence	116-7
Sick leave	46-8, 157
Special leave	48-9
Specialist recognition by private medical insurance companies	99
Specialist register, the	150-1
Staff grade, the	162-3
Study leave	44-6
Subsistence allowances	42
Superannuation, see Pensions	
Suspension, see Disciplinary procedures and exclusions	
T	
Telephones	41
Temporary additional NHDs (inc contractual basis and payment of)	10-1
Terms and conditions of service common to the two contracts	35-56
Annual leave	42-4
Cover during leave	51-2
Disputes procedures	55
Expenses and allowances	36
Grievance procedures	54
Lease or crown cars	36
Leave for attendance as an expert witness	49
Leave for trade union duties and activities	49
Local contractual variations	56
Maternity, paternity and parental leave	50-1
Medical indemnity	52-4
Mileage allowances for consultants not offered lease cars	37-9
Official journeys	38
Public holidays	44
Public transport rate	38
Removal expenses	39-41
Sabbatical leave	50
Salaries	35
Sick leave	46
Special leave	48

Study and professional leave	44-5
Subsistence allowances	42
Telephones	41
Termination of employment	55
Travel expenses	36
Travelling time	39
Training grades	166
Travel expenses	36
Treatment centres	179
W	
Woolf reforms of civil procedure rules, effects on working as a medical expert ..	101
Workforce planning	150-1
Specialist register, the	150-1
Working in the new NHS	103
Consultants working in competition with NHS employers	104
Working Time Directive, see European Working Time Directive (EWTD)	

British Medical Association
BMA House
Tavistock Square
London
WC1H 9JP