

The Consultant Handbook

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This handbook applies to consultants working in Northern Ireland only.

Introduction

Dear Colleague

I have great pleasure in recommending to you this the second edition of the Northern Ireland Consultant Handbook. It brings together in a readable format an enormous amount of information, guidance and advice on many of the important issues that govern your working life. We have updated the previous handbook, particularly with guidance on job planning for Northern Ireland. This has focused on advice for use of Supporting Programmed Activity (SPA) time in your job plan discussions with managers. We have also included new advice on resident on call work for consultants, and practical guidance on implementing the EC Directive on working time. This new edition is right up to date on all these changes.

Whatever your question, this handbook is a good place to start looking for the answer. Am I entitled to expenses for study leave? How much annual leave can I carry forward to my next leave year? How many supporting professional activities should I get on my six Programmed Activities (PA) part-time contract? The answers to these and hundreds of other questions are all here. Be sure to keep it handy to use whenever you are unsure about an employment based question. If you do need more information or help from the BMA, your next point of contact should be askBMA on 0300 123 123 3.

Your NICC representatives and BMA staff have worked extraordinarily hard on your behalf in recent years. We have not got everything right, and no side ever gets all that they want from any negotiation. However, I believe that consultants are better off in many ways as a result of these efforts, and not only financially.

The careful application of many of these new agreements and our relevant associated guidance can help us all achieve a better work-life balance, as well as giving a better service to our patients.

It is inevitable that handbooks such as this begin to get out of date over the years. I therefore urge you, if you have not already done so, to register at www.bma.org.uk/emailalerts to receive electronic notification of significant news and updates from your consultants committee and BMA. Communication is a two way process and we therefore remain keen to hear your views at info@ccsc.bma.org.uk

Yours sincerely

Dr Stephen Austin

Chairman
Northern Ireland Consultants Committee

Employment of consultants

Health and Social Care/Board/Trusts/Agencies

The vast majority of consultants working in the HSC/Board/Trusts/Agencies in Northern Ireland are employed directly by HSC/Board/Trusts/Agencies. Each trust is entitled to determine its own contracts and terms of service for its employees, including consultants. However, very few HSC/Board/Trusts/Agencies employers have deviated significantly from national agreements and the Department of Health Social Services and Public Safety (DHSSPS) expects all HSC/Board/Trusts/Agencies to offer the 2004 consultant contract to all new appointments.

Freedoms offered to foundation trusts have seen some divergence from national terms of service. With extended plurality of healthcare providers in the HSC/Board/Trusts/Agencies consultants now work for alternative providers or indeed as independent contractors to the service. At the moment there are no foundation trusts in Northern Ireland, however, this may change in the future.

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 DoH and NHS Employers.

In November 2004, Health and Personal Social Services (as it was known then) /Board/Trusts/Agencies Employers assumed responsibility from the DoH for negotiations on behalf of health service employers in England. Because of the autonomy HSC/Board/Trusts/Agencies 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.

All trusts have an LNC consisting of doctors elected by their colleagues to negotiate with trust management. All LNCs have been set up according to BMA guidelines and 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* Tel: 0300 123 123 3. BMA members can read more on the BMA web site.

Employment Break Scheme

HSC employers should provide all staff with access to an employment break scheme. The scheme should explicitly cover the main reasons for which employment breaks can be used, including childcare, eldercare, care for another dependant, training, study leave or work abroad. It should also indicate that other reasons will be considered on their merits.

People on employment breaks will not normally be allowed to take up paid employment with another employer except where, for example, work overseas or charitable work could broaden experience. In such circumstances, written authority from the employer would be necessary.

Information

Terms and Conditions of Service, temporary schedule 25 HSS (TC8)6/2006

Consultant contracts

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

- the pre-2004 Northern Ireland consultant contract – a number of current consultants retain this contract but it is not on offer to new appointments
- the 2004 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 – whilst job planning has been a theoretical requirement since 1991 participation in job planning is a mandatory requirement of the 2004 consultant contract. There are common job plan themes for both contracts.

Read more about academic contracts on page 92

The pre-2004 national consultant contract

(Read '[Terms and conditions of service common to the two contracts](#)' for further details)

The current form of the 'old' pre-2004 national consultant employment contract was determined by an agreement in 1979 between the DoH and the medical profession and was set out in the health circular HSS (TC8) 1/79, 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 is not available to consultants appointed since 31 March 2004.

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 (read more about job planning on page 355).

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, i.e. 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. 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 (read more here). A detailed examination of the rules on private practice can be found on page 54.

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 here, 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-superannuable 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 (read more on page 6).

The position of part-timers under the new contract is covered on page 10.

Fixed and flexible commitments

Under the pre-2004 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 (read more here) 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-2004 contract. These are often duties such as administration, audit and management responsibilities.

Temporary additional Notional Half Days (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 (e.g. as clinical or medical director)
- additional clinical work (e.g. to cope with short-term demand or to cover work otherwise done by absent colleagues)
- special responsibilities (e.g. 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 superannuable. However, in the circumstances of a straightforward alteration to the job plan, where clinical NHDs are replaced, for example, by NHDs for managerial duties as a clinical director, and there is no difference in overall contractual commitment, there is, of course, no effect on superannuation.

Information

- Terms and Conditions of Service, paragraph 14
- HSS (TC8)4/99 Calculation of Temporary Additional Notional Half-days
- HSS (TC8)10/90 Consultants' Contracts and Job Plans

Category 1 and 2 work

There are three categories of work for consultants working under the pre-2004 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 544) or category 3 work (see page 8).

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 online or in a hard copy from *askBMA*.

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 NICC does not regard secretarial and other office support as services for the purpose of the rule.

It is the view of the NICC 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 HSC/Board/Trust 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 HSC/Board/Trust 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
- HSS (TC8)13/95

Intensity supplements

Background

The intensity supplements scheme was introduced in November 2000 and still applies to consultants on the pre-2004 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 superannuable salary supplements.
- The scheme is a contractual entitlement for all consultants on pre-2004 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, except that it was 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 (i.e. there are no part payments).

Information

- HSS (TC8)2/01 Intensity Supplements for Consultants

Category 3 work

Category 3 work is a term coined by the CCSC/NICC to describe extra work undertaken on HSC/Board/Trust 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 HSC/Board/Trust 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 HSC/Board/Trust 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 HSC/Board/Trust medical indemnity, by another employer's indemnity or by their defence body, taking out additional cover if necessary read more here. 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
- HSS (TC8)13/95 Hospital Medical and Dental Staff: Category 1 and 2 Work Treatment of earnings from work outside the principal contract of employment

Domiciliary visits

(see page 16 for arrangements under the 2004 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 superannuable (see page 42). 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 read more here

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 (read more here)

Family planning in hospitals

(see page 16 for the situation under the 2004 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 remunerable.

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) (read more here).

Information

- HSS (TC8)6/76
- 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 ([read more](#))

Lectures

The rate for lecture fees for consultants on the pre-2004 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 (read more here).

Information

- Terms and Conditions of Service, paragraphs 165-166
- BMA Fees Guidance Schedule 3: [Miscellaneous work in the NHS](#)

Consultant locum appointments

(see page 19 for consultant appointments under the 2004 contract)

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. Because of this, no consultants should now be employed under the pre-2004 contract but a brief description of the terms are set out here for completeness.** If consultants are still on the pre-2004 contract, they should contact *askBMA* for advice.

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 (see page 64)

Under the pre-2004 contract, whole-time consultant locums are paid on a weekly basis or per NHD, (the equivalent of three and a half hours, flexibly worked). A higher rate of pay is paid to retired consultants engaged as locums who, prior to retirement, were at the top of the consultant pay scale. There are several other important issues relating to locum consultants' conditions of service:

- locum consultants are eligible to receive domiciliary visit fees
- annual leave is on the same basis as for substantive posts or pro rata where appointments are not for complete years
- NHS hospital locum appointments are covered by NHS indemnity
- consultant locums are entitled to receive home to hospital mileage allowances on the same basis as substantive post holders or, if it is more favourable, travel allowance payments for the home to hospital journey in respect of any distance where the journey exceeds 10 miles each way
- if a locum takes up temporary accommodation at or near to their employing hospital, a claim can be made, under the old contract, for the initial and final journey.

The DHSSPS's guidance recommends that locum consultants should be registered as a specialist with the GMC in an appropriate specialty and be adequately experienced to undertake unsupervised independent clinical practice.

Please go to the section 'Terms of service common to the two contracts' on page 22 for further contractual information.

Information

- Terms and Conditions of Service, paragraphs 113, 117, 147, 200, 211-13, 289
- HSS (TC8)2/98 A code of practice in HCHS locum doctor appointment and employment
- HSS Appointment of Consultant Regulations 1996 (NI)

Transferring to the 2004 contract from the old contract

Consultants who were in post prior to 31 March 2004 continue to have the option to transfer to the new contract or retain their existing terms. Such consultants can choose to transfer to the new arrangements at anytime (see page 21 for further details). Seniority is calculated up to the point of transfer of 1 April 2004.

The 2004 consultant contract (Northern Ireland)

(see page 22 for 'Terms of service common to the two contracts')

Since 31 March 2004, the new '2004 consultant contract' (NI) has been the only contract permissible for new HSC/Board/Trust consultant posts, including locums. Consultants in post before 31 March 2004 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 new 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 2004 contract is that it provides a clear maximum commitment to the HSC/Board/Trust, 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 (read more on page 55).

Information

- Consultant contract 2004 schedules 6 and 7

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 Articles 5(1), 5(2) and 8(1) of the Health and Personal Social Services (Northern Ireland) Order 1972. 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, multi-disciplinary 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 of other staff, medical education, continuing professional development, formal teaching of other staff, audit, job planning, appraisal, research, clinical management, service development 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 HSC/Board/Trust, reasonable quantities of work

for a government department, or specified work for the General Medical Council (GMC). This list of activities is not exhaustive.

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 here for more information on job plans.

Information

- Terms and Conditions of Service 2004, definitions
- Job planning: A summary for Consultants new to the 2003 contract in England and Northern Ireland, CCSC September 2004
- DHSSPS Regional guidance on Job Planning for medical and dental consultants in Northern Ireland, April 2008

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 direct clinical care 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 HSC/Board/Trust 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 2004, schedule 3, paragraph.3
- Part-time and flexible working for consultants: An agreement between the BMA(NI) NICSC and the DHSSPS(NI) for Consultants in NI (November 2003)
- BMA guidance: Supporting Professional Activities template

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 number of consultants on the rota and the typical nature of the response needed when called. For determining which frequency band a consultant falls into, the only consideration is the number of consultants on the rota: prospective cover should not be taken into account.

See Table - extract from Terms and Conditions of Service 2004 page 43, schedule 16

Number on on-call rota	Value of supplement as a percentage of full-time basic salary	
	Category A	Category B
High frequency: 1-2 consultants	8.0%	3.0%
Medium frequency: 5-8 consultants	5.0%	2.0%
Low frequency: 9 or more consultants	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.

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 percentage supplement on their basic salary 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 2004, schedule 16, paragraphs 7

Programmed Activities (PAs) allocation for emergency work

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 with effect from 1 April 2005 (or one PA until 31 March 2005) - (see Terms and Conditions of Service Schedule 5 paragraph 1). 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 (e.g. 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), e.g. recall to hospital to operate on an emergency basis.

Information

- Terms and Conditions of Service 2004, 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.

Information

- 'A practical guide to calculating on-call work', Modernisation Agency's Consultant Contract Implementation Team (8 March 2004)

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.

Information

- Terms and Conditions of Service 2004, schedule 8, paragraph 4
- BMA guidance: [Resident on-call work for consultants, December 2007](#)

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 HSC/Board/Trust employer.

Information

- Terms and Conditions of Service, schedule 8, paragraphs 1 and 5

Additional Programmed Activities (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 (read more here). 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.

Private practice and extra Programmed Activities (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 HSC/Board/Trust, if offered, before doing private work. (read more here) in the private practice section for further details.

Premium time

The new 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 2004, 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. There is also a clause in the new contract which requires a consultant to work at any site with the employing organisation, including new sites.

Information

-Terms and Conditions of Service, schedule 3 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 (e.g. DCC, SPA) for which the journey is necessary. Travel to and from work for HSC/Board/Trust emergencies, and 'excess' travel, also count as working time.

Information

- Terms and Conditions of Service 2004, schedule 12, paragraphs 10 and 11

Pay elements

Pay thresholds (transitional)

For consultants in post at 15 January 2004 (termed 'existing consultants' hereafter), there are detailed pay transition arrangements set out in schedule 13 of the terms and conditions of service.

Basic pay on transfer to the new contract from the pre-2004 contract 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) plus any additional credited seniority (in whole years) plus the year that the consultant is currently in.

Additional seniority may be given if the consultant has any consultant-level experience gained outside the HSC/Board/Trust (e.g. including employment outside the European Economic Area (EEA), voluntary service, employment in the independent sector, service in Her Majesty's Armed Forces), 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.

