



# Working Arrangements for Consultant Anaesthetists in the United Kingdom

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**This guideline has been seen and approved by the Council of the AAGBI.**

## Contents

1.	Introduction	4
2.	Principles of the 2003 consultant contract	5
3.	DCC PAs and their calculation	7
4.	SPAs and their justification	11
5.	WTR – rest and work patterns	15
6.	Leave of all sorts	18
7.	On-call	23
8.	Part-time and flexible working	28
9.	Job planning	31
10.	Changes to job plans when services are reconfigured	35
11.	Academic contracts	37
12.	Differences in the devolved nations	41
13.	The pre-2003 contract	45
14.	Starting out as a consultant	47
15.	References	50

## 1. Introduction

The Association of Anaesthetists of Great Britain & Ireland (AAGBI) receives a number of queries every year from members that relate specifically to working arrangements. Although not a trade union, the AAGBI has a responsibility to support and advise its members and it therefore responds to the majority of these queries. Although we refer some more detailed queries to the trade unions that represent doctors in the UK (the British Medical Association – BMA – and Hospital Consultants and Specialists Association – HCSA), many questions about working arrangements have common themes. Council of the AAGBI established a working party to consider questions and problems relating to working arrangements for consultants, and charged it with producing a concise guide for AAGBI members. Including representatives from the BMA, the Royal College of Anaesthetists (RCOA) and the Group of Anaesthetists in Training (GAT), the working party has produced this report. We plan to update the guidance as necessary, and we would welcome comments and suggestions from members about future editions of this document.

It is important to note that the AAGBI cannot arbitrate on or resolve disputes between consultants and their employers. This guidance is not a definitive document; it offers the opinion of the AAGBI on some common contractual issues. Consultants who fail to reach agreement with their clinical managers on the details of contracts, job plans, working arrangements, terms and conditions should follow mediation and appeals processes within their hospitals and should consider seeking the support of their Local Negotiating Committee (LNC). The AAGBI advises those anaesthetists who are not members of the armed forces to become members of a trade union that can offer them formal support in resolving disagreements about contractual matters.

## 2. Principles of the 2003 consultant contract

A contract is nothing more than an enforceable agreement that regulates the relationship between two parties. In this case, the two parties are the employer and employee, or consultant and their employing health authority, NHS Trust or Board. In short, it describes what one agrees to do, what one gets paid for doing it, and a mechanism for enforcing the agreement at law. The contract thus comprises the agreement between a consultant and his/her employer, and is described through the national model contract, the statement of particulars (the letter sent on appointment), the terms and conditions of service and the consultant's individual job plan.

The new consultant contracts were negotiated in order to address changes in the way the NHS and consultants had been working over the preceding few years and to prepare for future developments. Consultant job planning had been introduced in 1991 but too often remained just a discussion about the weekly timetable rather than developing into the intended conversations about a consultant's duties, objectives and responsibilities, and the allocation of time and other supporting resources to achieve these. From a consultant's point of view, job planning did not provide tools that were successfully able to control the growing workload of consultants due to both patient demand and the increasing burden of out-of-hours work.

The overall principle was that of accountability and mutual respect for both parties. The profession accepted a time-sensitive contract, in which there is a simple and direct relationship between the amount of time spent working and the payment for this work. The relationship did not go so far as to introduce 'clocking in and clocking out' – it is accepted that the assessment of time spent working should be brought to job planning meetings to discuss the prospective allocations of time, rather than consultants' being paid by the hour like many other grades of staff in the NHS. However, it did allow a consultant to control his/her workload by demonstrating the time spent on it, and where this workload was excessive, expect either a reduction in the workload or extra payments.

In return, the contract contained better tools to co-ordinate consultants' work with that of his/her hospital or employer, and the needs of his/her local health economy, through the use of job planning and objective setting. Consultants would now be expected to be able to account for the time spent on activities and objectives, whether clinical or other, and the outcomes achieved during that time, at the job planning meeting and in the appraisal meeting.

The practical changes were that a closer time-sensitivity came in through organising work into PAs (programmed activities); payments for work done while on-call were introduced, along with availability allowances for being on-call. An 'overtime rate' was introduced, with PAs being four hours in length except during premium time when they are three hours. Overall salary levels increased and new higher levels were introduced, along with a threshold system to require the consultant to fulfill basic engagement with the contract in order to access these higher levels. The '10% rule' reducing salary when one did significant amounts of private practice was replaced by a requirement to offer an extra paid PA to the NHS before engaging in private practice if one wished to progress through the pay thresholds, a requirement that most anaesthetists found was fulfilled through the new recognition of the excessive work they had undertaken under the old contract.

Working time was divided for all into direct clinical care – DCC (and patient-related administration was recognised for the first time in this category) - and supporting professional activities (SPA), with some consultants also undertaking additional NHS responsibilities or external duties. The contract defined a typical balance – so doctors employed in the consultant grade should, unless otherwise agreed, spend the 10 programmed activities of a whole time contract balanced between 7.5 DCC PAs and 2.5 SPAs. This balance was designed to emphasise the importance of consultants' undertaking quality assurance and quality improvement.

The consultant's job plan should contain objectives, and describe the supporting resources that the employer will provide in order to achieve these objectives. The contractual commitment is to do one's best to achieve the objectives, and discussion on this point should form a central part of the job plan review.

A new system of mediation and appeal was introduced in order to deal with those circumstances in which there was a failure to agree the job plan between the consultant and their employer.

Consultants who did not wish to transfer to the new contracts were able to remain on the old contract (except in Wales – see section 12), accepting lower salaries but keeping what was seen as less managerial control over their working lives.

Finally, the whole approach was supported by the introduction of a new clinical excellence award (CEA) scheme, extending the scope of the old distinction award and discretionary points schemes so that the majority of consultants should be able to progress to an award through application.

### 3. DCC PAs and their calculation

Direct clinical care programmed activities describe the portion of a consultant's working week devoted to the delivery of patient care; for an anaesthetist this is usually individual patient care. Employers are keen to maximise the proportion of a consultant's work week devoted to patient care, sometimes believing such PAs to be of greater worth; it should be remembered that the 2003 consultant contract rightly places equal value on both DCC and SPA PAs. The terms and conditions of service for the 2003 consultant contract defines direct clinical care activities as:

- Emergency duties, including emergency work carried out during or arising from on-call
- Operating sessions, including pre-operative and postoperative care
- Ward rounds
- Outpatient clinic work
- Clinical diagnostic work
- Other patient treatment
- Multidisciplinary meetings about direct patient care
- Administration directly related to the above (including but not limited to referrals and notes)
- Assessing patients in pre-assessment clinics and as ward referrals
- Checking equipment before use
- Drawing up and checking drugs before use
- Transfer of patient within and between hospitals
- WHO checklists
- Time spent checking/searching for beds for patients
- Time spent at end of list waiting/ensuring full and stable recovery from anaesthesia
- Clinic letters
- Telephone contact regarding patient care (outside of DCC period of duty)
- Travel time between hospital sites
- Travel time to and from hospital when on-call (from the time of first contact to arrival back at home)

It may be that other work may reasonably be included as DCC time. Such work might include:

- Planning, discussing or reviewing the management of complex cases
- Planning surgical lists, managing list throughput
- Theatre floor troubleshooting or postoperative recovery unit based work or supervision
- Special request pre-operative patient assessment
- The entire period spent within the hospital, whether actively working or not, while providing resident on-call cover

Direct clinical care time may be made up of time worked in standard time and time worked in premium time. Standard time is defined as the period from 07:00 h – 19:00 h Monday to Friday, excluding Bank Holidays. Premium time is any work outside of that period, including weekend and Bank Holiday working at any time of day. A standard time PA is 4 h in duration; a PA worked in premium time is 3 h in duration.

Traditional methods of calculating the number of DCCs in an individual job plan, such as allocating a PA tariff based on the number of half-day lists worked, are useful rules of thumb but may not properly represent the total number of PAs worked. Changes to anaesthetist's working patterns – same-day patient admission with corresponding earlier start times, all-day and long-day operating sessions together with decreased trainee presence for out-of-hours work – may have substantially altered the time associated with each clinical commitment. In financially straitened times it is particularly important that anaesthetists can demonstrate to employers the full extent of their clinical activity.

However, notwithstanding these caveats, many departments do find tariff systems convenient, allowing changes to sessions and work patterns without extensive recalculations of the hours worked. A commonly used tariff might be for an inpatient operating list (a standard 'session' of 4 h anaesthesia and operating time) to represent a standard 1.25 DCC PAs, including pre-operative and postoperative visits, machine and equipment checks, and drawing up drugs. Extending this value to other sessions such as a day surgery list, critical care session, obstetric anaesthetic session or outpatient session such as chronic pain or pre-assessment should be undertaken with caution. When using tariffs, care should be taken to ensure that the PA tariff allocated to a particular session is an accurate reflection of the total time spent.

A diary record of some sort is invaluable in demonstrating to an employer the range and duration of work that an individual consultant undertakes. An ongoing diary of work activity is accurate, is individually specific and can accommodate the normal workload variation between working weeks for a consultant anaesthetist. There are several electronic diary systems available, both commercial and freely available. An appropriate diary system must be capable of recording the time spent on different work activities and should deliver information acceptable to both parties in a job plan discussion. Alternatively, paper based diaries may be preferred. In this case, consultants should decide on a reference period of several weeks reflective of their normal working pattern.

First, record time spent on predictable emergency work during the reference period, note when the work was done (to note standard or premium time PAs). Add up the total time spent on predictable emergency work for both standard and premium time during the reference period. Divide each by the number of weeks in the reference period to create weekly averages (values W and Y below). Divide each value again by 4 or 3, as appropriate, to convert to PAs to reflect work undertaken in standard or premium time (values X and Z, below). Add together both the PA values (X and Z, below); call the sum value 'A'.

