

Contents

Employment of consultants	
2003 amendment to the national consultant contract in Wales	
Other terms and conditions of service (TCS)	
Job planning	
European Working Time Directive (EWTD)	
Redundancy	
Pensions	
Commitment and clinical excellence awards (CEAs)	
Private and independent practice	
Consultant appointments procedures	
Disciplinary procedures for hospital and community medical and hospital dental staff	
NHS complaints procedure	
Appraisal	
General Medical Council (GMC)	
Health	
Workforce planning	
Clinical academics	
The clinical team	
Clinicians in management	
NHS structure	
Health and hospital records	
The British Medical Association (BMA)	
Appendix A: The pre-2003 national consultant contract	
Acronyms	
Index	

This handbook applies to consultants working in Wales only.

BMA advisers

The BMA is dedicated to supporting its members in virtually all aspects of their professional lives. For all your employment advice and information, please call BMA advisers on 0300 123 123 3 between 8.30am and 6.00pm, Monday to Friday except UK-wide bank holidays, or email your query to support@bma.org.uk anytime.

Members should always call BMA advisers in the first instance. Your enquiry will be dealt with efficiently by our resident team of employment experts, with most queries being answered directly over the phone or by return email.

If, after contacting BMA advisers, it is found that you need direct representation locally, you will be referred to a member of our regional services team. BMA advisers.

- 0300 123 123 3
- support@bma.org.uk

To help us help you, please remember to keep your BMA membership and contact details up to date

Employment of consultants

Health Boards (HB)

The vast majority of consultants working in the NHS in Wales are employed directly by Local Health Boards (known as Health Boards). Each Health Board is entitled to determine its own contracts and terms of service for its employees, including consultants. However, very few NHS employers have deviated significantly from national agreements. On 1 December 2003 an amendment to the existing consultant contract was agreed with the Welsh Government. All consultants in Wales transferred to the new contract terms from this date and all new consultants are appointed on these amended terms.

NHS Trusts

There are three remaining NHS Trusts in Wales, ie Velindre NHS Trust, Public Health Wales NHS Trust and the Welsh Ambulance NHS Trust.

Local and national negotiations

National (England and Wales) NHS terms and conditions of service are negotiated through the Joint Negotiating Committee for senior hospital doctors (JNC(S)). The committee normally meets twice a year to discuss and negotiate issues surrounding changes and/or additions to the national contracts. It includes representatives from the BMA, the DH, NHS Employers and Welsh Government. In November 2004 NHS Employers assumed responsibility for negotiations on behalf of health service employers in England. In Wales changes to the amended Welsh consultant contract are negotiated by the Joint Welsh Consultants Contract Committee; which includes representatives from the Welsh Government, NHS Wales and BMA Cymru Wales.

Because of the autonomy of Health Boards/NHS Trusts, the BMA has worked hard to ensure that medical staff have appropriate local negotiating machinery in Health Boards/NHS Trusts to complement the national structures. The role of these local negotiating committees (LNCs) is to ensure that existing 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. There is a BMA accredited LNC in each Health Board consisting of employed doctors elected by their colleagues to negotiate with HB management. Where LNCs have been set up according to BMA guidelines they are formally accredited by the Association. This means that they receive advice and support from BMA staff, and their members receive training in negotiating skills and are protected by trade union law in undertaking their responsibilities.

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

Consultant contracts

The following sections of the handbook deal with contracts and terms and conditions of service for NHS employed consultants.

The consultant contract in Wales now differs from the contracts in England, Scotland and Northern Ireland. Information on the other nations' contracts is available in their own handbooks. There are, however, some terms of service, which are common to all of the nations' contracts and are set out in the sections on Appraisal, the General Medical Council, Clinical academics, the clinical team and the NHS structure.

2003 amendment to the national consultant contract in Wales

Since 1 December 2003 all consultants in Wales have been employed under the amendment to the national consultant contract in Wales. Consultants working as clinical directors, medical directors, or directors of public health are also covered by this amended contract.

The basic work commitment

The contract for consultants in Wales is based on a full-time work commitment of 10 sessions per week, each having a timetabled value of three to four hours each. After discussions with Health Board management, it was agreed that these sessions would be programmed in appropriate blocks of time to average a 37.5 hour week. Each consultant must have a job plan that sets out the number of agreed sessions the consultant will undertake, plus a list of the duties he or she is expected to perform within those sessions.

The consultant contract in Wales provides a clear maximum commitment to the NHS, including work done while on call. Depending on the scheduling of work, this could mean a basic commitment of 37.5 hours, with no requirement to work in excess of this. Any additional work above 10 sessions will be by agreement and paid at the full appropriate rate.

The working week

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

Direct clinical care (DCC): work directly relating to the prevention, diagnosis or treatment of illness that forms part of the services provided by the employing organisation under section 3(1) or section 5(1)(b) of the National Health Service Act 1977. This includes emergency duties (including emergency work carried out during or arising from on call), operating sessions including pre-operative and post-operative care, ward rounds, outpatient activities, clinical diagnostic work, other patient treatment, public health duties, multidisciplinary meetings about direct patient care and administration directly related to the above (including but not limited to referrals and notes).

Supporting professional activities (SPA): activities that underpin DCC. This may include participation in training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.

Additional NHS responsibilities: special responsibilities (not undertaken by the generality of consultants in the employing organisation) which are agreed between a consultant and the employing organisation and which cannot be absorbed within the time that would normally be set aside for supporting professional activities. These include being a medical director, director of public health, clinical director or lead clinician, or acting as a Caldicott guardian, clinical audit lead, clinical governance lead, undergraduate dean, postgraduate dean, clinical tutor or regional education adviser. This is not an exhaustive list.

External duties: duties not included in any of the three foregoing definitions and not included within the definition of fee-paying services or private professional services, but undertaken as part of the job plan by agreement between the consultant and employing organisation. These might include trade union duties, undertaking inspections for Health Inspectorate Wales, acting as an external member of an Advisory Appointments Committee, undertaking assessments for the National Clinical Assessment Service, reasonable quantities of work for the royal colleges in the interests of the wider NHS, reasonable quantities of work for the Welsh Government, 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 sessions for each of the different types of activities above. It will also set out the duties the consultant is expected to perform within those sessions. See the job planning section on pages 43-8 for more information on job plans.

Information

> [BMA, Job planning guidance, December 2003](#) > [NHS Wales, Consultants job planning guide, December 2003](#)

Balance of activities

The contract sets out that in a 10 sessions job plan there will typically be an average of seven sessions for direct clinical care (DCC) and three sessions for supporting professional activities (SPA). There is flexibility to agree a different balance of activities. For example, if a consultant has additional NHS responsibilities to carry out, such as being a clinical governance lead, they may reduce their DCC activities to fit this additional work into a 10 session job. Alternatively, they may agree to undertake extra sessions 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 DCCs and SPAs for part-time consultants:

Information

- > Amendment to the National Consultant Contract in Wales 2003, paragraphs 2.20 and 2.21
- > Amendment to the National Consultant Contract in Wales 2003, paragraphs 10.5-13

Emergency on-call work

The job plan should set out a consultant's duties and responsibilities in respect of emergency on-call work.

All emergency work that takes place at regular and predictable times (eg post-take ward rounds) will be programmed into the working week on a prospective basis and count towards a consultant's sessions. Less predictable emergency work will be handled through on-call arrangements.

The first three hours of work done during on-call periods per week – averaged over a six month period – unless specifically agreed otherwise will attract one direct clinical care session of time within the working week. Where this averages less than three hours, this will attract the appropriate proportion of a session of time.

Most consultants participating in the on-call rota will also receive the out-of-hours intensity banding supplement. The rates are issued by the Welsh Government and can be accessed here:

<http://www.wales.nhs.uk/workingforhswales/payandconditionsresources>

Consultants should complete the out-of-hours banding questionnaire to determine the intensity of the rota they are working.

Resident on call

In exceptional circumstances where the consultant is requested and agrees to be immediately present, ie 'resident on call', this will be remunerated at three times the sessional payment at point 6 of the consultant salary scale, excluding commitment awards and clinical excellence awards. In such circumstances, there will be an agreed compensatory rest period the following day.

For these purposes, a session will comprise four hours and apply between 5pm and 9am weekdays and across weekends.

Information

- > Amendment to the National Consultant Contract in Wales 2003, paragraphs 3.1-15

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.

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

Consultants will not undertake private practice which prevents them being available to the NHS when on call.

A consultant with a low likelihood of recall may undertake appropriate private practice when on call for the NHS, with prior agreement of their NHS employer that this will not affect their availability for NHS commitments. There will be exceptional circumstances in which consultants may reasonably provide emergency or essential continuing treatment for an existing private patient during NHS time on the basis of clinical need. Consultants will make alternative arrangements to provide cover where work of this kind impacts on NHS commitments.

Information

- > Amendment to the National Consultant Contract in Wales 2003, paragraph 9.9

Unrecognised additional work

Where it is identified, through the job planning process, that a consultant is undertaking a session or more a week of additional or pro rata for part-time work on a regular basis, in excess of their contracted hours, and not arising at the request of the employer, then the employer can request that such work be continued as additional sessions for the relevant period of time in excess of the contracted sessions or discontinued as required.

These additional sessions will be voluntary, and can be ended at the request of either the consultant or the employer, with reasonable notice. They may be undertaken during the working week in uncontracted time within an agreed overall annual total.

Where a consultant agrees to work extra sessions, these are payable at a rate of 10 per cent of basic pay (plain time rate), plus any commitment awards or national clinical excellence award (England and Wales).

After 24 months (from the introduction of the new contract) such sessions will be paid at a premium rate of 1.25 times the plain time rate, and subsequently at a higher premium rate of 1.5 after 48 months.

Information

- > [Amendment to the National Consultant Contract in Wales 2003, paragraphs 2.27-31](#)
- > [Amendment to the National Consultant Contract in Wales 2003, paragraph 5.11](#)

Planned additional sessions

Consultants may be requested by their employer to carry out additional sessions from time to time in excess of their contracted sessions. These additional sessions will be voluntary. They may be undertaken during the working week in uncontracted time within an agreed overall total. Remuneration for such work will be locally negotiated between the employer and the consultant.

Information

- > [Amendment to the National Consultant Contract in Wales 2003, paragraphs 2.32-5](#)

Location of work

It is generally expected that sessions will be undertaken at the principal place of work, which must be set out in the consultant's individual contract. Sessions of supporting professional activities, mutually agreed at the job planning review, may be scheduled across the week such that up to one session of contractual commitment may take place outside the normal working hours leaving a similar period free in which there is no contractual commitment during normal working hours.

Travelling time

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

Information

- > [Amendment to the National Consultant Contract in Wales 2003, paragraph 2.13](#)

Starting salary and pay progression

Consultants in Wales are remunerated according to an incremental pay scale. Above the minimum point, consultants will automatically progress through six pay points.

When a consultant is first appointed to the grade, the starting salary shall be determined in accordance with paragraphs 121 to 126 of the Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service (England and Wales) Terms and Conditions of Service September 2002 (as amended).

Where a consultant with less than two years' equivalent service is first appointed to the grade, employers shall have discretion to fix the starting salary at either of the two next incremental points above the minimum by reason of equivalent service of any of the following – service in HM Forces, or in a developing country, age, special experience and qualifications.

Previous regular service as an NHS consultant is counted in full for incremental purposes. In addition:

- where a regular NHS appointment in the consultant grade has been held, subsequent service as a locum consultant counts towards incremental credit as though it had been regular service in the consultant grade
- locum service, not preceded by a regular appointment, counts towards incremental credit at the rate of half that given for a regular appointment, but only where the locum appointment has been for three months or more continuously in an NHS hospital.

Under the amendment to the consultant contract in Wales, there will, in addition, be eight commitment awards occurring at three-yearly intervals for all consultants, awarded automatically on satisfactory job plan review or in the absence of an unsatisfactory job plan review.

Information

- > [Amendment to the National Consultant Contract in Wales 2003, chapter 4](#)

Fee-paying work

Fee-paying work including category 2 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 contract is that consultants should not be paid twice for the work they do. A consultant undertaking fee-paying work can keep the fee due if they are doing the work in their own time, ie not in NHS sessions, or if they 'time-shift' so that their NHS work is unaffected, or if the work is, by agreement, only minimally disruptive to NHS activities. In all other circumstances the consultant should remit the fee to the employer.

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

Relationship between private work, NHS work and fee-paying work

The amendment to the consultant contract in Wales clarifies the relationship between NHS work, private work and fee-paying work in that it sets out that a NHS consultant's first responsibility is to the NHS. Participation in private medical services or fee-paying services should not result in detriment to NHS patients or services or diminish the public resources available for the NHS. Essentially, consultants should not schedule private work or fee-paying work at the same time as NHS activities, unless there has been a prior agreement with the NHS employer.

Information

> [Amendment to the National Consultant Contract in Wales 2003, chapter 9](#)

> [BMA, Interface between NHS and private treatment: Guidance from the medical ethics department, February 2004](#)

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 the Welsh Government's annual pay circulars. Eligibility for each band depends upon the population served by the post and the weight of the post.

Additional responsibilities

It is recognised that some consultants have additional responsibilities agreed with their employer which cannot be reasonably be absorbed within the time available for supporting activities. These will be substituted for other work or remunerated separately by agreement between the employer and the consultant. Such responsibilities could include:

- Caldicott guardians
- clinical audit leads
- clinical governance leads
- undergraduate and postgraduate deans, clinical tutors, regional education adviser
- regular teaching and research commitments over and above the norm, and not otherwise remunerated
- professional representational roles.

Responsibilities of medical directors, clinical directors and lead clinicians will be reflected by substitution or additional remuneration agreed locally.

Information

> [Amendment to the National Consultant Contract in Wales 2003, paragraphs 2.40-1](#)

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 becomes available, as all consultant appointments are subject to the statutory consultant appointment procedures.

Whole-time consultant locums are paid on a weekly basis or per session. Locum consultants are generally paid at the monetary mid-point of the consultant pay scale. 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. The locum rates are clarified in the annual pay circulars issued by the Welsh Government.

Job planning

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

Job planning appeals

Where it is not possible to agree a job plan, either initially or at annual review, the matter will be referred to the medical director (or an appropriate person if the medical director is one of the parties to the initial discussion). Following the initial disagreement the meeting with the medical director or appropriate person must take place within two weeks.

If resolution of the dispute fails, then the formal resolution process of arbitration will be arranged.

In exceptional circumstances when any outstanding issue cannot be resolved informally, the medical director will consult with the chief executive prior to confirming in writing to the consultant and their clinical director (or equivalent) that this is the case. The formal resolution process of arbitration will be arranged.

The membership of the arbitration panel will be maintained by the two Welsh Government/BMA members ('the Guardians') nominated by the Joint Welsh Consultants Contract Committee.

The Guardians will randomly choose two arbitrators, one BMA appeals panel member and one service appeals panel member not previously connected with the dispute, and will confirm which arbitrator will act as chair for practical organisational purposes.

The employer will ask both parties to sign the arbitration agreement.

Both parties will exchange their written submissions/statements of case, including any documentation they may wish to refer to during the meeting, at least 14 days beforehand.

At the meeting each party will make an opening statement that draws attention to the main points of their respective cases, and which may include comments on the other party's written submission. The arbitrators may discuss the issues with the parties. The parties will be offered the chance to make a final statement to the arbitrators.

The arbitrators may announce the decision at the hearing, and will confirm their decision, in writing, to both parties usually within two weeks of the hearing.

If the arbitrators are unable to come to a decision, they will advise both parties and the Guardians in writing within two weeks of the hearing. A second arbitration panel may be convened.

Information

> [The Welsh Consultants Contract – Job planning appeals, December 2004](#)

Other terms and conditions of service (TCS)

Salaries

The Doctors and Dentists Review Body (DDRB) reports at the beginning of each year to the First Minister and the Minister for Health and Social Services (and to the relevant ministers in England, Northern Ireland and Scotland). 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 UK health departments, employers' organisations 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 November. Evidence from Wales is currently submitted as part of the evidence provided by the BMA UK-wide.