Existing consultants who gave a commitment to take up the new contract between 15 January 2004 and 31 March 2004 were eligible to have their pay backdated by three months. More generous pay backdating applied to those consultants who gave a commitment to transfer prior to 15 January 2004. The date to which consultants chose to backdate their pay is deemed to be the date of transfer to the new contract. Progression through pay thresholds becomes possible on the anniversary of transfer to the new contract.

Pay thresholds (new appointments)

New consultants appointed after 31 March 2004 will be appointed to the bottom of the salary scale unless they have consultant-level experience gained outside the HSC/Board/Trust (e.g. including employment outside the EEA, voluntary service, employment in the independent sector, service in HM armed forces) or if they have participated in flexible training or undergone dual qualification. Progression through pay thresholds for new consultants becomes possible on the anniversary of the date on which they started work under the new terms.

Information

- Terms and Conditions of Service 2004, schedule 13

Pay progression

There are eight pay thresholds under the new arrangements. The value of the thresholds is set out annually in a HSS (TC8) circular from the DHSSPS. 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. However, many existing consultants moving over to the new contract will move up the scale more quickly than this because of the transitional arrangements (see above).

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 (read more on page 55)
- work in line with the contract's private practice standards (read more on page 54).

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. There is a right of appeal against the chief executive's decision to withhold pay progression (read more on page 20).

Information

- Terms and Conditions of Service 2004, schedules 13 and 14

Fee-paying work

Fee-paying work (formerly called category 2 work – read more here) 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, i.e. not in HSC/Board/Trust PAs, or if they 'time-shift' so that their HSC/Board/Trust work is unaffected, or if the work is, by agreement, only minimally disruptive to HSC 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, Health and Social Care/Board/Trust work and fee-paying work

The 2004 contract clarifies the relationship between HSC/Board/Trust work, private work and fee-paying work in that it sets out that a HSC/Board/Trust consultant's first responsibility is to the HSC/Board/Trust. Participation in private medical services or fee-paying services should not result in detriment to HSC/Board/Trust patients or services or diminish the public resources available for the HSC/Board/Trust.

This relationship is set out clearly in schedule 9 of the TCS and in the 'Code of conduct on private practice' agreed between the DHSSPS and the NICC as part of the consultant contract negotiations in 2004 (read more here). Essentially, consultants should not schedule private work or fee-paying work at the same time as HSC/Board/Trust activities, unless there has been a prior agreement with the HSC/Board/Trust employer.

Information

- Terms and Conditions of Service 2004, 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 2004, schedule 16, paragraphs 8

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 DDSSPS TC(8) 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 11

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 (read

more here). Consultants are advised to contact the BMA pensions department if they have any queries about whether such payments should be superannuable.

Information

- Terms and Conditions of Service 2003, schedule 16, paragraph 10

Part-time contracts

Part-time consultants transferring onto the new contract can choose to transfer either based on the number of PAs nearest to their hours of work or based on the same number of PAs as their previous number of NHDs. Any rise in workload will be accompanied by the award of additional PAs.

Employers can offer part-time consultant contracts of between one and nine PAs per week. However, when consultants appointed after 1 April 2004 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, e.g. childcare, research, etc. Doctors requesting to work flexible patterns are entitled (with appropriate notice) to return to a regular pattern of work.

Information

- Part-time and flexible working for consultants: An agreement between the BMA's NICSC and the DHSSPS(NI) for consultants in NI (November 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 1 April 2004, all new consultant appointments, including locum appointments, must be under the new contractual arrangements. Except for the differences detailed below, all sections of the TCS apply to locum appointments.

Basic salary

Locums who have never held a substantive HSC/Board/Trust consultant post will usually be first appointed at the bottom of the new salary scale, unless they have gained consultant level experience outside the HSC/Board/Trust, in which case this should be taken into account when agreeing starting salary. Where a locum consultant's training has been lengthened by virtue of being in a flexible training scheme or because of undergoing dual qualification (required for the locum post concerned), the employing organisation will, where necessary, credit appropriate additional seniority to ensure that the locum consultant is not prevented from reaching the pay threshold they would have attained had they trained on a full time or single qualification basis.

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 with the relevant employer but who have held one in the past (e.g. retired consultants) should be paid the equivalent of

their most recent pay threshold or, if they have not previously been employed under the 2004 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 in respect of that year's service. If part of the previous 12 months' service has been for one or more other HSC/Board/Trust 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, e.g. for administrative support and continuing professional development, as other consultants.

Information

- Terms and Conditions of Service 2003, schedule 22

Facilitation and appeals processes

If there is a dispute over a job plan (read more on page 378) or a decision relating to pay progression, there is a process of facilitation and appeal that can be followed. These processes are set out in schedule 4 of the terms and conditions of service.

Facilitation

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(NI) and the DHSSPS. 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

DHSSPS regional guidance on job planning for medical and dental consultants in Northern Ireland.

Transferring to the 2004 contract from the old contract

Consultants in post prior to 31 March 2004 have the option to transfer to the new contract or retain their existing terms. Such consultants can choose to transfer to the new arrangements at any point in the future.

Information

- Terms and Conditions of Service 2004, 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.

For consultants transferring to these Terms and Conditions in 2003/2004, there will be full protection for one year, i.e. taking account of annual pay uplift for 2004/2005 for consultants on the previous national terms and conditions. After this date, protection will be on a mark-time basis (i.e. until the new salary exceeds the salary at the point of transfer).

This is provided the consultant continues to undertake the same level of duties and responsibilities and on-call commitments and remains employed by the same HSC/Board/Trust organisation or equivalent successor organisation.

Information

- Terms and Conditions of Service 2004, schedule 13, paragraphs 11 and 12

Former maximum part-time consultants

There are special arrangements for consultants transferring to the new contract between 1 April 2003 and 31 March 2005 who formerly held maximum part-time contracts. Their basic salary under the new contract is phased in, whereby during the first year of the contract (2004/05) they received their previous level of salary (including annual pay uplifts) plus a third of the difference between this and the level of salary to which they would otherwise have been entitled (the target salary) if they had been a whole-time consultant.

In the second year of the contract (2004/05), former maximum part-timers receive their previous level of salary (including annual pay uplifts) plus two thirds of the difference between this and the new target salary. This arrangement ceases on 1 April 2005, so any former maximum part-time consultant transferring to the new contract after this date will not have their salary subject to phasing-in. In addition, there are transitional arrangements covering former maximum part-timers' requirement to undertake additional PAs if they are working privately and wish to retain eligibility for pay progression. In the first year (2003/04) the consultant could be asked to undertake one extra PA every three weeks. In the second year (2004/05) this increased to one PA every two weeks. Again, this arrangement comes to an end on 1 April 2005.

Information

- Terms and Conditions of Service 2004, schedule 13, paragraph 17

Terms and conditions of service common to the two contracts

The issues set out below are relevant to all HSC/Board/Trust-employed consultants in Northern Ireland, whichever contract they hold. See the previous sections for issues specific to the pre-2004 and 2004 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 DoH (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.

See the current pay scales

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 will then make a decision on the DDRB recommendations and when the increases are implemented they are issued in the form of an Advance Letter from the DoH and incorporated into the national Terms and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Services (England and Wales). The rates of uplift for Northern Ireland will be agreed following the recommendations of the DDRB. See page 92 for information about clinical academic salaries.

Information

- BMA guidance: 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, the GWC handbook was still in use, but is likely to be replaced by updated terms and conditions for doctors in the near future.

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 travelling 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, Co2 emissions and the tax position. They are therefore advised to proceed with caution and should seek advice from *askBMA* and/or their accountant. [Read the BMA guidance.](#)

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.

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 (i.e. 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 [NHS official travel](#)
- BMA guidance: [Current mileage rates](#)
- HSS (TC8)9/90, Personal Transport Arrangements
- Terms and Conditions of Service 2004, schedule 21
- Terms and Conditions of Service, paragraphs 61, 275-308

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 109) 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. Read [Removal and associated expenses for NHS medical staff](#)

Information

- Joint Council Handbook, section 26
- BMA guidance: [Removal and associated expenses for NHS medical staff](#)
- Terms and Conditions of Service 2004, schedule 21, paragraph 61
- 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

- HSS (TC8)11/79, Provision of Telephones for Medical & Dental Staff

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

- Joint Council Handbook, section 22
- Terms and Conditions of Service 2004, schedule 21, paragraphs 54-56
- Terms and Conditions of Service, paragraphs 275-6 and 311

Terms and conditions of service common to the two contracts

This issues set out below are relevant to all HSC/Board/Trust-employed consultants in Northern Ireland, whichever contract they hold. See the previous sections for issues specific to the pre-2004 and 2004 contracts.

Annual leave

Consultants on the pre-2004 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 2004 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 (see page 39).

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. 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 (go here 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 (read more).

Information

- Terms and Conditions of Service 2004, schedule 18, paragraphs 1-4
- Terms and Conditions of Service, paragraphs 205, 209, 211-213 and 215
- Joint Council Handbook, section 1
- EC Working Time Regulations 1998

Public holidays

Consultants are entitled to 12 paid statutory and public holidays each year. These consist of ten 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.

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 DoH 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 DoH, participating in college duties or examining. Under the 2003 contract, such duties can be recognised as 'external duty' PAs (read more here).

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 DoH 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 (read more on page 33). 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

- Terms and Conditions of Service 2004, schedule 18, paragraphs 9-16
- Terms and Conditions of Service, paragraphs 250-254
- HSS (TM)3/75 & HSS (TC8)8/99

Sick leave

This is an area about which trusts are increasingly concerned and there may be some changes to conditions locally. 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 2004, schedule 18, paragraphs 18-32
- Terms and Conditions of Service, paragraphs 225-244
- Joint Council Handbook sections 1, 57 and 61
- HSS (TC8)18/83, 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.ir.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 page 54.

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 (read more here).

Joint Appointments/Clinical academics

Go here for clinical academic staff.

Special leave

For consultants on national terms of service, special leave with or without pay may be granted in accordance with terms laid down by the GWC. These give the following entitlements.

- special leave with pay may be granted for: compassionate purposes, absence from duty following contact with a notifiable disease, caring for a dependent relative, adoption and leave for magisterial duties (for a period not exceeding 18 days in any 12 months).
- special leave without pay may be granted, for example to apply for posts outside the NHS or to pursue parliamentary candidature.

Employers' discretion

In some cases it is entirely at the employer's discretion whether paid or unpaid leave is granted. This applies when consultants attend interviews for other posts with their own or another employer.

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 (read more here), 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 (read more on page 7).

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) (read more here), 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 2004, schedule 18, paragraphs 33-34
- Terms and Conditions of Service, paragraphs 260 and 262
- Joint Council Handbook, sections 3, 12, and 38

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. It is anticipated that discussions on a national sabbatical leave scheme will begin in the near future.

Information

- Terms and Conditions of Service 2004, schedule 18, paragraph 17
- Terms and Conditions of Service, paragraph 252
- Joint Council Handbook, 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 new consultant terms and conditions of service (tcs), 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 occupational maternity leave scheme, consultants must have normally had 12 months' service with one or more NHS employers, with no break in service of more than three calendar months, at the beginning of the eleventh week before the expected week of confinement to qualify for maternity leave and pay. Notice of intention to return to work must be given, in writing, before the end of the 15th week before the expected date of childbirth, and failure to return to work for the same or another Health and Social Care (HSC) 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 occupational 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 92 for information about clinical academic staff.

Information

- Joint Council Handbook, section 6
- Maternity and Parental Leave Regulations 1999
- BMA guidance: [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.

Information

- Terms and Conditions of Service 2004, schedule 2, paragraph 3
- Terms and Conditions of Service, paragraph 108

Terms and conditions of service common to the two contracts

The issues set out below are relevant to the all HSC/Board/Trust-employed consultants in Northern Ireland, whichever contract they hold. See the previous sections for issues specific to the pre-2004 and 2004 contracts.

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, e.g. independent sector treatment centres
- family planning work in hospitals (read more on pages 9 and 16)
- hospital doctor locum work, whether through a locum agency or directly with the employer
- domiciliary visits (read more on pages 9 and 16).

The NHS indemnity scheme does not necessarily cover:

- private practice work (read more on page 60)
- category 2 work, i.e. report for a third party where a fee may be charged (read more on pages 7 and 16)
- '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, e.g. waiting list initiatives (read more on page 8).

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 guidance [NHS medical indemnity](#).

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 DoH 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 DoH 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

- HSS (TC8)12/90, Handling Claims of Medical Negligence
- BMA guidance: [NHS indemnity](#)
- The National Health Service Litigation Authority – Framework Document

Terms and conditions of service common to the two contracts

The issues set out below are relevant to the all HPSS/Board/Trust-employed consultants in Northern Ireland, whichever contract they hold. See the previous sections for issues specific to the pre-2004 and 2004 contracts.

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

- HSS (TC8)5/91
- Joint Council Handbook, section 32

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

- Joint Council Handbook, 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 2004, schedule 18, paragraph 31
- Terms and Conditions of Service, paragraph 196

Terms and conditions of service common to the two contracts

The issues set out below are relevant to the all HPSS/Board/Trust-employed consultants in Northern Ireland, whichever contract they hold. See the previous sections for issues specific to the pre-2004 and 2004 contracts.

