



Mr. Peter May
Permanent Secretary
Department of Health
C5.11
Castle Buildings
Stormont
Belfast
BT4 3SQ

4 May 2022

Dear Sir

**Re: The Statutory Independent Public Inquiry into Urology Services in the
Southern Health and Social Care Trust**
**Provision of a Section 21 Notice requiring Witness Statement & the
production of documents**

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry is investigating the matters set out in its Terms of Reference. A key part of that process is gathering all of the relevant documentation from relevant departments, organisations and individuals.

In keeping with the approach we are taking with other departments, organisations and individuals, the Inquiry is now issuing a Statutory Notice (known as a 'Section 21 Notice') pursuant to its powers to compel the production of relevant documentation.

This Notice is issued to you in your capacity as Permanent Secretary in the Department of Health. It relates to documents within the custody or control of the Department of Health. The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you are aware the Department of Health has responded to our earlier Section 21 Notice requesting documentation. If the documentation previously provided deals with a request made within this S21 Notice request, please highlight the relevant document and bring it to the Inquiry's attention. In addition, if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Department and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you, your officials and/or the Department's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit your organisation must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty. The Inquiry will be pleased to receive your documents in tranches; you do not have to wait until you are in a position to fully comply with the Notice before you begin to send

documents. Indeed it will greatly assist the progress of the Inquiry's work if you immediately begin the process of forwarding documents to the Inquiry.

If your organisation does not hold documentation in respect of some of the categories of document specified in the Section 21 Notice, please state this in your response. If it is possible to indicate by whom such information might be held, if it is not held by your organisation, the Inquiry would find that of assistance.

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

Personal Information redacted by USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel:

Personal Information redacted by the USI

Mobile:

Personal Information redacted by the USI

**THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST**

Chair's Notice

[No 50 of 2022]

Pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

**TO: Mr. Peter May
 Permanent Secretary
 Department of Health
 C5.11
 Castle Buildings
 Stormont
 Belfast BT4 3SQ**

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.
2. The Notice requires you to do the acts set out in the body of the Notice.
3. You should read this Notice carefully and consult a solicitor as soon as possible about it.
4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.
5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

DOCUMENTS TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(b) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry the documents set out in the Schedule to this Notice by **12.00 noon on 15th June 2022**.

APPLICATION TO VARY OR REVOKE THE NOTICE

AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **12.00 noon on 8th June 2022**.

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 4th May 2022

Signed:

Personal information redacted by USI

Christine Smith QC

Chair of Urology Services Inquiry

**SCHEDULE
[No 50 of 2022]****General**

1. You are referred to the terms of reference of the Urology Services Inquiry ("USI"). Provide all documents within the custody or under the control of the Department of Health ("the Department") relating to paragraph (e) of those terms of reference, except where those documents have previously been provided to the Inquiry by the Department. If those documents have previously been provided, you are asked to draw the Inquiry's attention to the documents which specifically relate to paragraph (e) of the terms of reference.

MHPS Generally

2. All documentation including policies, consultations, directions and otherwise, relating to the introduction of *'Maintaining High Professional Standards in the Modern HPSS: A framework for handling of concerns about doctors and dentists in the HPSS'* ("MHPS") in November 2005.
3. Copy of the Department of Health, Social Services & Public Safety circular dated 30th November 2005 and all enclosures and attachments including *'Directions on Disciplinary Procedures 2005.'*
4. Please provide any notification received from the Southern Health and Social Care Trust, or its predecessors, outlining the actions undertaken by 31st January 2006 pursuant to the above mentioned circular dated 30th November 2005.
5. All further circulars, directions or guidance issued to Health and Social Care Bodies in Northern Ireland regarding the implementation of MHPS.
6. Copy of Circular HSS (TC8) (6)/98 as referred to at Section I paragraph 26 of MHPS regarding alert letters and any subsequent circulars, directions or guidance which has repealed or amended Circular HSS (TC8) (6)/98.

7. All documentation relating to any assessments or monitoring work conducted by the Department with regard to the implementation and effectiveness of MHPS by Health and Social Care Bodies in Northern Ireland.
8. All documentation relating to any reviews, consultations or considerations of or proposals for updating or amending the MHPS Framework implemented in 30th November 2005, to include any engagement with, for example, professional bodies, Royal Colleges, the defence organizations or employers.
9. With regard to the implementation and application of the MHPS Framework generally, what challenges have been identified by the Department concerning its effective implementation in practice? What action has been taken by the Department to address same? What future action may be required to, if necessary, strengthen the policy?

Mr Aidan O'Brien

10. Provide any documentation relating to any engagement (howsoever described) between the Department and the Southern Health and Social Care Trust concerning the implementation of MHPS in the case of Mr. Aidan O'Brien.
11. Based on the information available to the Department at present, how would you assess the implementation and application of the MHPS Framework by the Southern Health and Social Care Trust with regard to Mr Aidan O'Brien? Consider the effectiveness of the process in identifying and addressing any concerns, any delay in the conduct of the process and the outcomes of that process.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.



Advisory Division 1
2nd Floor
Lanyon Plaza
7 Lanyon Place
Belfast
BT1 3LP

Personal Information redacted by the USI

30th June 2022

By email only to:

Personal Information redacted by the USI

For the attention of Christine Smith QC
Chair of Urology Services Inquiry

**RE: Urology Services Inquiry (USI) – Section 21 Notice 50 of 2022 requiring
witness statement and the production of documents**

Dear Chair,

I refer to correspondence received from Anne Donnelly, Solicitor to Inquiry, dated 4 May 2022 including a Section 21 Notice and associated Schedule, which requested a witness statement from Peter May, the Permanent Secretary of the Department of Health and the production of certain documents.

I wish to acknowledge and express the Department's gratitude for the granting of an extension for the submission of the Witness Statement to 30th June 2022 following my letter dated 8th June 2022.

I am pleased to advise that the Witness Statement of Mr May has been attached to this correspondence, which also includes a number of appendices of documents that have been referred to within the statement and which have either not yet been provided to the Inquiry or did not have Bates numbers yet. Any references to documents within the statement that have already been provided to the Inquiry are referenced by their Bates numbers.

As Mr May only became Permanent Secretary of the Department of Health on 4 April 2022, the production of the witness statement has required collaborative input from a number of different directorates and groups within the Department. To ensure that the statement reflects an accurate record of events, officials have undertaken an extensive review of records held by the Department and have endeavoured to contact officials who were in the Department and have since moved to another area or have retired. These endeavours are set out within the statement. If the Inquiry has any further queries arising out of the content of the statement, we will be pleased to answer them.

The section 21 notice also required the production of certain documents. The Department has advised me as follows:

In relation to paragraph 2 of the Notice: On 6 June 2022 the Department initiated a search of hard copy files. A search for “*Maintaining High Professional Standards in the Modern HPSS: A framework for handling of concerns about doctors and dentists in the HPSS’ (“MHPS”) in November 2005*” found that two paper files had been created, but that both have since been destroyed under records management practices. A copy of the extant document “*Maintaining High Professional Standards in the Modern HPSS: A framework for handling of concerns about doctors and dentists in the HPSS’ (“MHPS”) in November 2005*” has been included in the appendices to the statement and uploaded to the USI server. No other documents from this time have been located.

In relation to paragraph 3: 4 documents have been uploaded to the USI server.

In relation to paragraph 4: Under paragraph 3 of the Directions on Disciplinary Procedures 2005, HSS bodies were required to notify the Department by 31 January 2006 of the action they had taken to comply with MHPS. Unfortunately, the Department cannot locate in its electronic records the correspondence from HSS bodies communicating the action they took to comply with MHPS. This is most likely due to the fact that the Department’s current electronic records system (first named TRIM, now called Content Manager) was only put in place in around 2007/2008.

In relation to paragraph 5: Subsequent to its introduction, there have been two separate, but ultimately unfinished reviews of MHPS, each led by the Department, but working with HSS bodies/HSC employers. As both of these reviews were unfinished and therefore unimplemented, no action has been taken by the Department in regard to amending MHPS. The information in Peter May’s statement in relation to the two reviews has come from a trawl of the Department’s Content Manager system, using the keyword searches “MHPS” and “Maintaining High Professional Standards”. The relevant documents found in this search were uploaded to the USI server on 30th June 2022.

In relation to paragraph 6: 33 documents have been uploaded to the USI server.

In relation to paragraph 7: All documentation relating to any assessments or monitoring work conducted by the Department with regard to the implementation and effectiveness of MHPS by Health and Social Care Bodies in Northern Ireland has been included as Appendices to this statement (paragraphs 41 – 101 of the statement refer).

In relation to paragraph 8: 116 documents have been uploaded to the USI server.

In relation to paragraph 10: All documentation relating to any engagement (howsoever described) between the Department and the Southern Health and Social Care Trust concerning the implementation of MHPS in the case of Mr. Aidan O’Brien is included as appendices to this statement (paragraphs 154 – 193 of the statement refer).

I trust this is satisfactory, but if you have any further questions please do not hesitate to ask and we will be pleased to respond.

Yours sincerely

Sara Erwin

Senior Principal Legal Officer, DOH Inquiries Team

Departmental Solicitor's Office



Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 50 of 2022

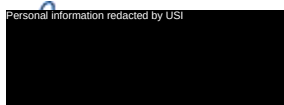
Date of Notice: 4 May 2022

Witness Statement of: Peter May, Permanent Secretary

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed:

Personal information redacted by USI


Date: 18/08/22



I, Peter May, will say as follows:-

1. On 4 April 2022, I took up post as Permanent Secretary for the Department of Health and Chief Executive of Health and Social Care (HSC). I previously held Permanent Secretary positions in the Department of Justice, Department for Infrastructure and the Department of Culture, Arts and Leisure.
2. My predecessor in the Department of Health was Richard Pengelly who was in post from 2014 and his predecessor was Dr. Andrew McCormick.
3. Given my recent appointment, I have limited first-hand knowledge of the events and issues set out. In preparing this statement, I have relied on a thorough review of the documentary evidence held by the Department and the recollections of senior colleagues who have a first-hand experience of the matters described.

My role

4. The Permanent Secretary's role is principal adviser to the Departmental Minister for all Departmental activities; I am responsible in this role for managing my Department, its staff and resources.
5. Each organisation in central government must have an Accounting Officer. Within NICS Departments this role is undertaken by the Permanent Secretary. As principal Accounting Officer, I am responsible to the NI Assembly through the Public Accounts committee for the sound management of public funds.
6. Acting under the authority of the Health Minister, I am required to ensure that the Department and any subsidiary of it or Arm's length Body (ALB) sponsored by it, operates effectively and to a high standard of probity.
7. The Department of Health's primary functions are in relation to the formulation and implementation of policy and legislation and the allocation of resources.

**Health & Social Care Trusts**

8. The Department of Health delegates its operational responsibilities to its sixteen ALBs. Six of these bodies are Northern Ireland's Health and Social Care Trusts (the five regional Trusts plus the Northern Ireland Ambulance Service). Each ALB is a legal entity in its own right, employing its own staff and operating at arm's length from the Department.
9. The Department sets the framework, budget, priorities and targets within which the Trusts must operate. Each Trust has a Board consisting of a non-executive Board Chair and Executive and non-Executive members. The Board of each Trust is responsible for holding the Chief Executive to account for the management of the organisation and the delivery of agreed plans and outcomes. Responsibility for the operation of Departmental policy within Trusts is the responsibility of the Trust Boards.
10. Alongside the delegation of operational responsibilities, as principal Accounting Officer I also delegate the Accounting Officer role to the most senior officer of each of the Departments ALBs, e.g. within each Trust to each Chief Executive.
11. From 2003/2004, the Department utilised Controls Assurance Standards (CAS) as a means of ALB Boards providing evidence and assurance that they were doing their 'reasonable best' to manage themselves in meeting their objectives and protect stakeholders against risk.
12. From 1 April 2018, a revised approach of proportionate assurance was introduced where-by ALBs provide assurance to policy leads in the Department with respect to their compliance with Departmental policy.
13. Each Chief Executive, as an additional Accounting Officer, is accountable, through the Permanent Secretary, to the Minister and Assembly in terms of performance and expenditure of resources. They are responsible for the sound management of funds allocated to them and for managing their organisation within agreed arrangements with the Sponsor Department.



14. The Medical Director is an Executive Director and member of each Trust Board. They advise the Trust Board and Chief Executive on all issues relating to professional policy, statutory requirements, professional practice and medical workforce including the Responsible Officer. They ensure that the Trust meets its obligations for medical regulation and training. They are responsible for the provision of strong professional leadership and direction and for ensuring high standards of medical practice.
15. The Department through its role as Sponsor monitors ALBs' compliance with Department of Finance policies in respect of the operation of the organisation and its Board which are applicable to all NI public sector bodies.