The DDRB recommends salary increases for consultants and other doctors and recommends the value of commitment awards, distinction awards, intensity payments, waiting list initiative payments and CEAs. The Assembly Government will then make a decision on the DDRB recommendations and when the increases are implemented they are issued in the form of a pay circular from the Welsh Government and incorporated into the national Terms and Conditions of Service.

Information

> [Advance Letter \(MD\) \(W\) 2/2006 – annually updated](#)

References are made throughout this section to paragraphs in the General Whitley Council (GWC) handbook. With the introduction of the Agenda for Change pay arrangements 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, although it has remained unamended since 2002. It may be replaced by updated terms and conditions for doctors in the future.

Expenses and allowances

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. 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.

Health Boards/NHS Trusts may also have their own schemes. Consultants should contact their employer's human resources department or LNC representative for further information.

Consultants interested in crown cars should be aware that the scheme will be economically advantageous only to some individuals, depending on variables such as annual private and business mileage, size of car and the tax position. They are therefore advised to proceed with caution and should seek advice from BMA advisers and/or their accountant. A BMA guidance note is available at www.bma.org.uk

Mileage allowances for consultants not offered lease cars

Consultants not offered lease cars, who are required to use their own car on NHS business, are entitled to allowances at the standard rate unless they are classified as regular users. Standard and regular user mileage rates vary according to engine capacity.

The mileage rate paid to regular users is lower than the standard rate but regular users are also paid a lump sum in equal monthly instalments regardless of the mileage covered.

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 traveling in the course of NHS business (this time to include the duties performed during the visits)
- are classified as 'essential users' because they fulfil the following criteria:
 - i) travel on average at least 1,250 miles (other than normal travel)
- between home or private practice premises and principal hospital) each year; and

- ii) have ultimate clinical responsibility, or on-call responsibility normally controlled by a rota system, for the diagnosis and treatment of patients in hospital with emergency conditions which require them to be immediately available for recall; and
- iii) are expected to be recalled to hospital in an emergency at an average rate of twice or more during a working week, the rate of emergency call out being averaged over the year but excluding periods of leave.

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

Mileage allowances for consultants who refuse a lease or crown car

Special provisions apply to those who refuse a lease or crown car.

Public transport rate

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

Official journeys

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

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

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

Travelling time

In calculating the amount of time spent on NHS work for their job plans, all consultants should include the time spent travelling between hospitals or NHS sites. This should also include 'excess travel' where the consultant travels to a site other than their normal place of work. Where this is further than they would normally travel to work the excess mileage and time may be claimed. Travelling time to and from the base hospital while on call should also be counted.

Information

- > [BMA Guidance Note: NHS official travel](#) > [BMA Guidance Note Supplement: Current mileage rates](#) > [Amendment to the National Consultant Contract in Wales, paragraph 2.13](#)
- > [Terms and Conditions of Service, paragraphs 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 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 for the Health Board 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. BMA advisers can give general advice and guidance to members on eligibility for removal expenses.

Information

- > [General Whitley Council, section 26](#)
- > [BMA Guidance Note: Removal and associated expenses for NHS medical staff](#)
- > [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 and/or subsequent outgoing NHS business calls. Where there is no clear Health Board agreement on mobile phones the issue should be raised with the LNC to produce clear guidance for consultants.

Information

- > [HC\(PC\) \(79\)3 Provision of telephones for medical and dental staff](#)

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 Health Boards/NHS Trusts have introduced their own schemes. In any event, consultants are advised to check their entitlement before incurring expenditure.

Information

- > [GWC Conditions of Service, section 22](#)
- > [Terms and Conditions of Service, paragraphs 275-6 and 311](#)

Annual leave

Consultants are entitled to six weeks' and three days annual leave per year, with each leave year commencing at their incremental date or its anniversary for those at the top of their scale. It should be noted that this entitlement, as specified in contracts following nationally agreed terms and conditions of service, is not affected by the provisions of the European Working Time Directive (EWTD), which refers to a minimum statutory entitlement of four weeks per year.

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

Information

- > Letter from Mrs Sheelagh Lloyd Jones, HR Director Welsh Government
- > Terms and Conditions of Service, paragraphs 205, 209, 211-3 and 215
- > GWC Conditions of Service, section 1
- > EC Working Time Regulations, 1998

Public holidays

Consultants are entitled to 10 or more usually 11 paid statutory and public holidays each year. These consist of eight public or bank holidays, plus two additional statutory days' paid holiday as determined by the employer. The two statutory days may be converted to three annual leave days, over and above the six-week entitlement, after agreement between the employer and local staff representatives. This has occurred in the majority of Health Boards/NHS Trusts in Wales. Consultants who are required to be on call on a public holiday will be granted time off in lieu.

Information

- > Terms and Conditions of Service, paragraph 214
- > GWC Conditions of Service, section 2

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.

The TCS make no distinction between professional leave and study leave, using the terms interchangeably. It is important to note, however, that the terms are discrete. The DH has clearly stated that professional leave is an allowance based on an individual's need, and has encouraged employers to release consultants for a range of duties which are necessary for the broader benefit of the NHS, but which involve consultants being away from their employment base, citing the examples of advising the DH, participating in college duties or examining. Under the amendment to the national consultant contract in Wales, such duties can be recognised as additional responsibilities or other external duties.

The day-to-day administration of study leave rests with the employing Health Board, and there are considerable variations between Health Boards/NHS 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. Terms and conditions clearly state that if study leave is granted, reasonable costs must be reimbursed. LNCs may have agreed alternative arrangements by negotiation, so it is worth checking the situation in your Health Board.

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 noneducational, including financial, grounds
- the DH has said that it is unreasonable for employers to pre-determine the level of expenses which they are prepared to approve in connection with study leave applications
- study leave should not be used for inappropriate purposes, for example attending advisory appointments committees.

Where study leave claims are turned down or expenses not paid, consultants have a number of options open to them, including pursuing the issue of non-payment of expenses to the county court. Additionally, cases may be pursued as a formal grievance in accordance with the local grievance procedure. In any event, consultants are advised to contact BMA advisers 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, paragraphs 250-4](#)

> [Amendment to the National Consultant Contract in Wales, paragraphs 2.40-6](#)

> [HM \(67\)27, Professional and Study Leave for Medical and Dental Staff in the Hospital Service > HM \(68\)50, Hospital Medical and Dental Staff and Headquarters Medical Staff of Regional Hospital Boards.](#)

> [HC \(79\)10, Hospital Medical and Dental Staff: Study Leave](#)

> [EL \(95\)53 Covering letter from NHSE Director of Human Resources \(reference to professional leave\)](#)

> [EL \(91\)92, Postgraduate and Continuing Medical and Dental Education](#)

> [EL \(96\)51, Postgraduate and Continuing Medical and Dental Education](#)

Sick leave

This is an area about which Health Boards/NHS 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, paragraphs 225-44](#)

> [GWC Conditions of Service, sections 1, 57 and 61](#)

> [HC \(83\)8, Introduction of statutory sick pay](#)

Income during sick leave

The allowance paid by the employer during absence on sick leave must not result in consultants receiving more than their normal salary for the period. In practice, many employers pay the consultant as normal and make separate arrangements to claim back the statutory sick pay from HM Revenue & Customs (HMRC), 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 BMA advisers. Disputes are dealt with by local HMRC offices (www.hmrc.gov.uk).

Private practice during sick leave

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

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 doctors with medical problems

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

Clinical academics

See section on clinical academics 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.

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, 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.

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), 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, paragraphs 260 and 262](#)
- > [GWC Conditions of Service, sections 3, 12, and 38](#)
- > [ACAS Code of Practice 3, Time off for Trade Union Duties and Activities](#)
- > [Trade Union and Labour Relations \(Consolidation\) Act 1992, sections 168-73](#)

Sabbatical leave

The amendment to the national consultant contract in Wales introduced the right for consultants during their career in Wales to seek a paid sabbatical for up to three months. The purpose of the sabbatical is to undertake activities away from normal duties that will subsequently benefit patient care. The need for a sabbatical should arise from a job plan review/appraisal and is subject to the agreement of the employer. A reasonable level of financial support will be granted during the sabbatical, and appropriate locum cover provided. The procedure for applying for a sabbatical should be determined locally with the LNC.

Information

- > [Amendment to the National Consultant Contract in Wales, paragraphs 14.1-9](#)

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 GWC conditions of service, consultants can take advantage of more beneficial occupational arrangements. Entitlements under both the statutory and GWC schemes depend on certain qualifying conditions, and the application of, and interrelationship between the schemes, is a complicated area.

Under the GWC 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 11th week before the expected week of

childbirth to qualify for maternity leave and pay. Notice of intention to return to work must normally 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 NHS employer for a period of three months may result in liability to repay some or all of the maternity pay.

Maternity leave with pay under the current GWC scheme consists of 39 weeks' pay made up of eight weeks at full pay (less any statutory maternity pay or maternity allowance, including any dependants' allowances receivable); 18 weeks' half pay (plus any SMP or MA, including any dependants' allowances receivable providing the total does not exceed full pay) and 13 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 52 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 BMA advisers for advice about their entitlements at the earliest opportunity.

See section on clinical academics for information about clinical academic staff.

Information

- > [General Whitley Council, Section 6](#)
- > [AL \(MD\) \(W\) 1/2006](#)
- > [AL \(GC\) \(W\) 1/2003](#)
- > [Maternity and Parental Leave Regulations 1999](#)

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 UK CC 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 UK CC 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, paragraph 106](#)

Medical indemnity

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

NHS indemnity scheme covers:

- work under NHS contracts including in non-NHS locations, eg independent sector treatment centres
- family planning work in hospitals
- hospital doctor locum work, whether through a locum agency or directly with the employer
- domiciliary visits. The NHS indemnity scheme does not necessarily cover:
- private practice work
- category 2 work, ie report for a third party where a fee may be charged
- 'good Samaritan' work, such as assisting at a traffic accident
- costs in GMC proceedings

- inter-hospital transfer
- work for a third party other than an employing authority

Consultants should ensure in **each case** that the work is covered either by NHS indemnity or by another employer or by their defence body, taking out additional cover if necessary.

Further information is in the BMA membership guidance note on NHS medical indemnity, available from BMA advisers or at www.bma.org.uk

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

In 1995 the National Health Service Litigation Authority was set up with the principal task of administering schemes to help NHS bodies pool the costs of any 'loss of or damage to property and liabilities to third parties for loss, damage or injury arising out of the carrying out of [their] functions'. The Clinical Negligence Scheme for Trusts (CNST) is one scheme via which member Health Boards/NHS Trusts pay an annual contribution related to their size, the nature of their clinical work and in due course, the level of their claims. In Wales, the Welsh Risk Pool undertakes this function. The vast majority of Health Boards/NHS 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 Health Boards/NHS Trusts which may bear significantly on clinical practice.

Both the BMA and the DH advise that it is essential that all consultants retain some form of personal indemnity insurance to cover any non-NHS work as well as NHS indemnity cover. Consultants should consult the defence bodies to determine the degree of cover required and the schemes available.

Information

- > [HSG \(96\)48 NHS indemnity – arrangements for handling clinical negligence claims against NHS staff](#)
- > [EL \(95\)40 Clinical negligence scheme for Trusts](#)
- > [BMA Membership Guidance Note: NHS indemnity](#)
- > [The National Health Service Litigation Authority – Framework Document](#)

Grievance procedures

Since 6 April 2009 employers have been required to follow the ACAS Code of Guidance on Disciplinary and 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. Nor should it be used when there is failure to agree a job plan. The grievance procedure should be designed to provide a speedy resolution of the grievance as close as possible to the source and regard should be given to good industrial relations practice. The procedures should provide for the reference of grievances to a person or body other than the employer, when both parties agree that this is appropriate.

Information

- > [HSG \(91\)28 Settling individual employee grievances in respect of NHS conditions of service](#)
- > [ACAS Code of Guidance on Disciplinary and Grievance Procedures \(4th Edition 2009\) \[www.acas.gov.uk\]\(http://www.acas.gov.uk\)](#)

Disputes procedures

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

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

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

Information

> GWC Conditions of Service, section 42

Termination of employment

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

Information

> Terms and Conditions of Service, paragraph 196

Local contractual variations

Although Health Boards/NHS Trusts have, since being established, had the power to offer amended or entirely different contracts, most Health Boards/NHS Trusts have not introduced significant change. Nearly all existing contracts refer to the national terms and conditions and all Health Boards/NHS Trusts are now meant to employ new consultants only under the 2003 amendment to the national consultant contract in Wales. In the past, however, some Health Boards/NHS Trusts have introduced flexibility by stating that the national terms and conditions will apply until such time as the Health Board introduces its own terms and conditions. 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 BMA advisers. It is strongly recommended that all new consultants ensure that the contract offered to them complies with the national contract. The best way of doing this is to send your contract to BMA Regional Services prior to agreeing it.

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 future.

Job planning

A job plan is a detailed description of the duties and responsibilities of a consultant and of the supporting resources available to carry them out. Job planning has been a responsibility for all consultants in the NHS since 1991, but the 2003 amended consultant contract in Wales 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.

BMA Cymru Wales has produced guidance on this issue for members *Job planning guidance – Wales* and it is available

via BMA advisers and the BMA website at www.bma.org.uk

The purpose of job planning

The job planning process should be a prospective agreement that sets out a consultant's duties, responsibilities and expected outcomes for the coming year. It should be based on a partnership approach to enable consultants and employers to:

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

Job planning can therefore be of great benefit and the WCC encourages all consultants to prepare for and participate actively in job planning on an annual basis, especially since pay progression via commitment awards will be informed by this process.

The process of job planning

The TCS are clear that the job plan is agreed between the consultant and the employer. The job planning meeting will normally take place between the individual consultant and their clinical manager (who will usually be the clinical or medical director).

There will be circumstances where generic issues relating to the job plan can be resolved at departmental or specialty level and there is scope for collective agreement on this with the employer via the LNC.

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
- what work is actually undertaken at the current time (this may well be different from the existing job plan)
- how the work that is currently undertaken fits into the contract's categories of work (eg what is direct clinical care, what is supporting professional activity)
- what the consultant would like to see changed in the job 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. The Health Boards/NHS Trusts' grievance procedure is not appropriate in these circumstances.

Format of job plans

There is no agreed national model of a job plan but the guidance document *Job planning guidance – Wales* contains further information on drawing up a job plan.

Job plan context

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

- a timetable of activities including duties such as out-patient clinics, ward rounds, operating procedures, investigative work, administration, teaching, audit, management commitments, emergency visits
- a summary of the total number of direct clinical care sessions and supporting professional activity sessions in the timetable
- the on-call arrangements
- a description of additional responsibilities to the wider NHS and profession (including external duties)
- any arrangements for unrecognised additional work or planned additional sessions
- any agreed arrangements for carrying out regular fee-paying services
- a list of any agreed outcomes (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.

Outcomes

Outcomes are a contractual expectation for consultants under the amended 2003 contract.

Outcomes could relate to activity and safe practice, clinical outcomes, clinical standards, local service requirements, management of resources or quality of care. They may flow from discussions and agreement at the annual appraisal. Consultants will need to make every reasonable effort to meet these outcomes to achieve pay progression and so they must be appropriate, identified and, most importantly, agreed between the consultant and employer. It is not reasonable to set outcomes where there are significant influencing factors outside the consultant's control, eg waiting list targets. Consultants have no obligation to sign up to outcomes that are unreasonable.

Information

> [Terms and Conditions of Service 2003, Amendment, Job Planning Guide, section 5](#)

Fee-paying work

The TCS and the amended 2003 contract in Wales operate on the general principle that consultants are entitled to receive fees for work done in their own time, but should not receive extra fees for work done during contracted time, ie not be paid twice for the same work. However, there is scope for consultants to retain fees for work done during contracted time 'where it is agreed the work involves minimal disruption to contracted NHS time'. Alternatively, consultants can ensure that their NHS work is made up at another time – effectively time shifting their work. Another option is to negotiate that the work is part of the working week and through the job planning process, negotiate an allocation in terms of sessional time.