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 (read more here) 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 2004 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 DoH in September 2003 as part of the documentation in support of the new consultant contract. However, these standards represented recommended guidance on best practice in relation to job planning, **both for consultants on the 2004 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](#). There is also job planning guidance for consultants choosing to remain on the pre-2003 contract in [Controlling workload, maximising rewards – guidance for consultants](#). The BMA has also produced additional advice for clinical academic staff (read more on page 922).

Information

- Consultant Job Planning, Standards of Best Practice, an agreement between the BMA's Central Consultants and Specialists Committee and the Department of Health for consultants in England read more here
- Terms and Conditions of Service 2004, schedule 3
- HSS (TC8) 10/90, Consultants' Contracts and Job Plans
- Terms and Conditions of Service, paragraphs 30 and 61
- DHSSPS [regional guidance on Job Planning](#) for medical and dental consultants in Northern Ireland, April 2008

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 HPSS 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 NICC 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 (read more on page 20) 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 (e.g. 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 (read more on page 20 for the 2004 contract and **on page 37 for the pre-2004 contract**).

Format of job plans

2004 contract

There is no agreed national model of a job plan but the NICC's advice 'Job planning: a summary for consultants new to the 2004 contract in England and Northern Ireland' contains a model for use by consultants and employers.

Pre-2004 contract

A model format for a job plan was included in the health circular HSS (TC8) 10/90. 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 (i.e. including fixed and flexible commitments).

Job plan context

The job plan will outline the consultant's commitment to HPSS. 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](#).

Objectives

The job plan is likely to include personal objectives. This is a contractual expectation for consultants on the 2004 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 2004 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, e.g. waiting list targets. Consultants have no obligation to sign up to objectives that are unreasonable.

Information

- Terms and Conditions of Service 2004, schedule 3, paragraphs 10-13
- DHSSPS [regional guidance on Job Planning](#) for medical and dental consultants in Northern Ireland, April 2008

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 read more here on the 2004 contract and read more here on the pre-2004 contract. Details are covered in the code of conduct for private practice (read more on page 54).

Information

- Terms and Conditions of Service 2004, 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.

A lack of appropriate supporting resources could have an impact upon consultants meetings 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 2004, schedule 3, paragraphs 14-16
- DHSSPS [regional guidance on Job Planning](#) for medical and dental consultants in Northern Ireland, April 2008

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 2004, schedule 3, paragraphs 17-22
- Terms and Conditions of Service, paragraph 30d
- DHSSPS guidance on Job Planning for medical and dental consultants in Northern Ireland, April 2008

Disputes over job plans

2004 contract

The mediation and appeals process for job plan disputes is set out in the contract section on page 20.

Pre-2004 contract

Where there are individual cases of disagreement, consultants are able to appeal to a special appeals panel established by their employer. A nominee of the employer, who sits together with an individual nominated by the consultant who is appealing and a third member from outside the trust chosen from a joint DHSSPS/BMA list. If either party to the dispute judges that it would be helpful, the panel may hear expert advice on matters specific to the specialty.

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) (read more on page 3).

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(NI) Northern Ireland Consultants Committee and The Department of Health, Social Services and Public Safety for Consultants in Northern Ireland read more here
- Terms and Conditions of Service 2004, schedule 3
- HSS (TC8), 10/90, Consultants' Contracts and Job Plans
- Terms and Conditions of Service, paragraphs 30 and 61
- DHSSPS guidance on Job Planning for medical and dental consultants in Northern Ireland, April 2008

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 non-compliance. 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. In the terms of the Directive, work is defined as 'working at his employer's disposal and carrying out his activity or duties'; the CCSC in its guidance on the implementation of the directive offers guidance on the activities that the definition can and cannot be deemed to cover. 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 have been 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.

At the time of writing, the European Commission was in the process of consulting to amend the Directive. Their focus is on the individual right to opt out of the working hours limit, the reference period for hours monitoring, and the definition of working time and compensatory rest time limits.

Go here for information about clinical academic staff.

Information

- Guidance on Implementing the EC Directive on Working Time for consultants, April 2008
- HSS (TC8) 10/99, Implementation of the Working Time Regulations
- EC Working Time Directive Regulations, October 1998

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, i.e. 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 industrial 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 General Council agreements, or local trust agreements. Under the GWC agreements, the amount of payment is calculated as follows:

When HSC/Board/Trust pension is payable (i.e. aged over 50 and with at least five year's service)

- 1.5 weeks' pay for each year of service at age 41 and over, plus 1 week's pay for each year of service from age 22 to age 40, subject to an overall maximum of 30 weeks' pay and 20 years' service.

When no HSC/Board/Trust pension is payable

- At age 41 and over, 2 weeks' pay for each year of service at age 18 and over, to a maximum of 50 weeks' pay, plus 2 weeks' pay for each year at age 41 and over to a maximum of 16 weeks' pay, subject to an overall maximum of 66 weeks' pay.
- At age 22-40, 1 week's pay for each year of service, to a maximum of 20 years.

Where HSC/Board/Trust pension is payable, providing all service is under national terms and conditions of service, there is an entitlement to receive an enhanced pension (by up to 10 years to a maximum of age 65 or a total of 40 years' service, whichever is the less). The higher the enhancement a consultant receives, the lower becomes the redundancy payment. The enhancement increases both the pension and the tax-free lump sum.

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 HSC/Board/Trust 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 HSC/Board/Trust pension scheme (HSC/Board/TrustPS).

Returning to the Health and Social Care/Board/Trust following redundancy

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

Information

- Joint Council Conditions of Service: sections 45,
- Arrangements for Redundancy Payments and 46, Payment of Superannuation and Compensation Benefits on Premature Retirement
- Labour Relations Agency Code of Practice Redundancy Consultation and Procedures, April 1998 ([web version www.lra.org.uk](http://www.lra.org.uk))
- Redundancy Payments guide - Department for Employment and Learning (www.delni.gov.uk)

Pensions

Occupational pension schemes

Most consultants are members of the HSC/Board/Trust Superannuation Scheme 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, so the HSC/Board/Trust scheme is described hereafter.

Advice for joint appointments/clinical academics can be found on page 922.

Much of the information in this section relates to the NHSPS. At the time of writing, the NHS Confederation was conducting a major review of the scheme which is likely to result in significant changes to the scheme in future. In particular, it is a proposal that the normal pension age for the HSC/Board/Trust scheme will be raised from 60 to 65 years. The consultation also raises the possibility of a move away from a final salary scheme.

Contribution rates

Consultants contribute 6 per cent of pensionable income. This attracts tax relief, and lower national insurance contributions, so the actual cost is about 3 per cent.

Pensionable income

This includes basic salary, distinction awards, discretionary points, CEAs, domiciliary consultation fees and London weighting allowance.

Income which is not pensionable in the Health and Social Care/Board/Trust 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

Consultants who did not join the HSC/Board/Trust scheme until after 1 June 1989 are subject to the earnings cap (£105,600 for 2005/2006). Anyone transferring between occupational pension schemes is subject to the cap in their new scheme. It is not possible to pay contributions or earn benefits beyond the level of the cap.

Pension

The HSC/Board/Trust pension is calculated in the following way: Pension = scaled service (years) x pensionable salary ÷ 80

It is possible to achieve a pension of 40/80ths of salary at age 60 or 45/80ths at age 65 or beyond.

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 guidance: [Salaried doctors](#)
- BMA pensions webpages www.bma.org.uk/pensions

Lump sum

In addition to the pension, a tax free lump sum 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.

Protection against inflation: index linking

The HSC/Board/Trust 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

The basic contribution rate to the scheme is 6 per cent of salary and another 9 per cent can be paid to purchase extra benefits. All 15 per cent attracts tax relief. The options available are as follows:

Unreduced lump sum

This is explained above.

Added years

By purchasing additional years of service, consultants receive an extra indexed pension and an extra tax free lump sum, calculated in the same way as the basic HSC/Board/Trust 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 voluntary contributions (AVCs) and free standing additional voluntary contributions (FSAVCs)

These produce extra pension but not extra lump sum. The amount of extra pension will depend upon:

- the amount invested (up to 9% of salary)
- 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 HSC/Board/Trust *scheme* to allow members to save more for their retirement. They are arranged with external insurance companies who have been selected by the HSC/Board/Trust Pension Agencies as AVC Providers to the HSC/Board/Trust.

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 guidance: [Improving benefits](#)

Retirement age

While there is now no compulsory retirement age for consultants employed in the HSC/Board/Trust, consultants may retire and claim their pension and lump sum 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

Consultants may retire on ill-health grounds if they are permanently incapable of carrying out their NHS duties. For consultants with more than 20 years' service, pensionable service is enhanced up to age 60 or by 62½, years whichever is the less. A return to HSC/Board/Trust work may be possible in a reduced or different capacity.

Information

- BMA guidance: [Ill-health retirement](#)

Redundancy; organisational change; interests of the service

These three options all involve a potential enhancement of pensionable service for doctors aged 50 or over. Pensionable service may be enhanced by up to 10 years, or to age 65, or to 40 years' service, whichever is less. In the event of redundancy or organisational change, a redundancy payment may also be payable depending upon the extent of this service enhancement. ([read more in the Consultant Handbook](#))

Voluntary early retirement

Consultants may retire voluntarily from age 50 with an actuarially reduced pension. Voluntary early retirement **without actuarial reduction** is possible if the employer agrees to meet the extra cost involved in not having the pension actuarially reduced.

Information

- BMA guidance: [Voluntary early retirement](#)

Mental health officer (MHO) status

Doctors who before 1995 worked full time 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.

This benefit was extended to part-time MHOs following legal action by the BMA, subject to further legal clarification in respect of doctors who did not submit employment tribunal claims until more than six months after leaving employment.

Information

- BMA guidance: [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 9 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 HSC/Board/Trust 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.

Information

- BMA guidance: [Salaried doctors](#).

Working in the Health and Social Care/Board/Trust after retirement

It is not normally possible to rejoin the HSC/Board/Trust scheme on returning to work after retirement. For consultants aged under 60, if the pension plus salary on return to work exceed pre-retirement salary, then the pension will be abated pro rata, except in cases of voluntary early retirement with actuarial reduction. Abatement will not be applied to consultants over the age of 60 who return to work after a break of at least one month.

Personal pension plans (PPPs)

Consultants in the HPSS Pension Scheme can take out a PPP in respect of non-HPSS income. Additionally, if the consultant returns to work after retirement, the HPSS income is not pensionable in the HSC/Board/Trust scheme and can therefore be pensioned in a PPP. The earnings cap (see above) applies separately to the HSC/Board/Trust scheme and the PPP.

Injury benefits

The HSC/Board/Trust injury benefits scheme provides benefits to any consultant who suffers a loss of earning ability due to an injury, illness or disease resulting from HSC/Board/Trust duties. The maximum benefit, together with any HSC/Board/Trust 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 (read more here). If this is successful there may be a consequent reduction in the HSC/Board/Trust injury benefit payable.

Information

- BMA guidance: [Injury benefits](#)

Further advice

The Superannuation Branch of the DHSSPS can provide estimates of benefits in advance of retirement and answer enquires about the HSC/Board/Trust scheme (the address and phone number are in all BMA pensions guidance). Consultants can also see the [pension webpages](#). Guidance can also be obtained *askBMA* or the BMA pensions department at BMA House.

Clinical excellence awards (CEAs)

Contents

What are CEAs?

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CEA Review

Clinical Excellence Awards (CEA) for Northern Ireland became effective in 2005 and combine distinction and discretionary points into a single scheme.

1. What are CEAs?

CEAs are financial awards in addition to the consultant basic salary. There are two award levels - higher awards and local awards.

Higher awards –

- these are decided by a regional committee - Northern Ireland Clinical Excellence Awards Committee (NICEAC)
- possess a regional / national element
- were formerly distinction awards
- will be recommended by the new NICEAC
- on the basis of contributions at a regional, national and international level
- NB it will be possible for consultants who deliver a wholly local contribution to progress to the higher awards.

Local awards –

- These are determined by Trusts
- Possess a local element
- were formerly discretionary points
- to primarily reward outstanding contributions to local service delivery objectives and priorities.

Points worth noting regarding the value of the awards are that –

- higher awards will subsume the value of any award held previously.
- for consultants who hold a distinction award or discretionary points – the award of CEA subsumes the value of any distinction awards or discretionary points already held
- part time consultant's award will be on a pro rata basis. Awards will be annually uprated taking into account Doctors and Dentists Review body (DDRB) recommendations.

2. Availability of awards

Awards should be considered annually and are limited, particularly at higher levels. They will be decided on a competitive basis based on the relative merits of individual cases. For the first 3 years no specific funding will be provided for lower awards. The Department of Health Social Services and Public Safety (DHSSPS) recommendation is that points should be recycled as consultants retire or leave. Trusts will have discretion, but will have to meet any additional costs out of its own resources. Essentially they are dependent on the number of retirements of existing award holders. Therefore awards available each year will be necessarily limited.