Employment and management of Doctors within HSC

16. Under section 44 of the Health and Personal Social Services Act (NI) 2001 the Department may direct a HSC Trust as to the terms and conditions of service on which it may employ staff. Under the same section, Health and Social Care Trusts have the power to determine the terms and conditions of service for their staff.
17. In practice, Trusts, and other HSC employers, have, by and large, adhered to regionally agreed terms and conditions negotiated through meetings with representatives of medical and dental staff, principally the British Medical Association and the British Dental Association, and facilitated by the Department in respect of staff employed by HSC organisations.
18. The current consultant contract was introduced in April 2004. Consultants are employed by the relevant Health and Social Care Trust. The Department does not have an employment relationship with consultants. The applicable terms and conditions applying to each consultant are in accordance with [Version 4 of the Consultant Terms and Conditions of Service \(Northern Ireland\) 2004](#). The Department issues a [model contract](#) to Trusts who are then able to vary it in order to meet their particular requirements and needs. The two documents are provided to the Inquiry at Appendix 1.



19. The Consultants' Contract was designed to provide a much more effective system of planning and timetabling consultants' duties and activities for HSC Trusts. For HSC Trust employers, this means the ability to manage consultants' time in ways that best meet local service needs and priorities. For consultants, it means greater transparency about the commitments expected of them by the HSC Trust and greater clarity over the support that they need from employers to make maximum effective contribution to improving patient services.

Maintaining High Professional Standards

20. Maintaining High Professional Standards in the Modern HPSS: A framework for the handling of concerns about doctors and dentists in the HPSS, was published by the then Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. It was modelled on a document titled "Maintaining High Professional Standards in the Modern NHS" which was first issued in December 2003 by the English Department of Health. The Northern Ireland MHPS document was effective from 1 December 2005 and remains in force. As will be detailed later in this statement, there have been no updates to the framework since its introduction in 2005.
21. I will refer to the document as "MHPS" throughout my statement. The "HPSS" in the title of the document stands for "Health and Personal Social Services". HPSS was reconfigured as Health and Social Care (HSC) under the Health and Social Care (Reform) Act of 2009, and the current Trusts were established under that Act. The Department of Health, Social Services and Public Safety (DHSSPS) was renamed "the Department of Health" ("DoH") in the Departments Act (Northern Ireland) 2016. I will refer to DHSSPS and DoH interchangeably as "the Department" throughout my statement.
22. MHPS was issued by the Department's then Human Resources Directorate Pay and Employment Unit on 30 November 2005, promulgated by Circular HSS(TC8) 6/2005. The Circular included a copy of the Directions on Disciplinary Procedures 2005, signed by the then Director of Human Resources, Mr David Bingham. The Directions – which remain in operation –



have the effect of directing all HSS bodies, from 1 December 2005, to comply with MHPS.

23. Under paragraph 3 of the Directions, HSS bodies were required to notify the Department by 31 January 2006 of the action they had taken to comply with MHPS. Unfortunately, the Department cannot locate in its electronic records the correspondence from HSS bodies communicating the action they took to comply with MHPS. This is most likely due to the fact that the Department's current electronic records system (first named TRIM, now called Content Manager) was only put in place in around 2007/2008.
24. On 6 June 2022 the Department initiated a search of hard copy files. A search for "*Maintaining High Professional Standards in the Modern HPSS: A framework for handling of concerns about doctors and dentists in the HPSS' ('MHPS') in November 2005*" found that two paper files had been created, but that both have since been destroyed under records management practices. Specifically, file BS/117/04 was destroyed on 20 May 2015; and file BS/660/06 was destroyed on 1 August 2016.
25. In order to conduct as comprehensive a search as possible, further searches of the file registry were conducted under the following titles, though without success:
 - (a). Directions on Disciplinary Procedures 2005.
 - (b). HSS(TC8) 6/2005
 - (c). Pay and Employment unit – correspondence (or emails) – 2005
 - (d). Pay and Employment unit – correspondence (or emails) – 2006
26. The introduction to MHPS (paragraph 1, page 1) states that the framework is "*for handling concerns about the conduct, clinical performance and health of medical and dental employees*". Paragraph 4, page 1 outlines that the framework is in six sections and covers:



Urology Services Inquiry

- (a). Action when a concern first arises;
 - (b). Restriction of practice and exclusion from work;
 - (c). Conduct hearings and disciplinary procedures;
 - (d). Procedures for dealing with issues of clinical performance;
 - (e). Handling concerns about a practitioner's health; and
 - (f). Formal procedures – general principles.
27. Paragraph 7 (pages 1 and 2) refers to the Department having “*entered into a Service Level Agreement with the National Clinical Assessment Authority (NCAA) in October 2004 to provide advice and guidance to the HPSS*” on the MHPS process to enable “*HSS Bodies to handle cases quickly and fairly - reducing the need to use disciplinary procedures to resolve problems*”. Paragraph 7 continues that “*the NCAA has become a division of the National Patient Safety Agency, and is now known as the National Clinical Assessment Service (NCAS).*”
28. The Inquiry will wish to note that NCAS has itself been replaced by Practitioner Performance Advice, a service delivered by NHS Resolution <https://resolution.nhs.uk/services/practitioner-performance-advice/>. The Department currently has a three-year Service Level Agreement in place with NHS Resolution, which started in April 2020, and I attach a copy to this statement at Appendix 2.
29. The SLA noted above sets out in paragraph 1 that Practitioner Performance Advice is “*an NHS Resolution function that provides impartial advice, assessment and intervention services to health organisations to help the effective management and resolution of performance concerns about the performance of doctors, dentists and pharmacists*”.
30. Paragraph 3.1 of SLA summarises the functions Practitioner Performance Advice will provide to HSC organisations which cover:



Urology Services Inquiry

- (a). an advisory service to the Department for advice on cases arising and an assessment service on a case-by-case basis as agreed between the parties;
 - (b). an assessment and intervention service, including Professional Support and Remediation (PSR) services when required;
 - (c). support to local efforts to improve good practice in relation to the resolution of difficulties and concerns between the Practitioners and their employers and contractors, through policy support and website resources;
 - (d). support for reporting at a local level.
31. Paragraph 10 of MHPS (pages 2-3) states that *“at the heart of the new arrangements is a co-ordinated process for handling the safety of patients posed by the performance of doctors and dentists when this comes to the attention of the HPSS”*, and outlines the need for all HPSS organisations to:
- (a). ascertain quickly what has happened and establish the facts;
 - (b). determine whether there is a continuing risk;
 - (c). decide whether immediate action is needed to manage the risk to ensure the protection of patients; and
 - (d). put in place action to address any underlying problem.
32. With regard to the need for all HPSS organisations to *“put in place action to address any underlying problem”*, the Department did not have a role in checking with HPSS organisations to ensure this was taking place. Indeed, as detailed further below, the role of the Department in MHPS was – and is - limited. MHPS instead puts the onus of action on HPSS/HSC organisations as individual employers in their own right.



Urology Services Inquiry

33. Paragraph 11 (page 3) states that *“All HSS bodies must have procedures for handling concerns about an individual’s performance... [that] must reflect the framework in MHPS...”*.
34. As I have set out, the Department sets policy for the Health and Social Care System in Northern Ireland and therefore has overall responsibility for MHPS. Within the Department, there has historically been shared interest in the policy between:
 - (a). what is now called the Workforce Policy Directorate (formerly the Human Resources Directorate) within the Department’s Healthcare Policy Group; and
 - (b). what is now called Quality, Safety and Improvement Directorate (formerly Safety and Quality Standards Directorate) within the Chief Medical Officer’s Group.
35. The Department’s operational role in the application of MHPS is extremely limited, covering only the following issues:
 - (a). review of longer term exclusions (see table on pages 19-20, and paragraphs 30 and 31 on page 19, of MHPS);
 - (b). the recruitment and selection of appeals panels in clinical performance cases (see Annex A of MHPS on page 35); and
 - (c). provision of process advice to smaller HPSS (now Health and Social Care) organisations, where necessary (pages 41-42 of MHPS).
36. It has become apparent that while both Directorates recognise they have a role with respect to MHPS as a policy within the Department, there has historically been a lack of clarity about who has lead responsibility for its review and maintenance. This has contributed to the slow speed of progress to date.
37. Other factors, which have contributed to the speed of progress have been (i) high staff turnover, particularly within the Department’s HR/Workforce Policy



Directorate, leading to reduced institutional memory over time; and (ii) the need to prioritise wider Departmental action; neither of which are unusual for a civil service Department.

38. The Department's Workforce Policy Directorate is in the lead on the policy going forward. The Chief Medical Officer's Group will actively contribute as the key Departmental advisory group on medical matters.
39. Subsequent to its introduction, there have been two separate, but ultimately unfinished reviews of MHPS, each led by the Department, but working with HSS bodies/HSC employers. As both of these reviews were unfinished and therefore unimplemented, no action has been taken by the Department in regard to amending MHPS.
40. The information in my statement in relation to the two reviews has come from a trawl of the Department's Content Manager system, using the keyword searches "MHPS" and "Maintaining High Professional Standards". The relevant documents found in this search will be provided to the Inquiry alongside this statement.

Commencement of the 2011–2013 MHPS Review ("the first review")

41. The first thoughts of a review of MHPS seem to have started in July 2009. The basis for the first review proper seems to have been a part of a Confidence in Care programme, led by the Department, as can be seen in an email chain at Appendix 3. Background to the Confidence in Care programme can be found in the Project Initiation Document at DH1/08/67646 and which is provided to the Inquiry at Appendix 3.
42. The email chain starts with an email from Victoria Colville in the Department's Pay and Employment Unit (a Branch within the then Human Resources Directorate) on 19 October 2010 advising the then Deputy Chief Medical Officer, Dr Paddy Woods, and a colleague in the Confidence in Care programme, Jane Lindsay, that the British Medical Association had asked that



Urology Services Inquiry

a paper be put together highlighting any issues that employers had with MHPS. The Inquiry will wish to note that Jane Lindsay is now known by her married name of Jane Kennedy and is National Head of the General Medical Council (GMC) Northern Ireland.

43. As to the reason for a review at that time, the Department recently, and in preparation for this statement contacted Jane Kennedy. She advised that there were two reasons for the review: (1) the GB version (see paragraph 20 above) had been updated, while the Northern Ireland version had not and (2) Medical Directors were feeding back that the process was 'clunky' and took too long, as it allowed legal representation for doctors at an early stage of the process, which caused significant delays in addressing the concern. A copy of this email exchange is provided to the Inquiry at Appendix 4.
44. On 19 October 2010, Jane Lindsay responded to Victoria Colville the same day to advise that *"Within the Confidence in Care Programme we have begun looking at MHPS with a view to a revised document that will reflect the changes to medical regulation, namely the role of the Responsible Officer and the implementation of a system of Revalidation"*.
45. A further email in the chain from Jane Lindsay on 21 October stated that *"We will be progressing this work in January - with the intention of gathering feedback on the current document more widely, developing a draft revision and consulting with our workstream members ...this includes the BMA and HR and Medical Directors, as well as internal HR colleagues"*.
46. A further email from Jane Lindsay to Victoria Colville of 12 April 2011 states that there was no update on the revision of MHPS but that it was expected to start work in June 2011. A further version of MHPS with suggested tracked changes made by Jane Lindsay was first saved into Content Manager on 15 July 2011, with a further version first saved into Content Manager on 2 August 2011. Refer to Appendix 5.



47. The review then seems to have progressed intermittently from the autumn of 2011 (starting with an email chain involving the BMA, Diane Taylor from the Department's Human Resources Directorate and Dr Paddy Woods) which was first saved into Content Manager on 3 October 2011 and culminating in some comments from the Labour Relations Agency of 27 August 2013. Between those two documents, there are 65 documents which provide detail on the review. All of the documents found on Content Manager are detailed in Appendix 6 to this statement and are provided to the Inquiry. That review does not appear to have resulted in a final, published revised version of MHPS. The issues identified in the first review will be highlighted later in this statement.

Commencement of the 2018 MHPS Review ("the second review")

48. The next attempt at a review of MHPS started with a letter of 3 January 2018 from Damian McAlister, [refer to Appendix 7] then Human Resources Director at the Belfast Health and Social Care Trust, to Andrew Dawson, then acting Director of Workforce Policy at the Department of Health. Neither Mr Dawson, any currently serving Departmental official, nor I have the knowledge as to why there was a gap in time between the first and second attempted reviews.
49. Mr McAlister asked *"that consideration be now given to a review of the documentation and its content. I believe that while the clear intent of the guidance is being, and has been, fulfilled by its operation over time, in reality its practical application in parts has become increasingly more difficult to the result that cases are now taking an inordinate and unacceptable amount of time to progress. I would welcome a discussion about this at a forthcoming HRD Forum and I have copied to Dr Paddy Woods and my Trust HR Colleagues for information"*.
50. Mr Dawson responded to Mr McAlister on 29 January 2018 [refer to Appendix 8] agreeing to table an item at the next meeting of the HR Directors Forum (a monthly meeting comprising all of the Human Resources Directors of the Department's Arm's-Length Bodies (with the exception of the Northern Ireland



Urology Services Inquiry

Fire and Rescue Service), chaired by Mr Dawson as acting Director of Workforce Policy in the Department).