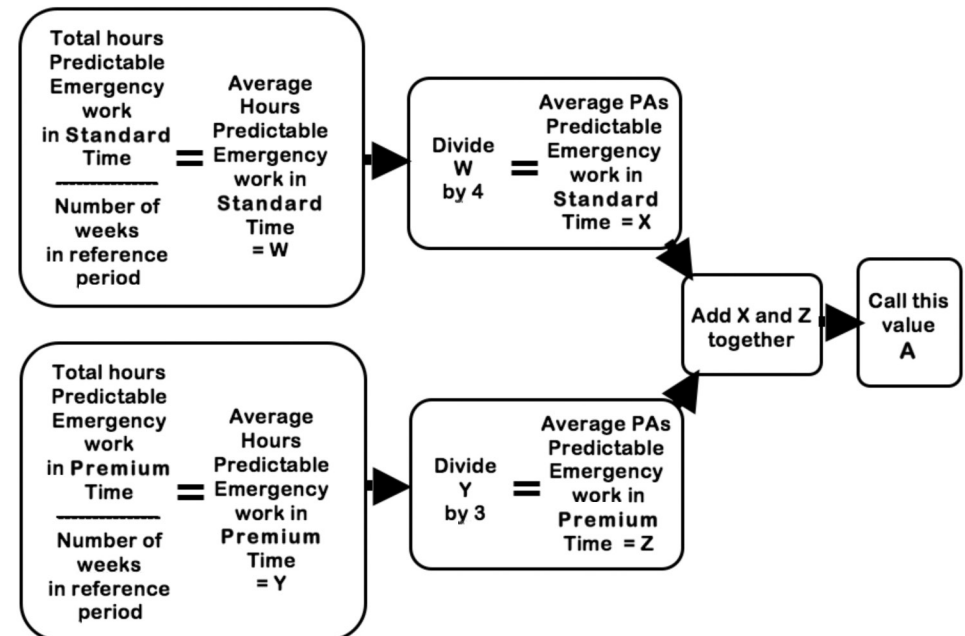


Figure 1: Calculating the PAs spent on predictable emergency work – for explanation see text.

Repeat the process for unpredictable emergency work; call that sum value 'B'.

Record the time spent on patient administration (clinic letters, results, multidisciplinary team meetings) during the reference period; note when the work was done (to note standard or premium time PAs). Add up the total time spent on patient administration for both standard and premium time during the reference period. Divide each by the number of weeks in the reference period as before to create weekly averages (values S and U, overleaf). Divide each value again by 4 or 3, as appropriate, to convert to PAs to reflect whether work

was undertaken in standard or premium time (values T and V, below). Add together both the PA values (T and V, below); call the sum value 'C'.

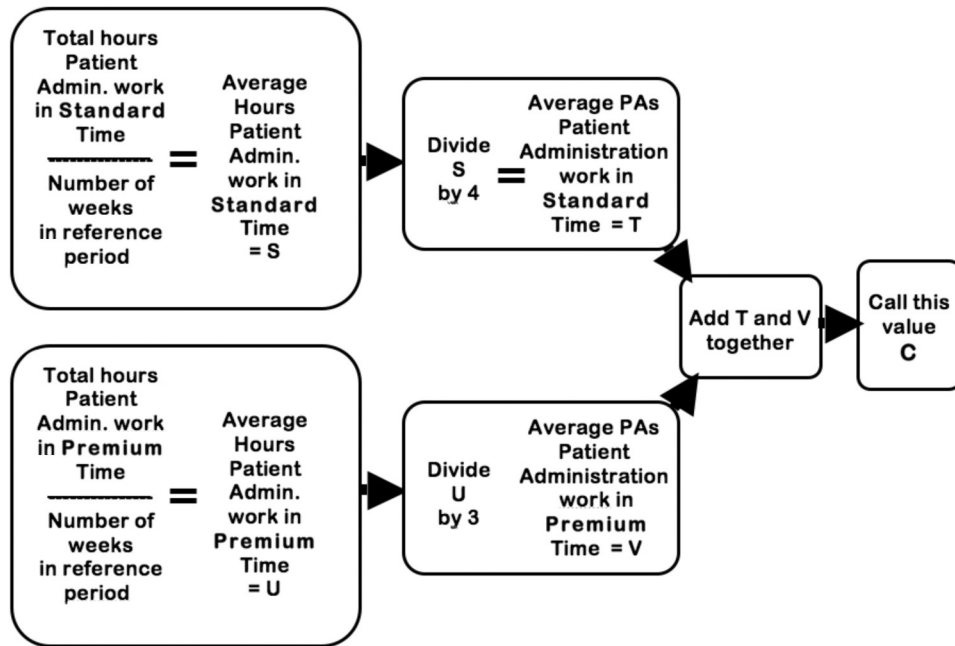


Figure 2: Calculating the PAs spent on patient administration – for explanation see text.

Repeat once more for non-emergency clinical work in the reference period (clinics, rounds, patient assessment, anaesthesia and operating etc). Call this value 'D'.

Add **A + B + C + D**; this gives a value for average DCC PAs worked over the reference period. Please note: unpredictable emergency work averaging over 2 PAs per week should trigger a job plan review with a view to decreasing the requirement for such work. It is useful to agree the method and standard of diary evidence that may be required before any job planning meeting.

Accurate diary monitoring is important in job planning (see page 31) and is particularly useful if agreement between a consultant and his/her clinical manager cannot be reached, and a mediation and appeal process is embarked upon. In fact, experience has suggested that if no diary data are presented, an appeal is likely to fail.

## 4. SPAs and their justification

Supporting professional activities are the activities that underpin direct clinical care in one's own practice and in that of other consultants. They can be defined for example as participation in training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities, but it may be more helpful to think of them as activities that are essential to **quality assurance** and **quality improvement**. Clinical practice is the largest part of the need for employing consultants but all practice, whether individual or in a team, will atrophy or fail to develop if not examined in a rigorous manner and the need for change and development considered.

The model contract states that [1]:

*"Subject to the provisions for recognising emergency work arising from on-call rotas below, the schedule in your Job Plan will typically include an average of 7.5 Programmed Activities for Direct Clinical Care duties and 2.5 Programmed Activities for Supporting Professional Activities. Where your agreed level of duties in relation to supporting professional activities, additional responsibilities and other duties is significantly greater or lower than 2.5 programmed activities there will be local agreement as to the appropriate balance between activities. Part-time consultants need to devote proportionately more of their time to Supporting Professional Activities. This should be agreed on an individual basis. Refer to the guidance on part time and flexible working for further information.*

*"The precise balance will be agreed as part of Job Plan reviews and may vary to take account of circumstances where the agreed level of duties in relation to Supporting Professional Activities, Additional NHS Responsibilities and External Duties is significantly greater or lower than 2.5 Programmed Activities."*

The meaning of this is clear. The consultant grade is characterised by a consultant agreeing this balance in his/her job plan, although there is scope to accept something different where appropriate – and agreed. You are strongly advised not to accept fewer SPAs in your job plan unless you are content with the reduced ability to work on quality assurance and quality improvement, and you should discuss it with a colleague or mentor if you are considering this. If your employer is not persuaded by your arguments on this, collect evidence and consider delaying agreement on your job plan until

further discussion and negotiation have been exhausted before going towards mediation and appeal.

It appears that some NHS employers do not understand the value of SPAs and believe that different specialties require different amounts of SPA time to underpin safe and effective performance. In particular, there seems to be a belief that the time of consultant anaesthetists is better spent giving anaesthetics and that anaesthetists have little need for SPAs. The AAGBI refutes these suggestions and supports the 2003 contract in recommending that the job plans of consultant anaesthetists should typically include 2.5 SPAs. Although SPAs might not be seen by some Trusts to be directly productive, this argument ignores the need for quality assurance and quality improvement through all the listed SPA activities. Not only is it a strict requirement for Trusts to undertake these activities, e.g. Clinical Negligence Scheme for Trusts (CNST) compliance, compliance with the recommendations of national audits, and clinical audit of innovative techniques, it is also essential for services to change and develop with time. Consultants hold the prime responsibility for doing this, and the link through learning about a new technique, planning its introduction and auditing the results is as valid for consultant anaesthetists as for anyone else. Productivity is about the efficient and effective generation of desired outcomes, with services continually improving, not simply carrying on doing what we did last year and the year before. Continuous improvement requires consultants to undertake continual reflection and change management.

Supporting professional activities are not as easy to count as patients on a theatre list, but they can and should be accounted for. The commitment for someone with 2.5 SPAs in their job plan is to undertake this amount on average over a representative period, not to do exactly that, no more and no less, each week. You should expect to undertake some SPAs in a fixed fashion, e.g. clinical audit meetings, committee meetings, weekly Continuing Professional Development (CPD) and journal clubs, and some in a more flexible fashion, e.g. writing a new clinical guideline, undertaking an audit, reviewing a proposed policy, mandatory training, dealing with correspondence and teaching at undergraduate and postgraduate level. It is reasonable for your clinical manager to expect some record of the time spent on these activities in aggregate so as to ensure that the prescribed balance of activities is being delivered. After all, a typical consultant anaesthetist is paid about 20% of his/her pay slip income for these 2.5 SPAs in his/her job plan.

This is also where job planning objectives come in. By agreeing objectives and working towards them, one can take to the job plan review or the

appraisal meeting a record of the outcomes achieved during SPA time. This is not only valuable to keep track of one's own professional development but also to demonstrate effective use of this time.

**It cannot be over-emphasised how important it is to place yourself in a position to be able to answer cogently when asked what you spend your SPA time on and what you have achieved during that time.**

It is sometimes argued that consultant anaesthetists need less SPA time than consultants in other specialties. This is wrong. Even though consultant anaesthetists tend to work in larger teams and departments than many other consultants, the breadth of scope of anaesthesia practice means that there need to be lead clinicians with specific responsibilities in a wider range of areas. A clinical director should maintain a list of departmental leads and responsibilities [2] and consultants could not only ensure that their name appears on that list in several places but also that they are active in those areas and can demonstrate what they have achieved over the past year. Box 2 (below) contains some suggestions for important roles and activities within a typical department of anaesthesia.