Information

> [Terms and Conditions of Service 2003, Amendment, chapter 9](#)

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 outcomes. It is therefore essential that the required resources are identified when job plans are agreed. Pay progression cannot be withheld if consultants have not met outcomes for reasons beyond their control.

Information

> [Terms and Conditions of Service 2003, Amendment, Job Planning Guide, section 6](#)

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 outcomes, 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 amended 2003 contract.

Information

> [Terms and Conditions of Service 2003, Amendment, chapter 1, paragraphs 1.30-3](#)

Disputes over job plans

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

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 BMA advisers:

- 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.

NB: This guidance has been produced for England only and the contractual arrangements are different in some respects in Wales. However, the guidance does provide useful information.

Information

> [Terms and Conditions of Service 2003, Amendment, chapter 1, paragraphs 1.34-9](#)

European Working Time Directive (EWTD)

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

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

The key aspects of the directive for consultants are:

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

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

Information

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

Compensatory rest

The Directive allows employers to exclude the provisions in relation to length of night work, daily rest, weekly rest and rest breaks if compensatory rest is provided. This means that where rest is delayed or interrupted by work, compensatory rest must be granted. However, there is flexibility about how and when compensatory rest is calculated.

The entitlement to compensatory rest will be granted by the employer 'wherever possible' (Regulation 24, Working Time Regulations 1998).

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

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

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

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

Example local agreement on compensatory rest

The collective national agreement for senior hospital doctors, implementing the Working Time Regulations (1998), provides that

where prescribed rest periods have been significantly interrupted, the doctor should take compensatory rest. This is not counted as annual leave. It is good practice for such compensatory rest to be taken immediately after the end of the working

period. A doctor may commence work at a later time on the day following a significant interruption to rest, after notifying the responsible manager where work was to be performed. This provision is important for the maintenance of patient safety and shall not be taken as amending the doctor's rights under the Working Time Regulations. Any consultant having to take compensatory leave should ensure that colleagues are forewarned in order that appropriate cover arrangements can be arranged if necessary.

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

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

Non-NHS work

With the changing nature of the NHS and increased plurality of provision, increasing numbers of consultants are working in a self

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

Redundancy

Introduction

It has been rare for medical staff to be made redundant, although this situation could change, as 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.

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

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

Alternative employment

Once an employer has identified staff to be made redundant the employer is required to take all reasonable steps to find alternative employment for those staff. In reality this is not always easy. However, where 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 have a right of appeal if they are made redundant. Consultants should be able to use appropriate Health Board appeal machinery ensuring that the appeal is heard by individuals not previously involved in the redundancy selection. There may in addition be recourse to an employment tribunal if the process has not been handled fairly.

The transfer of undertakings regulations

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

Redundancy payments

The new Age Discrimination Act came into effect in October 2006. This legislation generally outlaws any discrimination on age grounds in all employment sectors, unless a particular practice is covered by an exemption or can be objectively justified.

This has affected the redundancy payment scheme for NHS employees. The key difference between the old and new arrangements is a move from redundancy payment entitlement based on age and if over 50 years of age added years pension enhancement towards redundancy payment entitlement based on one month per year of complete service. An age related entitlement is retained with the provision for an employee aged 50 or over to opt to take early retirement on grounds of redundancy without actuarial reduction pension as an alternative to receiving a redundancy payment. Transition arrangements have also been agreed for existing staff.

The changes include:

- employees with at least two years' continuous employment will receive one month's pay per year of service
- maximum of 24 years or two years' pay
- the right for staff, over the minimum pension age, to opt to take early retirement on grounds of redundancy without actuarial reduction in their pension, as an alternative to redundancy payment.

Transition for existing staff

There will be a five-year transition period. The first phase of transition was from 1 October 2006 to 30 June 2007. Staff over 50 were able to access redundancy retirement based on their maximum pensionable service that would have been available on 30 September 2006, but with the final salary calculated on their pay up to the date of redundancy. This was also extended to staff who reach 50 after 30 September 2006.

The second phase of transition is from 1 July 2007 to 30 September 2011. As well as freezing enhancement, a further reduction to be implemented on those entitled to more than five years' enhancement on 30 September 2006, so that all enhancements are removed by 30 September 2011.

The total effect of these two transition phases means that after each year of the transition the maximum enhancement will have reduced by two years until no enhancement is available after 1 October 2011.

Staff under 50 who are made redundant or are not members of the pension scheme would receive payment based on the new redundancy arrangements – new staff would receive payment based on the new redundancy arrangements – existing staff in the NHS pension scheme would have the choice to take the transitional protection or take the new redundancy arrangements.

The old scheme

Previous NHS redundancy arrangements provided for the age of the member and length of service to determine the benefit they receive as follows:

- under age 22 years – half a week's pay for each complete year of service
- 22 to 41 years of age – 1 week's pay for each complete year of service
- 41 to 49 years of age – 2 weeks' pay plus extra 2 weeks' pay per year for up to 8 years after age 41
- over 50 years of age – members of NHS pension scheme could, depending on age and service, receive early retirement with service enhancement of up to 10 years plus redundancy pay although this is reduced if the member is entitled to receive more than 6 2/3 added years
- over 64 – redundancy pay is reduced by 1/12th per month until aged 65
- over 65 – no entitlement.

The new scheme

The most significant increase in entitlement under the new arrangements is the introduction of one month's pay for each year of complete service up to a maximum of 24 years reckonable service. This results in potential increases in maximum redundancy pay from 30 weeks to 104 weeks for the over 50s and from 66 weeks to 104 weeks for the under 50s.

The most significant reduction in entitlement in comparing old with new is the removal for the over 50s of the pension enhancement provisions and the value of taking without cost to the employee of an unreduced early pension.

Members and local negotiating committees can find further guidance on redundancy at www.bma.org.uk

Information

- > [BMA Guidance, New NHS redundancy arrangements](#)
- > [ACAS Advisory Booklet, Redundancy handling, July 2004 \(printed version\), December 2004 \(web version \[acas.org.uk\]\(http://acas.org.uk\)\)](#)
- > [Department for Trade and Industry, Redundancy entitlement – statutory rights: a guide for employees \(PL808\) \(\[www.dti.gov.uk/er/redundancy.htm\]\(http://www.dti.gov.uk/er/redundancy.htm\)\)](#)

Pensions

Occupational pension schemes

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

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

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

Contribution rates

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

Pensionable income

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

Income which is not pensionable in the NHS scheme

This includes private income, category 2 and 3 work, sessions beyond whole-time. Additional income from management posts is covered below under 'Clinical and medical directors'. It may be possible to pension this income in a personal pension scheme, and financial advice should be strongly considered.

Earnings cap

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

Pension

The amended NHSPS pension is calculated in the following way:

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

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

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

Scaled service

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

Information

> [BMA Pensions Factsheet: Salaried doctors](#) > [BMA Pensions website, www.bma.org.uk/pensions](http://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.

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

Protection against inflation: index linking

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

Purchasing extra benefits

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

Unreduced lump sum

This is explained above.

Added years

Since 1 April 2008 this facility has been withdrawn. Existing contracts to purchase additional years of service will be honoured and those consultants making maximum added years purchases are still able to purchase the new Additional Pension Purchase facility, introduced on 1 April 2008 to replace added years. The added years facility enabled doctors to purchase additional years of service, and thereby receive an extra indexed pension and an extra tax free lump sum, calculated in the same way as the basic amended NHSPS pension and lump sum. Added years also include important insurance cover, as the added years are usually credited in full in the event of ill-health retirement or death in service.

Additional Pension Purchase

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

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

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

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

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

This is an important reason why FSAVCs are most unlikely to provide better value than AVCs.

Information

> [BMA Pensions Factsheet: Improving benefits](#)

Retirement age

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

Early retirement

There are a number of early retirement options available:

Ill-health retirement

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

Information

> [BMA Pensions Factsheet: 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.

Voluntary early retirement

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

Information

> [BMA Pensions Factsheet: 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.

Information

> [BMA Pensions Factsheet: 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 sessions beyond full time, these will not be pensionable. If the substantive contract is part time (fewer than 9 sessions), then the extra sessions will be pensionable up to 10 sessions. The medical/clinical director sessions will also be pensionable if they simply replace pensionable clinical sessions. If the contract provides for extra salary to take account of medical/clinical director responsibilities, but the doctor remains full time, then the medical/clinical director income is pensionable.

The amended NHSPS pension and lump sum are based on pensionable income paid in the best of the last three years before retirement (see above). In negotiating a medical/clinical director contract, consultants should keep in mind that substantial pension benefits can accrue if medical/clinical director income is pensioned within three years of retirement, but that the contributions will have been wasted if this income finishes more than three years before retirement.

See also Clinicians in management.

Information

> [BMA Pensions Factsheet: Salaried doctors](#)

Working in the NHS after retirement

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

Personal pension plans (PPPs)

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

Injury benefits

The NHS injury benefits scheme provides benefits to any consultant who suffers a loss of earning ability due to an injury, illness or disease resulting from NHS duties. The maximum benefit, together with any NHS pension and state benefit which is payable, is 85 per cent of pay. In addition, it may be possible to make a claim for damages against the employer (see page 129). If this is successful there may be a consequent reduction in the NHS injury benefit payable. The scheme is currently under review.

Information

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

Further advice

NHS Pensions (www.nhs.gov.uk) can provide estimates of benefits in advance of retirement and answer enquiries about the NHSPS (the address and phone number are in all BMA pension factsheets). Consultants can also access the pension pages in the BMA members' area of the BMA website. Guidance can also be obtained from the website, BMA advisers or the BMA Pensions Department at BMA House.

Commitment and clinical excellence awards (CEAs)

Introduction

In Wales, with the introduction of the amended contract in December 2003, the existing discretionary points and distinction awards were replaced by new commitment and clinical excellence awards schemes.

The new award schemes are transparent, fair, based on clear evidence, open and accessible to all consultants. They better reward those consultants who continue to contribute effectively to service delivery and patient care on a sustained basis, and those who contribute most to the NHS, recognising their contribution to innovation and modernising the service.

The award schemes support the practical application of skills and knowledge (including teaching and research) for the benefit of patients and are related to a satisfactory appraisal and job plan review. The awards are reviewed regularly, to ensure a fair distribution between academic and non-academic award holders and to recognise innovation and modernisation.

The scheme comprises a regular progression of commitment awards available to all consultants throughout their career, once they have reached the top of their incremental scale, who have demonstrated their commitment to the service by satisfactory job plan reviews or by the absence of unsatisfactory job plan reviews. In addition, a number of clinical excellence awards are available to those consultants who have made outstanding contributions to the development of the service and/or the greatest level of achievement in research and/or teaching whether locally, nationally, UK-wide or internationally.

Transition to the new commitment and clinical excellence award schemes

Any consultant in receipt of discretionary points prior to the introduction of the amended contract on 1 December 2003 (the due date) had these automatically converted into the equivalent number of commitment awards from that date. Any such awards count towards the maximum number of eight such awards under the scheme.

Any consultant aged 57 or over at the due date (1 December 2003) automatically received their first new commitment award upon reaching the maximum of the consultant salary scale and at three-yearly intervals thereafter. This is subject to the consultant only being able to receive a maximum number of eight such awards, including any commitment awards arising from the conversion of discretionary points.

Any consultant aged between 51 and 56 at the due date (1 December 2003) automatically received their first commitment award one year after reaching the maximum of the consultant salary scale and at three-yearly intervals thereafter. This is subject to the consultant only being able to receive a maximum number of eight such awards, including any commitment awards arising from the conversion of discretionary points.

Any consultant aged between 43 and 50 at the due date (1 December 2003) automatically received their first commitment award two years after reaching the maximum of the consultant salary scale and at three-yearly intervals thereafter. Again this is subject to the consultant only being able to receive a maximum number of eight such awards, including any commitment awards arising from the conversion of discretionary points.

Basis of awards – commitment awards

All consultants will be eligible for a commitment award once they have completed three years' service, after reaching the maximum point on the consultant pay scale. Then they will be eligible at three yearly intervals, after they received their previous commitment award, until they have achieved the *eight* commitment awards levels available under the scheme.

The appropriate commitment award will be paid automatically in the absence of an unsatisfactory annual job plan review over the required period and it is anticipated that the overwhelming majority of consultants will achieve commitment awards on a regular basis. The aim is to help consultants achieve satisfactory outcomes for the benefit of the service. Therefore, any potential obstacles to achieving satisfactory outcomes must be raised and discussed between the consultant and their employer as soon as these become apparent, and not be delayed until the next planned review. This is to enable any remedial action to be taken and to avoid an unsatisfactory job plan review wherever possible.

In the rare event of an unsatisfactory job plan review, the employer will give details of the reasons for such a result, in writing, record whatever remedial action is agreed, and give a defined timetable for its completion. If such agreement is not reached there will be recourse to the appeals process.

An interim job plan review will be arranged no longer than six months following the unsatisfactory job plan review. If the consultant has remedied the situation, a satisfactory job plan review will be recorded as usual. If the interim job plan review is also unsatisfactory, the consultant will receive a formal letter outlining the reasons for deferring their commitment award for the period of one year, this deferment will also be subject to a right of appeal as agreed. Deferment may continue in subsequent years if agreed corrective action has not been completed at the next scheduled job plan review.

Each level of commitment award is worth an amount per annum which is permanent and superannuable.

Clinical excellence awards

In August 2003, the DH published a framework for the CEA scheme to replace the previous distinction awards and discretionary point schemes. The new CEAs were awarded for the first time with effect from April 2004.

Transition to the new scheme

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

Values of awards

The values of the awards are reviewed each year by the DDRB and can be found on the BMA website.
www.bma.org.uk/

Basis of awards – clinical excellence awards

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

- demonstrate sustained commitment to patient care and wellbeing or improving public health
- sustain high standards of both technical and clinical aspects of service while providing patient-focused care
- in their day-to-day practice demonstrate a sustained commitment to the values and goals of the NHS by participating actively in annual job planning, observing the private practice code of conduct and showing a commitment to achieving agreed service objectives
- through active participation in clinical governance contribute to continuous improvement in service organisation and delivery
- embrace the principles of evidence-based practice
- contribute to knowledge base through research and participate actively in research governance
- are recognised as excellent teachers and/or trainers and/or managers
- contribute to policy-making and planning in health and healthcare
- make an outstanding contribution to professional leadership.

Structure of the scheme

The higher value national awards (9-12), or bronze, silver, gold and platinum as they are more commonly known, will be decided by the Advisory Committee on Clinical Excellence Awards (ACCEA) and its subcommittees. All awards under the new scheme are determined according to a common rationale and objectives. The eligibility and assessment criteria for all awards are set nationally and standard nomination forms for all levels of award can be accessed from the Howis website (www.wales.nhs.uk/accea).

Eligibility

Those eligible for a clinical excellence award are:

Consultants who hold a medical or dental qualification, who are fully registered, and who are employed by organisations such as the following:

- Health Boards/NHS Trusts
- local health boards
- The National Assembly for Wales (where the consultant retains NHS terms and conditions of service)
- universities
- medical and dental schools
- other bodies, which are approved from time to time as proper employers of consultants for the purposes of the NHS eg the Wales Centre for Health
- academic general practitioners holding substantive contracts of employment as clinical academics at or above senior lecturer level (or equivalent) with a higher education institute and/or the Medical

Research Council and considered by the employer to be undertaking duties and responsibilities commensurate with consultant clinical academic staff, will be eligible for awards, provided that they:

- are registered GPs
- work at least half-time as an academic GP
- are practising clinicians providing some direct NHS services; and undertake at least six sessions on NHS work, or the equivalent of at least 21 hours per week, beneficial to the NHS including teaching and clinical research.

For honorary contract holders eligibility for awards will be based on the contribution made to the NHS defined in wider terms than direct care to patients. The entitlement to full eligibility for an award is based on four direct clinical care sessions and two supporting professional activity sessions (see paragraph 8.6 of the amendment to the consultant contract).