51. On 9 February 2018, Liz Hynes (Workforce Policy Directorate) emailed Dr Paddy Woods at the request of Andrew Dawson to see if Dr Woods could advise on the query raised by Mr McAlister. Dr Woods replied to Mr Dawson on 12 February to *"suggest HR directors are asked to itemise the issues with the guidance (I suspect BHSCT will have most experience in this regard) before deciding on the appropriate course of action"*. This exchange is saved is provided to the Inquiry at Appendix 9.
52. The HR Directors Forum meeting was held on 12 February 2018 and the minutes is provided to the Inquiry at Appendix 10. A copy is provided to the Inquiry. MHPS was discussed at agenda item 11 and the minutes state that Mr Dawson *"advised this was a CMO policy, but he agreed to write out to Trusts to ask for an indication of the issues with the document and then forward to DCMO for consideration of a review"*. Mr Dawson, now Director of Quality, Safety and Improvement in the Department, does not dispute that the minutes are an accurate record of the meeting, but advises me that his reference to MHPS as *"a CMO policy"* is not accurate. Mr Dawson will say that it was – at the time – his genuine understanding and belief, and that of his staff, that the Chief Medical Officer's Group was in the lead for MHPS. As has recently been clarified, in effect, the framework was (and is) the responsibility of Workforce Policy Directorate, although relying heavily on the CMO Group for professional insight and advice.
53. The action from the meeting was *"Andrew Dawson to write to HR Directors to request an indication of the issues with the document and then forward to DCMO for consideration of a review"*. Katherine Ferguson (Workforce Policy Directorate) wrote to HR Directors on behalf of Liz Hynes (Workforce Policy Directorate) on 8 March 2018 asking if comments could be sent to Ms Hynes *"for collation prior to the details being forwarded to the CMO's office for"*



consideration by CoP Friday 16th March". This exchange is provided to the Inquiry at Appendix 11.

54. The deadline appears to have been extended as responses were received from the Northern, Southern and South Eastern Trusts, and the Business Services Organisation, over a period up to 5 April 2018. All relevant correspondence is provided to the Inquiry at Appendix 12.
55. Unfortunately, it does not appear that any further work was carried out in pursuance of the second review. Like all senior civil service posts in the Department, the Human Resources/Workforce Policy Director has a very wide remit and must constantly prioritise the matters on which they devote their time and attention, and that of their subordinates. The Directorate faces many competing priorities including, issues of pay, terms and conditions, industrial relations dispute resolution, commissioning of pre-registration training, workforce planning, development and implementation of strategies and even the management of the Department's public appointments programme.

Issues reported to the Department regarding MHPS

56. Paragraph 9 of the Inquiry's Section 21 notice asks: "*With regard to the implementation and application of the MHPS Framework generally, what challenges have been identified by the Department concerning its effective implementation in practice? What action has been taken by the Department to address same? What future action may be required to, if necessary, strengthen the policy?*"
57. As outlined above, two separate reviews of the policy commenced in 2011 and 2018 respectively. Ultimately these reviews did not proceed to a conclusion and no changes were made to the MHPS Framework.
58. The Department has only a limited role in the application of MHPS and therefore limited direct knowledge of how HSC employers operate it in practice, beyond what was identified in the two unfinished reviews. In identifying issues



concerning its effective implementation, I must therefore rely on what has been reported to the Department by those organisations who have practical experience of its operation during these two unfinished reviews.

Issues identified in the first review

59. With regard to the first review, it has been difficult in the absence of personal recollection in the current staff of the Department to provide an outline of the challenges identified with MHPS in the first review. Current Departmental officials have reviewed the available papers on the Department's Content Manager system in an effort to address this point.
60. It would appear that the first review was taken as an opportunity to update the MHPS document: several versions of a draft MHPS document with tracked changes have been provided to the Inquiry by the Department. For example, the document "*MHPS in the 21st Century v2*" (provided to the Inquiry at Appendix 13) takes the opportunity to suggest the following amendments:
 - (a). Clarification over the treatment of adverse incidents;
 - (b). An update on good investigation practices;
 - (c). Updated definitions of roles and responsibilities in MHPS; and
 - (d). Clarification on steps in the MHPS decision-making process.
61. So far as we are aware, these suggestions appear to have been the thoughts of the reviewers at the time, responding to the issues mentioned by Jane Kennedy above.
62. The legal opinion of 29/3/11 from Paul Epstein QC was available to the reviewers. A copy of the legal opinion is provided to the Inquiry at Appendix 14. It appears to be a legal opinion that was provided to the then Department of Health in England in respect of its MHPS document. It discusses the following questions:



Urology Services Inquiry

- (a). Is MHPS automatically part of medical professionals' contracts of employment?
 - (b). Unfairness in the Employment Tribunal: Unfair Dismissal Claims.
 - (c). Particular parts and paragraphs of MHPS and Employment Tribunal fairness.
 - (d). Interim Relief.
63. If these issues were of note to the English Department of Health and its version of MHPS, then these would also have been issues for consideration in respect of the Northern Ireland version.
64. Provided to the Inquiry at Appendix 15, is a letter dated 12 September 2011 from Dr Paddy Woods (former DCMO) to Dr Anne Kilgallen (then Medical Director, Western HSC Trust) outlines the following:

"It was agreed that this [i.e. the revision of MHPS] presented an opportunity to refine the processes and guidance, incorporating lessons learnt from implementation of the current procedures, and from recent events. Initially several key issues have been highlighted requiring further discussion:

 - *separation of preliminary and extended investigation*
 - *definition of the specific role of the Medical Director*
 - *the role of NCAS*
 - *acceptance by HSC Trusts of rotational Trainees involved in disciplinary processes."*
65. Comments from P Flanagan of the Northern HSC Trust of 26 September 2011 (refer to Appendix 16) made a number of comments about the need for:
 - (a). User-friendliness of the document;



Urology Services Inquiry

- (b). Clarification on roles and responsibilities around doctors in training;
- (c). Consistent terminology;
- (d). Clarification on the content around formal and informal MHPS processes.

66. Provided to the Inquiry at Appendix 17 is an email from Jane Lindsay to, presumably, the MHPS review team of 15 November 2011 outlines the following:

“Our key aims in developing the framework are:

** Incorporate the learning from those who have used the processes and guidance in HSC organisations*

** Develop the guidance element of the framework to ensure it is fit for purpose, clear to follow and compliments existing organisational policies*

** Highlight the need to ensure robust recording when addressing concerns including decision made and how they were reached.*

** Stress the importance of reviewing investigations at key intervals*

** Ensuring that measures required to protect patients and the public are considered at the commencement and throughout an investigation, and reviewed to ensure they still address identified risks.”*

67. Provided to the Inquiry at Appendix 18 provides a copy of a note of the MHPS Working Group meeting of 18 November 2011 outlined the following points on the MHPS revision work:

- *Current revision of framework is too long and should focus on the formal and informal processes, investigations and roles and responsibilities.*
- *There is a degree of ambiguity in relation to roles and responsibilities when commencing an investigation and subsequent action if required. The role of*



Urology Services Inquiry

the Medical Director/Case Manager needs clarification; when should they be intimately involved in cases and when they should be made aware? Their role in relation to decision making is crucial, as is the obligation placed on them to accept and act on the findings of an investigation.

- *Separate section on managing concerns in relation to trainees may be helpful given potential for lack of clarity in relation to role of Employer and that of the Deanery & Responsible Officer. Issues arising where Deanery may have difficulty in securing a placement for a Trainee when there are concerns about his/her performance.*
- *There is a need to highlight the importance of organisational policies for performance management of all employees e.g. disciplinary, capability, health and describe their relationship to the Framework.*
- *Issues in relation to representation need to be addressed, including the consequences of delay arising from early legal representation.*
- *Access to appropriate remediation can prove challenging, and costly, for organisations.*
- *Importance of good management skills is crucial when addressing concerns, perhaps a need for training of senior clinicians in this area when Framework finalised.*
- *Need to define the use of the word investigation throughout the document. May imply formal process when at the beginning of the process we are trying to establish the facts in relation to the concern raised.*
- *Timescales in Framework require revision as often not achievable in practise.*
- *The narrative of processes in the Framework should capture any action taken prior to the formal raising of a concern e.g. the role of the critical friend in having a discussion with a colleague about a concern.*



Urology Services Inquiry

68. A copy of email dated 23 November 2011 from Dr Colin Fitzpatrick, is provided at Appendix 19, then lead NCAS adviser for Northern Ireland, to Dr Paddy Woods made the points that:
- *“MHPS would benefit from revision as experience since it was issued has identified a number of areas for improvement. However, we are concerned that awareness of the document and its provisions is not as widespread within HSC managers as we would have hoped. The experience of our advisors is that we frequently have to remind managers of the provisions and processes within MHPS”.*
 - *“A particular concern is the notification and review of exclusions as described in section II. We find that we are generally consulted before exclusion, although this may be after the trust has already made the decision. We are also concerned that regular reviews may not always occur, in particular the formal referral back to NCAS at the third review. I do not know whether the six month report to the Department occurs. It may be that we should have a discussion about how well this process is working.”*
69. Provided to the Inquiry at Appendix 20 is an email from Jane Lindsay to the MHPS working group of 27 January 2012 highlighted the following issue:
- *“At the last meeting of our MHPS working group we discussed the development of a section within the framework that specifically outlined managing concerns in relation to Trainees (see attached meeting note, point 3). The link below will take you to an operational framework developed by NES Scotland...”*
70. Provided to the Inquiry at Appendix 21 is a note of the MHPS Working Group of 8 February 2012 stated:
- *Current guidance requires simplification in relation to processes, timescales and constitution of performance panels. The role of the Medical Director in*



Urology Services Inquiry

the initial stages of an investigation requires clarification as they may be required to sit on a decision-making panel at a later stage.

- *The roles of the employer in ensuring practitioners are 'fit for purpose' and the GMC of ensuring 'fitness to practise' was discussed and key distinctions made. This should be clearer in the Framework.*
- *There are an increasing number of trainees with identified performance concerns requiring Deanery intervention, as well as correspondence from the GMC to the Deanery outlining required intervention for non-trainee medical staff. It was clarified the Deanery has no obligations to respond in relation to non-trainee staff but Margot felt the MOU with Conference of Postgraduate Medical Deans (COPMeD) may indicate otherwise. Margot undertook to share the MOU with Dr Woods.*
- *There was considerable discussion in relation to investigations and the importance of appropriately skilled investigators who have sufficient time to undertake the investigation. It was felt this was crucial to ensure timescales were met and that practitioners who had been excluded were able to return to practice (if appropriate) as soon as possible. The importance of separating investigation from decision making should be clearer in the Framework.*
- *Dr Kilgallen provided a flow chart outlining the key MHPS stages that provided a useful visual aid to the discussions. All agreed that the terms 'formal' and 'informal' in the Framework (used to describe processes and types of investigation) were not helpful and should be removed from the revision.*
- *The issue of legal representation and the implications this presents for a timely resolution to the concern was discussed.*
- *Challenges presented to organisations in relation to the rotational nature of trainees were discussed and it was agreed that if one organisation had*



Urology Services Inquiry

commenced a conduct/performance process with a trainee, they should not rotate to another Trust until the issue had been resolved. NIMDTA are currently revising their framework for the specific aspects of managing concerns in relation to trainees.

- *Presentational issues with the framework were discussed. The Framework will be further revised and circulated to members for comment. Dr Kilgallen will share the next revision with MD colleagues.*

71. Provided to the Inquiry at Appendix 22 is an email from Mervyn Barkley, Belfast HSC Trust, of 13 April 2012 to Dr Paddy Woods raised the following issue:

“The case of Lim v Wolverhampton Hospitals NHS Trust (2011), where the English High Court granted an injunction to prevent the Trust from convening/proceeding with a performance panel until the matter was referred to NCAS and until NCAS had advised that the dr's performance is so fundamentally flawed that no action plan would have a realistic prospect of success (see section IV para 7 of our version of MHPS). The court held that if the Trust proceeded in the absence of such advice from NCAS, it would be in breach of contract. This puts employers in a difficult position. You will know we have discussed the difficulties employers can have in arranging assessments. There can be circumstances, particularly in very small teams in which either the relationship between colleagues has broken down or where the safety concerns are such that we could not allow the practitioner to work or there is some technical reason that an assessment cannot be done in the practitioner's workplace that we have tried to arrange placement in other locations. I know from experience this has proved to be impossible in some cases and leaves both the practitioner and the employer in limbo. One way forward would have been to go straight to a performance panel which one way or another would have resolved the position; it would appear this option is closed off.”

