Becoming a Consultant – What you need to know

Claire Ashley
Employment Relations Delivery Manager
British Medical Association
19th June 2017
Essentials of the 2003 contract

1. Appointment process
2. Time
3. Types of PA
4. Job Planning
5. Money
6. Private practice
7. New contract proposals
1. Appointment process

Should be appointed via properly constituted Appointments Advisory Committee as per Regs

Foundation Trusts have power to vary the process – in practice they rarely do

Essential to see full job description and potential outline job plan before accepting post

Clarify resources, staff, on call arrangements, core job, additional activities

Take advice from BMA on any aspect of above. Better to get it right at the beginning
2. Time

Time based on **Programmed Activities**

Full time post defined as 10 PAs this includes any allocation for on call duties

1 PA = 4 hours in daytime 7am- 7pm weekdays

1 PA = 3 hours all other times (**Premium Time**)  

Consultants may refuse any non emergency activities outside 7am -7 pm (**Schedule3Para6**)  

**Job Plan** agreed with clinical lead - the bit of the contract you negotiate yourself

Most consultants continue to do a lot more than they are paid for
3. Types of PAs

Direct Clinical Care – work directly on patient care, includes ward rounds, theatre sessions, OPD clinics, all administration connected with named patients

Supporting Professional Activities – work underpinning patient care including teaching, audit, appraisal, research, training, clinical governance and clinical management

Additional NHS responsibilities – sitting on appointment or disciplinary panels, CEA panels, not necessarily for own employer but for benefit of NHS, Caldicott Guardian, Guardian of Hours

Other / External duties – senior positions in Royal Colleges, BMA, GMC, DH working parties or negotiating groups

Balance: contract states “typically” 7.5 DCC v 2.5 SPA but this is being eroded
4. Job Planning

Contract = 10 PAs

Average in acute specialities is probably 11.5 PAs

If accepting a contract over 10 PAs, identify what work is undertaken as Additional PAs (APAs)

On call typically valued at 1 PA but increasingly this is being challenged

Job plans should be reviewed annually or whenever there is significant change

Job plans form part of the contract and are therefore contractually binding on both parties
If you can’t agree.....

Medication process – normally with the Medical Director

Followed by formal Appeal – 3 member panel

• Trust appointed Chair
• Consultant nominee
• 3rd panel member from independent list
5. Money

**Basic pay** per PA @ 1/10 salary rate (pay for additional PAs the same)

**Progression** over time through **thresholds** takes 19 years to reach top of scale

**CEA points** if awarded (1-9 local awards, bronze, silver, gold, platinum)

**Other fees and allowances**

**On call supplements**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Return to work</th>
<th>Deal by phone</th>
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<tbody>
<tr>
<td>1 in 4 or more frequent</td>
<td>8%</td>
<td>3%</td>
</tr>
<tr>
<td>1 in 5 – 1 in 8</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>1 in 9 or less</td>
<td>3%</td>
<td>1%</td>
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Pay Progression

1st four pay thresholds at yearly increments

Next 3 at 5 yearly intervals

It is the norm for Consultants to progress unless they have demonstrably failed to:

• Take part in appraisal, job plan review, set personal objectives
• Made every reasonable effort to meet personal objectives
• Worked towards any identified changes linked to the organisations objectives
• Take up extra PA’s if offered, if they want to do PP
• Work in line with the PP code of conduct
6. Private practice and fee paid work

NHS work is called category 1, private is category 3. In between is category 2.

**Cat 2** is work on NHS patients but not as part of their treatment; reports for insurance, courts, employers, Government Departments. Uses your knowledge of the NHS patient but involves no treatment, possibly examination.

NHS allows Cat 2 work to be done in NHS time and space as time shifting as long as not excessive.
Emergency on call work

Recognised in 3 ways:

• **Predictable:** Work done on call e.g ward rounds, operating etc
  • Assessed prospectively and built in to the DCC PA’s
  • Likely to be in premium time depending on scheduling

• **Unpredictable:** Work done on call ‘emergencies’
  • Assessed prospectively and built into DCC’s

• **Availability Supplement:** based on
  • Number of colleagues on the rota
  • How likely a call would necessitate a return to site
New contract proposals 1

Redistribution of cash envelope to achieve better balance and to reflect new pensions arrangements which are career average not final salary schemes

Lower starting salary and lower top salary

Shortened progression – currently 19 years; expected to be no more than 4 points, maybe fewer. Rapid progression after first few years

May do away with local CEA schemes to fund this
New contract proposals 2

Major issue is removal of S3P6 which will allow routine activities to be scheduled evenings and weekends

If give up S3P6 need sufficient safeguards to avoid stretching services and overworking consultants (You will be familiar with these arguments!)

Without expansion of workforce more activity at weekends will lead to less activity during the week

Pressure to reduce SPA which NHSE/DH view as unproductive time
Questions?

www.bma.org.uk/consultants