For whole-time clinical teachers and research workers with less than the above contribution there are special provisions regarding the proportion of award payable.

Eligible consultants who are subsequently employed as deans in medicine and dentistry are fully eligible on the basis of their work in such posts.

Eligible consultants working as clinical or medical directors of Health Boards/NHS Trusts retain their eligibility for clinical excellence awards, account being taken of their clinical work and of their contribution over and above their expected duties whether or not they are remunerated as a clinical or medical director. Consultants spending time almost exclusively in medical management will be considered for awards. However, to ensure that they continue to be eligible for appropriate revalidation by the GMC, clinical consultants in medical management posts should undertake some clinical practice.

Eligibility for an award is dependent upon the participation in an annual appraisal interview/exercise unless failure to do so is not the responsibility of the consultant. Employers will be expected to confirm that a satisfactory appraisal has been undertaken within the 12 months leading up to the nomination. Employers will also be expected to confirm that the consultant's job plan and contractual obligations have been fulfilled and that the consultant has complied with the private practice principles reflected in the amended consultant contract. Unless these points are confirmed a consultant will not be eligible for an award.

Consultants employed on Trust contracts

Consultants in Health Boards/NHS Trusts are eligible for clinical excellence awards whether they remain subject to nationally determined terms and conditions of service or to terms agreed between them and the individual Health Board.

Clinical academics

Clinical academic staff are eligible for, subject to satisfactory job plan reviews, CEAs and commitment awards in line with the provisions that apply for consultants. The awards will be paid on a pro rata basis to part-time staff.

Who is not eligible?

Consultants employed in the following categories are not eligible for clinical excellence awards:

- locum consultants
- consultants employed in general management positions, such as chief executives or general managers and who do not undertake clinical work as a consultant under a separate clinical contract.

How to apply

All eligible consultants can self-nominate for CEAs using the ACCEA advice and the relevant forms which are available on the website along with details of the timetable for the national award round. 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. 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.

Applications must be submitted electronically. The original signed, countersigned (by the employer) and dated copy must be retained locally.

Values of awards

The values of the awards can be found at: www.dh.gov.uk

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

National awards will be made by the national ACCEA which will rely heavily upon advice received by its regional subcommittees.

Assessment of awards

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

Area 1: Delivering a high-quality service

Evidence of outstanding commitment to achieving NHS service priorities and objectives including flexibility in adapting to changing priorities and demands. Evidence of practical application of high standards in the technical and clinical aspects of their service.

The provision of patient-centred care, valued by patients and colleagues alike (or, in the case of public health, population-based service valued by stakeholders and colleagues alike).

Area 2: Developing a high-quality service

Evidence of active participation in clinical governance, leading to a major role in the continuous improvement and innovation in the organisation and delivery of services.

Evidence of outstanding commitment to evidence-based practice, which is taken forward appropriately for the benefit of patients through clinical audit and/or other evaluative tools.

Evidence of notable additions to the knowledge base of the NHS through research and discovery.

Evidence of a strong commitment to patient safety, learning from error and promoting safer systems and clinical/research processes. Evidence of commitment to the development of effective multidisciplinary team working.

Area 3: Managing a high-quality service

Evidence of excellent contributions to policy-making and planning in health and healthcare, either at a local or national level.

Evidence of excellent achievements in change management.

Evidence of managing a patient-centred service.

Area 4: Research, education and training

Evidence of excellent achievements in research and development.

Evidence of active participation in research governance.

Evidence of excellent performance as an educator or trainer.

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

Appeals against the process

Any consultant nominated for an award may seek a review of the process within which their nomination has been considered.

Appeals must be received at the ACCEA secretariat by 31 December in the year that the awards are published.

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 a short-term problem as the cause
- removal of the award or substitution of a lower award where the performance no longer merits the higher award with payment at the higher level continuing on a mark-time basis (ie the value of the higher award remains static while the lower award catches up through annual pay uplifts)
- in very extreme circumstances, removal of award and removal of payment.

Awards made by the ACCEA and its subcommittees will be reviewed by the committee which made the award.

Where disciplinary or professional proceedings have upheld concerns or allegations about the consultant's conduct or performance, an employer can request a review. Employers will be expected to notify the ACCEA if an award holder is subject to disciplinary or professional fitness to practise proceedings.

Retirement of award holders

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

Openness and transparency

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

- there is a fair distribution of awards between specialties
- there is a fair distribution of awards geographically
- there is a fair distribution of awards between types of hospital groups, such as female consultants and consultants from minority ethnic groups, who have in the past received disproportionately small numbers of awards, are being fully and fairly considered.

Private and independent practice

Introduction

This chapter sets out the position relating to private practice under national terms and conditions of service, the amendment to the national consultant contract in Wales and other national agreements.

Definition of private practice

Private practice is defined for consultants and other hospital doctors in the national 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.

Principles of private practice

As part of the negotiations on the consultant contract in Wales in 2003 the following principles were agreed.

Any consultant undertaking private practice must demonstrate that they are fulfilling their NHS commitments.

There must be no conflict of interest between NHS work and private work. The needs of patients in the NHS will not be prejudiced by the provision of services to private patients. Work outside NHS commitments will not adversely affect NHS work, nor in any way hinder or conflict with the needs of NHS employers and employees. NHS facilities, staff and services may only be used for private practice with the agreement of the NHS employer.

Disclosure of information

Consultants will inform their employers of any conflicts between their NHS commitments and their private practice and work with their employer using the job planning process to resolve any such conflicts.

This process will be undertaken at least annually or more frequently if changes for either the consultant or employer warrant job plan review.

The consultant will be required to inform their chief executive of any issues arising from their private practice which might significantly affect their ability to fulfil their NHS commitments as soon as possible.

Schedule of work

Consultants will not undertake private practice which prevents them being available to the NHS when on call.

A consultant with a low likelihood of recall may undertake appropriate private practice when on call for the NHS, with the prior agreement of their NHS employer that this will not affect their availability for NHS commitments. There will be exceptional circumstances in which consultants may reasonably provide emergency or essential continuing treatment for an existing private patient during arrangements to provide cover where work of this kind impacts on NHS commitments.

The consultants will ensure that there will be clear arrangements to avoid the risk of private commitments disrupting NHS commitments, eg by causing NHS activities to begin late, or to be cancelled.

If NHS sessions are to be disrupted the consultant should rearrange the private sessions. Agreed NHS commitments will take precedence over private work. The job planning process will determine when NHS sessions are to be scheduled. Where there is an agreed change to the scheduling of NHS work, the employer will be required to allow a reasonable period for consultants to rearrange any existing private sessions.

The transfer of patients between the NHS and private sector

When a patient is seen privately and it is agreed they will subsequently be transferred to a NHS waiting list, the patient will be entered on the list at the same point as if they had been seen under NHS arrangements. The arrangements for this are covered by the guidance set out in *Management of private practice in health service hospitals in England and Wales* (the 'Green Book').

Where an NHS patient seeks information about availability, or waiting times, for NHS and/or private services, practitioners should ensure that any information provided by them is accurate, to the best of the practitioner's knowledge and belief.

Use of NHS facilities and staff

Consultants may not use NHS facilities or staff for the provision of private services without the approval of the appropriate NHS body.

Consultants may use NHS facilities for the provision of fee-paying services, as set out in Appendix A, either in their own time, in annual or unpaid leave, or with the agreement of the NHS employer in NHS time where work involves minimal disruption.

Information

> [Private practice amendment to the National Consultant Contract in Wales, chapter 9](#)

Definition of private practice income

Consultants may receive fees and payments in addition to their NHS salaries, merit awards or commitment awards which are quite separate from the 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. These are:

- fees for category 2 work, for example medico-legal work, insurance reports
- fees for family planning services arranged by the employer
- fees for domiciliary visits
- fees for exceptional consultations in hospital managed by a different employer
- fees for lectures to hospital staff
- 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
- fees under the collaborative arrangements.

Fee-paying work including category 2 (such as for Government departments and additional work for NHS organisations) should not attract double payment. However, it may be carried out with the professional fee retained by consultants in the following circumstances, which will be agreed in the job plan review:

When carried out in the consultants' uncontracted time or in annual or unpaid leave.

Where it is agreed the work involves minimal disruption to contracted NHS time. This may be particularly relevant in circumstances such as the undertaking of the occasional post-mortem examination for the Coroner's office. This will be considered as part of the job plan review.

Where such work constitutes a significant element of time, consultants will identify this in the job planning process, and identify 37.5 hours of time provided to the NHS apart from this work.

If none of the above circumstances apply and the work is carried out within the NHS sessions with no compensatory time provided elsewhere, the professional fee is remitted to the employer. Otherwise provision as set out in the terms and conditions, paragraphs 30 to 39.

Domiciliary visits as defined in section 140 of the terms and conditions, and family planning fees will attract a fee when undertaken outside NHS sessions.

Where it is agreed there is minimal disruption in undertaking this work during contractual time, the practitioner will retain the fee.

Information

> [Terms and Conditions of Service, paragraphs 30-9](#)

Private practice in the NHS

Access to private beds

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

NHS charges for private practice

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

Involvement of other specialties

When patients are admitted privately, the primary consultant should explain to the patient that the professional services of an anaesthetist and the opinion of a pathologist or radiologist may also be required and that fees will be payable for these services.

It is essential that colleagues in the diagnostic specialties are properly involved in the treatment of private patients, so that a personal service may be expected.

Problems have arisen in the past over the practice of arranging the investigations of private patients through the NHS rather than privately. This practice developed for the historical reason that, until the contract changed in 1979, most pathologists and radiologists held whole-time contracts and therefore were not entitled to undertake any private practice. However, the guidance set out in the DH's Green Book (see page 80) helped to clarify the position where the general rule is that private patients should remain private throughout the whole treatment episode, although they do have the right to change their status between an NHS and private patient at any stage of their treatment.

Junior staff

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

Non-consultant medical staff

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

Information

- > [Section 65 of the NHS Act 1977 \(as amended\) – Authorised Accommodation for Private Patients](#)
- > [Section 63 of the NHS Act 1977 – Amenity Beds](#)
- > [Section 23 of the NHS and Community Care Act 1990](#)
- > [Management of Private Practice in Health Service Hospitals in England and Wales, 1986](#)
- > [Health and Medicines Act 1988](#)
- > [HC \(89\)9 Determination of charges for private patients and overseas visitors](#)
- > [Private practice and junior doctors, BMA Junior Doctors Committee, June 1999](#)

The Green Book

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

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

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. A private patient officer should be appointed at hospitals where private patients are treated, and, if consultants require advice on the procedure to be adopted, then this officer should be contacted.

Information

- > [Management of Private Practice in Health Service Hospitals in England and Wales, 1986](#)

Private prescriptions in the NHS

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

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

In cases where a private prescription has been issued, both an employer and a doctor can charge the NHS patient a separate fee, the employer for the cost of the drug prescribed and the doctor for the issuing of the prescription. The Health and Medicines Act 1988 provides for NHS employers to set their own charges for private prescriptions on what they consider to be the appropriate commercial basis.

The writing and issuing of a private prescription to any patient by a doctor does not form a written undertaking that the patient has become a private patient. A doctor cannot write an NHS prescription for a private patient unless it is for a separate condition than that for which the patient was admitted.

Information

- > [CCSC, Private prescriptions in the NHS and prescribing responsibility, June 2000](#)
- > [CCSC Secretariat, Letter, 18 February 2000 from N Cullen, NHSE, to J Woodcock](#)
- > [CCSC Secretariat, Letter, 22 September 1999 from V Jones, NHSE, to J Woodcock](#)
- > [Health and Medicines Act 1988](#)

Health Boards/NHS Trusts contracts with third parties

Health Boards/NHS 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.

Information

- > [Terms and Conditions of Service, paragraph 31](#)
- > [Health and Medicines Act 1988, section 7](#)
- > [Management of Private Practice in Health Service Hospitals in England and Wales](#)

Medical indemnity

Consultants should note that the NHS indemnity scheme (see pages 38-40) does not cover private work, either in the NHS or in private hospitals, although different arrangements apply to category 3 work. Consultants should ensure that they have appropriate indemnity with a medical defence body to cover them for private practice.

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

Private patients

It is important to note that in private practice, a direct contractual relationship exists between the doctor and patient, and not normally the doctor and insurer. While practitioners are, therefore, entitled to treat any patient privately, regardless of whether or not they have obtained specialist recognition for a particular insurance company, they would have an obligation to inform the patient at the outset that their insurer may not reimburse the full costs of treatment.

Consultants should note that health insurance companies have widely differing policies and that patients might not be fully aware of all the restrictions that apply. It is the responsibility of patients to ensure that they have adequate medical insurance to cover the costs of treatment and fees charged by specialists, which will vary from case to case, depending upon the time spent and complexity of individual procedures. Patients are responsible for meeting any shortfall between the fees levied by consultants and the costs reimbursed by their insurer. The BMA encourages consultants to forewarn patients at the earliest opportunity of the likely level of charges for treatment and to ensure that such charges are reasonable and transparent.

Private medical insurance companies: specialist recognition

Private hospitals and provident associations/insurance companies employ the concept of 'specialist recognition' to determine either who may practise from their hospital or who may treat their subscribers. Recognition is usually granted to individuals who hold, or have held, either a substantive consultant post in the NHS or to those who hold a certificate of completion of specialist training (CCST) or certificate of completion of training (CCT).

Insurers and private hospitals have the right to grant discretionary recognition to anyone they see fit to do so. This decision may take account of an individual's clinical abilities, experience, references where appropriate and how they see these factors fitting into their own selection criteria which are often not published.

All substantive NHS consultants should automatically be entitled to specialist recognition by insurers and while a small number of other practitioners may have also obtained recognition, on an individual basis, insurers are becoming increasingly firmer in this criterion's application. Consultants should contact BMA advisers 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 for 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.

NHS 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 NHS care. The combination of the payment by results and patient choice initiatives means that the plurality of NHS care provision will expand further. In England the Government is expanding its independent sector treatment centre (ISTC) programme which began in September 2003.

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 Care Standards Inspectorate Wales 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

> GMC, *Good medical practice*, fourth edition 2006

Fees for private medical work

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

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

Information

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

Fee-paying work

The arrangements under which NHS consultants may carry out fee-paid work, such as reports for insurance companies and medico-legal work are covered on page 87.

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 available from BMA advisers or via the BMA website www.bma.org.uk

Information

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

Medico-legal work

Medico-legal work is perhaps the most complex area of fee-paying work. Consultants are generally approached to provide medical reports in connection with a legal action and/or attend court to give evidence which may involve conferences with counsel or other related work.

Medico-legal work counts as fee-paying work and is distinct from private practice. The fees which may be paid will depend on the status of the witness, ie whether the consultant is a witness to fact, a professional witness, or an expert witness. There is also distinction between criminal and civil proceedings. It is important for consultants asked to undertake medico-legal work to be aware of these distinctions and also to agree in writing in advance the nature of the work to be undertaken, fees for that work (including cancellation fees) and any further commitments that may arise.

Information

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

Consultant appointments procedures

The NHS (Appointment of Consultants) (Wales) Regulations 1996

Consultants carry ultimate clinical responsibility for every patient seen in hospital under their care. The public is therefore entitled to expect that all consultants will have reached the highest standards of skill and knowledge, and this is guaranteed by means of a statutory appointments procedure laid down in regulations for Health Boards/NHS Trusts and local health boards.

The regulations and accompanying good practice guidance as applies to England only were amended most recently in 2004.

The Welsh Government will be issuing the good practice guidance applicable to Wales shortly. This chapter is based on the English guidance as it has been confirmed that the Welsh guidance will mirror this almost exactly.

Planning and advertising a consultant post

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

College and faculty regional advisers must be allowed to comment on the draft job description, and should be allowed to do so at the earliest opportunity. Where there is a disagreement, the matter will be referred to the president of the college. This will not, however, prevent an employer advertising the post.