72. Provided to the Inquiry at Appendix 23 is a letter of 15 January 2013 from Dr John Simpson, then Medical Director, Southern HSC Trust, to Jane Lindsay may be of interest to the Inquiry. It makes the following points:



Urology Services Inquiry

- “Referring to a Doctor’s entitlement to be accompanied by a companion, who may be legally qualified but he/she will not be acting in a legal capacity. In reality our experience is that as soon as an investigation is launched the doctor will contact the MDU (often directed by the BMA). The MDU will almost always engage with solicitors who will immediately start a chain of correspondence directly with the Trust HR Manager on the case. Although the doctor will be accompanied at hearing by the MDU, the representative is simply presenting the case on behalf of the solicitors. Therefore in reality the doctor is legally represented from the outset, with solicitors generating a lot of correspondence directly with the HR Managers throughout the investigation. As Trusts don’t generally involve their own legal advisors at an early stage in cases (unless warranted), this correspondence often has to be responded to by (non-legal) HR Manager working with the case investigator on the case.*
- The entitlement for the doctor to be accompanied by a Friend – is there any further guidance around the definition of “friend” as this is fairly vague/broad and could cover just about anyone provided they were not being paid for their assistance. If there was any further clarification on this, even confirming they cannot be paid would be helpful.*
- Timescales - Our experience of our MHPS investigations is that they are generally much longer than the suggested 4 weeks, given often the complexity and necessity to gather suitable evidence including patient records and seeking witness statements. I wonder if there is anything that can add flexibility here whilst maintaining the importance of completing it as quickly as possible – to avoid Trusts running the risk of possibly being criticised for taking much longer than 4 weeks?*
- Para 137 – Termination of employment with procedures incomplete - I feel it is important that this section is clear on the Trust responsibilities. We have recently experienced a number of doctors who left during a formal investigation under MHPS, reasons included temporary contract;*



Urology Services Inquiry

resignation; rotational junior doctor. In our experience, we completed the investigation but felt that it wasn't appropriate for the Trust to take any further action beyond this i.e. take to a clinical performance hearing or refer formally to NCAS given the doctor was no longer employed. In these cases, we had to consider the case and make a decision on referring the information to the appropriate body (i.e. GMC where doctor had left UK or moved to another Trust in UK and NIMDTA for doctor in training). Our legal advisors agreed that it would be very difficult for the Trust to take any different action in these cases. Undoubtedly Trusts should deal with all the concerns and complete the investigation wherever possible but I think it should be clear about the expectations of taking it further and reaching a final decision?/conclusion after they have left employment.

- *Disciplinary and Clinical Performance Hearings - Some of the case law around doctors and MHPS makes reference to independence of panels and I am wondering if there should be further guidance around this to protect Trusts?*
- *Disciplinary and Clinical Performance Hearings – Again some of the case law talks about legal representation in limited circumstances for doctors/dentists as the outcome of the case is argued to substantially influence an employee's right to work in their chosen career – will the revised MHPS provide any guidance on the application of case law on this issue.?*
http://www.medical1journals.com/index.php?option=com_content&view=article&id=219&Itemid=111 .
- *The document written by Paul Epstein from Cloisters is useful to consider in terms of the failings they see in the current MHPS document.*
<http://www.cloisters.com/news-pdf-downloads/maintaining-high-professional1standards-in-modern-nhs-2.pdf> . He refers to for example the lack of definition to be followed in pure conduct cases (which can vary



between employers particularly for gross misconduct) and how case law has therefore drawn comparisons with Part IV (clinical performance hearings)."

73. Provided to the Inquiry at Appendix 24 is a table from the Labour Relations Agency (seemingly from 27 August 2013) details some comments on the revised draft of MHPS. These largely relate to the drafting of the revised draft. However the following comment is of note:

[MHPS] "is much broader than any common or garden grievance procedure. The document must cross reference other professional codes of conduct and performance management systems as well as policies such as whistle-blowing in order to identify which takes precedence and whether or not they are "apt for incorporation".

74. The full suite of documents has been provided to the Inquiry. The twelve documents quoted in preceding paragraphs 60 to 73, seem to provide the most comprehensive list of issues encountered by the review team in the first review.
75. As to why the first review was not completed, the Department has asked Jane Kennedy for her recollection. She advises as follows:

"I think it was a capacity issue in DoH and the system- the new version would have required extensive negotiation with the BMA and we were already working with them to agree updated appraisal documentation to support the implementation of revalidation which was more urgent. It also would have required input from the Medical Directors and HR teams in Trusts – they were also working on preparedness for revalidation beginning "

Issues identified in the second review

76. With respect to the 2018 review, this began following an email from Damian McAlister, then HR Director of the Belfast Trust who wrote to Andrew Dawson, then acting Director of Workforce Policy at the Department of Health with respect to the practical application of the MHPS policy, asking *"that*



consideration be now given to a review of the documentation and its content”.

This exchange is provided to the Inquiry at Appendix 25.

77. Mr McAlister set out a position which suggested that *“while the clear intent of the guidance was being, and had been fulfilled by its operation over time he believed that in reality its practical application in parts had become more difficult.”* A particular concern of Mr McAlister was that the application of the MHPS framework was resulting in cases taking a long and unacceptable amount of time to progress.
78. He suggested a discussion about this at a forthcoming HR Directors’ Forum. Having consulted with Dr Paddy Woods, DCMO, the issue was discussed at a meeting of the HR Directors Forum on 12 February 2018. As the minutes of this meeting indicate, Andrew Dawson, then Acting Director of Workforce Policy at the Department agreed to write to Trusts to request an indication of any issues with the document which would then be forwarded to DCMO for review.
79. Responses were received from Northern, Southern and South Eastern Trusts, and the Business Services Organisation (BSO). The BSO attend the HR Directors’ Forum to represent the smaller HSC organisations. This exchange is provided to the Inquiry at Appendix 12.
80. Provided to the Inquiry at Appendix 12 are comments received from Paula Smyth, HR Director BSO on 5 April 2018, included input from a wide range of HSC colleagues. The BSO response noted that:
 - *“One of the major issues is the difficulty that currently exists around obtaining assessments from NCAS. The department is currently considering introducing a process of remediation for practitioners and are currently in discussions with NIMDTA regarding this.”*
 - *“Does not cover independent contractors. 90% of NI dentists are independent contractors”*



81. Provided to the Inquiry at Appendix 12, Zoe Park, Assistant HR Direct SHSCT, responded on behalf of that organisation on 15 March 2018 and raised a number of issues including:

- ***“Ability to take quick, effective action***

It seems a reasonable expectation that Trusts should be able to take quick effective action where there are serious concerns about the misconduct or capability of medical staff. However the nature and complexity of the existing MHPS framework make this extremely difficult. One would expect a “framework” document to be a high level list of principles to guide local policies. However the fact that MHPS is almost 50 pages long makes the document far too prescriptive to act as a framework. In reality it often leads to many legal challenges and consequently cases derailed meaning they can sometimes take years to conclude. Trusts can also often fall foul of the procedures due to the many complexities contained regarding what needs to be done when, by whom - all within very tight deadlines.

The ability of the Trust to take certain decisions is also very limited in some cases. For example it is impossible to take a doctor to a clinical performance hearing unless is if [sic] first considered by NCAS and they (normally after having completed a lengthy NCAS assessment) have determined that the doctors performance is “so fundamentally flawed that no educational and/or organisation action plan has a realistic chance of success”. We have had experience of a doctor who clearly fell into this category and was subsequently dismissed from their post – however the case took us years to complete.

The ability to deal fairly but quickly and effectively with a clear case of an underperforming doctor is thus severely hampered by this requirement – particularly when issues arise early in employment given probationary periods are not a common feature in medical/dental contracts. MHPS also includes a recommendation of dealing with mixed conduct and capability



Urology Services Inquiry

issues via the capability route. This is not always helpful as we feel strongly that misconduct is clearly best dealt with through a misconduct route.

- **Achievable Timescales**

Despite extensive procedural requirements, MHPS sets timescales that Trusts can very rarely comply with. Timescales are dotted throughout the document in the context of investigations, exclusions and panels which require line by line attention and often are totally unachievable. This is also problematic when it is set within the context of the enormous list of senior officers required to participate, particularly on capability and appeal panels with multiple external members required. The inclusion of legal representation throughout the process is also out-with what is afforded to all other NHS employees. Again the entitlement to professional legal representation throughout leads to many cases being delayed and disrupted by solicitor letters and legal argument.

It is important that Trusts can take quick, effective and appropriate action when there are serious concerns about a doctors' performance or conduct. Confidence and trust in the capability and conduct of our medical staff must be at the heart of everything that we do. The recent findings of Mr Justice O'Hara's report only serve to emphasise this. MHPS therefore needs to be reviewed urgently to ensure this remains an absolute priority and the aim should be for a procedure that is succinct, easy to interpret and proportionate to encourage frequent use for quick, early corrective or conclusive action."

82. The Trust also included a copy of its own internal document which had been developed to clarify and promote the informal stage of the MHPS process. This document is included within their response. This has been provided to the Inquiry at Appendix 12.



Urology Services Inquiry

83. Provided to the Inquiry at Appendix 12, Tracey Kane responded on behalf of Myra Weir, Director of Human Resources & Corporate Affairs at South Eastern Health & Social Care Trust, on 16 March 2018 and raised just two issues:
- *[MHPS is] “Cumbersome, too many people involved and too many layers which means the process is very lengthy & complex*
 - *Some of the timeframes are unrealistic (too short) given the number of people that need to be consulted”*
84. Provided to the Inquiry at Appendix 12, Gemma Lutton, responded on behalf of Elizabeth Brownlees, Director of Human Resources, Organisation Development and Corporate Communications at NHSCT on 16 March 2018 providing the general comments set out below:
- *“Does MHPS apply to Pharmacists – it is not references and if this is the case it needs to be clearer.*
 - *The general HSS terminology needs to be updated to HSC.*
 - *Clarification of the role of NCAS needed?*
 - *Clarification is required on the role of the Case Investigator when the Trust Disciplinary process is initiated. Normally the Investigating officer is also the presenting officer at the disciplinary hearing however under MHPS, the Case Investigator is purely a fact finding role. Should the presenting officer then be the Case Manager?”*
85. The responses received from Trusts highlighted a number of issues in regards to the policy, its implementation and application. The responses received would suggest three broad issues were identified by Trusts/BSO with respect to the 2005 MHPS Framework.
86. The most common issue raised related to how the framework operated, with a consensus view appearing to be that it took too long to move through the various steps of the MHPS framework. Related to this point, Trusts identified



that the requirements of the process were cumbersome with many of the timescales included within the framework being considered as too constrained or unrealistic.

87. Taken collectively, that would suggest Trusts considered a need to streamline the overall process or number of steps/stages within the framework but equally, be more realistic about the time needed to complete each stage.
88. The most substantial input received in response to the Department's request for input came from the Southern Health and Social Care Trust and this was the overarching theme of their response. The inputs received would have been provided after SHSCT had embarked on and completed the MHPS process with respect to Mr Aidan O'Brien. Mr O'Brien's specific case was not mentioned.
89. The second issue, or area for improvement, that Trusts have identified from reviewing the documentation relating to the limited 2018 review centred on a desire for greater clarity concerning roles, including the role of NCAS during the process; the role of the Case Investigator and the role of the Case Manager.
90. The third significant point raised centred on the coverage of the document in terms of which professional groups were considered to be in scope. The BSO pointed out that it did not include independent practitioners such as General Practitioners. One additional point worth noting here, and one which I would expect a future review of MHPS to consider, is the inclusion of whether MHPS should be extended to also include Pharmacists (not just Doctors and Dentists) directly employed by HSC organisations.
91. Unfortunately, but unavoidably, there was no further action taken after the responses had been submitted to the Department. It should be noted that due to the lack of a Northern Ireland Executive, the Department had no Minister at that time. The Department's Workforce Policy Directorate had to prioritise other matters, notably but not exclusively, a deteriorating industrial relations landscape centred on an inability to meet pay demands in the absence of Ministerial authority. While the industrial relations dispute was suspended in



Urology Services Inquiry

January 2020 upon the return of the NI Executive, the Inquiry will be cognisant that around this time, the challenges associated with Covid-19 pandemic were beginning to emerge and the Department of Health's focus and priority had to re-orientate quickly to focus upon that issue.

92. The review of MHPS was discussed at the HR Directors' Forum meeting of 18 October 2018. A copy of the minutes is provided to the Inquiry at Appendix 26. The minutes of that meeting record:

"18.7 – Maintaining High Professional Standards

Vivienne raised this issue and Liz advised the HR Directors that this piece of work was yet to start, but that it is anticipated that the review of this policy would begin in the new year.

Liz also advised that a review of the Recruitment and Retention Premia policy was due to begin in the new year, and that a Task and Finish Group would be required for both work streams.

Action 86/18 – Liz to update the HR Directors on the Review of Maintaining High Professional Standards."