3. The objectives of the scheme

To reward individuals who perform over and above the standard expected of a consultant in their post and who locally, regionally, nationally or internationally:

- Demonstrate sustained commitment to patient care and wellbeing or improving public health;
- Sustain the highest standards in both technical and clinical aspects of service delivery whilst providing patient focussed care;
- In their day to day practice demonstrate a sustained commitment to the values and goals of the Health and Social Care (HSC) 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 the knowledge base through research or other scholarly work and participate actively in research governance
- Are recognised as exceptional teachers and / or trainers and / or managers;
- Contribute to policy-making and planning in health care;
- Make an outstanding contribution to professional leadership.

NB Individuals will not be expected to meet all of these objectives as much will depend on the nature and type of the post they hold.

Assessment criteria that are common to all award levels are:

1. delivering a high quality service
2. developing a high quality service
3. managing a high quality service
4. research, teaching and training

4. Eligibility

A

(1) A consultant who has at least 3 years experience at consultant level, holds a medical or dental qualification, fully registered, and employed by organisations such as:

- Health and Social Services Trust;
- Health and Social Services Board;
- Central Services Agency (CSA);
- Health Promotion Agency;
- Blood Transfusion Service;
- Queen's University Belfast (QUB)
- DHSSPS (where consultant retains HSC / NHS Terms and Conditions)
- Other bodies which are approved from time to time as proper employers of consultants for the purposes of the HSC.

(2) Joint Appointees / Public Health Doctors

- Contribution made to the HSC defined in wider terms than direct care to patients. The entitlement to full eligibility for an award is based on 5 programmed activities (or equivalent sessional time) beneficial to the HSC, including teaching and clinical research.

(3) Eligible consultants who are subsequently employed as Deans (undergraduate and post graduate) in medicine or dentistry on the basis of their work in such posts.

(4) Eligible consultants working as Clinical Directors and Medical Directors of HSS Trusts – account being taken of both their clinical work and whether their contribution as Clinical Director or Medical Director is particularly noteworthy.

NB consultants spending time almost exclusively in medical management will be considered for awards (to ensure they continue to be eligible for appropriate revalidation by the General Medical Council (GMC), clinical consultants in medical management posts should normally undertake some clinical practice).

B

Eligibility for all awards is dependent upon participation in annual appraisal. Employers are expected to indicate that a satisfactory appraisal has taken place in the 12 months prior to application and that the job plan and contractual obligations have been fulfilled and that the consultant has complied with the Private Practice Code of Conduct and to confirm that no complaints have been upheld following disciplinary action by the employer or the General Medical Council (GMC) or General Dental Council (GDC). Employers will also be asked to advise the local committee and the NICEAC of any outstanding disciplinary matters.

C

For higher awards in the 2005-2006 award round, consultants must have achieved a minimum of 3 local awards to become eligible. During transition a minimum of 3 discretionary points will satisfy the eligibility criteria for higher awards.

For higher awards in the 2006-2007 award round, consultants must have achieved a minimum of 5 lower clinical excellence awards or 5 discretionary points to become eligible.

D

Not eligible to apply include:

- Locum consultants
- Consultants employed in full time general management positions e.g. chief executive, and who do not undertake clinical work as a consultant under a separate clinical contract
- Joint appointment academic general practitioners
- NICEAC do not expect applications from consultants who intend to retire soon

If an application for a higher award is successful, the award will be granted from the date immediately following the date of the relevant retirements / resignations etc.

The effective date of a local award should normally be paid from 1 April.

5. Application process

There is a standard CV self nomination form for all levels of awards and all applications must be made using this pro forma which is available at the NICEAC website - http://www.dhsspsni.gov.uk/index/hss/clinical_excellence_awards_scheme/cea_forms.htm

NB - Late applications to NICEAC for higher level awards 10 to 12 will **not** be accepted. Local trust awards committees will determine their own closing date for local award applications.

Higher award process

At the start of each awards round all eligible consultants will be invited by letter to self nominate for a higher award. If a consultant decides to apply they will be asked to complete and sign a short proforma (attached to letter). Consultants will then receive by email an account number which will enable access to the CV pro forma in a secure area of the NICEAC website.

NICEAC will recommend to the Department which HSC consultants should receive the higher value awards, having regard to the number of awards available for allocation.

Lower award quality assurance

Each Local Awards Committee (LAC) process for local (lower) CEAs will reflect regional guidance. LACs must ensure that they have a clear audit trail for all applications ensuring

decisions are properly documented and that the process is transparent, fair and based on clear evidence. Each LAC will produce an annual report containing details of the number of awards made including details of LAC membership.

6. Citation process

On receipt of a self nomination the NICEAC secretariat will seek citations. There will be a standard process for this at both local and regional level when a consultant self nominates for an award.

Award citations will be sought from:

For award levels 1–7 – the employer (normally completed by Clinical Director or consultants appraiser re local awards)

For award levels 8-9 – the employer and Senior Award Holder in the particular speciality

For award level 10 – the employer and Senior Award Holder

For award levels 11-12 – Employer, Senior Award Holder and either the consultant's royal college or speciality association

In the case of Joint Appointees, citations will also be sought from Queen's University, Belfast (QUB).

All citations must be made in the current format available at the NICEAC website.

7. Appeals against the process

Higher award -The new scheme will have an independent appeals process.

Any consultant who has applied for a higher award and who is dissatisfied with the NICEAC decision:

- Must, in the first instance, request feedback (written or a meeting) from the Chairman of NICEAC. Feedback must be requested in writing through the NICEAC secretary and the request should be received within 30 days of the decision being issued.
- If the consultant remains dissatisfied following receipt of feedback, s/he may then appeal to the independent appeals panel. A request for an appeal must be made in writing by the consultant concerned; should give reasons for the appeal; and should be sent to the NICEAC secretary. This must be received within 30 days of the date of the meeting with the Chairman (or the date written feedback was issued).

If you wish to make an appeal you should do so without delay to the NICEAC and ask for a copy of the appeals procedure that you will need to adhere to. An appeals panel will be set up and will comprise 3 people nominated by the Department and who were not involved in the original decision. It is important to note that the appeals panel can only consider the process by which the decision was made. It will not consider whether an award should or should not have been made. If the panel find a flaw in the process they will have the authority to ask NICEAC to look at the case again.

Local Award – employers will be required to have an appropriate appeal review mechanism in place for consultants who are dissatisfied with the decision made. Details should be available on request from your employer.

8. CEA review

The CEA scheme is reviewed on a 5 year basis.

The employer will also review the lower award CEA scheme every 5 years.

The NICEAC secretariat will notify consultants whose awards are subject to the 5 year review process and request them to complete the 5 year review CV form. The consultant must set out how they continue to meet the criteria for which the higher award was initially given. Those applying for renewal should demonstrate, by reference to their achievements since the original

award or the last review that they continue to meet the criteria for the scheme, and focus on activity within the 5 year period leading up to the review.

Review citation forms will also be required from employers.

Employers may consider at any stage that good evidence exists to support that an award should be reconsidered. If this is the case they have a duty to inform the chairman and Medical Director. NICEAC will then consider whether any action should be taken. The Chairman and Medical Director can recommend that an award should be withdrawn or downgraded or renewed for a shorter period than 5 years.

Before referring such cases to NICEAC the head of the secretariat will inform the consultant of the recommendation and the reasons for it. The consultant will have the opportunity to make a written submission to NICEAC before the final decision is taken. At the same time the head of the secretariat will inform the consultant's employer of the recommendation, and invite any further views that they may wish to bring to NICEAC's attention.

Please note if you are considering making an application for either a local or a higher award it is advisable to visit the full guidance which can be found at - http://www.dhsspsni.gov.uk/index/hss/clinical_excellence_awards_scheme.htm

For further detailed information regarding how this guidance may effect YOUR circumstances you may wish to make contact askBMA on 0300 123 123 3.

Eligibility

HSC/Board/Trust consultants and HSC/Board/Trust honorary consultants will be eligible for awards provided that:

- they have completed at least three 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.

Under normal circumstances consultants will be considered for higher awards after having achieved a minimum of four local awards. The new 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 self-nominate for CEAs using the NICEAC advice and the relevant forms which are available on the committee's website along with details of the timetable for the national award round. Employers are likely to have their own timetable and application process for local awards. 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

There are 12 levels of award, the first eight of which (levels 1-8) are awarded by LACs and the last three of which (levels 10-12) are awarded by the national NICEAC and its subcommittees. Level 9 may be awarded by either the NICEAC or the local committees – this will depend on the type of achievement being recognised. The values of the awards at 2005/06 (?) levels are as follows:

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.

NICEAC advises that LACs should comprise of between 4 and 6 members, of whom at least 50 per cent will be active consultants.

Higher awards will be made by NICEAC whose membership will be as follows:

- Lay Chairman (1)
- Vice Chairman (Medical Director) (1)
- Medical or Dental members HSC/Board/Trust (2)
- External medical members (GB) (2)
- Two employer members (2)
- One lay member (1)

Awarded by LACs Awarded by NICEAC

Level 1 £2,789

Level 2 £5,578

Level 3 £8,367

Level 4 £11,156

Level 5 £13,945

Level 6 £16,734

Level 7 £22,312

Level 8 £27,890

Level 9 £33,468 Level 9 (bronze) £33,468

Level 10 (silver) £43,997

Level 11 (gold) £54,996

Level 12 (platinum) £71,495

Numbers of awards

Higher awards

The DHSSPS has warned that the number of awards available each year will be necessarily limited, particularly at the highest levels. The number of awards available will be dependent on the number of retirements of existing award holders. All available awards will be decided on the grounds of merit.

Local awards - from the DHSSPS Guidance

The number of new awards available each year will again be limited. Awards will be decided on a competitive basis, based on the relative merits of individual cases. For the next three years no additional funding will be provided for lower awards, other than adjustments for annual uplifts. The formula for calculating the minimum number of points should not be applied. Our recommendation is that points should be recycled as consultants retire or leave. Trusts will have discretion but will have to meet any additional costs out of its own resources.

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: Contributing to the DHSSPS through 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 NICEAC 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 (i.e. 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 NICEA will be reviewed by the committee which made the award. Local awards will

be reviewed by LACs on an exception basis (e.g. 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 NICEAC 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.

Northern Ireland Clinical Excellence Awards Committee (NICEAC)

The Northern Ireland Clinical Excellence Awards Committee (NICEAC) is a Non-Departmental Public Body. Its function is to make recommendations to the Department on which HSC/Board/Trust consultants should receive the higher value awards, having regard to the number of awards available for allocation. It also has a quality assurance role over the local awards process.

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 92.

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 2004 contract negotiations, a new code of conduct for private practice was agreed. The aim of the code is to minimise the risk of a conflict of interest arising between a consultant's private practice and their HSC/Board/Trust commitments. While part of the 2004 negotiations, the standards of best practice are designed to apply to all consultants working in the HSC/Board/Trust, 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 HSC/Board/Trust 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 HSC/Board/Trust. Private commitments should be rearranged if there is regular disruption to HSC/Board/Trust work and private work should not stop a consultant from being able to attend HSC/Board/Trust 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 HSC/Board/Trust.

Private care in the HSC/Board/Trust

With the agreement of the employer, some private work may be undertaken alongside HSC/Board/Trust duties provided there is no disruption to HSC/Board/Trust services, although private patients should normally be seen separately. Consultants can only see private patients in HSC/Board/Trust 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 HSC/Board/Trust duty, initiate discussion about providing private services to HSC/Board/Trust patients.

Private patients to HSC/Board/Trust lists

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

Information

- A code of conduct for private practice - Recommended standards of practice for HSC/Board/Trust consultants. An agreement between the BMA(NI) Northern Ireland Consultants and Specialists Committee and the Department of Health, Social Services and Public Safety for consultants in Northern Ireland. November 2003.

HPSS/Board/Trust contractual provisions: 2004 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 HPSS/Board/Trust 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
- HPSS/Board/Trust commitments take precedence over private work and there should be no significant risk of HPSS/Board/Trust commitments disrupting private work
- consultants should not undertake private work while on call for the HPSS/Board/Trust 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 HPSS/Board/Trust facilities and staff for private work with the employer's agreement
- private patients should normally be seen separately from scheduled HPSS/Board/Trust 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 HPSS/Board/Trust, 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 HPSS/Board/Trust pay progression for that year
- any additional PAs offered must be offered equitably between all consultants in that speciality; 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

HPSS/Board/Trust contractual provisions: pre-2004 contract

Under the pre-2004 national terms of service, whole-time consultants (read more on page 5) 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 HPSS/Board/Trust 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 HPSS/Board/Trust duties, but only receive 10/11ths of whole-time HPSS/Board/Trust salary. Gross HPSS/Board/Trust salary is taken to include any discretionary points, distinction award or CEA payable, but not other HPSS/Board/Trust 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 HPSS/Board/Trust premises.

Whole-time consultants may practise privately in their own HPSS/Board/Trust 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 HPSS/Board/Trust patients. Consultants must give priority to their HPSS/Board/Trust 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 regraded to maximum part time and paid 10/11ths of the gross whole-time salary. After such compulsory regrading, 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 regraded. 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 regraded.