Where the job involves significant teaching commitments of undergraduates, it is also good practice to forward the job description for comment to the dean of the medical school.

As well as details of the post and proposed job plan, the job description should include the selection criteria that will be applied. Once the job description has been agreed, it cannot be changed, nor challenged by a member of the AAC (other than over a technical error).

The job description, together with selection criteria, should be made available to all applicants. The NHS guidance states that it should form part of a general information package which should include a list of the relevant terms and conditions of service, including pay and any local terms of service.

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

All posts must be advertised (unless a statutory exemption applies. Whole-time posts must also be available to part-timers, and all posts must be open to job sharers.

Appointments to a consultant post in the NHS are governed by a statutory instrument, which specifies the procedure to be followed and the membership of the AAC.

Eligibility for appointment

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

Membership of advisory appointments committees

The employer must constitute an AAC as follows.

Core members:

- a lay member (often the chair of the Health Board or another non-executive director)
- an external professional assessor, appointed after consultation with the relevant college or faculty
- the chief executive of the appointing body (or a board level executive or associate director)

- the medical or dental director of the Health Board (or person who acts in a similar capacity at that hospital) or the relevant director of public health for public health appointments
- a consultant from the Health Board, who, if available, should be from the relevant specialty.

The committee cannot transact any business in the absence of any core member.

Additional members:

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

Release of consultants for AACs

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

Training

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

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

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

Procedure of AACs

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

Applicants may be given the opportunity to visit the Health Board before interview, and such visits are a vital source of information about the hospital and the post. It is increasingly common for Health Boards/NHS Trusts to request candidates during these visits to make formal presentations to medical staff or members of the Health Board. Nonetheless, the NHSE guidance is quite clear that pre-interview visits do not form part of the selection process and must not influence the outcome. Canvassing for support of any application is prohibited.

The procedure adopted by the AAC is a matter for decision by the committee itself, subject to the statutory provisions and current employment legislation. The proceedings are confidential, but records will be retained by the employing body for a minimum of five years in case of discrimination claims in an employment tribunal (see the section on discrimination below). Individual members may also be questioned about their reasons for accepting or rejecting candidates.

The committee's role is to make a recommendation to the Health Board about which, if any, candidates are suitable for appointment. In practice, it is usual to recommend only one name, and the Health Board will have delegated to the AAC the power to offer the post to the chosen candidate, though the appointment will formally be made by the Health Board. NHSE guidance states that 'successful candidates should be formally offered posts in writing within two working days of the decision to appoint'.

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

Information

> [Welsh Health Circular WHC \(2003\)007](#)

Exemptions from the statutory procedure

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

- a consultant, working for the Health Protection Agency, the Defence Medical Services or a university, transferred to an NHS post in which the duties are substantially the same as those performed for the Agency, the Defence Medical Services or the university

- a doctor who has been appointed to a hospice post which is equivalent to an NHS consultant post
- a doctor who has retired as a consultant and returns to work for the same employer and specialty as the one he or she filled prior to retirement.

In some circumstances, eg agreed grade assimilations, or health problems requiring a move to lighter duties, the Secretary of State may approve an exemption from the requirement to advertise a consultant post.

Discrimination and fairness

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

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

Information

- > [The NHS \(Appointment of Consultants\) \(Wales\) \(Amendment\) Regulations 2005 \(Statutory Instrument No 3039\)](#)
- > [Good Practice Guidance \(Revised 2004 England\) NB Under revision in Wales](#)
- > [DGM \(96\)106, The NHS \(Appointment of Consultants\) \(Wales\) Regulations 1996 \(Statutory Instrument No 1313\) attaching Direction to NHS Trusts and Good Practice Guidance \(Annex A\)](#)

Fees and expenses

Applicants

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

Members of AACs

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

Information

- > [Amendment to the National Consultant Contract in Wales 2003, paragraph 313](#) > [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 Health Board for whom the appointment is being made. Alternatively, members of such an AAC who are not employed by the Health Board should seek a written express indemnity from the Health Board covering them for all legal costs and awards arising out of their role on the committee.

Disciplinary procedures for hospital and community medical and hospital dental staff

Health Boards/NHS Trusts in Wales are responsible for establishing their own local disciplinary procedures for medical and dental staff. Since the early 1990s, many Welsh Health Boards/NHS Trusts have developed new procedures, usually in consultation with BMA LNCs. These procedures are often based on those contained in the NHS Wales circular WHC (90)22 which set out the consultants' disciplinary procedures prior to the formation of Health Boards/NHS Trusts. Health Board professional and personal disciplinary procedures should cover the following areas:

- personal misconduct
- consultants' failure to fulfil contractual obligations
- less serious cases of professional misconduct or incompetence – an intermediate procedure
- serious cases of professional misconduct or incompetence
- appeals, including the right to appeal against termination of employment to an independent panel chaired by a legally qualified person from the Lord Chancellor's panel against a Health Board's decision to dismiss in cases of professional misconduct/professional incompetence. Also, the right for a consultant to appeal against a Health Board's decision as to whether a complaint or allegation relates to personal or professional issues.

These procedures are dealt with below.

Personal misconduct

Personal conduct is defined as 'performance or behaviour of practitioners due to factors other than those associated with the exercise of medical or dental skill'. This covers offences such as persistent lateness or absenteeism, rudeness to a colleague or, extreme cases of gross misconduct, theft or violence.

In cases solely involving personal misconduct, the position of a doctor or dentist is no different from that of any other health service staff. Procedures for dealing with allegations of personal misconduct are covered in the general disciplinary procedures of Health Boards/NHS Trusts. These detailed disciplinary procedures covering all staff should provide mechanisms for investigating alleged offences, disciplinary hearings, a series of warnings short of dismissal, dismissal itself and appeals against proposed disciplinary action. Each individual Health Board's procedure should define who has the power to issue warnings or to dismiss. It is important for consultants that only the Health Board itself should have the power to dismiss a consultant.

Consultants who retain a right of appeal against dismissal to the Welsh Government, under paragraph 190 of the hospital medical and dental terms and conditions of service, should be aware that this does not apply in cases of personal misconduct. However, some LNCs have successfully negotiated a local mechanism for appeals so that doctors and dentists who are facing dismissal solely on the grounds of personal misconduct can challenge the reason for dismissal at Health Board level.

Failure to fulfil contractual obligations

Some Health Boards/NHS Trusts in Wales have an agreed mechanism to deal with concerns about a consultant's failure to fulfil contractual responsibilities, known as the 'professional review machinery' under WHC (90)22 Annex D. This machinery is envisaged as an informal procedure operated by the profession for reviewing consultants who are alleged to have repeatedly failed to honour their contractual commitments, and is intended as a means of encouraging early informal action, avoiding the application of more serious procedures. Although to a large extent its function has been superseded by job plan reviews, some Health Boards/NHS Trusts have nevertheless used this mechanism for resolving difficulties in this area.

Intermediate procedure

Health Boards/NHS Trusts should have a procedure to resolve cases of alleged professional misconduct or incompetence where the outcome will fall short of dismissal. Under WHC (90)22 Annex E, such a procedure involves an investigation by external clinical assessors. It should provide a mechanism to deal with problems at an early stage and could be used either for specific disciplinary allegations, for problems arising from differing professional views or for problems arising because of personality conflicts within a department.

Role of the clinical assessors – the medical director is responsible for appointing external assessors. Under the WHC (90)22 procedures and under local Health Board procedures which follow the same principles, these are nominated by the Joint Medical Consultative Council c/o JMCC secretariat at BMA House. The assessors will visit the Health Board, investigate the problem (including interviewing those involved if necessary) and report to the Health Board medical director. They may claim expenses in respect of the visit.

Rights of the consultant – the consultant should be provided with a list of those to be interviewed, given the opportunity to ask for other individuals to be interviewed, provided with copies of written statements and should be able to be accompanied by a friend or medical defence organisation or BMA representative when interviewed.

Assessors report – The assessors are asked to provide a report setting out the findings and facts and making recommendations for action. The consultant should be able to comment on the factual content.

Disciplinary action – The medical director will need to decide what further action is required, which may include periods of retraining, study or mentoring as well as disciplinary warnings. The Health Board may want to set up a panel as a result of the report to decide upon any disciplinary action.

Appeals – The consultant must have the opportunity to appeal. Since these cases involve matters of professional conduct or competence, the appeal panel should include independent medical representation from outside the Health Board.

A serious case of professional misconduct or incompetence

Health Boards/NHS Trusts should have a procedure for handling serious disciplinary matters of a professional nature when the outcome could be dismissal. Under WHC (90)22 Annex B, such a procedure involves a panel enquiry where, because of the potentially serious outcome, evidence is likely to be legally tested. The following steps should be followed by the employer.

Preliminary investigation – The medical director should carry out a preliminary enquiry to establish if there is a prima-facie case which could result in serious disciplinary action. This may involve external assessment of the definition of the behaviour which has been called into question. The doctor should be informed immediately of the nature of the complaint and be given the opportunity to comment on the case before a decision is taken to proceed.

Decision to proceed – If the decision is to proceed, an investigatory panel will need to be set up to conduct the enquiry. If the facts have already been established in a court of law there is no need for an enquiry. The findings of a Government public enquiry may also be sufficient to mean that a further investigation is unnecessary.

Enquiry – The employer should set up a small panel which in most cases will be chaired by a lawyer from the Lord Chancellor's panel. There should also be independent professional input. The Joint Medical Consultative Council is used as a source of advice for choosing professional members where Health Board procedures adhere to WHC (90)22 Annex B or there is a similar local Health Board procedure. The hearing should be held in private and takes the form of a formal examination of the witnesses, with legal representation usually being provided by the medical defence organisation.

Panel report – The panel report should be in two parts; the factual part and the part containing the panel's views on whether the doctor was at fault. The second part may also contain recommendations for disciplinary actions. The doctor should have the opportunity to comment on the factual content of the report.

Health Board board's decisions – The Health Board should be responsible for determining any disciplinary action. The consultant should be informed of the recommendations and be given the opportunity to offer any mitigation.

Time limits – The Health Board should have time limits in operation for each stage of the case. Under WHC (90)22 such a procedure should be completed within 32 weeks.

Appeals – There should be an independent appeals mechanism against disciplinary decisions of the Health Board, whether that decision be dismissal or less serious action. In addition, consultants who have retained pre-Health Board terms and conditions of service are eligible to appeal against dismissal to the Welsh Government under paragraph 190 of the terms and conditions of service.

For the majority of Welsh Consultants who do not enjoy paragraph 190 protection, most LNCs in Wales have negotiated local professional appeal panels within their Health Board, normally with a legally qualified chair from the Lord Chancellor's panel. The Health Board should provide a member of the appeal panel, for example the Health Board chair or another non-executive director. If a member of the Health Board is on the appeals panel, it is important that they should have been excluded when the Health Board made its original decision on the disciplinary action. There should also be external consultant input nominated by the hospital medical staff committee and agreeable to the Health Board.

Paragraph 190 appeals – Consultants who were employed prior to Health Board status being granted, retain the right of appeal to the National Assembly for Wales against dismissal from an NHS post where they consider the appointment has been unfairly terminated. This is in addition to a right to submit appeals under any local Health Board medical and dental disciplinary procedures. The procedure to be followed is described in paragraph 190 of the hospital medical and dental terms and conditions of service.

To be eligible to appeal, consultants must have been dismissed on the grounds of professional misconduct, professional incompetence, redundancy or some other substantial reason. Consultants dismissed on the sole grounds of personal misconduct are ineligible (although the grounds for dismissal can be challenged within a one-month timescale under paragraph 190 (d)). Consultants, who have been summarily dismissed ie dismissed without notice, may not have the right to appeal under paragraph 190.

During the course of a paragraph 190 appeal, consultants should remain suspended on full pay. The Welsh Government will seek advice from a professional committee which normally interviews the practitioner and employer representative(s). There are strict time tables to be observed. These are detailed in paragraph 190 of the terms and conditions of service.

Information

> WHC (90)22, Disciplinary procedures for hospital and community medical and dental staff > Hospital medical and dental terms and conditions of service, paragraph 190

Suspensions and exclusions

Occasionally, Health Boards/NHS Trusts may find it necessary to suspend the medical or dental practitioner from duty in order to assist the process of investigation and/or to protect the interest of patients, the practitioner and other staff. In order that clear procedures can be set up locally, Health Boards/NHS Trusts should take due account of the guidance on suspension contained in National Assembly for Wales Circular DGM (95)44. The guidance includes an indicative time scale. Where suspension is considered the following principles should be borne in mind:

- the employer is required to give serious consideration to alternatives to suspension and it is important to ensure this has been done
- suspension should not be seen as a punitive measure and is without prejudice to subsequent enquiries
- suspension should always be on full pay
- periods of suspension should be kept to a minimum and every effort made towards early resolution of the case. A review of the position should take place regularly (Circular DGM (95)44) and the practitioner kept informed of the developments after each review.

At the time of writing WCC are involved in negotiations with the Welsh Government on a new disciplinary and suspensions procedure for all medical and dental staff employed in NHS Wales.

Alert ('grey') letters

Alert letters are confidential letters issued by the Welsh Government on advice from LHBs and Health Boards/NHS Trusts alerting other employers of the dismissal or suspension of a member of medical or dental staff or where the employer believes that there are sufficient, reasonable grounds to support the view that they could be considered to be a potential danger to the safety of patients, other staff or themselves and where there is reason to believe that they may seek work elsewhere. The issuing of an alert letter obviously has serious implications for the doctor concerned. There are concerns that although the information contained in an alert letter is meant to be factual, there is currently no appeals mechanism for a doctor to challenge the accuracy of this information.

Information

> DGM (95)44

National Clinical Assessment Service (NCAS)

NCAS has established an office in Wales and many Health Boards/NHS Trusts have elected to use their services as a preliminary to suspension and/or disciplinary procedures.

However, consultants are not obliged to agree to an NCAS referral as part of current disciplinary and suspensions processes in Wales. Advice should always be sought from the medical defence organisation or BMA as to whether an NCAS reference is appropriate in any given case. The NCAS procedure is set out below.

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), 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 former NCAA (National Clinical Assessment Authority) 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 Health Boards/NHS Trusts and hospital and community Health Boards/NHS Trusts faced with concerns over the performance of an individual doctor. The service also provided 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 judgment, that confidentiality safeguards are in place, that sufficient evidence is gathered prior to the decision to convene a panel and that a written record of the investigation is kept. The case investigator will not decide what action should be taken or whether the employee should be excluded from work and may not be a member of any disciplinary or appeal panel relating to the case.

If it is decided that an investigation will be undertaken, the consultant concerned must be informed in writing by the case manager. The consultant must be given access to any correspondence relating to the case, together with a list of the people that the case investigator will interview and should have the opportunity to put their view of events to the case investigator.

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

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

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

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

Restriction of practice and exclusion from work

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

Key features of exclusion from work:

- an initial 'intermediate' 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 returning 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 case 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 Health Board 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 Health Board 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.

NHS complaints procedure

Introduction

The new NHS complaints procedure for Wales was issued in April 2003. The Directions which implement the new complaints procedure are entitled 'Directions to Health Boards/NHS Trusts and Local Health Boards/NHS Trusts on Hospital Complaints Procedures'. These Directions are supplemented by a guide *Complaints in the NHS: a guide to handling complaints in Wales*.

In 2002, following a consultation exercise in Wales, the WG endorsed the principles that:

- as many complaints as possible should be resolved using local resolution
- the process should be faster and more independent of NHS organisations
- provide adequate support for those who wish to complain, and those complained against
- ensure that the NHS in Wales learns from complaints.

Local complaints procedures should be drawn up involving the LNC and should form part of the clinical governance and quality framework. The independent health care sector should have their own complaints procedures.

The complaint process

There are two stages to the complaints procedure.