- Clinical Director
- Chairman of the Department
- SAS Mentor
- Revalidation Advisor and Coordinator
- Appraisal Lead
- Rota-writer
- Job Planning Lead
- Productive Operating Theatre Lead
- On-call Rota-writer and Trouble-Shooter
- College Tutor and Deputy
- Trainee Rota-writer
- Local Induction Lead
- Clinical Governance Lead
- Risk Management Lead
- Clinical Governance Links for Subspecialty Areas
- Audit Coordinator
- Safety Lead
- NICE Guideline Lead
- Complaints Lead
- Guideline Development and Monitoring
- Critical Incident and Serious Untoward Incident Investigator
- Blood Transfusion Lead
- Infection Lead
- Pharmacy Link
- Equipment Lead
- Medical Devices Training Lead
- Health Informatics Lead
- Procurement Lead
- Airway Lead
- Cell Salvage Lead
- Resuscitation Lead
- Sedation Lead
- Pre-assessment Lead
- Subspecialty Area Leads
- Educational Supervisors
- Programme Directors
- Trainee Mentors
- Acute Pain Lead
- Library Monitor
- Student Work Experience Lead
- Research Lead
- CPD Lead
- Allergy Testing Lead

For most consultants, the majority of SPA time is not spent on service objectives in pursuit of the employer's goals, but is spent on personal development objectives and other activities that contribute to appraisal and revalidation. A heavy managerial responsibility should be agreed as an additional NHS duty, not as SPA time. The Academy of Medical Royal Colleges has stated that consultants need a minimum of 1.5 SPAs per week on average to undertake the activities that will lead to personal revalidation, and more to undertake any duties or responsibilities in management, any teaching or training or research, and they emphasise that all consultants must engage in service development and clinical governance activities [3]. All this applies to consultant anaesthetists as much as anyone else.

Time and place is important when thinking about SPAs. The spectrum might run from a Trust in which complete freedom exists to undertake SPA work whenever and wherever one likes, to a Trust in which one is expected to sit at a specific desk for 10 h every Wednesday. Neither is particularly supported by the terms and conditions of service, and neither is necessarily appropriate, but some principles are important:

- If you undertake clinical work during SPA time, which may be appropriate from time to time, then you have a right to have that SPA time returned to you.
- If you agree to be in a specific place at a specific time, then your employer must provide proper supporting resources. A chair might be sufficient for attending a clinical audit meeting, but for individual governance work then a desk, computer, office and solitude are as likely to be important.
- If you take time back one week, put it in the next.
- Be reasonable and repay the trust that someone places in you.

Supporting professional activities are a vital part of consultant practice. Think as carefully about planning and delivering your SPAs as you do about your clinical work and all is likely to be well. The AAGBI believes that the outcome of the time spent on SPA is more important than the number of minutes spent per week, but consultants should be prepared to deliver – and to show that they deliver – on the time agreed within their job plans.

## 5. WTR – rest and work patterns

The Working Time Regulations (WTR) is British and Irish health and safety legislation that has applied to consultants and other career grade doctors since 1998 – often incorrectly called the European Working Time Directive (EWTD). The application of WTR to junior doctors has been on a phased basis, but applied in full – a 48-h maximum average working week – from August 2009. A very small number of specific junior doctor rotas have received derogation to have a 52-h working week until 2011. The reason that WTR impacts so significantly on healthcare services is as a result of two European Court of Justice (ECJ – Europe's highest court) rulings (SiMAP and Jaeger) on working time while on healthcare premises. These rulings have effectively ended the longstanding practice of on-call duties and made shift working the norm for doctors resident in hospitals. Box 3 (below) illustrates these rulings.

### **SiMAP ruling (2000)**

This defined all time when a doctor is required to be present on site as actual working hours for the purposes of work and rest calculations.

### **Jaeger ruling (2003)**

This confirmed that this was the case even if the doctor is allowed to sleep when their services are not required.

In April 2010 the European Commission announced its work plans during the European Parliamentary Session, which would include collation of data in relation to the actual implementation of the WTR across EU member states, its actual impact on health services and, most importantly, plans to renegotiate the Directive by the end of 2010. However, in practice, even if a new EWTD is agreed at the end of 2010, there will be at least a 2 – 3 year period before any change to employment law is actually enshrined in individual member state law.

The elected membership of the current European Parliament has moved significantly towards the right politically following elections during 2009. This is likely to alter the views of Parliament as a whole on many social issues, including WTR.



The European Commission, after consulting European social partners, has issued opinions on the WTR derogations for the UK underlining that the average weekly working time for doctors in training may not exceed 52h, including on-call at the work place, and that the temporary extension will last until 31 July 2011 [4].

The European Trade Union Confederation recently called upon the European Commission to pursue infringement proceedings against member states not adhering to the current WTR rules, including the ECJ rulings. The Commission has signalled its intention to delay any infringement proceedings for most countries in order to give individual member states further time to comply with the rulings but has commenced proceedings against Greece and Ireland, which on paper have poor track records of implementing WTR within their healthcare sectors.

### **‘Hot’ weeks in ICU**

Over recent years, especially in intensive care units (ICUs), it has become customary for consultants to have ‘hot’ or very busy weeks on duty. These hot weeks allow improved continuity of patient care. This is acceptable under WTR since guidance specifies that the average 48-h working week is calculated over a 26-week reference period. The single area that may not be averaged is the rest period; therefore, ICUs should be staffed to ensure that all doctors working there have an 11-h rest period in a given 24-h period. Although consultants can derogate from many aspects of the WTR, they may not derogate from the requirement to have an 11-h rest period (see Box 4, below). Those with responsibility for agreeing the job plans of consultant intensivists should be aware of this. Some ICU rotas provide for a ‘warm week’ in which a consultant acts as a backup to allow the first-on consultant to take the rest period if necessary.

#### **May consultants derogate from the average weekly working hours rules in the WTR?**

The answer is yes – but with two provisos:

- 1) That they should not be obliged to do so by their employers
- 2) That they may not derogate from the requirement for 11-h continuous rest period within any 24-h period

### **Indemnity**

The three main UK Medical Defence Organisations (MDOs) and the NHS Litigation Authority (NHSLA) have confirmed that doctors are indemnified when working in excess of a 48-h working week. The main exclusion from this indemnity cover would be wilful neglect or negligence by any doctor working in contravention of the General Medical Council guidance – ‘Good Medical Practice’ [5]. A doctor working as a locum (even via an agency) solely within the NHS will remain covered by the NHS Litigation Authority (NHSLA). The AAGBI advises that all doctors work responsibly, be mindful of not working excessive hours or treating patients when tired, and recommends that AAGBI members should be members of one of the MDOs. While not mandatory, it is prudent to notify your MDO if you voluntarily opt out of the WTR maximal working week, advising them of the actual hours you are working. This should be done in advance of working prolonged hours.

Members should note that NHSLA cover applies to work in the NHS but does not include all matters that can include representation at coroner’s courts, disciplinary cover and professional guidance on an individual basis – thus the recommendation to be an MDO member.

#### **Private practice and the WTR**

- Question:** Do the WTR apply to private practice?
- Answer:** The WTR only apply to employed work. However, there is a legal requirement for doctors not to present for work in an unfit condition.
- Question:** Can I do private work during my compensatory rest period?
- Answer:** This is not recommended, as problems with patient care might be ascribed to your being unfit for work because of fatigue.

## 6. Leave of all sorts

### Annual leave

Consultants are entitled to six weeks' annual leave. In England, consultants are allowed an additional two days called statutory days ('stat' days). Consultants in Northern Ireland have an additional two Bank Holidays (St Patrick's Day and Orangemen's Day). Consultants in Scotland and Wales have to make do with only the six weeks. In England and Northern Ireland, consultants on the 2003 contract and in post for seven years or more have an addition two days' annual leave. While there is no standard definition of a leave week, it is sensible and fair that this is commensurate with an individual's working week. Thus, someone who works three days per week should expect to calculate leave entitlement on the basis of  $6 \times 3$  (plus any additional) days, i.e. 18 (plus any additional) days and take leave of 18 (plus any additional) working days only. This should be defined in local leave policies and be fairly and equitably applied.

### Calculating annual leave

Six weeks' leave can be 42 days, 30 working days or six weeks' worth of clinical sessions. Departments have different ways of calculating leave, but leave calculations can still be the source of much unhappiness. Consultants should agree a mechanism for ensuring fairness in leave taking. The AAGBI thinks that it may sometimes be unfair to employers to take leave primarily on days that would otherwise include NHS clinical activity. In an extreme example, a consultant's working week could be compressed into two long clinical activity days. If the consultant were to take just these two days off in each of 21 weeks, they would have taken 42 days' leave but would have avoided clinical work for five months. This is evidently unfair. The AAGBI suggests that leave periods should in general contain the same proportion of DCC and SPA time as is in the consultant's job plan.

Another way of achieving fairness to employee and employer is to calculate consultant leave in terms of clinical sessions missed. Calculated in this way, a consultant who has six weeks' annual leave and who does six operating lists per week would be allowed to miss 36 lists per year. Additional days' leave can be calculated as proportions of a week. For instance, if a consultant is entitled to six weeks and four days' leave, this equals 6.8 weeks in decimal notation. If they do six lists per week, this comes to  $6 \times 6.8 = 40.8$  sessions. The kind Leave Monitor will round this up to 41 sessions. The punctilious Leave Monitor will allow 41 sessions' leave in four out of every five years but only 40 sessions in the fifth year.

It is worth noting that some employers are taking an increasingly unsympathetic view of consultants who seek special leave (see page 21) to perform duties for the wider NHS, such as work for the AAGBI, RCoA or BMA. As a result, some consultants are being forced to take annual leave to fulfil these valuable duties. If this is the case, and if such dates tend to fall on days when a consultant would normally be committed to direct clinical care, it is hoped that the Leave Monitor and Clinical Director will take a lenient approach and relax the approach suggested in the box above. It is also worth noting that consultants who maintain a meticulous and continuous year-round work diary will have a record of how many DCC PAs they have delivered for their Trusts. This may inform discussions and negotiations about leave, as it will provide an accurate record of what work has actually been done rather than a calculation of what should have been done.