"Vivienne" is Vivienne Toal, HR Director at SHSCT. "Liz" is Liz Hynes, who had been seconded to the Department from HSC since 2008 as an advisor on medical and dental terms and conditions.

93. MHPS was mentioned in the October 2019 and January 2020 HR Directors' Forum meetings, but in the context of its use in the planned Single Employer for doctors and dentists in training. Copies of the minutes is provided to the Inquiry at Appendix 27.
94. A proposed review of MHPS was mentioned in the February 2020 HR Directors' Forum. A copy of the minutes is provided to the Inquiry at Appendix 28. The minutes record:

"IHRD Update



Urology Services Inquiry

Andrew said that the Minister is to meet with families affected.

Jacqui outlined some of the issues and limitations with the Maintaining High Professional Standards (MHPS) framework – that Trust investigations should only proceed in respect of those aspects of the case that are not directly related to the police investigation underway.

MHPS is due to be reviewed by the Department.”

“Andrew” is Andrew Dawson, then Departmental Director of Workforce Policy, and current Departmental Director of Quality, Safety and Improvement. “Jacqui” is Jacqui Kennedy, HR Director, Belfast Health and Social Care Trust.

95. The review was mentioned further on 18 and 19 December 2018. A member of the public emailed the Department on 18 December to ask about the “screening” of the MHPS policy. In internal correspondence, Liz Hynes advised that *“A review has not yet taken place, it is due to be reviewed by the end of March 2019”*. Unfortunately that did not occur, again because other matters had to take priority, notably an escalating industrial dispute with Agenda for Change trade unions. The full exchanges are provided to the Inquiry at Appendix 29. If it would be helpful to the Inquiry, I can arrange to forward copies of the minutes of the HR Directors’ Forum meetings from that time, which detail the priorities that Workforce Policy Directorate was facing.
96. There is a small number of other documents relating to MHPS on Content Manager, but nothing further, as far as the Department can determine, in relation to reviews of MHPS, or in relation to the case of Mr O’Brien.
97. In particular, there is an exchange of correspondence between the Belfast HSC Trust and the Department in January and February 2019 on the review of a longer term exclusion of a doctor (one of the Department’s few operational roles under MHPS - see table on pages 19-20, and paragraphs 30 and 31 on page 19, of MHPS) and a six month review of the same case. The correspondence has been password-protected to protect the doctor’s confidentiality. I hope it



Urology Services Inquiry

provides sufficient detail on the nature of the correspondence. However, I can provide a redacted version if the Inquiry so wishes. These exchanges are provided at Appendix 30.

98. Documents provided to the Inquiry at Appendix 31, reflect work being led by the Department to incorporate MHPS into a new Single Employer entity that was being created for doctors in training.
99. A copy of letter of 5 September 2019 from Ann McConnell, then HR Director, Western HSC Trust, is provided to the Inquiry at Appendix 32, belatedly advising the Department of the extended suspension of a doctor under MHPS who had since resigned. The covering email shows that the Department's then acting Director of Workforce Policy, Andrew Dawson, noted this on 16 September 2019.
100. A letter of 16 July 2020 from the then DoH Permanent Secretary to the Chair of the Belfast Health and Social Care Trust; and a letter of 13 January 2022, from the Minister of Health to the Chair of the Assembly Health Committee; in respect of Dr Michael Watt. Letters are provided to the Inquiry at Appendix 33.
101. A small amount of correspondence which mentions MHPS in the context of the closure of the former HSC Board, and the formation of the new Strategic Planning and Performance Group in the Department. This exchange is provided to the Inquiry at Appendix 34.

The Independent Neurology Inquiry

102. This Inquiry will be conscious that the Independent Neurology Inquiry (INI) recently reported on 21 June 2022. While, at this time, the Department is still digesting the content and recommendations of that report, I have noted that a number of recommendations identified in that report directly relate to MHPS and to how the HSC more widely deals with the raising and investigation of concerns surrounding an individual's clinical practice.



103. Of particular note is the conclusion of the 'Independent Neurology Inquiry: Report June 2022. Volume 3' paragraph 13.45(iii), page number 196, that "*The intricacies of the Maintaining High Professional High Standards ("MHPS") procedures make dealing with doctors in difficulty a more cumbersome process than should be the case.*" This finding clearly chimes with some of the issues that had been raised in the reviews that were begun by the Department in 2011 and 2018. Excerpt provided to the Inquiry at Appendix 35.
104. A further challenge noted by the INI was that the present informal process within MHPS was considered to be opaque which led to different doctors taking different approaches to investigation. The INI also considered that the present balance of the procedure is weighted towards the protection of the doctor and in the confidentiality of the process rather than patient safety.
105. Indeed the Independent Neurology Inquiry Panel recorded its view that reform of the existing MHPS procedure is long overdue, a view I and my Department have accepted.
106. Having considered the documentary evidence available to the Department, it is clear that a number of issues have been identified with respect to the implementation of MHPS and its application by colleagues across HSC.

Future action

107. It is evident, not least because the framework was first introduced in 2005 and the two reviews that did not complete, that a substantive review of the MHPS policy is overdue and must be made a priority for my Department.
108. The recently published report of the Independent Neurology Inquiry identified a number of issues and made recommendations for improvement that will need to be reflected within a revised and updated MHPS policy framework. These recommendations will be a starting point for a review. A review of MHPS will also need to consider the issues that had been highlighted previously through



Urology Services Inquiry

the two (2011 and 2018) reviews of the policy which began and did not complete.

109. Turning to the future action to strengthen the MHPS policy, it is my view that a rapid but fundamental review of MHPS must be started – and, most importantly, completed – as soon as possible and as a matter of priority.
110. I consider that such a review should be commissioned by the Department but conducted by persons external to the Department. Options for such a review will be put to the Minister for consideration and selection of a preferred option. The Department's Workforce Policy Directorate, working with the Chief Medical Officer Group, will take responsibility for the commissioning of the review.
111. The Inquiry will note that the 'Independent Neurology Inquiry: Report June 2022. Volume 1, page 31, (INI) report, published on 21 June 2022, made three specific recommendations (recommendation 16-18) to the Department in relation to MHPS, and those recommendations will be fully considered within the review. Excerpt is provided to the Inquiry at Appendix 36. The recommendations are that:
 - Recommendation 16: The NI Department of Health should ensure that the confidentiality dimension of the MHPS process is always subordinate to patient safety considerations;
 - Recommendation 17: The NI Department of Health should review paragraph 39 of MHPS and issue guidance on the appropriate balance between confidentiality for the clinician and safety for the patients;
 - Recommendation 18: The NI Department of Health should oversee the establishment of a group to consider the balance between the fair treatment of clinicians and the safety of patients under MHPS. The group should focus on reducing the complexity of processes and re-evaluating the degree of confidentiality. The group would benefit from input from appropriate experts to include Human Resource expertise and Medical Directors.



112. The review of MHPS will take place in the context of other significant policy work which I shall detail in the following paragraphs.
113. Firstly, the Department will be considering the appropriate implementation of the INI report published on 21 June 2002. The report makes 76 recommendations to the Department, Healthcare Organisations, the General Medical Council and the Independent Sector in the context of the findings of the INI in relation to Dr Michael Watt. In addition to the three MHPS recommendations for the Department detailed above, there are four recommendations for the Department in relation to reform of patient complaints processes; and three recommendations in relation to staff appraisal. I will be happy to forward the full action plan for implementation of the accepted INI review recommendations as soon as it is completed and approved.
114. Second, the Department will be continuing its work to implement the 96 recommendations (which have been translated into 120 actions) of the report of the Inquiry into Hyponatraemia-related Deaths, which was published in January 2018. It is intended that the Minister of Health will shortly make a written statement to the Assembly on progress to date. This statement will say that, in total, 45 recommendations (49 actions) have been identified as actioned in the first phase of the programme, meaning that there is adequate evidence that they have been implemented across the HSC. Further assessment and monitoring may be required to provide evidence of a consistent regional approach to continued implementation of these recommendations.
115. Phase 2 of the IHRD Implementation programme will allow the remaining recommendations to receive focused attention. Future progress will be overseen and assured by a newly-constituted IHRD Programme Board, with refreshed programme management structures, which will be chaired by me as Senior Responsible Owner for the IHRD Programme. When fully implemented, the IHRD recommendations will have implications for the medical profession in relation to candour and being open; death certification; the Trusts' duty of



Urology Services Inquiry

quality; paediatric care; serious adverse incidents; education and training; and professional regulation.

116. I will arrange to forward a copy of the Minister's Assembly statement when it is made, together with a comprehensive briefing document. However, in the context of the issues being investigated by the Urology Services Inquiry, I consider that it would be worth outlining in more detail in my statement the ongoing and planned work in relation to:

- (a) Candour and openness; and
- (b) Serious Adverse Incidents.

117. Separately from the IHRD programme, I also wish to use this statement to outline future action in relation to:

- (a) the Department's Early Alert system; and
- (b) a fundamental review of regulation.

118. These actions outlined below may or may not impact on MHPS. This will be determined as the actions are addressed. However, the future actions will represent a comprehensive body of policy work which would change the medical workforce model. The information provided will, I trust, also give further background as to where the MHPS framework sits within the wider policy context in respect to patient safety and reporting concerns. It will, I hope, also provide some background and context to the actions detailed later in my statement which set out the Department's contacts with SHSCT and actions taken since it was first made aware of the concerns relating to Mr O'Brien's practice.

Candour and Openness

119. As part of the IHRD implementation programme established by the Department, the Duty of Candour Workstream, and its Being Open Sub Group, were set up to take forward the recommendations relating to candour and openness. The



Urology Services Inquiry

Workstream took on board research, evidence and feedback from stakeholders to develop draft policy proposals for consultation.

120. The consultation ran from 12 April – 31 August 2021 and received 334 responses. The themes identified from analysis of the responses were considered by the Workstream and formed the basis of their proposals to implement the recommendations on candour and openness. The Workstream submitted its assessment to Minister for his consideration in February 2022.
121. The Minister has asked officials to focus on the development of detailed policy in respect of the Being Open Framework which is based on the following five principles:
 - (a) Routine Openness in all aspects of Health and Social Care;
 - (b) Openness across the system to promote learning when things go wrong;
 - (c) Candour when things go wrong and harm or death has resulted so that subsequent investigations and engagement with families and carers are open and honest;
 - (d) Support for openness and candour so that staff and patients are provided with appropriate help and support to exercise and experience openness and honesty in all circumstances; and
 - (e) Governance of openness and candour so that there are appropriate monitoring and accountability arrangements in place.
122. This Being Open Framework will underpin an open and candid culture where concerns and complaints can be raised freely without fear. This will include engagement with relevant stakeholders and staff, and proposals for the rollout of Being Open guidance and training across the HSC, in order that staff have the appropriate knowledge, skills and supports to play their part in creating and maintaining this culture.



123. It is important that staff and organisations continue to learn and improve and openness is essential to this and to moving away from fear and blame while ensuring that mistakes are investigated in a just and fair way. As well as training and guidance, staff must be given space and resources to interact with one another and with service users in an open manner. Staff should be able to provide feedback and learn when something has not gone as well as expected and this learning should be shared.
124. Guidance will also be developed for service users, carers and their families in relation to openness when accessing Health and Social Care services. This will outline what they can expect, how they will be involved and how to access support, including when things go wrong. Organisations must also respond to feedback and complaints from service users, carers and their families.
125. Cultural change takes time but focusing on the development of relevant guidance, training and supports now will help ensure that they are in place, operational and familiar to staff, ahead of the formal commencement of any legislation.
126. Concurrent with the work on the Being Open Framework, officials will continue to further develop detailed proposals on how a statutory duty of candour might work in practice, including reporting requirements when things go wrong. These proposals will take account of the potential impacts of introducing an individual duty of candour, with specific reference to any legal and workforce implications.
127. The aim of any statutory Duty of Candour will be to support the cultural change being facilitated by the Being Open Framework and not to lead to unintended negative consequences. A just and open culture should support staff to be open and honest, have a focus on learning not blame, ensure service users are valued and listened to and be committed, from the top down, to a safe and supportive environment.



Urology Services Inquiry

Serious Adverse Incidents

128. I have attached an overview of the basis for the Serious Adverse Incidents policy position [DOH-1882 – DOH-1885] and accompanying documents which are provided to the Inquiry at (Appendix 37

129. The following table details the numbers of SAls dating back to 2012:

Notification	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total
Level 1		61	557	498	308	266	311	381	415	515	3312
Level 2	296	343	194	122	103	71	60	82	79	72	1422
Level 3	2	2	9	5	3	3	9	9	24	13	79
Total	298	406	760	625	414	340	380	472	518	600	4813

To note: Level 1 Reviews were introduced to the process via the 2013 Procedure. Child Deaths were reported as SAls in line with the 2013 Procedure, they were then removed from the process in February 2016 – hence a decrease in total numbers reported in 2016.