Local resolution

Complaints should be acknowledged within two working days, and thoroughly and fairly investigated. Support should be offered to both the complainant and those complained against. The Health Board should provide both support and advice to any staff who are complained about. The Health Board should have a range of options to resolve complaints locally including meetings between the complainant and staff, offering a second opinion on clinical issues and offering independent mediation. A full written reply should be provided within four weeks. Where there are prima facie cases of clinical negligence or legal action is threatened, this process should still be completed.

Complaints should be handled by senior staff, and the Health Board board should receive a regular report on complaints. Consultants and other staff should be trained to ensure that they know how to deal with a complaint.

Staff who are complained about should be told as soon as practically possible when a complaint is made about them, and they should see any letters of complaint in which they are mentioned. They should then be kept updated throughout the process and informed of the outcome. If assistance is needed in preparing reports or evidence, the member of staff should seek advice from their trade union, professional association or defence body.

Staff complained against may be interviewed by the complaints manager, or asked to provide a statement. Other staff may be asked for clinical advice relating to a complaint. All NHS staff are required to cooperate with any complaints procedure, and if this is refused could result in disciplinary action.

Independent review

If a complainant remains dissatisfied following the local resolution process, they have 28 days to request an independent review of their complaint. This request will go to the independent complaints reviewer. The independent complaints reviewer, a lay adviser and, where relevant, a clinical adviser, may suggest further action under local resolution procedures, or will set up an independent panel. The complaint will then be considered by an independent review panel made up of two independent lay people appointed by the WG and, where relevant, a clinical adviser. The panel may make recommendations to Health Boards/NHS Trusts to improve systems, or to give redress.

Any persons named in the complaint will be advised that a request for an independent review has been received. Any member of NHS staff complained against may be asked to provide further information to the independent panel, and may be asked to attend to give evidence. NHS staff cannot be compelled to attend or to give evidence, but if they refuse a reasonable request this will be noted in the panel's report, and the employing Health Board may decide to take disciplinary action. Any member of NHS staff complained against should be given the opportunity to express their views on the complaint. Both the complainant and the person complained against may be accompanied to the panel, but not by anyone acting in a legal capacity.

After any independent review panel, the Health Board should draw up an action plan to implement the recommendations. This applies equally to the independent healthcare sector.

If the complainant remains dissatisfied they may write to the Ombudsman and ask for a further investigation.

Dealing with complaints

Where there are allegations of abuse, the child protection/vulnerable adult procedures should be used, rather than the complaints procedure.

If a member of staff receives a complaint directly from a patient they should first check that the patient's immediate healthcare needs are being met, and should allow the complainant to discuss their concerns in private. The member of staff should ensure that any clinical complaints are discussed with the clinician concerned, and should advise the patient of their right to complain to the complaints manager or chief executive. If the staff member cannot deal with the complaint, they should refer it on to a more senior member of staff or the complaints manager.

Adverse incidents

All Health Boards/NHS Trusts should have separate procedures for dealing with adverse incidents (sometimes called critical incidents). The purpose of these procedures is to ensure that lessons are learnt. If a patient has also complained about the incident, the two processes should continue in parallel. All such incidents must be reported to the National Patient Safety Agency for the purpose of learning lessons, and to implement solutions nationally where appropriate.

Relationship between complaints and discipline

If at any stage of an investigation serious concerns are raised about a member of staff, this should be reported to the Health Board who may decide to carry out an investigation under the relevant disciplinary procedures. This may include referral to the relevant professional body, the NCAS or the NHS Counter Fraud Office. If any of these actions are taken before the complaint procedure has been completed, then consideration should be given to how far the complaints procedure can continue, and whether other investigations can run alongside it. The complainant may be advised in general terms on any disciplinary action taken against a member of staff.

Information

> [Directions to NHS Trusts and local health boards on hospital complaints procedures > Complaints in the NHS: A guide to handling complaints in Wales, April 2003](#)

Appraisal

Introduction

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

Appraisal is a contractual requirement for consultants 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 CEA application process whether a consultant has participated in the appraisal process during a particular year.

Definition and aims of appraisal

Appraisal should be a professional process of constructive dialogue, in which the consultant has a formal structured opportunity to reflect on his or her work and to consider how his or her effectiveness might be improved. For the employer, it is an opportunity to give consultants feedback on their performance, to chart their continuing progress and to identify development needs.

Appraisal is a forward-looking process essential for the development and educational needs of an individual. It is not the primary aim of appraisal to scrutinise doctors to see if they are performing poorly but rather to help them consolidate and improve on good performance. However, it can help to recognise, at an early stage, developing poor performance or ill health, which may affect practice.

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

The aims and objectives of the appraisal scheme are to enable NHS employers and consultants to:

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

Appraisal process and content

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

The GMC's core headings are: good clinical care; maintaining good medical practice; relationships with patients; working with colleagues; teaching and training; probity and health.

Who undertakes the appraisal

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

The appraiser will be able to cover clinical aspects and matters relating to service delivery, and will usually be the clinical director, if this is appropriate to the management arrangements of the employer.

Where there is a recognised incompatibility between proposed appraiser and appraisee the chief executive will be responsible for nominating a suitable alternative. This decision will be final. In circumstances where the clinical director is not on the register, the medical director, having first consulted the clinical director, should conduct the appraisal or select a suitable lead consultant or other appropriate consultant to do so. In these circumstances, the clinical director will be fully consulted before the appraisal meeting takes place and will undertake the subsequent job plan review. The clinical director will also ensure that the appraiser and appraisee are aware of and consider all relevant issues at the appraisal meeting.

This may be best achieved through an agreed contribution to the appraisal meeting and outcome report.

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

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

Preparation

The consultant being appraised should prepare for the appraisal by identifying those issues which he or she wishes to raise with the appraiser and prepare a personal development plan. Consultants should also consider whether the appraiser has adequate professional knowledge to appraise their work and whether some element of peer review is required (see below).

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

Appraisees should also submit any other data that is considered relevant to the appraisal.

In advance of the appraisal meeting, the appraiser should gather the relevant information as specified above and consult in confidence and where appropriate, the medical director, other clinical directors/lead consultants and members of the immediate care team.

The information and paperwork to be used in the appraisal meeting should be shared between the appraiser and the appraisee at least two weeks in advance to allow for adequate preparation for the meeting and validation of supporting information. Adequate time must be allocated in lieu of other duties for the preparation and appraisal meeting.

Scheme content

Clinical performance

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

- clinical activity with reference to data generated by audit, outcomes data, and recorded complications. This should permit discussion of factors influencing activity, including the availability of resources and facilities
- concerns raised by clinical complaints that have been investigated. If there are any urgent and serious matters that have been raised by complaints made but that have not yet fully been investigated, these should be noted. **The appraisal should not attempt to investigate any matters that are properly the business of other procedures, eg disciplinary procedures**
- continuing professional development, including the updating of relevant clinical skills and knowledge through continuing medical education
- the use and development of any relevant clinical guidelines
- risk management and adherence to agreed clinical governance policies of the Health Board and suggestions for further developments in the field of clinical governance
- professional relationships with patients, colleagues and team working.

Teaching and research activities

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

Personal and organisational effectiveness

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

Other matters

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

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

Peer review

The assessment of some of the more specialist aspects of a consultant's clinical performance is best carried out by peers who are fully acquainted with the relevant areas of expertise and knowledge. Where it is apparent that peer review is an essential component of appraisal, the appraiser and the appraisee should plan this into the timetable in advance of the appraisal interview.

If, during the appraisal, it becomes apparent that more detailed discussion and examination of any aspect would be helpful and important, either the appraiser or the appraisee should be able to request internal or external peer review. This should normally be completed within one month and a further meeting scheduled as soon as possible thereafter (but no longer than one month) to complete the appraisal process.

As a matter of routine, the results of any other peer review or external review carried out involving the consultant or the consultant's team (eg by an educational body, a professional body, or the Healthcare Inspectorate Wales 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 1998.

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 Health Board processes concerned with clinical governance, quality and risk management and the achievement of service priorities. In discharging this accountability, the chief executive and medical director will have confidential access to any documentation used in the appraisal process. In these circumstances, the individual concerned will be informed.

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

Serious issues relating to poor performance

Serious issues relating to poor performance will most often arise outside the appraisal process and must be addressed at that time. It is not acceptable to delay dealing with such issues until the next scheduled appraisal. Such concerns should be dealt with in accordance with the normal agreed employer procedures. This may include the chief executive feeling it necessary to inform the board in a closed session.

In the event of serious concerns being identified during an appraisal, they should be dealt with in the same way. The appraisal will then be suspended until the identified problems have been resolved.

Personal development plan

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

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

Revalidation

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

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

Consultants working in more than one Health Board

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

Clinical academics

As recommended by the Follett report, consultants with substantive university appointments or NHS consultants with major academic duties should undergo joint appraisal in respect of their complete range of NHS and university duties (either with one appraiser for each component, or a single joint appraiser if properly qualified for this task). Separate documentation is available for the clinical academic appraisal scheme. In addition to those noted above, for clinical academics a copy of the appraisal summary document will be sent, in confidence, to the nominated university representative.

Appraisal in private practice

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

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

Information

- > GMC, Continuing professional development for doctors, April 2004
- > Department of Health, Further guidance for appraisal for consultants in public health medicine, November 2002
- > Department of Health, Clinical academic staff (consultants) appraisal scheme, July 2002
- > Annual Appraisal for Consultants AL(MD) 6/00 and AL(MD) 5/01 (further guidance)
- > An agreement between the British Medical Association and the Independent Healthcare Forum, October 2004

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 WCC advises that consultants should in most cases bring concerns about colleagues to the attention of their medical director in the first instance. The GMC has produced guidance for doctors and other healthcare professionals on referring a doctor to the GMC which is available on its website (www.gmc-uk.org/concerns/making_a_complaint/index.asp).

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

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

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

The adjudication stage consists of a hearing of those cases that have been referred to a fitness to practise panel. At any stage of the

investigation the GMC may refer the doctor to an Interim Orders Panel (IOP). An IOP can suspend or restrict a doctor's practice while the investigation continues. Fitness to practise panels hear evidence and decide whether a doctor's fitness to practise is impaired.

From May 2008, the GMC introduced a provision for the use of the civil standard of proof (the balance of probabilities) at fitness to practise panel hearings when panelists are making decisions on disputed facts. Previously the GMC used the criminal standard of proof (beyond reasonable doubt). The requirement to move to the civil standard of proof was a result of the Shipman inquiry and the Government's subsequent white paper, *Trust, assurance and safety: the regulation of health professionals in the 21st century* published in February 2007. The balance of probabilities, as applied in the civil standard of proof, means that the tribunal need only be satisfied that the alleged facts are more likely than not to have happened. The criminal standard of proof of 'beyond reasonable doubt' meant that the tribunal had to be sure that the case was proven. Panel hearings are the final stage of the GMC's procedures following a complaint against a doctor. Panels of three to five medical and non-medical members are appointed by the GMC. In addition to the chairman, who is not necessarily medically qualified, there must be at least one medical and one non-medical member on each panel. A legal assessor sits with each panel and advises on points of law and fact.

Once the panel has heard the evidence, it must consider three matters:

whether the facts alleged have been found proved; whether, on the basis of the facts found proved, the doctor's fitness to practise is impaired; and if so, whether any action should be taken against the doctor's registration. The application of the standard of proof applies only to the first of these questions.

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

Office of the Health Professions Adjudicator (OHPA)

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

Handling of local concerns

The Health and Social Care Bill proposes the creation of GMC affiliates to be based at SHA level. The role of the GMC affiliate will be to lead regional medical regulation support teams. The Bill will also enable regulations to require all organisations in England, Wales and Scotland employing doctors to appoint or nominate a 'responsible officer' with responsibilities relating to the regulation of doctors. It is envisaged that responsible officers will address concerns about doctors, oversee local revalidation processes and be a central point for holding and sharing information on complaints and concerns about doctors. It is as yet unclear how the responsible officer will liaise and interact with GMC affiliates.

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

Council for Healthcare Regulatory Excellence (CHRE)

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.

Constitution of the GMC Council

As part of the reform programme, the GMC, with Government agreement, has lifted restrictions on a lay majority on the Council to

make provision to have equal numbers of lay members and professional members on the governing body. In June 2008 the GMC advertised for 12 lay members and 12 medical members to join the Council body.

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

Information

> Good Medical Practice, GMC, 2006

> GMC website: www.gmc-uk.org

Health

Introduction

The role of Health Boards/NHS Trusts as employers 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, 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.

Information

> [NHS Employers, The management of health, safety and welfare issues for NHS staff, new edition 2005](#)

Management responsibilities

All employers have legal obligations under the Health and Safety at Work Act etc 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 £173m in 2001-02. The Management of Health and Safety Regulations 1999 emphasise a risk management approach which requires employers to identify hazards and assess risks, develop appropriate measures to eliminate or minimise risk and record their findings. Such work would not just reduce accidents but also release additional money for healthcare.

For example, the Health and Safety Commission has reported that one Trust saw the cost of manual handling injuries fall from £800,000 in 1993 to £10,000 in 2001. Consultants should also note that the EC Working Time Regulations 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 reorganisations have often left Health Boards/NHS Trusts with out-of-date policies and that more effort across all Health Boards/NHS Trusts will be required if the health service is to meet the targets for accident/ill-health reductions that have been set by the NHS.

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

Occupational health services

All NHS employers must ensure that their staff have access to confidential occupational health services, including a consultant in occupational health medicine. Where the occupational health team is made up of an occupational health nurse and/or non-consultant occupational health physicians, managers are obliged to ensure that there is access to and advice from a consultant. The DH has provided a national policy lead on occupational health issues for some years through *The management of health, safety and welfare issues for NHS staff* (1998) and *The effective management of health and safety services in the NHS* (2001). In 2004, the DH circulated a draft of the first NHS occupational Health and Safety Strategy for England, which set out its vision for a safer, healthier NHS. The strategy was developed in response to The National Audit Office report *A safer place to work* (2003). The responsibility for encouraging the implementation of good occupational health and safety policy across the NHS has now been transferred to the NHS Employers organisation, which will act in an advocacy and advisory role to NHS senior managers.

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

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

Information

- > [HSC 98\(64\) Management of health, safety and welfare issues for NHS staff](#)
- > [Department of Health, The effective management of health and safety services in the NHS, 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 BMA advisers 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, \[www.hse.gov.uk/stress\]\(http://www.hse.gov.uk/stress\) and \[www.hse.gov.uk/healthservices/index.htm\]\(http://www.hse.gov.uk/healthservices/index.htm\)](#)

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 Health Board 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, \[www.hse.gov.uk/violence/index.htm\]\(http://www.hse.gov.uk/violence/index.htm\)](#)
- > [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

> Department of Health, *Taking alcohol and other drugs out of the NHS workplace, 2001*

Transmission of infection

In March 2007 the DH published *Health clearance for tuberculosis, hepatitis B, hepatitis C and HIV: New healthcare workers*. This aims to clarify the position on testing for blood-borne viruses for NHS staff. The guidance recommends that, on appointment, all new healthcare workers should have standard healthcare clearance checks. All new workers should have checks for tuberculosis disease/immunity and be offered hepatitis B immunisation, with post-immunisation testing of response and the offer of tests for hepatitis C and HIV. It states that where a new member of staff's duties include performing exposure prone procedures (EPPs), additional healthcare clearance should also be obtained before confirmation of an appointment. This includes being non-infection for:

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

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

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

There is further BMA guidance on this at www.bma.org.uk/

Sources of professional advice

BMA Counselling is a service available 24/7 and allows doctors to speak to a team of fully-qualified counsellors. Any issue causing

distress or difficulty can be prevented. Prevention of infection from hepatitis and HIV the DH 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.

The **Doctors for Doctors** Unit is run by the BMA and offers doctors in distress or difficulty the option of speaking in confidence to

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

Please visit www.bma.org.uk/

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

In 2005 the Welsh Government published *Designed for life*, which outlined the strategic direction for health and social care in Wales for the next 10 years. *Designed for life* acknowledged the importance of workforce planning, development and maintaining a workforce that could deliver modernised healthcare services.