The annual leave year usually begins at the anniversary of commencement of the consultant contract but some employers have a standard leave year for all employers, e.g. 1st April, which should be specified in the contract. Consultants on a substantive contract may carry over up to five days of untaken annual leave, although more may be carried over by special arrangement. Consultants who are not able to take all of their annual leave or to carry it over may be paid in lieu if this is in line with local agreements. Consultants must seek formal permission to take leave. Up to two days' leave may be taken with notification but without formal permission. Many departments set leave rules that allow the continuation of clinical service. These often include a minimum booking period, e.g. at least six weeks in advance of the leave to be taken, and a maximum number of consultants who can be away at the same time. All Trusts will have an agreed leave policy, which should be referred to.

### Sickness during annual leave

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

### Public holidays

A consultant is entitled to 10 days' public holidays or days in lieu thereof, which consists in England of eight public or Bank Holidays plus two 'statutory days', and in Northern Ireland 10 public or Bank Holidays. Some Northern Irish employers add these two additional days to annual leave entitlement. A consultant who works or is on-call on a Bank Holiday is entitled to a leave day in lieu. A common problem encountered is when a consultant requests a day in lieu because they were on-call on the night before a Bank

Holiday, and was therefore on-call for the period from midnight to the time of consultant on-call handover. The terms and conditions of service for consultants are clear: if a consultant is disturbed by work between midnight and 09.00 h of a Bank Holiday, that consultant is entitled to a leave day in lieu. In the old (pre-2003) contract, consultants on-call the night before a Bank Holiday were entitled to a lieu day whether or not they were working in the hospital or disturbed by calls after midnight.

### Study and professional leave

The distinction between professional leave and study leave can be confusing as the terms may be used interchangeably. Study leave is essentially to enable a consultant to participate in continued professional development (CPD) and may include:

- Study, usually but not exclusively or necessarily on a course or programme
- Research
- Teaching
- Examining and taking examinations
- Visiting and attending professional conferences
- Approved postgraduate purposes
- Working with colleagues in order to acquire new knowledge or skills

The recommended standard for consultants is leave with pay and expenses within a maximum of 30 days (including non-clinical and non-duty days falling within the period) in any three-year period. Leave will normally be granted to the maximum extent and all reasonable expenses should be met regardless of the employer's financial constraints. The Department of Health has clearly stated that professional leave is an allowance based on an individual's needs to attend to duties that are important for the broader benefits of the NHS and necessitates the consultant being away from their base of employment. Such duties can be recognised as 'external duty' PA rather than as professional leave. Any grant of leave is subject to the need to maintain NHS services.

#### What's the difference between study leave and professional leave?

A good guide to the usual difference is:

Study leave is when you are a registrant at a meeting and your employer should pay for you to attend it.

Professional leave is when you are part of the faculty at a meeting.

Where a consultant is employed by more than one NHS organisation, leave must be approved by all these organisations. During study leave with pay, the consultant **should not undertake any remunerative work** without the special permission of the leave granting authority. Unlike supporting activity, study leave facilitates absence for several days or even weeks at a stretch, where necessary. Therefore, study leave is a means of achieving professional activity goals *in addition to* (not in place of) SPA time.

### Special leave with or without pay

The provisions of Section 3 of the terms and conditions of service will still apply. This leave is granted without formal restriction and some consultants find it useful in working for medical Royal Colleges or professional associations.

#### Can my employers cancel my study, professional or special leave if it is within my allocation of 30 days per three years?

Yes, they can. Your employers can cancel this leave if not to do so would impair clinical activity in the hospital. However, employers should make every reasonable effort to avoid cancelling this leave.

### Sabbaticals

A consultant may apply for sabbatical leave according to existing arrangements. Proposals for sabbatical leave should be made before annual appraisal and considered in the annual job plan review. The contract in Wales has provision for consultants to seek a paid sabbatical for up to three months in order to pursue activity away from normal duties that will subsequently benefit patient care.

### Sick leave

A consultant is entitled to sick leave with pay where they are absent from work due to illness, injury or other disability. If unable to work for more than three days, a self-certificate can be submitted for up to the first seven days of sickness. For longer absences, another medical practitioner should provide regular medical certificates. The employer is entitled to ask for more frequent certificates and to assessment by its own appointed medical practitioner. Entitlement to paid sick leave relates to the duration of NHS service. This may be extended at the employer's discretion. Your employer will have a policy that will determine whom you should tell if you have to take sick leave. However, as a senior professional within the organisation, it would be right to tell those people in the area in which you were to be working that day.

### **Maternity leave, domestic, personal and care relief**

The regulations relating to these different forms of leave are determined by local employers on the basis of the NHS terms & conditions. Consultants should check with their employing hospitals.

## **7. On-call**

Emergency work is an important aspect of the clinical duties of consultant anaesthetists and intensivists. Indeed, it could be argued that all anaesthetists and intensivists should have emergency work of some sort included in their job plan. For the large majority of consultants, this will be provided within the on-call service for their employing hospital. For the minority who do not do on-call, emergency work can be conducted in the form of trauma lists, daytime or evening emergency lists, covering the Accident & Emergency Department during weekday hours or other activities likely to bring the consultant into contact with emergency work.

The 2003 consultant contract includes payment of an on-call availability supplement that takes into account the frequency and intensity of the on-call duties (see table).

<b>Frequency of rota commitment</b>	<b>Value of availability supplement as a percentage of full-time basic salary</b>	
	<b>Category A</b>	<b>Category B</b>
High frequency: 1 in 1 to 1 in 4	8.0%	3.0%
Medium frequency: 1 in 5 to 1 in 8	5.0%	2.0%
Low frequency: 1 in 9 or less frequent	3.0%	1.0%

The work of consultant anaesthetists and intensivists is almost always in intensity Category A. It is worth noting that this supplement does not include payment for work conducted; it is simply for availability. The predictable amount of work involved in doing on-call work should be included in the DCC PAs within the consultant's job plan, taking into account that most, if not all, of this work is conducted in premium time, i.e. at weekends and between 19.00 h and 07.00 h on weekdays. If there is doubt about the amount of work performed during on-call duties, a diary monitoring exercise that covers at least one full on-call cycle should be conducted. The results of such an exercise can be used to inform the job planning process.

### **Compensatory rest after on-call**

Consultants are subject to the provisions of the WTR, and therefore cannot be expected to fulfil a work pattern that does not include 11 consecutive hours of rest per day. Therefore, predictably onerous on-call duties that almost always involve work at night should lead to a consideration of whether the consultant should have clinical duties allocated during the daytime before

a night on-call or the day after a night on-call. If a consultant is required to work during a night on-call, he/she is entitled to compensatory rest the following day. Indeed, patient safety considerations will often mean that it would be foolish to continue to work after a busy on-call night or period of duty. If a consultant is scheduled to be working in the operating theatre on the day after a night on-call that proves to be very busy, the consultant can demand compensatory rest and miss the lists. In doing so, the consultant should take into account any risks to safe patient care that this might involve. In turn, the Clinical Manager of the department of anaesthesia (Clinical Director, CD) should make every effort to ensure that tired consultants are not expected to work after onerous nights on-call. A question that is commonly asked is whether, having missed a list through compensatory rest after a night on-call, the consultant can be expected to do an additional list to make up for the list that was missed. The answer is no. Job plans should be designed such that predictably busy nights on-call are not scheduled before a day of clinical duties, or indeed SPA activity. In this way, compensatory rest can be built into consultants' job plans without compromising service, safe patient care or CPD activities. A consultant should think carefully before conducting other clinical activities during an identified period of compensatory rest after on-call duties.

<b>Question:</b>	If I have a very busy night on-call and miss an NHS list the next day because I am taking compensatory rest, do I have to pay that list back?
<b>Answer:</b>	No, you do not have to pay the list back in any way.
<b>Caveat No 1:</b>	Consultants' job plans should be designed such that NHS duties are not scheduled in the day after predictably busy nights on-call.
<b>Caveat No 2:</b>	Consultants should not deliberately arrange their on-call duties so as to place them the night before NHS duties.

### Coming off the on-call rota

Almost all consultant anaesthetists and intensivists are appointed to job plans that include on-call duties. During their working life, some consultants seek to relinquish their on-call duties for a variety of reasons that include illness, increasing age, and family or other domestic or professional commitments. If a consultant wishes to drop his/her on-call duties, he/she should discuss this with his/her CD. If the reason relates to stress or illness, assessment by the Occupational Health Department (OH) is appropriate. If OH recommends

that the consultant be removed from the on-call rota for health reasons, employers should make every effort to make this possible. Consultants should note that if they are released from on-call duties for health reasons, they should think carefully before making themselves responsible for the emergency cover of any patients out-of-hours. This might occur if the consultant anaesthetises a private patient who stays overnight in a private hospital. Under such circumstances, the consultant might wish to ensure that another consultant is on call for this patient and that there exists a written agreement confirming this.

The AAGBI has recommended that "there should be a review of on-call responsibilities for anaesthetists over 55 years of age" [6]. Consultants have no right to drop on-call duties at a set age, as this would be contrary to UK age discrimination legislation, but CDs should consider reasonable requests to discuss on-call duties from older members of the department. Small departments may find allowing a consultant to come off the on-call rota very difficult because of the increase in on-call frequency for the remaining consultants. Larger departments will find it easier to allow people to leave the on-call rota but should be wary of creating a rule that consultants over a set age should not do on-call, first because this may be contrary to the provisions of age discrimination legislation and second, as the demographics of the consultant body may mean that a large group of consultants of a similar age may all demand to come off the on-call rota at roughly the same time at some point in the future, and this may severely compromise service provision. Some CDs ask consultants coming off the on-call rota to take on additional duties such as additional weekday lists or regular out-of-hours emergency commitments such as evening or weekend trauma lists. Such arrangements should be individually negotiated. No consultant has the right to come off the on-call rota other than for health reasons. No CD has the right to demand additional work to compensate for coming off the on-call rota. Contracts can only be changed by mutual consent from employer and employee. Clinical Directors should take reasonable steps to cooperate with consultants who wish to come off the on-call rota for family reasons; Human Resources Departments are useful points of contact when discussing the rights and responsibilities of employers and employees in such matters. Again, negotiation lies at the heart of such arrangements, and it is usually possible to reach equitable agreements without formal referral to Human Resources or senior managers. Where agreements cannot be reached, the BMA's Industrial Relations Officers (IROs) can be an invaluable source of support and advice.