[Source: Department of Health, Strategic Planning and Performance Group Datix]

130. The Minister of Health will shortly publish an RQIA review of serious adverse incidents in Northern Ireland. The terms of reference for the review were as follows:

- (a). To review the systems/ processes in place for reporting and follow-up of Serious Adverse Incidents (SAls) across the six HSC Trusts, the HSCB



Urology Services Inquiry

and Public Health Agency in Northern Ireland, between 30 November 2016 and 31 March 2018.

- (b). To engage with families affected by SAIs reported between 30 November 2016 and 31 March 2018, to determine their level of involvement in the Serious Adverse Incident process.
- (c). To assess the process for the classification of the severity of SAIs and to determine whether incidents are appropriately classified through this process.
- (d). To assess the level of independence of the SAI reviews progressed and assess whether a multi-disciplinary systems-wide approach to reviews has been undertaken.
- (e). To assess the development and effectiveness of action plans and recommendations arising from SAIs reviews.
- (f). To assess whether appropriate learning has been identified from the SAIs and disseminated regionally, and whether the learning can deliver measurable and sustainable improvements in the quality and safety of care.
- (g). To determine current understanding of the role of respective organisations, including the Coroner, in the process for SAI reviews, and how this understanding compares to the published roles and responsibilities as outlined in the procedure for the Reporting and Follow up of Serious Adverse Incidents.
- (h). To assess the level of professional support provided to staff who were delivering care at the time of the SAIs, as well as staff conducting the review of the SAIs.
- (i). To provide a report of the findings to the Department of Health, making recommendations for improvement as relevant to the overall response



to SAs, their assessment and review, and the learning arising through these processes.

131. The review recommendations will suggest actions for the Department intended to deliver a new regional policy for reporting, investigating and learning from adverse events. I will share a copy of the report with the Inquiry as soon as it is published.
132. Further, recommendation 23 of the INI report states that the Department should review (and if necessary, change) the early warning alert process to assure itself that it is clear, well understood and operates in the interests of patients.
133. This INI recommendation will be incorporated into the forthcoming policy work to implement the RQIA report on SAs in Northern Ireland described.

Early Alerts policy

134. In June 2010, the process of reporting Early Alerts was introduced following issue of circular HSC (SQSD) 10/2010. The Early Alert System provides a channel to enable Chief Executives and their senior staff in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the Department.
135. The established communications protocol between the Department and HSC organisations emphasises the principle of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:



Urology Services Inquiry

- (a). Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;
- (b). The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;
- (c). The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;
- (d). The event may attract media interest;
- (e). The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless:
 - (i). there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or
 - (ii). evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or
 - (iii). the Coroner's inquest is likely to attract media interest.
- (f). The following should always be notified:
 - (i). the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;



Urology Services Inquiry

- (ii). the death of, or significant harm to, a Looked After Child, a child on the Child Protection Register or a young person in receipt of leaving and after care services;
 - (iii). allegations that a child accommodated in a children's home has committed a serious offence; and
 - (iv). any serious complaint about a children's home or persons working there.
 - (g). There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.
136. It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (Director level or higher) communicates via a phone call to a senior member of staff in the Department (Permanent Secretary, Deputy Secretary, Chief Professional Officer, Assistant Secretary or professional equivalents) regarding the event, and also an equivalent senior executive in SPPG and the PHA, as appropriate, as well as any other relevant bodies.
137. The next steps regarding the alert should be agreed during the reporting phone call, and appropriate follow-up action taken by the relevant parties. In all cases the reporting organisation must arrange for the content of the initial contact to be recorded on the Early Alert proforma and forwarded within 24 hours of notification of the event to the Department's Early Alerts Team.
138. On receipt of the Early Alert proforma, the Department's Early Alerts Team will circulate to the appropriate policy lead/leads within the Department for to consider any further action (if any) they need to initiate in relation to their policy area. This may include liaising with the HSC organisation to ascertain further details surrounding the event; reminding the HSC organisation to give proper consideration as to whether or not the event also meets the criteria to be categorised as an SAI; liaising with the Private Office, the Press Office and



other relevant policy areas regarding handling arrangements including preparation of a formal submission to Minister or any other immediate action deemed necessary.

139. It is the responsibility of the reporting HSC organisation to comply with any other possible requirements to report or investigate the event they are reporting in line with any other relevant applicable guidance or protocols (e.g. Police Service for Northern Ireland (PSNI), Health and Safety Executive (HSE), the Safeguarding Board for Northern Ireland, Professional Regulatory Bodies, the Coroner etc.) including compliance with GDPR requirements for information contained in the Early Alert proforma and the mandatory requirement to notify the Information Commissioner's Office (ICO) about any reportable personal data breaches.
140. There will also be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert which has already been reported, and communicate with a senior member of staff in the Department regarding the update. This is not mandatory but reporting organisations should exercise judgement as to whether there has been a substantive change in the position which would warrant notifying the Department formally of an update.
141. The Department holds a database of all Early Alerts received following the introduction of the Early Alerts System in June 2010. The number of alerts received each year is presented in the table below:

Year	Total Number of EAs received each year
2010	13 ¹

¹ Number of alerts received from 1 June 2010 to 31 December 2010.



2011	60
2012	116
2013	95
2014	151
2015	158
2016	183
2017	136
2018	166
2019	267
2020	429
2021	545
2022	226 ²

142. Further, recommendation 23 of the INI report states that the Department should review (and if necessary, change) the serious adverse incident process to

² Number of alerts received from 1 January 2022 to 24 June 2022.



assure itself that it is clear, well understood and operates in the interests of patients.

143. Departmental officials will recommend to the Minister that this INI recommendation should be progressed by the Department as a priority.

The role of the Regulation and Quality Authority, and a planned fundamental review of regulation

144. The RQIA was established under Article 3 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 ("The Order"). The Order created the enabling legal framework for RQIA to have overall responsibility for monitoring and regulating the quality of health and care services delivered in Northern Ireland; The Order gives responsibility for and powers to regulate a wide range of care services including many services delivered by the HSC as well as services delivered by the independent sector
145. The Order makes provision for the duties and responsibilities of the RQIA. These can be summarised as 3 main aims:
- (a). Keeping the Department informed about the overall state and provision of health and social care services, and in particular, about their availability and their quality.
 - (b). Encouraging improvement in the quality of services by conducting reviews of health and social care organisations' clinical and social care governance arrangements against quality standards; and thematic and service reviews; and specific investigations as directed by the Department.
 - (c). Regulation of the following establishments and agencies:
 - (i). children's home;
 - (ii). a day care setting;



- (iii). an independent clinic;
 - (iv). an independent hospital;
 - (v). a nursing home;
 - (vi). a residential care home;
 - (vii). a residential family centre;
 - (viii). a domiciliary care agency;
 - (ix). a fostering agency;
 - (x). an independent medical agency;
 - (xi). a nursing agency;
 - (xii). a voluntary adoption agency;
146. In 2014 RQIA was tasked to undertake inspections of acute hospitals. This is done under the provision for using inspection as part of a review (article 35 1(d)) of the 2003 Order. The Hospital Inspection Programme (HIP) is a rolling programme of inspections.
147. During a hospital inspection RQIA will speak to a range of staff from “board to ward” and beyond. RQIA hold focus groups with staff at all grades – including medical, nursing, support, doctors in training and management. RQIA also meet with board members around their oversight of the service and how they hold the executive team to account. RQIA observe practice, speak to patients and visitors and examine policies and procedures. All of this information is triangulated to gain an holistic overview of the quality of care delivered.
148. After a hospital inspection RQIA delivers detailed verbal feedback to the executive team and set out any areas of concern as well as good practice. This is followed with a note of the feedback and then an inspection report.



149. RQIA's Hospitals Programme Team had planned to undertake a series of inspections to outpatient departments during 2021/22 as part of follow up of the RQIA review of Governance Arrangement in the Belfast Trust. Being mindful of the significant and escalating service pressures across HSC hospitals and in particular the phased plans for Rebuilding Health and Social Care Services, this work has not yet commenced.
150. The HIP is not the only presence RQIA have in hospitals. RQIA conducts rolling programmes of hygiene inspections and inspections of augmented care services. These inspections focus on specific elements of care and are centred on meeting the standards associated with the delivery of that care. These inspections include examination of clinical and social care governance.
151. Hospitals are not regulated in Northern Ireland. RQIA can however issue Improvement Notices where they find non-compliance with the 2006 Quality Standards. Where RQIA have serious concerns they may suggest that the Department introduce special measures to a hospital or Trust but the decision as to whether to accept RQIA's recommendation rests with the Department. Another function is RQIA Reviews, which seek to provide assurance to the public about the quality, safety and availability of health and social care services in Northern Ireland. The reviews aim to encourage continuous improvements in health and social care services and ensure the rights of service users are safeguarded. Of relevance to this Inquiry may be the review of Consultant Medical Appraisal Across HSC Trusts September 2008, which is provided to the Inquiry at Appendix 38.
152. In terms of governance reviews, RQIA has published its reviews of clinical and social care governance arrangements in health and social care boards, Trusts and agencies across Northern Ireland. The findings from its reviews demonstrate how the concepts and practicalities of clinical and social care governance and risk management are being taken forward in health social care organisations across Northern Ireland. A list of relevant governance reviews is provided to the Inquiry at Appendix 39 to this statement.



153. The preceding paragraphs are a means of providing the context for a forthcoming fundamental review of regulation, to be led by the Department. A draft consultation document on such a review had been completed in 2020 but was not published owing to the Covid pandemic. That draft is currently being updated to take account of lessons learned from the pandemic, as well as from the findings of the INI and indeed the preparation of this statement. It is the Minister's intention that this fundamental review will be taken forward during the current mandate of the Assembly. A copy of the draft, unpublished consultation document 'The Right Touch: A New Approach to Regulating Health and Social Care in Northern Ireland' is provided to the Inquiry at Appendix 40 to this statement. An analysis of issues 'The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 – Gaps and Issues' is provided to the Inquiry at Appendix 41.

Mr Aidan O'Brien - Urology Concerns Timeline

154. The Department first became aware of concerns relating to Urology Services in the Southern Trust on 31 July 2020 when the Trust submitted Early Alert pro forma (ref EA 182/20) [DOH-19704] to the Department on the basis of the likelihood of the Trust needing to contact patients about possible harm.
155. In accordance with the Early Alert protocol, the Trust also notified the Department in advance of submitting the pro forma via a telephone call from the Trust Medical Director to the Office of the Chief Medical Officer (CMO). The proforma was copied to the HSCB, also in line with the Department's Early Alert protocol.
156. Policy guidance on the Establishment of an Early Alert System was issued by the Department to the HSC on 28 May 2010 as Circular HSC (SQSD) 10/2010 (a copy is provided to the Inquiry at Appendix 42). The Early Alert System became operational on 1 June 2010 as a means of complementing, not replacing, existing formal and informal channels of communication. It provides a channel to enable HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services



Urology Services Inquiry

provided or commissioned by their organisations, which may require immediate attention by the Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the Department, and which meet one or more of the following criteria:

- Requires urgent regional action
- Contacting patients/clients about possible harm
- Press release about harm
- Regional media interest
- Police involvement in investigation
- Events involving children
- Suspension of staff or breach of statutory duty

157. The Early Alert 182/20 advised the Department that on 7 June 2020 the Southern Trust had become aware of potential safety concerns regarding a consultant urologist who was employed by the Trust from 6 July 1992 until his retirement on 17 July 2020. As a result of these potential patient safety concerns, the Trust advised that it had conducted a lookback exercise of the consultant's work over a 17 month period (from 1 January 2019 - 31 May 2020) to ascertain whether there were wider service impacts.

158. The lookback exercise concentrated on whether patients had a stent inserted during procedure and if this had been removed, and found that:

- of 147 patients taken to theatre who were listed as being under the care of the consultant during the lookback period, concerns were identified in 46 of these cases;
- of 334 elective-in patients reviewed, 120 cases were found to have experienced a delay in dictation ranging from 2 weeks to 41 weeks, one of



whom had (at that time) been identified for screening for Serious Adverse Incident review;

159. A further 36 patients were identified who had no record of care noted on the regional Electronic Care Record (NIECR) system. To date one of the elective in-patient cases has been identified for screening for Serious Adverse Incident review.
160. In addition, the Early Alert 182/20 advised that two recent cases managed by this consultant had been identified which were (at that time) being screened as Serious Adverse Incidents. These cases involved two prostatic cancer patients that indicated potential deficiencies in care provided by the consultant, where these deficiencies potentially had an impact on patient prognosis.
161. The Early Alert 182/20 advised that the following actions had been taken:
 - The Trust had held discussions with the General Medical Council's (GMC) employer liaison service;
 - The case had been discussed with NHS Resolutions who had recommended restrictions of clinical practice including a request to the consultant not to undertake private practice in his own home or other premises pending further exploration;
 - Restrictions had been placed by the Trust resulting in the consultant no longer being able to undertake clinical work or access or process patient information, either in person or through others either in hard copy or electronically.
 - The consultant had been requested to voluntarily undertake to refrain from seeing any private patients at their home or any other setting and to confirm the same in writing.