The National Leadership and Innovation Agency for Health, NLIAH was established in March 2005 as the national strategic resource to support NHS Wales in delivering *Designed for life*. In April 2006 as part of the Welsh Government's reform of public services, Health Professions Wales was disbanded and its functions transferred to the Healthcare Inspectorate Wales, NILAH, and the newly created Workforce Development Education and Contracting Unit. WDECU was to work closely with the Deanery and the Welsh Government's Professional Advisors and the Professional Advisory Networks.

BMA Cymru Wales was concerned that in the new proposals planning arrangements for medical and dental workforce planning would be fragmented. However, the new arrangements incorporated the Statutory Advisory Committees; the Welsh Medical and Dental Advisory Group, which provide independent, professional advice on medical and dental education and training directly to the Assembly Minister for Health and Social Care which ensures the importance and uniqueness of the medical and dental workforce is appropriately represented.

At UK level the BMA is currently contributing to the House of Commons Health Select Committee Inquiry into Workforce Needs and Planning for the Health Service, further information can be found on the BMA website.

Specialist register

On successful completion of specialist registrar training, doctors are currently awarded a certificate of completion of training (CCT, previously known as CCST) allowing them to practise across Europe as recognised specialists. From September 2005 the Postgraduate Medical Education and Training Board (PMETB) was established by the General and Specialist Medical Practice (Education and Qualifications) Order 2003, to develop a single unifying framework for post graduate medical education and training across the UK. Under the new arrangements there are now two routes on to the specialist register:

A certificate of completion of training gained via a specialist training programme.

A statement of eligibility for registration, following an application under article 14 of the Order.

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

Article 14

Under Article 14(4) doctors may apply to have their training qualifications and experience (whether obtained in the UK or overseas) considered against the standard for a certificate of completion of training in their specialty. Article 14(5) applies where a doctor has training or specialist qualifications obtained outside the UK in a medical specialty that is not standard in the UK. PMETB requires doctors to provide extensive evidence in support of their article 14 applications, including information of training qualifications and experience. Further information is available on the PMETB website at www.pmetb.org.uk.

The specialist register

On successful completion of speciality training, doctors are currently awarded a certificate of completion of training (CCT), allowing them to practise across Europe as recognised 'specialists'. The Postgraduate Medical Education and Training Board (PMETB) recommends CCT holders for inclusion on the specialist register, administered by the GMC. PMETB was established by the General and Special Medical Practice (Education and Qualifications) Order on 4 April 2003 to develop a single, unifying framework for postgraduate medical education (PGME) and training across the UK. PMETB has a duty to

establish, maintain, and develop standards and requirements relating to postgraduate medical education and training in the UK. The board is made up of 16 medical and eight lay members with observers from

the UK health departments. The specialist register includes the names of all CCT holders together

with those of other eligible specialists, and shows their specialty and, if requested, any particular field of expertise within it.

Eligible

specialists are defined as:

- European Economic Area nationals holding recognised specialist qualifications

- other overseas nationals holding specialist qualifications that are deemed equivalent to the CCT

- doctors who have followed academic or research training paths, resulting in a level of knowledge and skill consistent with NHS

consultant practice in that specialty.

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

Clinical academics

Contracts

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, by a university without a medical or dental school, or by the MRC (usually through the university) and has an honorary (unpaid) appointment with a Health Board.

A and B contracts

The consultant is employed either:

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

In Wales like their NHS colleagues, clinical academics are all now employed under the amendment to the National Consultants Contract.

Information

> [Terms and Conditions of Service 2003, paragraphs 78 and 81](#) > [Terms and Conditions of Service 2003, Amendment Chapter 8](#)

Pay

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. Clinical academics who experience problems in being awarded the annual DDRB recommendation should contact BMA advisers for advice.

Job planning

BMA Cymru Wales has produced guidance on the integrated job planning process for clinical academics on the 2003 amended contract as part of its guidance on job planning for the amended consultant contract in Wales. The main points of the guidance are summarised below:

Clinical academics will have a commitment to the university/academic employer and the NHS employer. This will typically be four sessions of academic work and six sessions of NHS work for a full-time employee. Within the NHS commitment, there should be a typical ratio of four direct clinical care sessions to two supporting professional activities sessions.

The integrated job plan should be agreed between the academic employer, NHS employer(s) and the clinical academic staff member. Additional sessions 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 sessions. A key feature of the 2003 amended 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.

Information

> [Terms and Conditions of Service 2003, Amendment, chapters 1 and 8](#)

Appraisal

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

Information

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

Disciplinary procedures

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

Private practice and spare professional capacity

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, eg 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 BMA advisers for further advice. That said, in general terms, the arrangements applicable in the NHS apply, apart from cases where it is an expectation of academic employment that some private practice is carried out. Where this is the case, this should be clearly identified in the integrated job plan, and should not affect pay progression. It should be noted that private practice in this context is only the diagnosis and treatment of patients by private arrangement, and does not apply to any other activities, for example, writing text books.

Clinical excellence awards (CEAs) and commitment awards

Clinical academic staff are eligible for, subject to satisfactory job plan reviews, CEAs and commitment awards in line with the provisions that apply for consultants. The awards will be paid on a pro rata basis to part-time staff.

Sick leave

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

A and B contract holders are subject to NHS sick leave entitlements.

Maternity and parental leave

Honorary contract holders are subject to the maternity and parental leave provisions laid down by individual universities. Previous continuous service within the NHS does not normally count towards continuous service for maternity and parental leave purposes in university contracts.

However, there is reciprocity when moving from the university to the NHS as the main employer.

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

A and B contract holders are subject to NHS maternity leave entitlements.

European Working Time Directive (EWTD)

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

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

Removal expenses

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

Pensions

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

The clinical team

Consultant responsibility

Only a consultant or a principal in general practice can accept ultimate medical responsibility in Health Boards/NHS TRusts. The development of new working patterns and increased multidisciplinary working should not alter this basic principle.

Consultants must nonetheless work constructively within multidisciplinary 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
- NHS Direct
- Referral Management Centres
- widened prescribing rights for new groups of health professionals
- proposals to extend clinical autonomy to staff and associate specialists and some doctors in training.

The WCC also advises consultants always to inform the patient's GP of advice given or treatment proposed, as recommended by the GMC, and on which the CC has issued guidance jointly with the BMA General Practitioners Committee (www.bma.org.uk/).

Where nurse referrals are accepted under local protocols, these protocols should be drawn up with medical input. The CCSC's guidance on access to secondary care offers consultants a detailed commentary on the way that traditional referral patterns are changing and advice on what steps to take if they have concerns about the ways that referrals to secondary care are being made.

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

It states that:

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

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

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

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

Information

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

> CCSC, Towards tomorrow: the future role of the consultant, 1996

Specialist doctors

Until the agreement reached between the BMA and NHSE Employers on the specialty doctor contract in 2008, there were essentially two types of pre-CCT specialty doctors: associate specialists and staff grade doctors. Associate specialists are senior hospital doctors, responsible to named consultants. The associate specialist grade is a career grade and, for those employed under national agreements, appointments are subject to a year's probationary period, and may be held until retirement.

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

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

The staff grade was a non-training career grade intended to provide a career in hospital medicine for doctors who did not wish, or were unable to train for, consultant status. Staff doctors exercised an intermediate level of clinical responsibility and worked to a named consultant. Their commitments related solely to service requirements and they did not have continuous 24-hour responsibility for their patients. Following representations by the BMA and other organisations, the Postgraduate Medical Education and Training Board (PMETB) established a mechanism for assessing the experience of doctors who had not been able to complete their specialist training, but who had worked as associate specialists and staff grades for a number of years, in order to ascertain their eligibility to be on the specialist register. The process was established under Article 14 of General and Specialist Medical Practice (Medical Education, Training and Qualifications) Order 2003. The BMA has produced guidance for applicants available on its website: www.bma.org.uk/

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

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

Having been granted a Certificate of Eligibility for Specialist Registration, holders may apply, if they wish for consultant posts. In

practice, however, as the business case for a new consultant post may require the abolition of the doctor's current post, and taking part in open competition for the new consultant post, this option is not always taken.

Information

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

Clinical assistants

Clinical assistants are appointed under paragraph 94 of the Terms and Conditions of Service of Hospital Medical and Dental Staff. Clinical assistant posts are part-time hospital posts that were initially intended for GPs who wished to work in a hospital. In theory, there were limits on the number of (notional half days) 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 BMA advisers 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.

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 Health Board's medical staffing plan.

Any concerns that a Health Board is deviating from these targets should be raised initially through the LNC.

This policy has not, as hoped, prevented Health Boards/NHS 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

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

Consultants are expected to play their part in managing their organisations, not least to ensure that medical matters are given proper priority in the Health Board's decision making process.

Health Boards 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 Health Boards use other terms to describe medical managers who carry out similar roles.

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

Remuneration

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

The CC Medical Managers Subcommittee's survey of medical manager remuneration published in March 2005 revealed a wide variety of ways in which medical managers were paid for their management work and the amounts received. Medical managers are advised to consult the survey as a source of general information on remuneration and seek advice from BMA advisers on negotiating the best possible deal for themselves. A further survey on the workload and remuneration of medical managers in primary care was published in May 2007. Many respondents comment that the current level of remuneration did not reflect the level of responsibility, the increasing workload and the expanded role expected as a manager in primary care. It also indicated significant differences within this group of medical managers but also from medical managers in secondary care. A further survey of the workload of medical managers in secondary care was issued in June 2008.

Guidance on pensions for clinical and medical directors can be found on page 60.

Clinical directorates

Under a system of clinical directorates, management responsibility is decentralised and devolved from unit to sub-unit level (the directorate). The role of clinical directorates within Health Boards/NHS Trusts may be different and the position of individual clinical directors within the overall management structure may vary from Health Board to Health Board. 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 Health Board, 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 Health Boards/NHS 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 113 for further details.

Human resources

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

Other important points include:

- clinicians and the clinical director have a joint responsibility to ensure that the work of the directorate is successfully carried out
- clinical directors must have the confidence of the consultants within the directorate
- clinical directors who relinquish clinical sessions in order to carry out their managerial duties must seek to ensure that they have the right to have such sessions reinstated when they step down from being clinical director
- clinical directors must be able to call upon support from other services within the Health Board when carrying out management functions, and should be given adequate training and secretarial and office support to carry out their job.

Medical directors

Guidance produced by the CC's Medical Managers Subcommittee is available from BMA advisers and on the website: www.bma.org.uk/medicalmanagers

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

Corporate responsibilities

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

Professional responsibilities

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

Management responsibilities

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

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

Information

> [Guidance for Developing the Role of Medical Directors \(May 2007\)](#)

> [HC\(85\)9, Health Services Management \(1\) Consultants and General Practitioners in General Management; \(2\) Unit Medical Representatives with General Management Duties.](#)

> [The Roles and responsibilities of the clinical director \(BAMM 2003\)](#)

NHS STRUCTURE

The National Assembly for Wales

Full executive power for health in Wales has been devolved to the National Assembly for Wales since 1999. From May 2007, the Government of Wales Act 2006 permitted the National Assembly to pass 'Assembly Measures' in the field of health which will allow the Assembly to do anything which an act of Parliament at Westminster could do. The Minister for Health and Social Services is accountable to the National Assembly for Wales for all health policies and, for the running of NHS Wales. The minister is not accountable for non-devolved areas such as professional regulation, abortion and fertilisation issues, genetics, or the control and safety of medicines. The National Assembly's Health Committee can call the director of NHS Wales, and the chairs of all Health Boards and LHBs in Wales, to account.

Department for Health Social Services and Children

The DHSSC is an organisational arm of the Welsh Government, responsible for managing the NHS in Wales. It is led by a director and provides strategic leadership, as well as ensuring policy implementation. The department also advises the minister for health and social services about securing and allocating health resources. There are also three regional offices within the DHSSC – North Wales, South East Wales and Mid and West Wales – each led by a regional director who is accountable to the DHSSC director. The regional offices are responsible for the performance and improvement of the local healthcare services. In particular, they monitor LHBs and NHS Trust performance.

The chief medical officer (CMO) for Wales

The CMO is the Welsh Government's principal medical advisor, and as such has direct access to ministers. The CMO is also the head of the medical civil service in Wales. The post has direct involvement in development of health policy in Wales including prevention, health promotion, health protection and harm reduction. The CMO also has lead responsibility for issues such as clinical effectiveness, quality assurance, accreditation and research and covers the spectrum of health-related issues.

Health boards (HBs)

Wales has 8 HBs. These have adopted many of the functions of the previous health authorities and are intended to develop services to provide for locally identified needs. HBs commission primary care services and hospital and community health services and develop and implement health, social care and wellbeing strategies. Each HB has a decision-making board and an executive team. HBs share common boundaries with local government and it is expected that a more integrated approach to health and social care will develop. A business service centre in Wales provides support services for all 8 HBs where there are benefits of scale in areas such as information management and technology, human resources and finance. It also operates contractor services for payments and provides administrative support to HBs over contract applications.

Public Health Wales (PHW)

Some of the work previously done by health authorities (eg management of public health resources) was transferred to a single organisation for the whole of Wales: Public Health Wales. This organisation provides locally delivered guidance and advice to HBs

– each HB has a public health director who is part of the PHW. The service has input from academic departments and public health laboratory services in Wales, which incorporates the communicable disease surveillance centre in Cardiff. The NPHSW forms part of the Velindre NHS Trust.

NHS Trusts

There are 3 NHS Trusts in Wales they are:-

- The Welsh Ambulance NHS Trust, based in North Wales.
- The Velindre NHS Trust is 'Host' to a number of external organisations. 'Host' status is defined by the organisation(s) have their own 'board' where more detailed discussions and sign-off of strategy and performance takes place or where there is direct sponsorship from another statutory body e.g. Welsh Government. By having such arrangements they are outside of the usual Trust management arrangements and are not, for example, the same as our 'managed' Divisions of the Trust who have Directors who are directly accountable for strategy and operational management to the Chief Executive and are represented on the Trust Board and are members of the Executive Management Board.
- Public Health Wales NHS Trust provides locally delivered guidance and advice to Health Boards/NHS Trusts, each Health Board has a public health director who is part of the PHW NHS Trust. The service has input from academic departments and public health laboratory services in Wales, which incorporates the communicable disease surveillance centre in Cardiff.

Health and hospital records

Health records

Doctors have always had the discretion to allow patients to see their health records and to share information where appropriate with the carers of children and incapacitated adults. Additionally, in recent years Acts of Parliament have given certain statutory rights of access to records. None of the legislation prevents doctors from informally showing patients their records or, bearing in mind duties of confidentiality, discussing relevant health issues with carers. The implementation of data protection legislation in early 2000 changed patients' statutory rights of access to their health records.

All manual and computerised health records about living people are accessible under the Data Protection Act 1998. Doctors may wish to order, flag or highlight their records so as to ensure that, should the patient ultimately seek access, it will be straightforward to identify which the patient may see, and those where an exemption to the right of access applies. The appropriate health professional must be consulted about applications for access. In secondary care, this will normally be the consultant responsible for the clinical care of the patient. Consultants are advised to contact BMA advisers for guidance on the fee that they may charge for making records available.

Deceased patients

The Data Protection Act 1998 only covers the records of living patients. When the patient has died, the patient's personal representative and any person who may have a claim arising out of the patient's death has a right of access to information in the deceased's records necessary to fulfil that claim. These rights are set out in the Access to Health Records Act 1990 or Access to Health Records (Northern Ireland) Order 1993. The provisions and fees are slightly different from those in the Data Protection Act. Further information can be found in the BMA's guidance *Access to health records by patients* that is available at: www.bma.org.uk/

Medical reports

The Access to Medical Reports Act 1988 (the Act) and Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 (the Order) give patients rights in respect of reports written about them for employment or insurance purposes. They cover reports written by the applicant's GP or a specialist who has provided care, including an occupational health doctor. Reports written by an independent medical examiner are not covered by the Act or the Order. In the BMA's view, patients are entitled to access these reports under data protection legislation. Further information can be found here: www.bma.org.uk/

Information

- > **Medical Ethics Today: the BMA's handbook of ethics and law (2nd ed) (2004) www.bma.org.uk**
- > **Data Protection Act 1998 www.opsi.gov.uk/Acts/Acts1998/ukpga_19980029_en_1**
- > **Good Medical Practice, General Medical Council, May 2006 www.gmc-uk.org/guidance/good_medical_practice/index.asp**
- > **Medical information & insurance: Joint guidelines from the British Medical Association and the Association of British Insurers, BMA, December 2002 www.bma.org.uk/**

Caldicott guardians

The Caldicott Committee was established by the chief medical officer to review all patient-identifiable information which passes from NHS organisations in England and Wales to other NHS or non-NHS bodies for purposes other than direct care, medical research, or where there is a statutory requirement for information. The purpose was to ensure that patient-identifiable information is only transferred for justified purposes and that only the minimum necessary information is transferred in each case.