### **Changes to the frequency of on-call**

Changes in the number of consultants in the department, in the number of active consultants in the on-call rota and in the number or nature of on-call rotas provided by the department may produce changes in the frequency of on-call duties. Consultants have a responsibility to help the department fulfil its service commitments safely and effectively, but changes to a consultant's job plan and contract should only be made by mutual agreement after negotiation. If changes to the frequency of on-call affect the on-call availability supplement or number of DCCs paid for predictable work during on-call periods, these should be reflected in the pay of consultants.

### **Consultant residency on-call**

Consultants are not obliged to provide a resident on-call service. The 2003 contract states that "a consultant will only be resident during an on-call period by mutual agreement" [1]. However, changes in trainee numbers and working hours, and service reconfiguration within a hospital may mean that consultant residency in out-of-hours periods in the form of shift working or residency on-call may form part of a possible solution to service demands. In these circumstances, the AAGBI recommends that the consultants negotiate with their employers and in doing so make sure that adequate recognition is made in their job plans and in their pay for the additional work and inconvenience that such changes will involve. The LNC should be involved in such a change; the BMA's IROs can offer invaluable support in negotiations. Consultants should not commit to such a change without a formal written agreement that includes the opportunity to review and change the arrangements after a period of their implementation. Some departments consider responding to requests for consultants to do shift work or become resident on-call by making them a requirement of recently appointed consultants but not of established consultants in a department. The AAGBI joins the BMA in arguing against such practice; it risks dividing the consultant body and creating potential tensions that will not be conducive to safe and effective patient care.

### **Covering trainee absence on-call**

A consultant has a duty to deputise for absent consultant colleagues so far as is practicable, but this does not include joining trainee on-call rotas. However, consultants do have a professional obligation to ensure that emergency clinical services offered to patients are undertaken safely and effectively. When faced with a situation in which a trainee scheduled to work an overnight shift is unavailable because of illness or rota failure, consultants have a responsibility to work with managers to obtain a locum. Sometimes, this is not possible and the consultant may have to work in the place of the

trainee as a last resort. If undertaking work of this kind, the consultant should ensure that they possess all the necessary competencies required for the role. For example, some trainee roles require training in safe patient transfer, and consultants working in some subspecialties not requiring these skills may not have current training. If a consultant agrees to do this, a written agreement is highly desirable before the start of any resident work. Local Negotiating Committees should be encouraged to prepare *pro forma* agreements to facilitate these negotiations. The BMA provides a model agreement for LNCs to use in such circumstances. If the agreement includes payment for the consultant under these circumstances, the rate of pay should reflect the grade of the doctor doing the work, not the grade of doctor being replaced, i.e. the consultant should be paid to do this work as a consultant, not as a trainee.

## 8. Part-time and flexible working

The Department of Health has stated that the current consultant contract should provide the necessary flexibility for those who wish to work either part-time or flexibly in nature. Part-time contracts may be offered between one and nine PAs. For appointments after January 2004, where the request to work part-time is in order to undertake private practice, the contract should not normally be for more than 6 PAs. Those with reasons other than private practice, but who may wish to undertake some private work, can be appointed to a contract of more than 6 PAs. Part-time consultants wishing to undertake remunerated clinical work in their non-NHS time would be expected to offer up to one extra PA on top of their normal working week.

Transitional arrangements from the old contract will require accurate diary evidence to permit the transfer from notional half days (3.5 h) to programmed activities (4 h). Any increase in workload can only occur by mutual agreement and the award of extra PAs. The division of PAs between DCC and SPA is roughly pro rata but it is acknowledged that part-time consultants need the same opportunity to maintain their skills through CPD. Proportionally, more of the PA time should be directed towards SPAs. Part-time consultants will not carry the same clinical load as full time consultants. Recommended numbers of SPAs for part-time contracts are shown in the box below.

Total number of PAs	Number of SPAs
2 or less	0.5
2.5 – 3.5	1.0
4.0 – 5.5	1.5
6.0 – 7.5	2.0
8.0 or more	2.5

Apart from the PAs, a part-time consultant should have no other NHS commitments during the working week. Participation in an on-call rota will receive remuneration with the same supplement as a full-time consultant on that rota. Part-time consultants may undertake on-call either at a reduced frequency – for example at a 90% frequency for a consultant working a 9 PA job plan – or at the same frequency as full time colleagues. If the consultant works on-call at a 90% frequency, the on-call supplement is calculated as a percentage of 9 PAs. If they work on-call at the same frequency as other full-time colleagues, the on-call supplement is calculated as a percentage of a full-time, 10 PA salary. If the consultant undertakes an on-call duty on a day

that they do not normally work, then time off in lieu or additional payment will be agreed.

Flexible training adds time within the training grade. This may make it difficult for people who have undergone flexible training to reach the top of the consultant pay scale. Where necessary, they will have their progress through the thresholds adjusted so that they will reach the threshold they would have reached if in training on a full-time basis.

The contract allows for flexibility in timing and location of consultants PAs. Employers have a duty to make reasonable attempts to accommodate this. The employee has a right to return to a regular pattern of work after a period of flexible working. Examples of flexible work patterns include job-sharing, annualised hours contracts, flexi-time and term-time working. Annualisation allows employees to vary their weekly commitment, for example, during school holidays, making the time up in term time.

### Annualised working

Although the 2003 contract offers little detail to guide CDs and consultants in devising and agreeing annualised contracts, it does make provision for them. There are a number of ways that a job plan can be annualised, but anaesthesia lends itself to such manipulations, as clinical care is readily divisible into operating lists and clinics. The important principles are as follows:

- Consultants should work an agreed annual total of PAs instead of the same number each week.
- The arrangement must be compatible with best practice in job planning for consultants.
- The arrangement must be agreed, as it would be for any job plan.
- The number of PAs to be worked in a year is usually the product of the number of PAs per week in a base job plan multiplied by the number of weeks in a year. For a 10 PA job plan, this would be 520 PAs.
- Consultants do not work 52 weeks per year, so reasonable allowance must be made for Bank Holidays, annual leave, study and professional leave, sick leave, maternity leave, special leave, etc. The usual range of working weeks used in annualised working calculations is 40 – 42 weeks per year.

We will provide one sample calculation as an example. Dr HG is a consultant anaesthetist whose outside activities include heavy commitments to the RCoA, AAGBI, NICE and ACCEA. He wishes to annualise his contract

to give him the flexibility to attend a large number of meetings. His base contract is for 10 PAs, and comprises 5.5 operating lists per week, 2.5 SPA and 0.5 PA for predictable emergency work on-call.

He and his CD agree that his annual leave (6 weeks and 4 days) and Bank Holidays together will amount to 8 weeks per year, his study/professional leave will be 2 weeks per year and that his special leave allowance on top of this, given his level of national activity, shall be an additional 1 week. This means that the number of lists he will be expected to do will be  $41 \times 5.5 = 223$  lists per year. He is allowed to work this fully flexibly given that he gives at least 6 weeks' notice of times of the week that he is available to work. He agrees with his CD that he will also work his  $41 \times 2.5 = 102$  SPAs flexibly and will agree verifiable outcomes for this SPA time. They agree that if sick leave is taken during periods of annual leave, time will be given back using a formula of 6 sessions per week's sick leave. Both Dr HG and his CD are happy with this arrangement.

Annualised contracts are not the perfect solution for everyone, and a department of anaesthesia would not wish too many of its consultants to work in a fully flexible fashion. The AAGBI recommends that those consultants working annualised contracts make it clear when they plan to take their allocated annual leave in order to avoid any arguments if sick leave is taken in non-working weeks, as sick leave taken during annual leave should be 'paid back', but sick leave during non-working periods that are not annual leave need not be.

## 9. Job planning

Job planning is the process by which the aims and requirements of employer organisations are translated into agreements detailing how individual consultants will contribute to the delivery of those aims. All employing Trusts want DCC and SPA activity aligned to the Trust's needs; job planning is the mechanism to ensure this. It allows Trusts to obtain maximum value from DCC and SPA sessions. There are some minor differences in the devolved countries. Country-specific information can be found in detail within the terms and conditions of service for the country in which you are employed.

Job planning takes place at least annually and is a prospective process. All consultants, whether or not they are employed under the 2003 consultant contract arrangements, are obliged to undergo annual job plan reviews. Job planning is a partnership process; job plans may not be imposed – the agreement of both parties is required. Job planning is a separate process to appraisal although outputs from the job plan review will inform the appraisal mechanism. Should there be significant change to a consultant's commitments, then an interim job plan review can be requested at any stage.

There is extensive guidance describing job planning and how to undertake it. Unhappily, although the requirement for consultant job plans has existed since 1991, job planning can still be a poorly conducted process: the process may focus simply on the development of a timetable or be seen as an opportunity to reduce PAs. At its heart, job planning is really about objectives and the SPAs that help deliver them. The process is intended as a partnership activity that delivers benefit for both consultant and employer. It allows consultants the opportunity to lead on service development both in quality and productivity and to identify the resources needed to deliver objectives. Employers are afforded the ability to extract the added value that consultants bring. Both parties benefit from clarity about commitments.

Preparation for job plan review is essential. Some supporting information will be required; a work diary is invaluable, where possible supported by activity data, comparative workload and/or ideal workload data. Consultants must have an appreciation of the process itself. It is helpful to have read some of the available guidance ahead of the review meeting. Similarly, it is advisable for consultants to consider what they need from the review and where they might be challenged.