Urology Services Inquiry

- The Trust had undertaken a preliminary discussion with the Royal College of Surgeons' 'Invited Review Service' regarding the consultant's practice and potential scope and scale of any lookback exercise.
162. I am advised that, in the days subsequent to receipt of the Early Alert 182/20, senior officials in the Department engaged in further discussion with Trust senior management in order to ascertain the details of the lookback exercise for the purpose of advising the Minister and determining the appropriate level of response and oversight that may be required.
163. The Health Minister was notified of this Early Alert 182/20 by way of a submission on 06 August 2020 [DOH-00684 – DOH-00691]. The submission asked the Minister to note the latest Trust advice that at that time the number of patients who may have received sub-optimal care comprised approximately 230 patients, and that the full scope of the consultant's practice (i.e. work potentially carried out in other Trusts, in cross-border or in private healthcare settings) was not currently known.
164. On 18 August 2020, SHSCT submitted an update to the Chief Medical Officer via email [DOH-00667 – DOH-00668]. This update advised that:
- the doctor had retired and that the Trust was in contact with him through his legal representative;
 - on advice of NHS Resolutions and the General Medical Council he had agreed not to see private patients;
 - the SHSCT did not have an oversight of his previous private patients;
 - to the best of the SHSCT's knowledge he was not working for another Trust and was not registered with the Medical Council of Ireland;
 - the SHSCT was liaising with GMC regarding professional matters;
 - the SHSCT was continuing to consider any potential quality of care issues;



Urology Services Inquiry

- the SHSCT was liaising with the Royal College of Surgeons to engage with the British Association of Urological Surgeons to consider the import and extent of its findings and to access subject matter experts in relation to Serious Adverse Incidents (SAIs);
 - the SHSCT was minded to make a decision on the requirement for a formal look back exercise and what the nature and scope of such a process would look like, and enquiring what information would be required by the Department to allow for a determination on this to be made; and,
 - the SHSCT was preparing to contact the service users impacted as part of the SAI process.
165. On 24 August 2020, SHSCT provided an update to the Department of Health via a telephone call from the Medical Director to Jackie Johnston, then Deputy Secretary, Healthcare Policy Group (a copy of which is provided to the Inquiry at Appendix 43) which provided an outline of the issues which the Trust had identified as requiring a decision on the appropriate way forward in relation to:
- requesting the Royal College of Surgeons to carry out a lookback exercise;
 - an appropriate process for investigating the conduct of the Doctor concerned;
 - involvement of an expert patient to sit on the panel to be established to review the three SAI cases; and,
 - the timing of external communications including with SAI patients' families.
166. I understand that on 28th August, Maria O'Kane the then Medical Director of the SHSCT contacted the Office of the Chief Medical officer and spoke to the Deputy Chief Medical Officer (DCMO), Dr Naresh Chada, regarding clarification and the distinction between the Early Alert process (informing the Department of an issue that had arisen) and Alert letter process (whereby the Department



informed other HSC organisations and CMO counterparts in other jurisdictions about the concerns with an individual doctors practice).

167. Dr Chada followed up by sending copies of relevant extant guidance to Ms O’Kane on 4 September 2020. This included a copy of the circular HSS (TC8) 6/98 which described the policy relating to Alert Letters and a link to HSC (SQSD) 5/19 the Circular which *“provides updated guidance on the operation of the Early Alert System which is designed to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events which may require the attention of the Minister, Chief Professional Officers or policy leads”*. Copy of Circular HSS (TC8) 6/98 is provided to the Inquiry at Appendix 44. Further clarification regarding the two processes was provided in a series of emails between Departmental officials and the Trust between 17 September 2020 to 7 October 2020. Refer to [DOH-43931 – DOH-43952].
168. There were concerns expressed by SHSCT that Aiden O’Brien may try to seek employment and continue to work. Moreover, given that he was no longer in the employment of the Trust, the Trust was unsure as to what mechanisms were in place to prevent Aiden O’Brien from working in the Republic of Ireland or undertaking work with private patients.
169. In summary it was confirmed that the two processes are different in that the Early Alert process normally only refers to the incident itself rather than giving details of clinician(s) or professional staff involved. There may be occasions where the Early Alert process may interlink with the Alert Letters process which is about Hospital and Community Medical and Dental Staff under Investigation. The Alert Letter process was summarised as follows;
 - NI Alert Letters are issued when the HSC Trusts contact CMO office.
 - Trusts will email/write to the Chief Medical Officer / Deputy Chief Medical Officer with concerns and details of the issue.



Urology Services Inquiry

- CMO/DCMO considers all the available information and then makes the decision to issue an alert letter or not.
170. Following this, I am informed that on 03 September 2020, SHSCT hosted a Zoom meeting in order to update the Department of Health, HSCB, and Public Health Agency (PHA). Unfortunately, a written record of the meeting was not maintained. The recollection of officials involved was that this meeting was to allow the Trust to provide an update regarding its ongoing internal scoping work in relation to Aiden O'Brien's patients and the development of operational plans regarding communications with patients/families and the establishment of a dedicated helpline. I am informed that these became weekly meetings to allow the Department to be sighted on developments and to form a collective view with Commissioners (HSCB and PHA) about the level of oversight that would be required to draw assurance from the Trust's response to and management of the emerging situation. Accordingly, from 10 September 2020, officials from the Department, HSCB and PHA participated in weekly progress update calls with the Trust, leading to the formal establishment of the Urology Assurance Group from 30 October 2020.
171. On 15 October 2020, the Early Alert EA 182/20 was updated on the basis of three criteria, i.e. that urgent regional action was required, that patients/clients would need to be contacted about possible harm, and potential regional media interest. This is provided to the Inquiry at Appendix 45. This was due to new and significant concerns arising from the scoping work about the consultant's prescribing practice, which had been identified following an initial meeting of the Trust's Serious Adverse Incident review team that week.
172. The concerns related to the subject's prescribing practices which included use of unlicensed and sub-therapeutic dosages of Bicalutamide, which the Trust considered to be a significant and potentially wide patient safety risk requiring immediate action. The Trust advised that staff were working with the HSCB medications team to gain a better understanding of the implications of this latest



development in terms of scale and scope and to identify patient groups that may be at risk.

173. It was recognised that this prescribing issue involved medicines that are prescribed by primary care providers on advice from the secondary care team. In addition to updating the Early Alert, the Trust noted that senior staff at HSCB, PHA and Department of Health had been briefed directly of this development, and that the Trust was continuing to liaise directly with colleagues in each organisation in order to determine and take appropriate action.
174. The Department issued an alert letter (related to the process outlined previously) on 16 October 2020 in respect of Mr Aidan O'Brien
 - The alert was issued by Quality Regulation Policy and Legislation Branch (QRPLB) in line with the normal protocol, i.e. a request from the DCMO, which was made by email on 13 October 2020. This was in light of the issues which the Department was made aware of through confidential Early Alert EA 182/20 and subsequent communication from the Southern Trust, which at that point had not provided a satisfactory degree of certainty with regard to the consultant's intention to desist from further medical practice or otherwise. The Alert Letter NI Alert 2020/01 was issued to the Health and Social Care Board (HSCB) and the Public Health Agency. [DOH-43956].
 - Alert Letters NI Alert 2020/01 were also issued to five Health and Social Care Trusts, the Business Services Organisation, and CMO Wales and CMO Scotland by post on the 16 October 2020 [DOH-43957]; and
 - A further Alert Letter NI Alert 2020/01 was issued by email on 16 October 2020 to NHS Resolution, Practitioner Performance Advice (formerly NCAS). [DOH-43959 - DOH-43960].
175. On the 26th of October the Minister provided a written statement to the Assembly which outlined the concerns relating to the consultant's practice but not naming the consultant.



176. On the 10th of November the consultant's solicitors wrote to the Chief Medical Officer advising that they had advised the Southern Health and Social Care Trust on 16 July 2020 that Mr O'Brien had "*no difficulty in undertaking to refrain from seeing any private patients at his home or any other setting*", and that Mr O'Brien had issued personal assurances by letter to the GMC on 31 July 2020 that he had no intention of seeking employment elsewhere, nor of seeing private patients. [DOH-35184 – DOH-35186].
177. Michael O'Neill, the Acting Director of General Healthcare Policy wrote to Mr O'Brien's solicitor on 24 November 2020 [DOH-35224] confirming that the Alert letter had been issued, to whom it was issued and why. He further advised that it was now being withdrawn based on the information which the Department had received. Mr O'Brien's solicitors were further advised that the Minister was going to make an oral statement to the assembly. All relevant emails relating to this correspondence is provided to the Inquiry [DOH-35220 – DOH-35221], [DOH-35225] and [DOH-35235]. Copies of the related alert letters is provided to the Inquiry [DOH-35238 – DOH-35239]. The Alert Letters were cancelled on 24th November 2020.
178. By 10 December 2020 there were further indications that Aiden O'Brien had been attempting to work which were brought to the attention of the Department. [DOH-44126 – DOH-44127]. This included an approach to the Directorate of Legal Services (DLS), the provider of legal services to the health and social care sector (HSC). In addition, there were allegations of three further cases that had come to the attention of SHSCT where Aiden O'Brien had allegedly undertaken private work but this required verification. The details of the concerns were provided by the Southern Trust and outlined in a memo [DOH-44143 – DOH-44149] from Michael O'Neill to Lourda Geoghegan & Naresh Chada dated 13 December 2020 (and updated on 15 December 2020).
179. Consideration was given to whether there would be justification for the issue of Alert letters again. However, further investigation demonstrated that Aiden O'Brien had not in fact sought to undertake further medico-legal work from DLS



Urology Services Inquiry

and the veracity of two of the other three allegations was difficult to verify, as they could be regarded as transitioning care back to the patient's GP. On that basis, it was considered that a further letter was not required.

180. It was also the case that by this point Aiden O'Brien had received an 18-month full suspension following the GMC interim orders panel meeting on 15th December 2020. No further action was taken by the Department in relation to the Professional Alert letters.
181. On 22 October 2020, my predecessor as Permanent Secretary, Richard Pengelly, wrote to Shane Devlin, CEO of the SHSCT to advise that a Department-led Urology Assurance Group (UAG) would be established. [DOH-43730 – DOH-43733].
182. The purpose of this Group was to provide external oversight to the ongoing SHSCT review process and the management of issues arising from it. The Terms of Reference agreed in October 2020 stated that the group would:
 - (a). review the progress of the initial scoping exercise;
 - (b). consider emerging strategic issues;
 - (c). commission and direct further work as necessary;
 - (d). monitor the impact on urology and related services;
 - (e). ensure coordination with other associated reviews / investigations; and;
 - (f). oversee communication across all stakeholder groups
183. A copy of the original Terms of Reference for this Group has previously been provided to the Inquiry [DOH-00297-DOH-00299].
184. The UAG consists of senior officials from the Department of Health, Health and Social Care Board (now the Strategic Planning and Performance Group within the Department), Public Health Agency, Regulation and Quality Improvement Authority, and the SHSCT.



Urology Services Inquiry

185. The establishment of the UAG was announced in the Ministerial Written Statement to the Assembly of 27 October 2020, titled “Clinical concerns within Urology at Southern Health and Social Care Trust”.
186. The Urology Assurance Group (UAG) held its first meeting on 30 October 2020, (DOH-00300-DOH-00305). Since its inception, 16 meetings of the UAG have been held on 06 November 2020, (DOH-00306-DOH-00311); 13 November 2020, (DOH-00312-DOH-00319); 20 November 2020, (DOH-00320-DOH-00323); 04 December 2020, (DOH-00324-DOH-00328); 18 December 2020, (DOH-00329-DOH-00333); 08 January 2021, (DOH-00334-DOH-00340); 22 January 2021, (DOH-00341-DOH-00346); 05 March 2021, (DOH-00359-DOH-00364); 19 March 2021, (DOH-00365-00371); 16 April 2021, (DOH-00372-DOH-00380); 14 May 2021, (DOH-00381-DOH-00389); 18 June 2021, (DOH-00391-DOH-00399); 01 November 2021, 23 February 2022, and 23 May 2022. Minutes of these last three meetings are provided to the Inquiry at Appendix 46.
187. The Terms of Reference of UAG were updated on 23 May 2022. These revisions did not alter the core objectives of the UAG. The key amendments included updating the participant list and frequency of meetings. The revised Terms of Reference is provided to the Inquiry at Appendix 47.
188. Given the seriousness and extent of the concerns identified with the practice of Dr O'Brien, on 20 November 2020 a submission (INV-1873-2020 (SUB-2174-2020), (DOH-44004-DOH-44008) was provided to Minister, recommending that the establishment of a Public Inquiry under the Inquiries Act 2005 would be an appropriate approach to ensure that the full extent of the concerns are identified and for the patients and families affected to see that these, and all relevant issues, are pursued in a transparent and independent way.
189. It was considered whether the Independent Neurology Inquiry could be recast to include the concerns arising with this consultant, but it was decided not to do so as there would be an impact on the delivery of the intended INI report.