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's private practice committee.

Information

- Terms and Conditions of Service, paragraphs 40-43
- HSS(TC8) 1/70, contracts of consultants and other senior hospital medical and dental staff

Definition of private practice income

Income from private practice and category 3 work (read more on page 8) counts towards the 10 per cent limit under the pre-2004 contract. However, consultants may receive fees and payments in addition to their HPSS/Board/Trust 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 (read more on pages 7 and 8)
- fees for family planning services arranged by the employer (read more on page 10)
- fees for domiciliary visits (read more on page 9)
- fees for exceptional consultations in hospitals managed by a different employer (read more on page 9)
- fees for lectures to hospital staff (read more on page 10)
- 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 (read more on page on page 6) fees under the collaborative arrangements.

Private practice in the Health and Social Care(HSC)/Board/Trust

Access to private beds

Under the NHS and HPSS (NI) Order 1991 trusts may make pay beds available to those staff who are entitled to admit their own patients to the hospital for HSC/Board/Trust treatment, i.e. 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 (Northern Ireland) Order 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 HSC/Board/Trust 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 DoH's Green Book (see below) 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 HSC/Board/Trust hospital in the same way as their HSC/Board/Trust 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 HSC/Board/Trust 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 HSC/Board/Trust.

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 HPSS/Board/Trust(NI) Order 1991
- 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 HSC/Board/Trust

The Green Book clarifies that patients receiving HSC/Board/Trust 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 HSC/Board/Trust 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 HSC/Board/Trust 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 HSC/Board/Trust. 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 HSC/Board/Trust 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 (Northern Ireland) Order 1988 provides for HSC/Board/Trust 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 HSC/Board/Trust 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 HSC/Board/Trust can be found on page 25.

Information

- Private Prescriptions in the NHS and prescribing Responsibility, NICC June 2000
- Letter, 18 February 2000 from N Cullen, NHSE, to J Woodcock,
- Letter, 22 September 1999 from V Jones, NHSE, to J Woodcock, CCSC Secretariat
- The Health and Medicines (Northern Ireland) Order 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-2004 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 HSC/Board/Trust 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's 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 HSC/Board/Trust indemnity scheme (read more here) does not cover private work, either in the HSC/Board/Trust or in private hospitals, although different arrangements apply to category 3 work (read more here). 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 licenses they would still be covered by HSC/Board/Trust 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 HSC/Board/Trust 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 HSC/Board/Trust or to those who hold a certificate of completion of specialist training (CCST). 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 HSC/Board/Trust 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.

HSC/Board/Trust provision in the independent sector

In recent years, there has been a considerable growth in the use of the independent sector in the provision of HSC/Board/Trust care. The combination of the payment by results and patient choice initiatives means that the plurality of HSC/Board/Trust care provision will expand further. The patient choice initiative commits PCTs to offer at least one private care option for elective work by December 2005.

The government is expanding its independent sector treatment centre (ISTC) programme which began in September 2003. As of October 2004, one fixed and two mobile ISTCs were in operation with an expectation there will be 34 schemes operational by the end of 2005. These are units established to provide intensive treatment programmes, often relating to a specific aspect of healthcare such as orthopaedic or ophthalmic surgery. They 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 who could be employed to undertake work in treatment centres. In particular, staff who had worked in the HSC/Board/Trust in the previous six months were not allowed to work in ISTCs. The BMA has objected to this 'additionality' restriction and consideration is being given to the terms for the second wave of centres. There are other concerns about the impact of ISTCs, for example on the financial stability of existing HSC/Board/Trust hospitals.

Despite the current additional restrictions in treatment centres, the development of the plurality and choice agenda is likely to see additional employment and contracting opportunities for consultants in the independent sector.

Regulation of independent sector care

The Care Standards Act 2000 established the National Care Standards Commission to inspect and regulate the independent care sector. The commission's inspection functions passed to the Healthcare Commission in April 2004.

GMC guidance concerning financial interest

The GMC advises doctors that treating patients in an institution in which they have a financial or commercial interest may lead to serious conflicts of interest. If such an interest exists, patients and anyone funding the treatment must be made aware of it, similarly, if they plan to refer patients to an organisation in which they have an interest, the patients must be informed. In the case of NHS patients, the healthcare purchaser must be notified. As a general principle, financial or commercial interest in organisations providing healthcare (or in

pharmaceutical or biomedical companies) must not affect the way the patients are prescribed for, treated or referred.

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

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 here for those on the pre-2003 contract and here 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's [fees guidance schedules](#).

Information

- BMA guidance: [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 1999)
- BMA guidance: [Expert witness guidance](#)

Comment: What is this please?

Consultant appointments procedures

Appointment of Consultants Regulations (Northern Ireland) 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 HSS trusts and Special Agencies. The regulations and accompanying Direction must be followed by employing authorities, but they do not apply to honorary contracts or locums.

Consultant appointments can only be made by employing authorities on the advice of an Advisory Appointments Committee (AAC), established by the employing authority. The AAC does not make the appointment but acts in an advisory capacity having interviewed and assessed candidates.

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.

Specialty 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 HSS guidance states that it should form part of an information package. This package 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: read more here). Whole-time posts must also be available to part-timers, and all posts must be open to job-sharers.

Eligibility for appointment

Since 1 January 1997 it has been a legal requirement for all doctors to be on the GMC's specialist register before they can take up a consultant appointment (see pages 100 for the specialist register). However, trainees may explore the possibility of post-CCST careers as soon as it is apparent that a CCST 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 CCST (or recognised equivalent, if outside the UK) falls no more than three 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.

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 short listed. 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 travelling, subsistence and financial loss allowances and subsistence expenses. The HSS guidance stipulates that these should be paid in accordance with statutory rates. It is, therefore, advisable to check with the trust what these rates are.

Information

- Terms and Conditions of Service 2004, schedule 21, paragraphs 58-60.
- 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 which 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

The BMA and the DHSSPS have negotiated and agreed a new 5 part framework governing disciplinary procedures and exclusions (suspensions) to be followed by HSC/Board/Trust employer. The framework can be found [here](#)

The new frame work is intended to:

- ascertain quickly what has happened and establish the facts
- determine whether there is a continuing risk
- decide whether immediate action is needed to manage the risk to
- ensure the protection of patients.

The new arrangements will cover:

1. Action when a concern first arises
2. Restriction of practice and exclusion from work
3. Conduct hearings and disciplinary hearings
4. Procedures for dealing with issues of clinical performance
5. Handling concerns about a practitioners health

Additional advice for clinical academic staff can be found [here](#).

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 NCAA (www.ncas.npsa.nhs.uk) was a special health authority established as one of the central elements of the NHS's work on quality. It began work in April 2001 to provide a support service to health authorities, primary care trusts 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. The NCAA became the National Clinical Assessment Service (as part of the National Patient Safety Agency) in April 2005.

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

Employment Relations (Northern Ireland) Order 1999, the companion may be another employee of the HSC 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 HSC/Board/Trust 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 HSC/Board/Trust 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 HSC/Board/Trust 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 joint appointments/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 HSC/Board/Trust. 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 DHSSPS Superannuation Branch 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)

Health and Social Care (HSC)/Board/Trust complaints procedure

Introduction

The NHS complaints procedure was established under Directions issued by the Secretary of State for Health in April 1996. These Directions (and those that followed in 1998) require NHS trusts and health authorities to have written procedures for dealing with complaints. These procedures were known as 'local resolution'. NHS organisations were also required to run the second part of the procedure known as 'independent review'. With the abolition of health authorities their duties with regards to the complaints procedure passed to PCTs on 1 October 2002 under the NHS Reform and Health Care Professions Act 2002.

During 1999 and 2000 the complaints procedure was independently evaluated and the NHS plan in 2000 committed the government to taking action in response. A report, NHS complaints procedure national evaluation, was published on 3 September 2001 along with Reforming the NHS complaints procedure – a listening document. These papers identified concerns that the process was not seen to be sufficiently independent or responsive to patients, particularly at the independent review stage. In response, the DoH published NHS complaints reform – making things right on 28 March 2003. This set out proposals for the improvement of the whole complaints process.

The DoH has stated that 'the programme for delivery of complaints and clinical negligence reform is an essential and integral element of the department's programme for improving patients' overall experience of health care'. Some of these proposals formed part of the Health and Social Care (Community Health and Standards) Act 2003. The intention of the DoH was to build on the existing process, along with other initiatives, and to introduce what it described as operational improvements. These consisted of: making the system more flexible, improving local resolution, reforming independent review and ensuring that complaints became a key part of achieving safe and high quality healthcare. Under the Health and Social Care (Community Health and Standards) Act 2003 the Secretary of State has powers to make regulations on complaints procedures.

A consultation document was issued on 17 December 2004 with the consultation period running to 31 March 2004. The DoH then began working on implementing its proposed changes in full. However, following a letter from the Solicitor to the Shipman Inquiry, it was decided that implementation should be phased because the inquiry was not due to report until the end of 2004.

Consequently, the legal framework for local resolution remains largely the same pending the DoH's consideration of the reports of the Shipman, Neale and Ayling inquiries. It is intended that amended regulations will be presented in 2005. It should be noted that NHS foundation trusts have their own procedures for dealing with complaints, though the independent review part of the process does apply. Nonetheless, changes to the independent review stage were made with the NHS (Complaints) Regulations, which came into effect on 30 July 2004. These gave the Healthcare Commission the responsibility for this stage of the process.

Local resolution for hospital and community health services

Investigation

As part of its procedure, each HSS body is encouraged to establish a clear system to ensure the appropriate level of investigation. Complaints might be best resolved through face-to-face meetings with the complainant and early consideration will need to be given to this approach. Equally, the Complaints Officer may decide, on a case-by-case basis, what other action would be more helpful.

The current procedure stipulates that HSS bodies should ensure impartiality when undertaking investigations into complaints. It is important that any investigating officer (Complaints Officer or any other suitable person appointed by the HSS body) considers the complaint with an open

mind, being fair to all parties. Investigation must not be adversarial and must uphold the principles of fairness and consistency.

Complaints affecting more than one HSC/Board/Trust body

Where a complaint relates to the actions of two or more HSC/Board/Trust bodies – for example, two Trusts, or a family health services practitioner and a Trust, full co-operation between the complaints staff of these bodies is encouraged to resolve the complaint.

Out of Area complaints

Where the complainant or patient lives in Northern Ireland and the complaint is about events elsewhere, the HSS Board that commissioned a service or purchased care for that patient is responsible for co-ordinating the investigation and ensuring that all aspects of the complaint are investigated.

Each HSS Board is responsible for commissioning the care of patients or clients in its respective Board area. Where a patient or client receives “out of area” treatment, any request for an Independent Review is dealt with by the HSS Board area in which the patient or client lives.

Target Timescales

The target timescale for a full investigation at the local resolution stage of a complaint is 20 working days. For Family Health Services this target is 10 working days.

Fast tracking is sometimes invoked when the complainant raises issues which are life threatening, or where the complaint involves a terminally ill patient. In these cases, the Complaints Officer can invoke fast tracking at either the local resolution stage or the independent review stage. It is important to remember that the first priority of a recipient of a complaint is to ensure that, where applicable, the patient’s/client’s immediate health and social care needs are being addressed before taking action on the complaint. Thereafter, the objective is to ensure that the complainant’s concerns are dealt with rapidly and in a friendly, sensitive and confidential manner.

Responding to a Complaint

Best practice suggests that local resolution should normally be rounded off with a letter. If it is considered that a complaint can be resolved by discussion, then there should be a clear record made of that discussion. If a letter is considered appropriate, it should confirm the oral response given. Organisations endeavour to issue this letter within 5 working days from receipt of the complaint.

In dealing with complaints, staff are expected to demonstrate sensitivity in all written correspondence. The response needs to be clear, accurate, balanced, simple, fair and easy to understand. It should avoid technical terms, but where technical terms are used to describe a situation, events or condition, an explanation of that term should be provided. All the points raised in the complaint should be addressed. An outcome, or explanation of planned action, should be included where the investigation finds that something could, should have been done differently, or if there is anything to be done as a result of the complaint.

The response must also refer to the complainant’s right to request an Independent Review within 28 days of the date of the letter if they remain dissatisfied with any aspect of the response.

Independent Review

Complainants who are dissatisfied with the result of local resolution may request an Independent Review (IR). During 2003/04 there were a total of 118 requests for Independent Review (89 by Trusts and 29 by FHS). Of these 118, 15 were referred to an Independent Review Panel (11 for Trust and 4 for FHS). The right to have a complaint reviewed is not automatic and a request for review is considered by a convenor in consultation with an independent review panel lay chair, both of whom are appointed by the local HSS Board.

Convenors are non-executive directors of Boards. Their role is to provide the complainant with an independent and informed view on whether any more can be done to resolve their complaint. In reaching his/ her decision, the convenor will take appropriate clinical or professional advice where the complaint relates in whole or part to action taken in consequence of the exercise clinical or professional judgement.