The process is based on agreement; job plans are not imposed. A draft job plan should be prepared by the Clinical Manager – this forms the basis of



discussion at the review meeting. More than one meeting may be required. Both parties may be assisted at the meeting(s) – the Clinical Manager by a General Manager and the consultant by a colleague or advisor.

The job plan review should be systematic. Trusts may be keen to focus on elective work; it is more appropriate to give early consideration according to clinical priority or on areas where agreement may be more difficult. Emergency work should be the first priority – time spent dealing with predictable on-call work should be reviewed first followed by unpredictable on-call. On-call activity should be averaged over a 1 – 8 week reference period. Contentious areas may be, for example, work undertaken in premium time, SPA allocation or Additional PAs and fee-paying services. Although consultants cannot be required to undertake planned work in premium time, there is an increasing need for consultant presence; it may be helpful to consider a local agreement. Similarly, it should be borne in mind that SPAs are not an automatic entitlement – they need to be justified and accounted for with agreed outputs in objective setting.

After discussion the job plan is signed off as agreed by both parties. If agreement has not been possible consultants may use the mediation and appeal process.

### **Mediation and appeal**

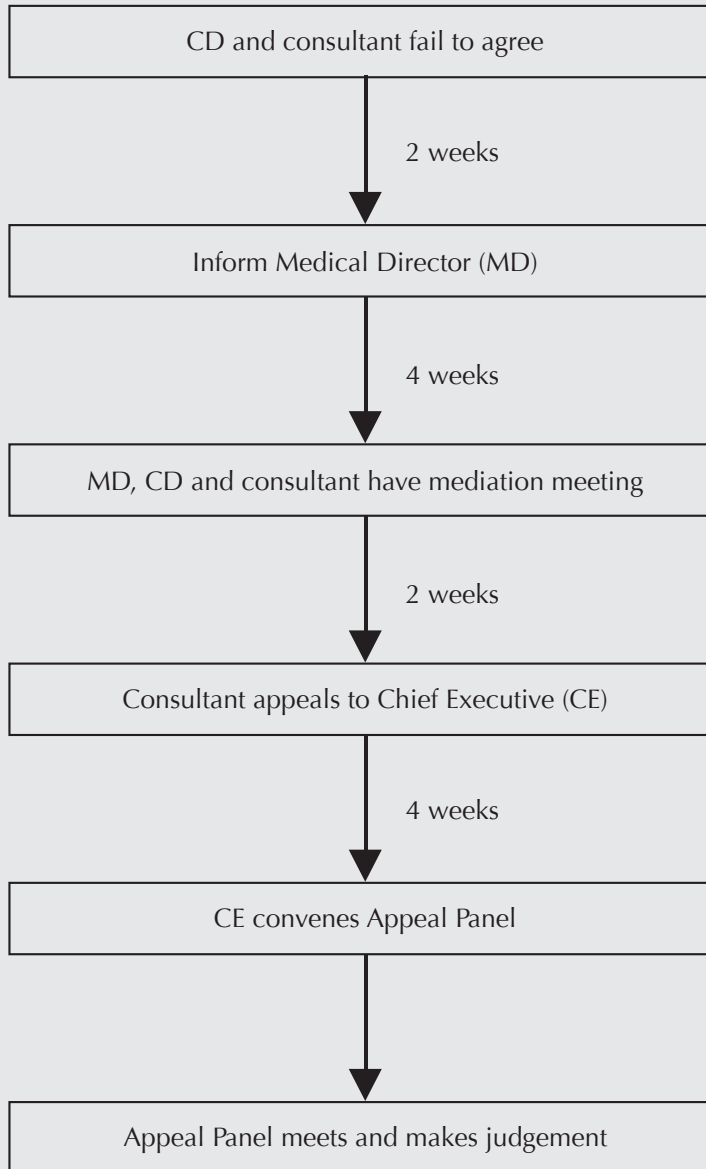
The mediation and appeal process is part of the 2003 consultant contract process to help resolve disputes over job plans and pay progression. It is not designed for use in other settings, for example disagreements over CEAs. Although consultants on the pre-2003 contract are required to undergo annual job planning, their contractual arrangements do not include mediation and appeal.

Mediation and appeal are incremental processes. Mediation, a less formal process, is tried first, before moving on to appeal where necessary. When a job plan or pay progression cannot be agreed either the consultant or the Clinical Manager may refer the matter, in writing, to the Trust's Medical Director within two weeks of the disagreement. The referral will describe their view of the matter, and the other party will be invited to respond in writing. It is recommended that all areas of dispute be brought to mediation in case they need to be formally considered at some later stage by an Appeal Panel. The Medical Director will convene a meeting between the Clinical Manager, the consultant and him/herself within four weeks of receipt of the referral. Agreement between parties is sought at the meeting; if this is not possible then the Medical Director will decide the matter and will inform all parties in writing.

If the consultant is still not satisfied, then he/she may lodge an appeal in writing, outlining the basis of the appeal, to the Chief Executive within two weeks of the outcome of mediation. The Chief Executive will convene an Appeal Panel that should meet within four weeks of receipt of notification of appeal. An Appeal Panel consists of three members, none of whom should have been involved with the case previously. The panel is chaired by a nominee of the Trust, often a senior non-executive director. The second member is nominated by the consultant. The third member is chosen from a list held by the Strategic Health Authority of approved independent appeal panellists. Such members may either be from BMA/BDA backgrounds or have managerial backgrounds, often within Human Resources. Either party can object to the third member suggested and a new member will be appointed. The 2003 consultant contract specifies that the Appeal Panel will be arranged by the Chief Executive to meet within four weeks of the written request from the consultant. Although delay is undesirable, in reality, given the difficulty in arranging the attendance of consultants and other senior NHS personnel, the four-week timescale may be subject to some slippage. When delay occurs the appellant should not normally be penalised; any contested payments should be backdated to at least the date on which the appeal was lodged.

Both parties make written submissions ahead of a hearing, and copies are sent to all panellists and to the other party. At the hearing, at which the consultant may be represented but not by a legal representative, both parties present their case to the panel. Expert advice may be required by the employer, the consultant or the panel. Panel members may ask questions of both parties and of the expert advisor(s). The appeal hearing lasts no more than one day. The Appeal Panel makes its judgement within two weeks of the hearing, notifying both the Trust Board and the consultant in writing. The Trust is not obliged to accept the panel's recommendations but would normally be expected to do so.

**Job planning is by agreement, not decree: what to do if you cannot reach agreement**



## 10. Changes to job plan when services are reconfigured

Clinical and other services will change with time and so will your job plan. The usual principle applies – all changes should be agreed changes. Furthermore, both parties should act reasonably, especially when considering changing the job plan to fit in with changes in local service provision. However, from time to time the employer will need to change a consultant's job plan to fit in with service changes, to reconfigure services, cut costs or introduce new technologies.

When facing such a situation, and particularly if it seems likely to involve a change to one's own job plan, it would be important to think about the potential changes and whether one is dissatisfied with them. For example, would it substantially change the nature of the service that one provides? Would it involve more or inconvenient travelling? Would it have an impact on the ability to meet commitments, for example through having on-call responsibility for a hospital that is further away? You should seek to discuss such questions with your clinical manager at the earliest opportunity.

Nevertheless, at some point you may be faced with a change to your job plan that is prompted or required by a reconfiguration and with which you are unhappy. You should seek personal advice from a trade union representative as soon as possible, either through the LNC or the BMA. The normal processes of mediation and appeal are important but in this case there will be other factors that will affect the judgment that an arbitrator will make on the disagreement. A consultant would usually be badly advised to seek to obstruct changes by attempting to veto changes to their job plan when, for example, a hospital closes or reconfigures its services.

### Agreeing or disagreeing with changes

Contractual changes should be by agreement unless an employer is prepared to give notice of a change. You should know the circumstances under which you give your agreement and what rights and support you have if you do not wish to agree. Giving one's agreement to a job plan change can be tacit as well as explicit. Most changes to job plans over the years are implicit, and an important function of job planning meetings is to codify such changes so that there is an explicit written understanding; but a change need not be written to be a contract variation. So, where an employer imposes a unilateral change to a job plan, for example the timing or location of an operating list, and the consultant carries on working without complaint, they will be treated by the

law as having agreed to that change. It is a common misconception that one can preserve one's rights through refusing to sign a document; it is not the failure to sign, but the employee's conduct, that is important.

Should you want to disagree, if you have not already done so, now is the time to seek professional advice. You should also look for information on job planning that may be available from the RCoA, AAGBI or BMA websites.

Any unilateral imposition of contractual changes may result in a claim for breach of contract, or a resignation and then claim for constructive dismissal. Except where intractable disputes arise or the business needs reorganisation, Trusts are very unlikely to do this – in the vast majority of cases you will be able to address problems through negotiation.

## 11. Academic contracts

This section illustrates principles for job planning in a post where the basic week is roughly 50:50 divided between NHS and university. Clearly, other arrangements are possible and may be explored using similar principles.

### **The basic week**

The basic working week comprises 10 PAs. Regardless of whether academic posts are fully funded by the university (some senior staff and some Foundation Chairs) or co-funded by the NHS, the principles are the same. In addition, the split of this 10 for planning purposes should be regarded as about five to be planned with the university and about five to be planned with the NHS – and, if you are a university employee, agreed with the university. All basic contracts comprise 10 PAs and there is no obligation on either the employer to offer or the employee to accept contracts >10 PAs. Accordingly, all advertised jobs should include a base 10 PA job plan.

### **Five PAs for the university**

This may be for research, teaching or management as agreed with your line manager. Typically, for Research Excellence Framework (REF)-returned, research-active staff, the major activity will be research. None of this time is to be used for NHS management or other NHS clinical or non-clinical activities.

### **Five PAs for the NHS**

This comprises a mix of SPA time and DCC. The vigour with which the NHS partner pursues clinical work from university-employed clinical academics inevitably reflects their underpinning funding. If the clinical time is university-funded, then the NHS partner may reasonably take a 'light touch' approach. Conversely, where the five PAs are NHS-funded (by recharge), then they may have higher expectations in terms of clinical work delivery.