When the committee reported in 1997, one of its recommendations was that a senior person, preferably a health professional, should be nominated in each health organisation to act as a guardian, responsible for safeguarding the confidentiality of patient information. The responsibility of this person is to ensure that the purposes for which patient information is used within an organisation are robustly justified, that the minimum necessary information is used in each case, and that good practice and security principles are adhered to.

Information

- > **Protecting and using patient information: a manual for Caldicott guardians, NHSE, 1999 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4068134**
- > **The Caldicott Guardian Manual 2006 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062722**

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 Welsh Government, Health Boards/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 Health Boards/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, Health Boards/NHS Trusts can release information even if it is incomplete or misleading.

Consultants are, therefore, advised to attempt to persuade Health Boards/NHS 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 1998 does not protect consultants against the release of information on clinical performance or complaints. The Data Protection Act 1998 is designed 'to protect the private lives of individuals'. Hence, if a request is received for information to be released relating to an individual's 'private life' (eg details of the person's family life or personal finances) this information is likely to deserve protection under the terms of the Data Protection Act and hence would not normally be disclosed.

However, if the information relates to an individual's 'non-private' life, for example if it concerns someone acting in an official or work capacity, this information would normally be disclosed.

Information

- > CCSC, Freedom of Information Act 2000 – Guidance from the CCSC, April 2005
- > Public Partners website, <http://www.foi-uk.org/>
- > The UK Government's official website for the Act, www.foi.gov.uk/
- > Information regarding the implementation of the Act by NHS bodies, www.foi.nhs.uk/
- > The Information Commissioner's Office website, www.informationcommissioner.gov.uk
- > The full text of the Freedom of Information Act 2000, www.legislation.hmso.gov.uk/acts/acts2000/20000036.htm

The British Medical Association (BMA)

The BMA is a voluntary association set up in 1832 'to promote the medical and allied sciences and for the maintenance of the honour and interests of the medical profession'. It is the professional association of doctors in the UK and is registered and certified as an independent trade union under employment legislation. The BMA has sole bargaining rights for all NHS doctors employed under national agreements, irrespective of whether or not they are members. It is also recognised by many employers of doctors practising in other fields. The BMA offers advice to members on contractual and professional matters via BMA advisers and provides individual and collective representation at a local level through BMA Regional Services.

As a spokesperson for the medical profession to the public, the Government, employers, MPs and the media, the BMA addresses matters as wide ranging as medical ethics and the state of the NHS.

BMA divisions

The BMA divisions are the local branches of the Association, based on geographical areas, and cover all branches of practice. Every UK member of the BMA is automatically a member of one of 204 divisions. Each division should have a chair, secretary and an executive committee including representatives of the branches of practice locally. Professional and administrative support to divisions is provided by BMA Regional Services.

Medical staff committees (MSCs)

Each NHS hospital Health Board 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 Health Board (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 the Welsh consultants committee 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.

Welsh consultants committee (WCC)

The WCC represents NHS consultants in Wales, irrespective of BMA membership, and has full delegated authority to negotiate on devolved matters for those it represents. It also develops policy and responds to consultation documents produced by the Welsh Government and other bodies on behalf of NHS consultants. Its membership is drawn from a wide range of its constituents across Wales.

Joint Welsh Consultants Contract Committee (JWCCC)

WCC has nominated some of its members as negotiators with WAG and NHS employers in Wales. The agreed purpose of this group is to systematically review the amendment to the national consultant contract in Wales ('the amendment') and its implementation to date.

Central Consultants (CC)

The CC is elected by and represents all consultants except those working in public and community health. It has sole negotiating rights with the DH for consultants employed under national agreements, and conducts negotiations with the 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 CC. It debates motions presented to it by medical staff committees, RCSCs and CC subcommittees which guide the work of the CC in the following year.

Welsh Council

The Welsh Council of the BMA is a standing committee of the BMA and has full delegated authority to consider all matters especially concerning Wales and, in conformity with the decisions of the representative body, deal with all such matters. It includes 15 directly elected members who are elected for three years, Branch of Practice Chairmen, Members of UK Council whose electoral zone is Wales, limited to the duration of their UK office and while having a registered address in Wales, Chief Officers of the Association.

BMA Council (UK)

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 chair of CC. The Council is elected biennially by postal ballot of the membership of the BMA. Council delegates its authority to five major branch of practice committees including the CC. There are also committees for armed forces doctors (which has representatives of the medical reserves) and for private practice.

Annual representative meeting (ARM)

The ARM determines the policy of the BMA. The representatives are either elected by the BMA divisions or are appointed by branch of practice committees.

BMA advice and support

The Welsh branch of practice committees are supported by a professional secretariat based in the BMA Cymru Wales office in Cardiff. Each of the UK branch of practice committees and conferences as well as the ARM are supported by a professional secretariat based in BMA House in London. The BMA also has a number of regional centres staffed by secretaries, employment advisers and industrial relations officers who provide support to regional and local committees and help and advice in disputes or negotiations with Health Board management.

The first point of contact for all individual queries is BMA advisers on 0300 123 123 3. 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 Wales press office aims to maintain a high profile for the Association, the *BMJ Group* and the wider medical profession to the Welsh media. It generates 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, such as members of national committees such as the WCC. Individual members of the BMA who are facing media enquiries can seek help from the press office at any time by calling 029 2047 4611.

The Welsh Joint Medical Consultative Council (WJMCC)

The WJMCC was set up by the royal colleges and the BMA as a committee able to speak for the consultant body with one voice. The WJMCC represents the medical profession in discussions with the National Assembly for Wales on matters of policy relating to hospital practice in Wales (excluding the remuneration and terms of service of hospital medical and dental staff and the pursuit of political purposes). The WJMCC discusses any such matters with the CMO for Wales, the National Assembly for Wales and other appropriate bodies. Members include the presidents of the royal colleges and their faculties and representatives of the BMA's WCC, the Welsh staff and associate specialists committee and the Welsh junior doctors committee.

Information

- > [BMA, Your BMA; a guide to membership benefits](#)
- > [Articles of the Association and Byelaws of the BMA, 2005](#)
- > [The Welsh Consultants Committee Standing Orders](#)
- > [The Welsh Council Standing Orders](#)
 - > [The Welsh Joint Consultants Committee: Modus Operandi and Terms of Reference](#)

Appendix A: The pre-2003 national consultant contract

(see Other terms and conditions of service (TCS) for further details)

The pre-2003 national consultant contract forms the basis of the amended contract in Wales after 1 November 2003.

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

Types of contract

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

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

Whole-time contract holders are limited to deriving no more than the equivalent of 10 per cent of their gross NHS earnings from private practice. Maximum part-timers receive 10/11ths of the whole-time salary, but are free to earn an unlimited income from private practice and 'category 3' work (see page 176). A detailed examination of the rules on private practice can be found on pages 74-87.

With the agreement of their employer, whole-time or maximum part-time contract holders can voluntarily switch from one form to the other, although the workload commitment remains unaltered. Change from whole time or maximum part time to part time again can only be with the agreement of the employer. The rules in relation to private practice income, as outlined above and described in detail on page 74, 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.

Fixed and flexible commitments

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

Fixed commitments

These are regular scheduled NHS activities. They are formally defined as those that substantially affect the use of other NHS resources, such as other staff or facilities. Examples of fixed commitments include operating lists and outpatient clinics. Some work may or may not be a fixed commitment depending on whether or not it is a regular scheduled activity.

Fixed commitments should be fulfilled, except in an emergency or with local management's agreement, which should not be unreasonably withheld. Depending upon the type of contract consultants hold, along with several other factors, the number of fixed commitments should be as follows:

Whole-timers and maximum part-timers: normally between five and seven NHDs per week.

Other part-timers, job-share contracts and honorary contract holders: normally at least half of the NHDs covered by the NHS contract.

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

Honorary contract holders: the number of fixed commitments is agreed by the consultant and the chief executive in consultation with the dean or head of the academic department in respect of service commitments of university staff. NHS employers should be more flexible in the way in which NHS commitments are fulfilled by members of academic staff, and should be prepared to agree temporary variations to the number and timing of fixed commitments where necessary.

Flexible commitments

As well as setting out the consultant's fixed commitments, the consultant's job plan (see pages 43-8) should also set out clearly the total number of hours spent each week on NHS duties, including non-fixed commitments – commonly referred to as 'flexible' commitments under the pre-2003 contract. These are often duties such as administration, audit and management responsibilities.

Temporary additional NHDs

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

Additional NHDs are regularly paid to consultants who undertake:

- managerial work (eg as clinical or medical director)
- additional clinical work (eg to cope with short-term demand or to cover work otherwise done by absent colleagues)
- special responsibilities (eg as clinical tutor or audit coordinator).

Contractual basis of and payment for any temporary additional NHDs

Temporary additional NHDs are not covered by the consultant's standard contract of employment, but form part of a separate contract.

This separate contract is reviewable not less than annually and is terminable at three months' notice on either side.

Extra NHDs are each paid at the rate of 1/11th of the appropriate whole-time salary (including discretionary points or local clinical excellence awards (CEAs). Where a consultant is in receipt of a distinction award or national CEA, temporary additional NHDs will be calculated as if the consultant had reached point eight of the discretionary point pay scale or level nine of the local CEA scale.

Maximum part-timers' private practice rights are unaffected if they are contracted for temporary additional NHDs.

Temporary additional NHDs are not 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](#)

> [AL\(MD\) 5/98 Calculation of temporary additional notional half days](#)

> [HC \(90\)16, Consultants' contracts and job plans](#)

Intensity supplements scheme

Background

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

General features of the scheme

Payments are in the form of annual superannuable salary supplements.

The scheme is a contractual entitlement for all consultants on pre2003 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 (ie there are no part payments).

Information

> [AL\(MD\) 5/2000, NHS Executive, November 2000](#)

Category 1 and 2 work

There are three categories of work for consultants working under the pre-2003 terms and conditions of service. Diagnosis, treatment or prevention of illness of NHS patients and related examinations and reports are known as category 1 work and this will form the basis of a consultant's contract with their Health Board.

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 74) or category 3 work (see below).

A report on a patient not under observation or treatment at the hospital, often for a third party, which may involve a special examination, is category 2 work, in which case a fee may be charged. (If the patient is under observation or treatment at the hospital, reports for a third party not requiring a special examination are usually category 1 work.) Examples of category 2 work include medical examinations for life insurance purposes, and reports and examinations for coroners.

BMA guidance schedules on fees for part-time medical services are available from BMA advisers

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. Health Boards/NHS 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 WCC does not regard secretarial and other office support as services for the purpose of the rule.

It is the view of the WCC that where the consultant who has been requested to provide the report requires an investigation from another department headed by a consultant, for example a radiology department, the radiologist would also be entitled to charge a fee, a proportion of which would be due to the employer for the use of NHS facilities. In this case, the first consultant would not be required to pay the employer a proportion of the fee unless the first consultant had used NHS facilities. The two consultants should charge the client separately for their services, but it is considered good practice for the first consultant to inform the client/patient in advance that a report from another department will be required and that there will be a separate bill.

Information

> [Terms and Conditions of Service, paragraphs 30-8](#)

> [Department of Health, The Walden Report on 'The Review of Category 2'](#)

> [PM \(81\)30B, paragraph 34](#)

Category 3 work

Category 3 work is a term coined by the WCC to describe extra work undertaken on NHS patients by separate arrangement outside the principal contract of employment. An example of category 3 work is work under the waiting list initiative.

The position on the treatment of the category 3 earnings of whole-time consultants is as follows. Patients treated under such arrangements remain NHS patients and should continue to be treated as such.

However, such work is under a separate contract, and is not subject to the terms and conditions of service of hospital medical and dental staff. Any income will count against the 10 per cent limit even though there is no private arrangement between doctor and patient and the patient remains an NHS patient. This does **not** include the situation where the employer and the practitioner have entered into a separate contract for an additional NHD to undertake work which is not part of their contractual duties.

Consultants carrying out this type of work should ensure in each case that the work is covered either by NHS medical indemnity, by another employer's indemnity or by their defence body, taking out additional cover if necessary (see pages 38-9). Consultants are also advised to ensure that they have proper contracts in place for this work.

Information

- > [Terms and Conditions of Service, paragraphs 42-3](#)
- > [AL\(MD\) 4/94, Treatment of earnings from work outside the principal contract of employment](#)

Domiciliary visits

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 56). 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 electroconvulsive 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 anaesthetist.

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 140-54](#)
- > [RHB \(51\)11, Specialist service in the patient's home](#)
- > [BMA Fees Guidance Schedule 3: Miscellaneous work in the NHS](#)

Exceptional consultations

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

Information

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

Family planning in hospitals

(See page 17 for the situation under the 2003 contract)

The provision of family planning services in hospitals does not form part of consultants' contractual duties, but is the subject of separate arrangements between consultants and their employers.

Consultants (normally general surgeons, gynaecologists or urologists) are expected to reach agreement with the employer on the number of family planning cases to be accepted each year. They then receive remuneration on a per case basis at a rate

reviewed annually by the Doctors and Dentists Review Body (DDRB). Anaesthetists, pathologists and radiologists need not enter into any special agreements but are entitled to a fee in respect of each family planning case in which they are involved.

A condition of participation in family planning arrangements is that there should be no reduction in consultants' responsibilities and volume of work under their main NHS contract. Subject to that, family planning work can be undertaken at any time.

In practice, the budgets set for family planning work by Health Boards/NHS 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) (see page 7).

Information

> [HP\(PC\) \(76\)20, Family planning in hospitals](#)

> [HSC\(IS\) 32, 1974 Memorandum of Guidance of Family Planning Services](#)

> [HN \(89\)9, Income Generation Initiative – Section 5 of the NHS Act 1977 EL \(91\)63](#) > [BMA Fees Guidance Schedule 4: Family planning](#)

Lectures

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

Lectures to non-medical staff

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

Lectures to medical staff

Consultants' fees for lectures on professional subjects to medical staff should be paid by the employer of the majority of the hospital staff who attend the lecture. Where this does not apply, the consultant's employer should pay the fee provided that the lecture forms part of a recognised programme of postgraduate education and that no other fee is received for the lecture.

Fees are not payable for any lecture given during the course of consultants' clinical duties to teach other practitioners who are working under their clinical supervision. Where a fee is payable, travelling and subsistence expenses may be claimed (see page 17).

Information

> [Terms and Conditions of Service, paragraphs 165-6](#)

> [BMA Fees Guidance Schedule 3: Miscellaneous work in the NHS](#)

Consultant locum appointments

(See page 88 for consultant appointments under the 2003 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-2003 contract but a brief description of the terms are set out here for completeness.** If consultants are still on the pre-2003 contract, they should contact BMA advisers 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 88).

Under the pre-2003 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 DH'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 refer to the section 'Terms of service common to the two contracts' for further contractual information.

Information

> Terms and Conditions of Service, paragraphs 113, 117, 147, 200,

211-3, 289 > EL (97)48, A Code of Practice in HCHS

> Locum Doctor Appointment and Employment

> NHSE Good Practice Guidance, The National Health Service (Appointment of Consultants) Regulations 1996, Annex B

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