Where the convenor feels that local resolution has not adequately addressed a complainant's concerns the case is passed back to the service provider for further local consideration, perhaps involving conciliation. If the convenor considers that local resolution has been adequately pursued – in that the complaint has been properly investigated and an appropriate explanation given – and that nothing further can be done even though the complainant remains dissatisfied, the complainant is advised of the reason for this decision and informed of their right to put their case directly to the NI Commissioner for Complaints.

When the Convenor feels, for whatever reason, that further local resolution would not be appropriate and that there are grounds for the complainant's continued dissatisfaction, he/ she may decide to convene an independent review panel. Independent Review panels must be composed of three members: an independent lay chair (from the Board list), the convenor (non-executive director of Board) and a third independent lay panel member (from the Board list). If the case involves the exercise of clinical judgement, at least two clinical assessors will be appointed to advise the panel. The panel is appointed by the HSS Board for the area in which the organisation complained against is located.

At the conclusion of the panel's work, a report will be produced. The report may include actions the service provider might take to satisfy the complainant and suggestions arising from the investigation that the panel considers would improve services. The report will be made available to the complainant, panel members, the complained against and the clinical assessors. A summary of the report will be made available to Chief Executive for presentation to his/ her board so that they may consider the action needed to implement its recommendations.

The above HSC/Board/Trust complaints procedure is currently under review and a public consultation on a proposed new procedure is expected in the autumn. BMA have been involved in the review.

A complainant or a person or organisation complained against that is unhappy with the outcome of the hearing may complain to the Northern Ireland Ombudsman.

The Northern Ireland Commissioner for Complaints (Ombudsman)

If complainants remain dissatisfied they can appeal to the Commissioner for Complaints (Ombudsman). The Ombudsman is independent of both the HSC/Board/Trust and the government. In 1997 all complaints by or on behalf of HSC/Board/Trust patients, including actions taken wholly or partly as a result of the exercise of clinical judgment were brought within the Ombudsman's jurisdiction.

The Ombudsman will not generally investigate complaints until the HSC/Board/Trust complaints procedure has been exhausted. In deciding whether to take on a case the Ombudsman will have access to all papers relating to local resolution and the independent review, including the assessors' reports. The Ombudsman is advised by medical and nursing officers and will engage external professional advisers.

Appraisal

Introduction

The development of clinical governance 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 HSC/Board/Trust consultant staff. 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 2004 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.

Every consultant being appraised should prepare an appraisal folder. This is a systematically recorded set of all the documents: information, evidence and data that will help inform the appraisal process. Once the folder has been set up it can be updated as necessary. The documentation will allow access to the original documents in the folder in a structured way, record what the appraisal process concluded from them and, finally what action was agreed as the outcome following discussion.

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 NICC 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 HSC/Board/Trust 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 HSC/Board/Trust
- 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 HSC/Board/Trust 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 (e.g. 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

Current medical activities

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

Good medical practice

This should include:

- Clinical care 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, e.g. disciplinary
- 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 - 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.
- 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.

Management activities

Information about formal management commitments, records of any noteworthy achievements and any recorded feedback if available.

Research

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.

Development action

Continuing professional development, including the updating of relevant clinical skills and knowledge through continuing medical education

The NICC 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 (e.g. by an educational body, a professional body, or the National Clinical Assessment Service 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, e.g. 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, e.g. 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

It is intended that the appraisal process will be the vehicle through which the GMC's revalidation requirements will be delivered for consultants. However, revalidation is currently on hold pending the government review following the fifth report of the Shipman Inquiry. Appraisal discussions and evidence gathering are hopefully sufficiently broad to cover what are likely to be the essential requirements of revalidation.

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.

Joint Appointments/Clinical Academics

As recommended by the Follett report, consultants with substantive university appointments or HSC/Board/Trust consultants with major academic duties should undergo joint appraisal in respect of their complete range of HSC/Board/Trust and university duties (either with one appraiser for each component, or a single joint appraiser if properly qualified for this task). The documentation is very similar to that required for HSC/Board/Trust consultants and is designed to support the requirements of the GMC's revalidation procedures. In addition to those noted above, for joint appointments / 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 to adhere to the Code of Conduct for Private Practice - Recommended Standards of Practice for HSC/Board/Trust Consultants - agreed with the NICC. The standards are designed to apply equally to joint appointment contract holders in respect of their work for

the HSC/Board/Trust. The Code covers all private work, whether undertaken in non-HSC/Board/Trust or HSC/Board/Trust facilities and adherence to the standards in the Code will form part of the eligibility criteria for clinical excellence awards. The Code should also be used at the annual job plan review as the basis for reviewing the relationship between HSC/Board/Trust duties and any private practice.

Appraisal is seen as the gateway to both processes and the BMA, alongside the Independent Healthcare Forum and supported by the HSC/Board/Trust, has produced advice on this issue, available on the BMA website (www.bma.org.uk).

Doctors employed by HSC/Board/Trust trusts and who also work privately, are recommended to participate in 'whole practice appraisal' within their HSC/Board/Trust appraisal, to cover all elements of their practice. Appraisal should take place within the HSC/Board/Trust framework, using HSC/Board/Trust 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 - HSS (TC8)09/03
- Appraisal for Consultant Clinical Academic Staff - HSS (TC8)10/03
- Annual Appraisal for Consultants HSS (TC8)3/01 & HSS (TC8)11/01
- Whole Practice Appraisal - A Guide to Independent Sector Appraisal.
- An agreement between the British Medical Association and the Independent Healthcare Forum, October 2004

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 'has powers to permit doctors to practise, and to remove or restrict the right to practise if they fail to meet the standards it has set'.

The GMC exercises its powers by determining whether individuals should be registered as doctors in the UK, monitoring undergraduate medical education and coordinating postgraduate medical education in the UK and through its establishment of a framework of standards and ethics embodied in Good medical practice. This 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 doctor's 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 practise 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 NICC 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.

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 could be discussed with one of its caseworkers. It can be contacted on 0845 357 0022 or email practise@gmc-uk.org

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

Until 2004 there were three main procedures which the GMC could invoke if it had concerns about a doctor's practice: the disciplinary, performance and health procedures. However, since 1 November 2004 the way in which fitness to practise cases are handled has changed. Rather than being handled under one of three separate procedures, cases are now assessed 'in the round'. In addition, it is intended that there will be more investigation of complaints at the initial stages of the procedures, and the screening and Preliminary Procedures Committee stages have been abolished, leading to a single investigation stage.

Changes introduced in May 2004 enabled early discussions to take place between the GMC and employers. The intention being that the GMC would have a clearer idea of a doctor's practice before deciding what action to take. Broadly speaking this could either be a further investigation by the GMC of the doctor's fitness to practise or referral to the employer or other relevant body to address the concerns raised in the complaint. Investigations are supervised by the Investigations Committee and undertaken by case examiners from both medical and lay backgrounds. The case examiner and the Investigations Committee determine whether a case should be referred to a fitness to practise panel for a full hearing, taking into account the GMC's 'duty to act in the public interest' and 'whether there is a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration'. However, if it is felt that patients would be at risk if a doctor continued to practise, registration can either be suspended or restricted by an Interim Orders Panel. The GMC can also issue warnings, which will be disclosed to a doctor's employer, where 'there has been a significant departure from Good medical practice' or there is 'cause for concern about a doctor's performance considered as a whole'.

If it is decided that a full hearing is required the case is passed to the adjudication process. The cases are heard by fitness to practise panels staffed by appointed panellists rather than GMC members. The decision that the panels have to make is 'do the findings we have made show that the doctor's fitness to practise is impaired to a degree justifying action on registration?' That action could be: erasure, suspension, conditional registration or, in exceptional cases, no action. If fitness to practise is found not to be impaired, warnings can still be issued.

Council for Healthcare Regulatory Excellence (CHRE)

The CHRE has the power to refer a decision by a fitness to practise panel to the High Court (or its equivalent throughout the UK) for the protection of the public, if it considers the decision is unduly lenient. The CHRE has 28 days to decide whether to refer a decision following the doctor's 28-day appeal period. CHRE reviews all decisions of GMC fitness to practise panels that have not resulted in erasure.

Licensing and revalidation

The GMC had also intended to introduce a new licensing and revalidation system for doctors in April 2005, with doctors being required to demonstrate their continuing fitness to practise in order to remain registered. However, in light of recommendations made in Dame Janet Smith's fifth report on the Shipman case, the government decided to review the proposed revalidation system. The review includes the role of HSC appraisal and will cover the GMC's arrangements for examining a doctor's fitness to practise within the revalidation process. The intended launch of revalidation from April 2005 was therefore postponed.

Consultants facing the possibility of investigation by the GMC are advised to seek advice initially from their medical defence society. Costs of GMC proceedings are not covered under HSC/Board/Trust indemnity.

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 wellbeing. To justify that trust, we as a profession have a duty to maintain a good standard of practice and care and to show respect for human life. In particular as a doctor you must:

- make the care of your patient your first concern
- treat every patient politely and considerately
- respect patients' dignity and privacy
- listen to patients and respect their views
- give patients information in a way they can understand
- respect the rights of patients to be fully involved in decisions about their care
- keep your professional knowledge and skills up to date
- recognise the limits of your professional competence
- be honest and trustworthy
- respect and protect confidential information
- make sure that your personal beliefs do not prejudice your patients' care
- act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise
- avoid abusing your position as a doctor; and
- work with colleagues in the ways that best serve patients' interests.

In all these matters you must never discriminate unfairly against your patients or colleagues. And you must always be prepared to justify your actions to them.'

Good medical practice

The Council published the third edition of Good medical practice in 2001. The guidance is currently under review. It describes the principles of good medical practice 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, May 2001, third edition
- GMC website: www.gmc-uk.org
- GMC Continuing Professional Development for Doctors (guidance issued in April 2004)
- GMC Fitness to Practise Procedures came into force 1 November 2004

Health

Introduction

The role of the HSC/Board/Trust 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 (read more here). 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 2001-2002.

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 (read more here) are a health and safety measure.

Concerns about the failure of employers to fulfil 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 HSC/Board/Trust.

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 HSC/Board/Trust 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 responsibility for encouraging the implementation of good occupational health and safety policy across the DHSSPS/Boards/Trusts lies with the DHSSPS(NI).

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

- HSS (Gen) Occupational Health Services for NHS Staff
- HSS (Gen) 4/2000 Health & Safety in the Health & Personal Social Services
- 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*

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

Prevention of infection from hepatitis and HIV

The DoH has issued guidance to protect healthcare workers against infection with HIV and hepatitis viruses. The recommendations are based on the principle that it is not possible to identify all patients who may be infected with blood-borne viruses. The guidelines describe primary measures for prevention of occupational exposure to HIV and blood-borne hepatitis viruses using procedures described as 'universal/standard precautions'. These are based on the principle that all blood and body fluids are potentially infectious and workers must ensure that they use the appropriate gloves, protective clothing, eye protection and other equipment, if they are at risk of contamination by blood or other body fluids. A range of infection control measures, including universal/standard precautions, has been recommended by various expert bodies.

Hepatitis B vaccination

The hepatitis B vaccination programme was set out by the DHSSPS(NI) guidelines Protecting health care workers and patients from hepatitis B which highlighted the policies which NHS trusts and hospitals should have for the provision of an hepatitis B virus vaccination. The programme aims to identify staff who are not immune to hepatitis B virus and to protect them against infection which could be acquired during their work. Staff who do not wish to be immunised, for whatever reason, should notify their occupational health department of their decision in writing. The programme also aims to identify any infected worker whose work involves exposure prone procedures (EPPs) and who may pose a risk to patients. EPPs are defined as those where there is a risk that injury to the worker may result in the exposure of the patient's open tissues to the blood of the worker. The BMA has issued guidance on the implementation of the guidelines.

Transmission of infection to patients

Healthcare workers who are, or believe that they may be, infected with or have been exposed to hepatitis or HIV must promptly seek and follow suitably qualified appropriate medical advice, for example from a consultant in occupational medicine. The DoH states that healthcare workers who know that they have been infected with the Hepatitis C virus should be tested for hepatitis C virus RNA. Those who are infected with hepatitis B or C or who refuse to be tested may not undertake EPPs. It should be noted that for the purpose of enforcing this rule, trusts and health authorities may wish to adopt a wide-ranging definition of an EPP, to include procedures where there is any break in the patient's skin or mucous membrane.

Hepatitis C infected healthcare workers who have successfully responded to antiviral therapy and have been hepatitis C virus RNA negative for six months can be allowed to resume EPPs. For the rest, employers should arrange appropriate alternative work or retraining opportunities. Where hepatitis C has been acquired at work the NHS injuries benefits scheme and the industrial injuries disablement benefit scheme provides benefits.

Healthcare workers who are infected with HIV and who perform or who may be expected to perform EPPs must obtain further expert advice about the need for modification or restriction of their working practices.

The DoH is currently consulting on proposals by the Ad Hoc Risk Assessment Expert Group that all new entrants to the NHS workforce should be subject to health clearance. Ministers have accepted this advice. The proposals include checks for TB and hepatitis B immunity and the offer of testing for hepatitis C or HIV. Proof of clearance for blood-borne viruses would be

required for persons undertaking EPPs. These proposals would also apply to re-entrants such as medical reservists returning from service and those who have periods of unemployment, such as some locums. At the time of writing guidance from the DoH was said to be imminent.