### **SPA time**

Mindful of personal development, CPD requirements and the increasing burden to be expected with revalidation, this will never be <1.5 PAs and will commonly be 2.5 PAs. Remember that all clinicians need CPD to the same level, regardless of the total amount of clinical work that they do. You must be prepared to account for your SPA time. Commonly, NHS clinical departments will allow 1.5 PAs of SPA time as a baseline for personal CPD, etc. Frequently, SPA time between 1.5 and 2.5 needs to be accounted for in some detail, e.g. having responsibility for a particular role within the NHS department. NHS partners typically recognise that consultants may engage in important NHS-

related and other specialty activities outside the Trust. This may include roles in medical Royal Colleges, specialist societies, regional and national NHS bodies, etc. This may, with agreement, be properly included in SPA time and where such agreed activities are extensive then the allowance of SPA time may be more than 2.5.

**Clinical work (DCC)**

This includes clinics, operating lists, ward-rounds as well as patient related paper work and meetings. This must be agreed with the NHS partner. Note that in order for clinical work to attract PAs over and above the basic week, a clear and agreed account must be given for first five PAs for the NHS.

**Additional PAs for the university**

The university may offer additional academic time to clinical academic staff. This additional academic time is discretionary and you may decline it if you wish.

**Additional PAs for the NHS**

By agreement with the NHS and with the approval of your university line manager, you may work additional PAs to a maximum of 12. On-call is typically paid for in this part of the contract. Clinical work such as clinics will only attract additional PAs if the basic 5 PAs for the NHS are clearly described and justified.

**Special activities for the NHS**

Special roles for the NHS such as research work, Network Lead, R & D Director, Clinical Manager, clinical governance, etc may be described in SPA time. It may be appropriate to include these as additional SPAs for the NHS provided that the underpinning description of the basic NHS commitment is convincing and overall commitment is not impacting on academic performance.

**Actual contract**

In practice almost all staff employed under the 2003 consultant contract opt to agree additional activity. Where this is to be offered an alternate shadow job plan will also be prepared illustrating how an agreed longer working week might be structured. Typically, a job plan will comprise the university sessions (paid for and managed by the university) and NHS sessions paid by the university, managed (with joint appraisal and job plan agreement, see overleaf) by the NHS partner and recharged at cost to the NHS partner by the university.

**University sessions**

A typical academic contract will contain about five university sessions in the basic 10; there are therefore about 20 h that the staff member should work in an actively managed process against agreed the university activities, e.g. management, teaching and research.

**NHS time**

NHS time will comprise a mixture of DCC PAs and SPAs. The NHS part of the job plan must include a proportion of SPA time. It is important that the NHS proportion of the job plan contains an adequate amount of SPA time in order to give the clinical academic sufficient time to address the non-clinical part of their NHS role and to ensure that this does not spill over into the University-funded academic time. The following table indicates a typical DCC/SPA split. This provision of SPA time should be regarded as a minimum and where the post holder undertakes significant SPA activity for the NHS partner a greater allocation may be appropriate.

NHS PAs (total including on-call)	DCC PAs	SPAs
6	4	2
5	3.5	1.5
4	2.75	1.25

**Total contract**

The clinical academic consultant contract is a single contract, not two half-contracts, and it is ultimately accountable in its entirety to the university line manager and the employing university, although the active management of the clinical proportion of the job plan is typically delegated by agreement to a clinical manager within the NHS partner. The total job plan should not exceed 12 PAs.

**Job planning, appraisal and accountability**

NHS pay progression rules require that individuals complete a job planning process and appraisal every year in order to be eligible for pay progression and CEAs. Universities endorse and apply this principle. Appraisal of the university staff with three or more NHS PAs in their job plan should be joint appraisal (this means three people in one room at the same time, not separate NHS and University appraisals). The job plan (final version as signed by the NHS line manager) must be agreed with the university line manager and a copy lodged with the university HR section (and updated every year).

### **Implementation guidance**

Individual NHS partners have developed detailed implementation guidance and this can usefully be applied to the university staff.

### **Management responsibilities**

The university staff may (with the prior agreement of their university line manager) adopt management roles within NHS partner organisations. Such roles may be reimbursed by the NHS partner using varied mechanisms. Typically this involves substitution of management for clinical activity (without additional payment) or additional payment without allocation of time or some combination of the two. All NHS management activities whether paid or unpaid must be accommodated within the proportion of the job plan allocated to NHS activities. University time is not to be used for NHS management activities.

### **Teaching**

The nature and quantity of teaching undertaken by clinical academics must be prospectively and transparently agreed and unequivocally located within the job plan. Typically, the university clinical academic staff will undertake some teaching within their actively managed university sessions and will not receive additional payment for this. Where (by prior agreement) teaching takes place during the NHS proportion of their contract, it may take place as an SPA (without additional payments), by substitution for fixed clinical commitments (without additional payment) or as additional contracted activity which must be included in the job plan and the total job plan must not exceed 12 PAs. It is not acceptable for university staff to solicit or receive supplementary payment for teaching (via NHS partners) and expect or be expected to deliver this within their contracted university time.

### **Annualised contracts and additional leave**

Some NHS clinicians operate annualised contracts wherein the total quantum of work for the year is agreed and delivered flexibly (again by prior agreement). In some cases working weeks beyond 12 PAs are recognised by 12 PA contracts with additional annual leave. Such arrangements for the university clinical academic staff should be regarded as exceptional and should in all cases be prospectively approved by the university.

Universities recognise that clinical academics are hard working, versatile individuals and expect that contractual arrangements may reasonably be operated with considerable flexibility. A key principle is transparency, accountability and continual clarity about time allocation and the proper relation between NHS and the university duties.

## **12. Differences in the devolved nations**

### **The 2004 contract in Northern Ireland**

By 2010 over 98% of consultants had transferred to work on this contract, which closely mirrors the 2003 English contract. Despite some years having passed since the introduction of this contract, many consultants continue to work to retrospective job plans – Trusts do not appear to have caught up with prospective job planning. The two main reasons advanced for this are Trust and NHS reorganisation and lack of medical managerial manpower or time. It is likely that there will be major change, as the Northern Ireland Health Service is under severe financial strain and faces further financial cutbacks. A 2009 moratorium on study leave funding was lifted in some Trusts in 2010 but there is a requirement for annual savings of over £100 million in the coming years, and there are suggestions that medical staff posts may remain vacant to save money.

The 2004 Northern Ireland consultant contract has four main elements:

- Direct Clinical Care (DCC)
- Supporting Professional Activities (SPA)
- Additional HPSS (Health and Personal Social Services) Responsibilities
- External Duties

The recommended norm is for a 7.5 DCC to 2.5 SPA split in contractual obligations. In recent times and associated with budgetary restrictions, consultant SPA has come under very severe downward pressure with a suggestion from DHSSPSNI (Department of Health, Social Services and Public Safety of Northern Ireland) to Trusts that 1.5 SPA should be 'core' with all other SPA 'earned on an individual basis'. Both the BMA and AAGBI continue to recommend a 2.5 SPA allocation per consultant. In case of dispute it is essential that each consultant has a detailed and accurate diary outlining the actual work that they are doing should they need to follow the contract dispute processes of Facilitation (called Mediation in England) and thence Appeal.

There were moves from Trusts to assign Additional HPSS responsibilities and External Duties to a new category of leave – 'special leave'. However, this work is outlined specifically in the terms and conditions of service and advice should be taken from BMA / HCSA on the appropriate time to be included within a negotiated and agreed job plan.

Each individual consultant anaesthetist should seek prospective job plans for the year ahead and retain copy documentation of all contact / communications seeking job planning.

The latest rates of pay can be found on the BMA website [7].

Take home pay is determined by considering the following:

- Basic salary
- Any additional Programmed Activities
- On Call Allowance / Intensity Supplement
- CEAs / Discretionary Points
- Additional allowances – such as travelling expenses

Since 2007 Northern Ireland has had five Trusts. Each Trust should have an active LNC that engages with Trust management in negotiating local contractual arrangements. Issues that are under Trust control include payments for waiting list initiatives, resident consultant shift working out of hours and relocation allowances for consultant anaesthetists affected by acute service reconfigurations. In anaesthesia, resident shift working out of hours is increasingly likely and contact should be made with the local LNC to ensure the position and views of anaesthetists are properly represented.

### **The consultant contract in Wales**

Unlike the contract in England, the Welsh contract is an amendment to the original consultant contract and any points not covered in the amendment are unchanged from the original contract [8]. The amendment document is therefore much briefer than the necessarily more comprehensive English contract. However, many of the principles are the same, though it is important to appreciate that some of the points in the rest of this guide do not apply to consultants working in Wales.

The main amendments that are different from the English contract include:

- A basic 37.5-h working week (10 sessions of variable length).
- Typically, 7 DCC and 3 SPA sessions. Increasingly, Health Boards (formerly NHS Trusts) are appointing new consultants on 8 DCC and 2 SPA and there is pressure on existing consultants to come in line unless they can demonstrate extra activity to justify the third SPA.
- The first 3 h per week (in place of 3.75 h) of work as part of on-call (based on an average over 6 months) is counted as 1 session of DCC. Time worked over this is counted towards additional 3.75-h sessions.

- Provision that 1 SPA may take place at home in the evening (recognising the work by some consultants at home), allowing uncontracted free time during the day.
- No requirement to provide an additional session of time to the NHS in order to acquire the right to undertake private practice.
- Additional sessions for routine work are entirely voluntary with no requirement for compulsory weekend or evening work.
- Extra sessions requested by the Health Board are voluntary and locally negotiated for time and payment.
- In exceptional circumstances, resident on-call is remunerated at three times the sessional payment with an agreed compensatory rest period the following day.
- Commitment award scheme replaced discretionary points awarded with progress depending on satisfactory job planning (though expected to be universally awarded). This ensures continued pay progression throughout a consultant's career. National Excellence Awards are currently the same as in England.
- Recognition of different patterns of work intensity, particularly later in consultant's career.
- There is good provision for part-time and academic working through open, individualised job planning.
- A sabbatical scheme of up to three months of paid leave to undertake activities away from normal duties that will subsequently benefit patient care. The application and award of sabbatical leave is made locally.
- Flexibility and professionalism is encouraged as much as possible within the contract.
- In the event of a job-planning dispute, an initial conciliation procedure followed, if necessary, by a balanced appeals procedure that is binding on the Trust and the consultant.