If it is believed that a colleague has not followed the procedures, the DHSSPS(NI) guidelines state that an appropriate person in the trust should be informed, such as an occupational health physician, the medical director or director of public health. The guidelines also acknowledge that individuals may wish to seek advice from their regulatory body in the first instance.

The National Minimum Standards for Independent Healthcare (2002) require those in the independent sector to comply with DoH guidelines.

Healthcare associated infections

The DHSSPS has begun to respond to widespread concern regarding the high rate of healthcare associated infections in Northern Ireland. In June 2005 the DHSSPS issued proposals for wider consultation among the HSC, patient representative groups and the general public under cover document "Strategy for the prevention and control of healthcare associated infections". The DHSSPS intention is to develop a detailed action plan for implementation based on comments received and analysed. The report set out 'a clear direction on the action necessary to reduce the relatively high levels of certain healthcare associated infections.'

One of the seven 'action areas' in the report was clinical practice. In addition to the precautions on blood-borne viruses noted above the report called for 'high levels of compliance with hand washing and hand disinfection protocols', appropriate induction programmes and for infection control being part of the personal development plans of all staff. On 1 September 2004 the National Patient Safety Agency launched a national campaign (cleanyourhands) to encourage hand washing and from April 2005 alcohol based rubs will be placed next to all beds in acute hospitals.

Information

- HSS (Gen) Occupational Health Services for NHS Staff
- HSS (GEN) 4/2000 Health & Safety in the Health & Personal Social Services
- BMA, 'the Misuse of Alcohol and Other Drugs by Doctors', 1998
- UK Health Departments 1998, Guidance for clinical health care workers: protection against infection with HIV and hepatitis viruses: recommendations of the expert Advisory Group on AIDS
- British Orthopaedic Association 1991, Guidelines for the prevention of cross infection between patients and staff in orthopaedic operating theatres with special reference to HIV and the blood borne hepatitis viruses
- Association of Anaesthetists of Great Britain & Ireland, HIV and other blood-borne viruses – guidance for anaesthetists, 1992
- HIV Post-Exposure Prophylaxis: Guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS, February 2004, revising guidance issued in 2000
- NI: HSS (MD) 4/94 & Addendum HSS (MD) 28/96 Protecting Health Care Workers & Patients from Hepatitis B

Sources of professional advice

BMA counselling: a service for members and their families

This service is available to members and their families to help with personal, emotional and work-related problems, such as:

- 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. The service is available 24 hours a day, every day of the year. All calls are charged at local rates.

On phoning the BMA counselling service, a counsellor will ascertain from the doctor whether they wish to speak to a counsellor or be put in touch with a doctor adviser. If they wish to speak to a doctor adviser the doctor's name, contact details and presenting problem are obtained and they are then given the name and contact details of a doctor adviser. The adviser's details are available from a list held by BMA counselling provided by the doctors for doctors unit. In addition, the list details advisers' availability and any special interest the adviser may have such as dealing with minority groups. The doctor is advised that the advisory service is not an 'emergency service'. Should more urgent help be needed, the caller will be directed to a counsellor at First Assist for immediate advice.

BMA doctors for doctors unit

The doctors for doctors unit is committed to provide support for doctors in distress and difficulty by helping them make informed decisions about their health, working with them to gain insight, facilitating access to appropriate care and supporting them through this process. The unit is developing its services and is only able to accept a limited number of self-referrals at present. The unit has produced a resource pack as a self-help tool to aid doctors in accessing appropriate help. This is available on the BMA website.

For further information call 020 7383 6739 or email info.d4d@bma.org.uk.

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.

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For further information call 020 7383 6739 or email info.d4d@bma.org.uk.

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.

Workforce planning

The specialist register

On successful completion of specialist registrar (SpR) training, doctors are currently awarded a CCST, allowing them to practice across Europe as recognised 'specialists'. The Specialist Training Authority, a statutory body comprising representatives of the profession, the GMC, postgraduate deans and patients, recommends CCST holders for inclusion on the specialist register, administered by the GMC.

From September 2005 this function will be taken on by the Postgraduate Medical Education and Training Board (PMETB). 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 member with observers from both UK health departments.

The specialist register includes the names of all CCST 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 national holding specialist qualifications that are deemed equivalent to the CCST.
- 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 are consultants in the NHS before 31 December 1996 were automatically transferred to the specialist register.

There is no body in Northern Ireland that has the specific remit of workforce planning. The Hospital Services Sub-Committee of the Central Medical Advisory Committee performs this function. The establishment of SHO's and SPR's in each speciality is discussed annually with advice from the relevant specialty advisors. This advice is restrained by funding and by the training capacity available and largely for financial reasons has often underestimated the number of posts required to deliver a consultant-based service.

Despite the pressure to delegate many traditional medical tasks to practice specialist nurses and other health workers, the number of doctors required to deliver a service will rise rapidly in the foreseeable future. This is driven by factors such as European Working Time Directive, the new contracts of employment under which doctors of all grades work, the move from generalist to specialist base service and the fragmented sites at which secondary and tertiary care continue to be provided in Northern Ireland.

To accommodate these changes the intake at Queens University Medical School has been increased to 240 per annum. This will have a profound affect on the Medical Workforce in the future.

Other inputs are provided by:

Specialty Advisory Committees

- Empirical appointment of staff either as Locums or without the training grades by individual Trusts.
- The current relaxation of the restriction on the numbers of staff grade doctors and associate specialists. Each of their appointments is vetted by the BMA's NICC.

The DHSS has commissioned a review of Medical Workforce Planning by Touche/Deloitte, which will report at the end of 2005.

Joint Appointments/Clinical Academics

(Please note that there are cross-references throughout this section to the correlating guidance for NHS consultants in other parts of the handbook.)

Contracts

See the pre-2004 national consultant contract pages from page 5 and the 2004 consultant contract pages here for HSC/Board/Trust 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 HSC/Board/Trust 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 HSC/Board/Trust employer).

Like their HSC/Board/Trust colleagues, joint appointments/clinical academics may be employed under the 'new' 2004 consultant contract, or under the pre-2004 contract if employed prior to April 2004.

Information

- Terms and Conditions of Service, paragraphs 78 and 81
- Terms and Conditions of Service 2004, 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 16

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

Job planning

(See page 35)

The BMA has produced detailed guidance on the integrated job planning process for joint appointments/clinical academics on the 2004 contract in Northern Ireland which is available separately. In broad summary:

- joint appointments/clinical academics will have a commitment to the university/academic employer and the HSC/Board/Trust employer. This will typically be five PAs of academic work and five PAs of HSC/Board/Trust work, although these proportions can be varied according to the needs of the job (for example, 6:4, 3:7)

- within the HSC/Board/Trust 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 HSC/Board/Trust employer
- the integrated job plan should be agreed between the academic employer, HSC/Board/Trust 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 2004 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-2004 contract.

Information

- The Clinical Academic Consultant Contract (Northern Ireland) 2004, BMA advice on Integrated Job Planning.

Appraisal

(See page 74)

Appraisal is separate from, but informs, the job planning process. As with job planning for joint appointments/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 66)

Clinical academic staff are subject to the newly agreed HSC/Board/Trust procedures for issues arising from their HSC/Board/Trust 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 joint appointments/clinical academics, which is available from the DoH website

Information

- Maintaining high professional standards in the modern HSC/Board/Trust Guidance on Joint Appointments/Clinical Academics

Private practice and spare professional capacity

(See page 54)

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, i.e. 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 HSC/Board/Trust 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 46)

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 HSC/Board/Trust, as outlined below:

Pre-2004 contract, discretionary points and distinction awards Paragraphs 81 and 82 of pre-2004 terms and conditions refer – joint appointments/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	Proportion of award of clinical work per week
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 3.5 hours	15%

2004 contract, discretionary points and distinction awards

Average number of PAs work	Proportion of award per week of benefit to the HSC/Board/Trust
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-2004 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 HSC/Board/Trust including teaching and clinical research.

Average number of hours 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 HSC/Board/Trust including teaching and clinical research.

Average number of hours 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 27)

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

A and B contract holders are subject to HSC/Board/Trust sick leave entitlements.

Maternity and parental leave

(See page 30)

Honorary contract holders are subject to the maternity and parental leave provisions laid down by individual universities. Previous continuous service within the does HSC/Board/Trust 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 HSC/Board/Trust maternity leave entitlements.

European Working Time Directive (EWTB)

(See page 39)

All joint appointments/clinical academics are covered by the EWTB. At the present time, joint appointments/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 joint appointments/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. Joint appointments/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 24)

There is no national policy for provision of removal expenses for joint appointments/clinical academics by university employers. Individual universities may provide some reimbursement. On consideration of a new contract of employment, joint appointments/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 422)

All joint appointments/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. Joint appointments/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*.

The clinical team

Consultant responsibility

Only a consultant or a principal in general practice can accept ultimate medical responsibility in HSC/Board/Trust units and the development of new working patterns and increased multi-disciplinary 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.

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

- moves to increase provision in primary care and community settings
- 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 NICC advises consultants to insist, wherever possible, on referrals coming from a named medical source (with the patient's consent) and always to inform the patient's GP of advice given or treatment proposed, as recommended by the GMC. Where nurse referrals are accepted under local protocols, these protocols should be drawn up with medical input. The NICC'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.

Information

- CCSC guidance, Access to Secondary Care, January 2000
- GMC, Good Medical Practice 2001, Third Edition

- GMC, The Doctor as Teacher, 1999
- Towards Tomorrow: The Future Role of the Consultant (CCSC 1996)

Associate specialists

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. However, the PMETB is due to consider how associate specialists' experience can be assessed so that they can be given access to the specialist register and, thereby, apply for consultant posts.

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 increasingly, trusts advertise for and recruit associate specialists directly. This would be appropriate where an associate specialist had vacated a post and a continuing need for it to be filled was established by the trust, or where it was established that a new associate specialist post was required and that it would not be appropriate to create a consultant post.

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

Information

- BMA guidance: [The associate specialist grade](#)
- HSS (TC8)1/92 - The associate specialist grade
- HSS (TC8)12/92 - Appointment to the associate specialist grade

Staff grade doctors

The staff grade is a non-training career grade intended to provide a career in hospital medicine for doctors who do not wish, or are unable to train for, consultant status. Staff doctors exercise an intermediate level of clinical responsibility and work to a named consultant. Their commitments relate solely to service requirements and they do not have continuous 24-hour responsibility for their patients. Consultants who wish to establish a staff grade post in their department should apply to their employing authority which will need to consider whether it is the most appropriate means of meeting service requirements and to this end, consultants in the relevant specialty in the trust and representatives of the MSC or equivalent should be consulted. The employer will need to ensure that the creation of such a post would not lead to inappropriate staffing ratios.

Information

- BMA guidance: [The staff grade](#)
- HSS (TC8)1/98 - Terms and Conditions of Service for the Staff Grade
- HSS (TC8)11/89 – 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 GPs who wished to work in a hospital. In theory, there were limits on the number of NHDs 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 *askBMA* 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. The position of all three grades of doctor outlined above is subject to change following the negotiations between the staff and associate specialists committee of the BMA and NHS Employers due to be completed in the spring of 2006.

Hospital practitioners

The hospital practitioner grade is available to GPs who wish to work in hospitals for up to five NHDs 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 manpower 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

Consultants are 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. NHS trusts are required to appoint a medical director to their board. 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.

The GMC has produced guidance for doctors as managers entitled *Management in health care: the role of doctors*. This guidance available on the GMC website (May 1999) is valid until superseded by the revised guidance due for issue in 2006. However, an early conclusion of the Review Group was that the guidance should apply to all doctors not just to those with formal management responsibilities.

The NICC clinical and medical directors 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. The subcommittee will be working on guidance on remuneration drawing on this survey. Meanwhile, 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.

Guidance on superannuation for clinical and medical directors can be found on page 44.

Clinical directorates

At the time of going to press, publication of revised guidance for clinical directors is being prepared by the NICC's clinical and medical directors subcommittee. It is intended that this guidance will give more details on the areas summarised below and cover the appointment process, contract, remuneration and job description. The guidance will be sent to all clinical directors in the UK, and will also be available from *askBMA* and on the website on the consultant pages.

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 74 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 2004 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 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.

Medical directors

At the time of going to press, publication of revised guidance for medical directors is being prepared by the NICC's clinical and medical directors subcommittee. It is intended that this guidance will give more details on the areas summarised below. The guidance will be sent to all medical directors in the UK, and will also be available from *askBMA* and on the website on the consultants' pages.

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.