### **The consultant contract in Scotland**

The Scottish model contract remains broadly similar to that in England although three amendments have been made with respect to maternity arrangements, flexible working and redundancy payments. Transitional arrangements, salary scale and the pay progression timescales are similar to those in England and an updated version of these may be accessed in the NHS circular PCS(DD)2007/11. Also explicit in the circular are the arrangements for payment of waiting list initiative work. They are: three times the hourly rate at point 20 on the seniority scale or, alternatively, twice the rate of pay with time off in lieu or standard rate plus twice the time off in lieu.

Premium time exists between the 20.00 and 08.00 h as opposed to the 19.00

and 07.00 h in England. In addition to this, non-emergency work may be programmed on a Saturday between 09.00 and 13.00 h, although this work is at premium rate and not standard.

As in England, the need for NHS employers to squeeze SPA time is evident in the current advertisement of consultant posts with less than 2.5 PAs identified for SPA in a 10 PA contract. The BMA (Scotland) and Academies of the Royal Colleges in Scotland have reached a level of understanding with the Management Steering Group (a self-appointed advisory group to the Scottish Executive Health Department) whereby all new posts will be advertised with time explicit for essential CPD. All other SPA must be agreed during the job planning process. This places accurate diary evidence as a priority for any consultant within NHS Scotland. All newly appointed consultants are advised to keep accurate diaries and to request a job plan review no later than three months after appointment if they feel their work balance is inappropriate.

Mediation and appeals for the job planning process are handled in a similar manner to England although the Divisional Chief Executive has a role in Scotland and the appeal panel make-up differs slightly.

The Merit Award and Discretionary Points system (SACDA – the Scottish Advisory Committee on Discretionary Awards) has been replaced by SACCLEA (the Scottish Advisory Committee on Clinical Leadership and Excellence Awards). Details of the new system are uncertain at the time of publication.

Local Negotiating Committee involvement remains crucial for the following issues where national arrangements do not exist: prospective cover included, re-imburement for consultants resident on-call, and provision for leave for forms of leave not otherwise specified.

## 13. The pre-2003 contract

This section is primarily intended for those clinicians with responsibility for management, leadership and job planning of consultant anaesthetists still on the pre-2003 contract. It is assumed that holders of these contracts are fully aware of the merits of both contracts and have elected to remain on the old contract. It is not the remit of this document to advise on that choice. This contract is not available to any consultant appointed since November 2003 or to those who have changed to the 2003 contract.

### Types of contract

This contract, initially agreed in 1979, describes units of work in terms of notional half days (NHDs) worked flexibly. Each NHD lasts 3.5 h. There is no premium for work in unsociable hours although there is provision for intensity payments. There are two main types of this contract for those who work full-time: whole-time and maximum part-time. Holders of both have a contractual commitment to devote substantially the whole of their working time to NHS activities with a minimum of 10 NHDs. There is also provision in this contract for part-time working in which there is no expectation that the post-holder will devote substantially the whole of their professional time to the NHS. Part-time contracts may range from one to nine NHDs.

Holders of whole-time contracts are limited to earning not more than 10 per cent of their gross NHS earnings in private practice and are required to make an annual declaration confirming this. Holders of maximum part-time contracts are not subject to any restriction on their private practice income but forfeit 1/11th of their NHS salary. There is also an effect on accrual of pension benefits in that holders of maximum part-time contracts will be credited with 10/11ths of a year's service for each year worked in pension calculations.

### Travel arrangements

Maximum part-time contract holders may count up to 30 min per journey each way for travel between home or place of private practice and their NHS place of work.

### Job planning

All consultants should expect to have annual job planning meetings and reviews in which both fixed and flexible work is defined. The same principles apply to job planning and appraisal for those on the pre-2003 contract as to those on the 2003 contract. Fixed commitments will largely be clinical work and times and locations of each NHD should be determined and agreed,

although NHDs may be flexible in time, location and type of activity. There is no difference in the number of fixed NHDs expected of full-timers and maximum part-timers. Normally this is between 5 and 7.

Non-fixed or flexible work describes that work covered in 2003 contract as SPAs as well as on-call and other irregular or unscheduled work necessarily undertaken. Evidence of activity and output would be expected. There is no reason why a consultant anaesthetist on the pre-2003 contract would need any less time for those activities that underpin their professional knowledge and skills. However, there may be an argument that those who spend substantial amounts of time working in private practice should devote some of their own time to supporting their professionalism and revalidation.

#### **Additional NHDs**

Consultants may be contracted for additional NHDs for clinical or non-clinical work, normally up to a maximum of two NHDs. These are temporary and non-pensionable activities that are remunerated at 1/11th of the full time salary.

**Question:** If you are on the old contract, does it mean that you do not have to undergo an annual job planning process and do not have to account for activities performed in paid non-clinical NHDs (notional half-days)?

**Answer:** The answers are definitely 'no' and 'no' respectively.

## **14. Starting out as a consultant**

Obtaining a consultant job is just the beginning; it is really just the start of even more hard work. Whilst new consultant anaesthetists must focus on their clinical workload, the other roles of a consultant must not be forgotten. With the likely introduction of revalidation, ongoing proof must be provided that time has been spent on continuing professional development. There are also a number of pitfalls to avoid. It is important not to take on every new role offered to you when starting as a consultant. The majority of new consultants are undoubtedly eager to get involved with their department but it is also possible to be swamped. It is worth taking time to decide what your priorities are and if necessary delaying these decisions until you are aware of the likely workload. Courses are run to help with 'saying no'; the ability to say 'no' can greatly improve your working and personal lives.

#### **Continuing Professional Development**

Ongoing learning as CPD does not end on achieving a consultant post. The Trust employing a doctor expects that they will achieve adequate and appropriate CPD each year. Guidance from the RCoA and Medical Education (England) will be taken into account in this process; for example, the RCoA gives advice on how much CPD is provided per activity and which activities are appropriate. Details of this and the number of CPD points you are expected to achieve per year are available at from the College's website. These CPD points may be acquired by attending a mixture of departmental, regional, national or international meetings as well as attending and teaching on courses. Suitable educational activities not awarded CPD points by the College may, however, be accepted by both the Trust and the individual to contribute to professional development. Trusts are encouraged to provide adequate study leave; if you have difficulties with your study leave allowance, you should consider contacting the BMA. A detailed portfolio or personal folder including certification should be kept of all activities to assist with the appraisal process. As well as speciality specific training, you will be expected to attend Trust mandatory training in areas such as child protection and manual handling.

#### **Supporting Professional Activity**

The 2003 consultant contract specifies that posts should typically contain 7.5 DCCs and 2.5 SPAs per week. With the current financial climate, SPA time is under scrutiny to ensure that it is being used effectively. If 1.5 SPAs per week is considered sufficient to maintain revalidation purposes, qualification for or maintain of the additional SPA may be based on evidence of activity. This may vary from service improvement projects, formalised teaching, to



being the departmental lead in a variety of different areas, e.g. paediatrics. Some new consultants may be happy to start with 1.5 SPAs but it should be noted that 2.5 SPAs are recommended by the AAGBI and other professional bodies for all consultants, including those newly appointed. Should a smaller number of SPAs be agreed, there must be opportunity for this to increase as non-clinical workload changes. Anaesthetic departments may pool their 2.5 SPAs per consultant, allotting more to those fulfilling a higher non-clinical workload. Maintaining a diary of how SPA time is spent allows the department to justify the ongoing allocation of such non-clinical time. Some Trusts may insist on a fixed SPA session or being on site for at least one of these; this is something that may need to be negotiated with your CD. Regardless of the number of SPAs decided upon, a formal meeting should be arranged at six months to reassess and adjust the number of sessions if required.

### **Job planning and development**

It is important to discuss, finalise and agree your job plan as soon as possible after the consultant interview process. You must ensure that your job plan when appointed matches the job plan advertised. A small alteration here may lead to a dramatic change in your job or in your work-life balance. It may be possible to adapt a job plan before starting work or even during the appointment process. Recently appointed consultants should ensure that their job plans do not involve a degree of professional isolation by scheduling work primarily in locations away from main operating theatre suites. The ready support and availability of experienced consultants can be valuable in the first few months and years of consultancy. Job plans should continue to evolve during your time as a consultant and it is important to meet with your CD to review and update your plan on a regular basis, e.g. at least once a year. You should sit down at the beginning of your new post and agree with your CD what is expected of you and your clinical commitments. It is better to find out exactly what is expected of you at the beginning of the job. Ongoing diary monitoring of your job will help inform future job plan discussions; in particular, the clinical burden may be either more or less than expected when the job plan was instituted. A consultant post may be held for 30 years so this ongoing review process of your job plan is important to keep you motivated and utilise your skills fully.

### **Where to get help**

Consultants of any age may need help, but it is likely that those starting out on their consultant careers will need more support and advice than those in mid-career. Some hospitals have a Young Consultants Group that promotes the discussion of common issues. Some departments of anaesthesia allocate

senior mentors to junior consultants; the AAGBI supports this. Even if there is no formal system within your department, you will usually find useful and sympathetic help and support if you need it. If you wish to seek help outside of your department, the AAGBI, RCoA and BMA offer support schemes. The AAGBI supports the BMA Doctors for Doctors scheme, where support can be found 24/7 for any welfare issue on 0845 920 0169. The AAGBI recognises the importance of supporting members and the AAGBI Welfare Committee has been established to help support all members, including those experiencing problems during this difficult time of transition. Further information can be found on the AAGBI's website ([www.aagbi.org](http://www.aagbi.org)) and a Welfare Resource Pack is also available to download. For more practical career advice or less urgent advice from the AAGBI, email [wellbeing@aagbi.org](mailto:wellbeing@aagbi.org).

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