Information

- CCSC Guidance for Developing the Role of Medical Directors (1997)
- CCSC Guidance for Developing the Role of Clinical Directors (1996)
- CCSC Model Contract for Medical Directors
- HSS (TC8)2/86 - Payment of Clinicians as Unit Medical Representatives
- The Roles and Responsibilities of the Clinical Director (BAMM 2003)

NHS structure

Introduction

The NHS has come under substantial review in recent years and many new initiatives have profoundly changed the health service framework and the ways in which services are provided in the UK. The NHS plan (2000) and The NHS improvement plan (2004) set out the current government's structured and prioritised plan for investment and reform, intending 'to give the people of Britain a health service fit for the 21st Century: a health service designed around the patient.' The government's health policy is hence focused on delivering a service that it hopes will be both local and participatory. This service is perpetually being reviewed but currently consists of the following components.

HSC/Board/Trust organisations

The Department of Health Social Services and Public Safety (DHSSPS). The DHSSPS is responsible for formulating health and social care policy across Northern Ireland. 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, DHSSPS social care and public health.

NHS Modernisation Agency

The NHS Modernisation Agency was created in April 2001 'to support the NHS and its partner organisations in the task of modernising services and improving experiences and outcomes for patients'. It worked with SHAs to develop health capacity and improvement locally and includes the NHS Leadership Centre. Following the government's Arms Length Bodies Review in 2004, the Modernisation Agency closed in April 2005 and was replaced by the NHS Institute for Learning, Skills and Innovation, which also took on the responsibilities of the NHS University.

NHS Employers

In October 2004, responsibility for employment issues (including the Modernisation Agency's work on pay modernisation) was devolved from the DoH to a separate Employers' Organisation, overseen by the NHS Confederation. The Employers' Organisation is responsible for pay negotiations, wider human resources issues 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. NHS Employers is also responsible for NHS Careers which provides information on careers in the NHS in England (www.nhscareers.nhs.uk).

NHS Estates

An executive agency of the DoH, it provides advice, information and guidance on estates and facilities management. It sets national standards for the stewardship of the NHS estate and among its key work areas is the Clean Hospitals Programme.

HSC/Board/Trust

Health and Personal Social Services in Northern Ireland are provided as an integrated service.

Monitoring the health and personal social services is the duty of the four Health and Social Service councils – one for each board area. The councils advise the public about services. They also advise on how services might be improved.

There are currently four Boards:

- Eastern Health and Social Services Board
- Northern Health and Social Services Board
- Southern Health and Social Services Board
- Western Health and Social Services Board

Boards coordinate the provision of healthcare locally on behalf of the DHSSPS. 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.

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

Trusts

5 Trusts have been established across Northern Ireland, they are responsible for meeting the needs of local communities by running primary and community services and commissioning secondary care. 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.

A number of Trusts 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. Current health policy is based around the government's belief that primary care professionals are best placed to identify local and individual health needs. As of 2004, Trusts hence control 75 per cent of the total DHSSPS budget. The government is proposing further devolution of purchasing decision making to GP practices with the introduction of practice based commissioning

Other Agencies Include:

- Blood Transfusion Service
- Central Services Agency
- CREST
- Eastern Health and Social Services Council
- Health Promotion Agency
- Hospice Review Northern Ireland
- NI Social Care Council
- NI Guardian ad Litem Agency
- Northern Health & Social Services Council
- Regional Multiprofessional Audit Group
- Southern Health & Social Services Council
- Transplant NI

The regulatory framework

The current system of regulation is carried out by the Registration and Inspection Units within the four Health & Social Services Boards in relation to residential and nursing home care and by eleven HSS Trusts in relation to under 12's services. This makes it more difficult to set and enforce standards in a consistent and independent manner here. It is proposed therefore to extend regulation of social care services to include a wider range of services and to establish a Northern Ireland Commission for Care Services to carry out the regulation of the current and extended range of services.

It is proposed to extend and improve the regulation of services to cover: statutory homes, homes covered by Charters and Acts of Parliament, small residential homes for adults, day

care for adults, supported accommodation, nursing agencies, schools with boarding departments, the private and voluntary healthcare sector and agencies providing:

- domiciliary care;
- fostering;
- adoption;
- services for children under 12, and
- nursing home care

Northern Ireland Commission for Care Services

To discharge this more comprehensive regulation of services it is proposed that Northern Ireland Commission for Care Services be established. The Northern Ireland Commission for Care Services would carry out the regulation of the current and extended range of services and would mirror the National Care Standards Commission established for England and Wales.

The National Care Standards Commission (NCSC) is a new independent Regulatory body for social care services and private and voluntary health care. The NCSC will be responsible for the regulation of the whole range of care services from care homes for the elderly, children's homes, domiciliary care, fostering and adoption agencies through to private hospitals and clinics. The Secretary of State for England and the National Assembly for Wales have powers to make regulations governing the conduct of services regulated and to issue minimum national standards applicable to all the services to which the registration authorities and providers must have regard. The NCSC will ensure all regulated care services are provided to national minimum standards laid down by the Secretary of State in England and the National Assembly for Wales, through regulation and inspection. It will investigate complaints against registered services and report to the Secretary of State (or National Assembly for Wales) on the range and quality of regulated services. The NCSC will encourage improvement in the quality of services (through e.g. disseminating examples of good practice and giving advice to providers on how to meet the national minimum standards) and make information available to the public about the quality of services. This might include information about the location and types of services available, as well as the results of its inspections of individual providers. The NCSC will advise the Secretary of State or provide information about any aspect of the provision of services and about changes to the national minimum standards with a view to seeking improvement in the quality of services.

Functions of the Northern Ireland Commission for Care Services (NICCS)

The Northern Ireland Commission for Care Services (NICCS) would be established as an independent non-departmental public body. The functions of the NICCS would be to:

- take over responsibility for the work currently carried out by the Registration & Inspection Units within the four HSS Boards;
- register and inspect a wider range of care services;
- investigate complaints against registered services;
- where necessary take appropriate enforcement action to ensure standards are improved;
- serve improvement notices, prosecute and where necessary de-register services;
- regulate the private and voluntary healthcare sector;
- monitor and enforce the adherence to the Codes of Practice for employers as laid down by the Northern Ireland Social Care Council, and
- work in collaboration with other bodies including the Health and Social Services Improvement Authority and the Mental Health Commission on issues pertaining to that area of work.

National Institute for Clinical Excellence

The National Institute for Clinical Excellence (NICE) is a special health authority established in April 1999 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).

The Clinical Resource Efficiency Support Team (CREST)

Established in 1988 under the auspices of the DHSSPS Medical Advisory Structure, is responsible for promoting clinical efficiency in the Health Service in Northern Ireland, while ensuring the highest possible standard of clinical practice is maintained. CREST considers standards and guidelines emanating from NICE and other standard setting bodies.

Health and hospital records

Health records

From 1 March 2000 throughout the UK the rights of access by living individuals to their health records are as set out in the Data Protection Act 1998, and the Regulations made under that Act.

Subject to a number of exemptions, the Act gives patients a right of access to all computerised and manual records which contain information about their physical or mental health or condition. Access is available to all records whenever they were made, and unlike previous legislation, there are no date restrictions. Records should be communicated to patients in an intelligible form, accompanied where necessary by an explanation of any terms which are unintelligible. Patients are entitled to explanations for the courses of treatment that have been prescribed for them, and are entitled to take various actions where they believe data in records is inaccurate. However, the right of access is not absolute, and, for example, if the information is likely to cause serious harm to the patient or another person, or identifies another person (who is not a health professional involved in the care of the patient), access may be denied to those parts of the record.

The BMA supports the GMC's advice that doctors must keep 'clear, accurate and contemporaneous patient records which report the relevant clinical findings, the decision made, the information given to patients and any drugs or other treatment prescribed'. Records should be legible and factual, and personal views about a patient's behaviour or temperament should not be included unless these have a potential bearing on treatment.

Doctors should ensure that their manner of keeping records facilitates access by the patient if requested. They should discuss uncertainties of diagnosis or prognosis with the patient at the time of recording information and note such discussions in the record. 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

Statutory rights of access to the records of deceased patients are contained within the Access to Health Records Act 1990. Any person with a claim arising from the death of a patient has a right of access to information covered by the Act and directly relevant to that claim.

Access to patient records under the Access to Health Records Act 1990 applies only to records that came into existence on, or after, 1 November 1991. Access to information recorded before this date may only be given where this is necessary to make any later part of the records intelligible.

In circumstances where there is no claim, nobody can claim a legal right of access to information about a deceased patient, although doctors may consider disclosure to be justifiable based on the particular circumstances and knowledge of the patient's wishes.

As with the Data Protection Act 1998 certain exemptions apply – for example, if the information is likely to cause serious harm to someone, or identifies another person (who is not a health professional involved in the care of the patient), access may be denied to those parts of the record. Further information can be found in the BMA's guidance Access to health records by patients.

Medical reports

Under the Access to Medical Reports Act 1988 individuals have a right to see medical reports written about them, for employment or insurance purposes, by a doctor who they usually see in a 'normal' doctor/patient capacity. This right can be exercised either before or after that report is sent. (A patient who chooses not to see the report before it is sent may apply for a copy of the report within six months of it having been supplied.) The individual patient/client then has the right to signal any disagreement with matters of fact recorded in that report, and to append their disagreement to the report, or to withhold the report wholly, effectively by withdrawing consent to the release of information.

Further information can be found in the BMA guidance [Access to Medical Reports Act](#).

Information

- [Access to Health Records by patients](#), BMA, 2002
- [Access to Medical Reports Act](#), BMA, 1995
- [Medical Ethics Today](#): the BMA's handbook of ethics and law (2nd ed) (2004)
- Data Protection Act 1998
- Good Medical Practice, General Medical Council, May 2001.
- [Medical information and insurance](#): Joint guidelines from the British Medical Association and the Association of British Insurers, BMA, December 2002.

Caldicott guardians - do not apply to Northern Ireland

In the absence of this the doctor must follow the guidance from the GMC.

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
- 'Report of the Review of Patient-Identifiable Information' (Department of Health, December 1997)
- The Caldicott Committee: Report on the review of patient identifiable information (Department of Health, December 1997)

Hospital records

Different parts of the NHS have traditionally used different systems of recording information. As a consequence, the national Hospital Episode Statistics project was established to tackle this problem.

Under the project all information is collected centrally and disseminated. In December 2001 the Security and Confidentiality Advisory group of the DoH issued a Fair Collection Notice to all consultants that informed them of the type of information concerning them which the DoH held and how it was intended to be used. The notice was sent to all chief executives and medical directors with a request for them to share it with all consultants in the trust. The CCSC is aware of concerns that not all consultants saw the notice. If a consultant did not see the notice, they are advised to contact their medical director.

The Security and Confidentiality Advisory Group came under pressure to release some of the information that was held, for example the consultant codes (the system which allowed reference to be made to the work of individual consultants without actually identifying them). The Group's legal advice was not to release any data as consultants had been properly informed of this intention. However, the enactment of the Freedom of Information Act in January 2005 changed the position with regard to data collection and dissemination. The CCSC has been informed that the DoH is moving towards the public release of data and that it is intending to agree a protocol on how this will take place.

Many consultants have concerns about the accuracy of the hospital data. The DoH has responded to this by encouraging consultants to liaise with their local information adviser if their information is incorrect. The Consultant Enquiry System, developed in conjunction with the NHS Information Authority, is designed to provide 2003-2004 data to consultants when they request it. In addition, medical directors will have access to information relating to all consultants in their trust. Consultants will need to be linked to an NHS net to access it and it is intended that the data would be available for a limited period only.

Information

- HES for Clinicians, currently being drafted by the Department of Health
- The statistics pages of the Department of Health website include a link to Hospital Episode Statistics: www.dh.gov.uk/PublicationsAndStatistics/Statistics

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 DoH, 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' (e.g. 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, January 2006](#)
- [The UK Government's Official website for the Act](#)
- [Information regarding the implementation of the Act by NHS bodies](#)
- [The Information Commissioner's Office](#)
- [The full text of the Freedom of Information Act 2000](#)

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 crafts. 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 crafts 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

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 DoH 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 of the BMA. 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. Senior hospital doctors are represented on council by three representatives elected on a national basis, seven elected on a regional basis and the chairman of CCSC. The council is elected biennially by postal ballot of the membership of the BMA. Council delegates its authority to five major craft 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 craft committees.

BMA advice and support

Each of the BMA craft 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 askbma@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 crafts 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

- BMA Membership Services and Benefits Guide: Your BMA
- [Articles of the Association and Byelaws of the BMA \(2004\)](#)

The Joint Consultants Committee (JCC)

The JCC was set up in 1948, by the royal colleges and the BMA, as a committee able to speak for the consultant body with one voice. The JCC represents the medical profession in discussions with the DoH on matters relating to the maintenance of standards of professional knowledge and skill in the hospital service and the encouragement of education and research. Members include the presidents of the royal colleges and their faculties and representatives of the BMA's CCSC, the staff and associate specialists committee and the junior doctors committee.

Information

- The Joint Consultants Committee: Modus Operandi and Terms of Reference

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

CCST Certificate of Completion of Specialist Training

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

DDRБ Doctors' and Dentists' Review Body

DHSSPS(NI) Department of Health Social Services and Public Services (Northern Ireland)

DoH 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 and Service Care
HSE Health and Safety Executive
HSG Health Service Guideline
HPSS Health and Personal Social Services
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