Urology Services Inquiry

190. This recommendation was accepted by Minister, who subsequently provided an oral statement to the Assembly on 24 November 2020 regarding Urology in the SHSCT (extract from Hansard appended is provided to the Inquiry at Appendix 48).
191. This statement confirmed the impending establishment of a statutory public inquiry on this matter, in addition to providing an update on associated actions including the initial lookback exercise.
192. On 08 March 2021, Minister Swann announced the appointment of Christine Smith QC as Chair of the Urology Services Inquiry, by way of Written Assembly Statement (DOH-00940).
193. This was followed on 31 August 2021, by a further Written Assembly Statement from Minister Swann announcing the Urology Services Inquiry Terms of Reference, a setting up date and the appointment of a panel member and assessor (DOH-01510-DOH-01511).

Application of MHPS Framework by the Southern Health and Social Care Trust

194. Paragraph 11 of the Inquiry's Section 21 notice asks: *"Based on the information available to the Department at present, how would you assess the implementation and application of the MHPS Framework by the Southern Health and Social Care Trust with regard to Mr Aidan O'Brien? Consider the effectiveness of the process in identifying and addressing any concerns, any delay in the conduct of the process and the outcomes of that process."*
195. I have set out above, the detail of the interactions between SHSCT and the Department from when the concerns surrounding Mr O'Brien's practice were first brought to the attention of the Department, it further provides a timeline of actions taken by the Department leading to the establishment of the Independent Urology Inquiry.
196. As detailed above, the Department has a limited operational role in the application of MHPS, covering only the following issues:



Urology Services Inquiry

- (a). review of longer term exclusions (see table on pages 19-20, and paragraphs 30 and 31 on page 19, of MHPS);
 - (b). the recruitment and selection of appeals panels in clinical performance cases (see Annex A of MHPS on page 35); and
 - (c). provision of process advice to smaller HPSS (now Health and Social Care) organisations, where necessary (pages 41-42 of MHPS).
197. While there has been significant interaction between the two organisations since the issues involved were first brought to the Department's attention, the limited role of the Department with respect to its involvement in individual MHPS processes, coupled with the clear responsibility placed upon the Chief Executive of an organisation with respect to ensuring MHPS procedures are followed, mean that Departmental officials do not have a sufficiently detailed knowledge of the process in this individual case. No-one in the Department, myself included, would feel confident in any assessment we would make of the effectiveness of how MHPS was implemented and applied in this particular case. Further, the Department would not wish to pre-empt or influence the consideration of the Panel in this important aspect of the Inquiry.
198. I have detailed above my belief that a substantive review, in general terms, of the MHPS policy should be undertaken by the Department as a matter of priority. That will be put as an option to the Minister for very early consideration. I am committed to sharing further information emerging from any review with the Inquiry as it progresses, should that assist your deliberations.

CONSULTANT TERMS AND CONDITIONS OF SERVICE

(NORTHERN IRELAND) 2004

Department of Health, Social Services and Public Safety

Version 2	November 2006
Version 3	May 2008
Version 4	April 2013

+Consultant Terms and Conditions of Service (Northern Ireland) 2004

	Page
Definitions	4
Schedule 1 Commencement Of Employment.....	6
Schedule 2 Associated Duties And Responsibilities.....	7
Schedule 3 Job Planning.....	8
Schedule 4 Facilitation And Appeals.....	12
Schedule 5 Recognition For Emergency Work Arising From On-Call Duties.....	14
Schedule 6 Extra Programmed Activities And Additional Professional Capacity..	16
Schedule 7 Premium Time.....	18
Schedule 8 On-Call Rotas.....	19
Schedule 9 Provisions Governing The Relationship Between HSC Work And, Private Practice.....	20
Schedule 10 Fee Paying Services.....	23
Schedule 11 Principles Governing Receipt Of Additional Fees.....	25
Schedule 12 Other Conditions Of Employment.....	27
Schedule 13 Basic Salary And Payment For Additional Programmed Activities For Consultants Appointed Before 15 January 2004.....	29
Schedule 14 Basic Salary And Payment For Additional Programmed Activities For Consultants Appointed After 15 January 2004.....	35
Schedule 15 Pay Thresholds.....	38
Schedule 16 Pay Supplements.....	40
Schedule 17 Pension Arrangements.....	43
Schedule 18 Leave And Public Holidays.....	44
Schedule 19 Termination Of Employment.....	50
Schedule 20 Incorporated General Terms And Conditions of Service.....	52
Schedule 21 Model Provisions For Expenses – HSC Consultants.....	53
Schedule 22 Locum Consultants.....	66
Schedule 23 Joint Appointments.....	68
Schedule 24 Maternity Leave and Pay (Temporary Schedule).....	77
Schedule 25 Employment Break Scheme (Temporary Schedule).....	86
Schedule 26 Caring for Children and Adults (Temporary Schedule)	88
Schedule 27 Flexible Working Arrangements	90
Schedule 28 Balancing Work and Personal Life	92
Schedule 29 Redundancy Pay (Temporary Schedule)	96

The terms and conditions set out in this document shall incorporate and be read subject to any amendments which are from time to time the subject of negotiation by the appropriate negotiation bodies and are approved by the Department of Health, Social Services and Public Safety after considering the results of such negotiations. Any amendments should be published.

DEFINITIONS

Contractual and Consequential Services: the work that a consultant carries out by virtue of the duties and responsibilities set out in his or her Job Plan and any work reasonably incidental or consequential to those duties. These services may include:

- Direct Clinical Care;
- Supporting Professional Activities;
- Additional HSC Responsibilities;
- External Duties.

Direct Clinical Care: work directly relating to the prevention, diagnosis or treatment of illness that forms part of the services provided by the employing organisation under section Articles 5(1), 5(2), 7(1) and 8(1) of the Health and Personal Social Services (Northern Ireland) Order 1972. This includes emergency duties (including emergency work carried out during or arising from on-call), operating sessions including pre-operative and post-operative care, ward rounds, outpatient activities, clinical diagnostic work, other patient treatment, public health duties, multi-disciplinary meetings about direct patient care and administration directly related to the above (including but not limited to referrals and notes).

Supporting Professional Activities: activities that underpin Direct Clinical Care. This may include participation in training of other staff, medical education, continuing professional development, formal teaching of other staff, audit, job planning, appraisal, research, clinical management and local clinical governance activities.

Additional HSC Responsibilities: special responsibilities – not undertaken by the generality of consultants in the employing organisation – which are agreed between a consultant and the employing organisation and which cannot be absorbed within the time that would normally be set aside for Supporting Professional Activities. These include being a Medical Director, Director of Public Health, Clinical Director or lead clinician, or acting as a Caldicott guardian, clinical audit lead, clinical governance lead, undergraduate dean, postgraduate dean, clinical tutor or regional education adviser. This is not an exhaustive list.

External Duties: duties not included in any of the three foregoing definitions and not included within the definition of Fee Paying Services or Private Professional Services, but undertaken as part of the Job Plan by agreement between the consultant and employing organisation. These might include trade union duties, undertaking inspections for the Commission for Health Improvement (or its equivalent or successor body in Northern Ireland), acting as an external member of an Advisory Appointments Committee, undertaking assessments for the National Clinical Assessment Authority, reasonable quantities of work for the Royal Colleges in the interests of the wider HSC, reasonable quantities of work for a Government Department, or specified work for the General Medical Council. This list of activities is not exhaustive.

Emergency Work: predictable emergency work: this is emergency work that takes place at regular and predictable times, often as a consequence of a period of on-call work (e.g. post-take ward rounds). This should be programmed into the working week as scheduled Programmed Activity. Unpredictable emergency work arising from on-call duties: this is work done whilst on-call and associated directly with the consultant's on-call duties (except in so far as it takes place during a time for scheduled Programmed Activities), e.g. recall to hospital to operate on an emergency basis.

For the purposes of Schedule 3, paragraph 6, non-emergency work shall be regarded as including the regular, programmed work of consultants whose specialty by its nature involves dealing routinely with emergency cases, e.g. A&E consultants.

Fee Paying Services: any paid professional services, other than those falling within the definition of Private Professional Services, which a consultant carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 of the Terms and Conditions.

Private Professional Services (also referred to as “private practice”): such services as include:

- the diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972), excluding fee paying services as described in Schedule 10 of the terms and conditions
- work in the general medical, dental or ophthalmic services under Part IV of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited “list”, e.g. members of the hospital staff).

Professional and Study Leave: professional leave or study leave in relation to professional work including:

- study, usually but not exclusively or necessarily on a course or programme;
- research;
- undergoing a period of teaching;
- examining or taking examinations;
- visiting clinics and attending professional conferences;
- participation in personal training.

Programmed Activity: a scheduled period, nominally equivalent to four hours, during which a consultant undertakes Contractual and Consequential Services.

Premium Time: any time that falls outside the period 07:00 to 19:00 Monday to Friday, and any time on a Saturday or Sunday, or public holiday.

General Terms and Conditions: the terms and conditions of service of general application as determined by the Department of Health, Social Services and Public Safety, as may be amended from time to time, or any provisions which may be agreed through the NHS Staff Council or the Northern Ireland equivalent and may reasonably be considered to have replaced the current conditions of service.

SCHEDULE 1**Commencement of Employment**

1. The date from which employment under this contract began must be stated in paragraph 2 of the consultant's contract of employment.
2. The date from which continuous employment began for the purposes of the Employment Rights (Northern Ireland) Order 1996 must be set out in paragraph 2 of the contract of employment and should include, if applicable, employment with predecessor organisations that had previously held the contract, e.g. former HSC employing authorities from whom the current contract was transferred under TUPE or equivalent arrangements. Previous employment with other HSC employing organisations does not count as continuous service for the purposes of the Employment Rights (Northern Ireland) Order 1996 except as provided for under the Health and Social Services (Northern Ireland) Order 1991 or any other statute.

Calculation of seniority

3. HSC organisations should take into account all previous service as a consultant with other HSC employing organisations and any equivalent experience in another EEA Member State. The employing organisation may, at its discretion, take into account service outside the HSC, for example including:
 - employment outside the EEA;
 - voluntary service;
 - employment in the independent sector;
 - service in HM armed forces.
4. For newly appointed consultants the date of appointment will be regarded as the date of employment with the Trust as set out in the contract of employment.

SCHEDULE 2**Associated Duties And Responsibilities**

1. A consultant has continuing clinical and professional responsibility for patients admitted under his or her care or, (for consultants in public health medicine) for a local population. It is also the duty of a consultant to:
 - keep patients (and/or their carers if appropriate) informed about their condition;
 - involve patients (and/or their carers if appropriate) in decision making about their treatment;
 - maintain professional standards and obligations as set out from time to time by the General Medical Council (GMC) and comply in particular with the GMC's guidance on 'Good Medical Practice' as amended or substituted from time to time;
 - maintain professional standards and obligations as set out from time to time by the General Dental Council (GDC) (Dental consultants only).
2. A consultant is responsible for carrying out any work related to and reasonably incidental to the duties set out in their Job Plan such as:
 - the keeping of records and the provision of reports;
 - the proper delegation of tasks;
 - maintaining skills and knowledge.
3. Consultants in collaboration with the employing organisation shall be expected in the course of their professional duties to ensure continuity of patient care.
4. Consultants shall be expected so far as is practicable and for short periods of unforeseen absence only to provide cover for consultant or associate specialist colleagues, even if on occasions this would involve interchange of staff within the same employing organisation. This does not include deputising where an associate specialist colleague is on a rota with doctors in training.
5. When deputising is not practicable or when the absence extends beyond such a short period, the employing organisation (and not the consultant) shall be responsible for the engagement of a locum tenens (or other appropriate arrangement), but the consultant shall have the responsibility of bringing the need to the employer's notice at the earliest possible opportunity. In circumstances where the engagement of a locum tenens is not practicable the employing authority, save in exceptional circumstances, shall, within 14 days of receiving such notification and, in consultation with the consultant(s) concerned, agree the redistribution of direct clinical care activities and/or payment of additional work thereafter.

SCHEDULE 3**Job Planning****General Principles**

1. Job planning will be based on a partnership approach. The clinical manager will prepare a draft job plan, which will then be discussed and agreed with the consultant. Job plans will list all the HSC duties of the consultant, the number of Programmed Activities for which the consultant is contracted and paid, the consultant's objectives and agreed supporting resources.

Job Content

2. The Job Plan will set out all of a consultant's HSC duties and responsibilities and the service to be provided for which the consultant is accountable. The Job Plan will include any duties for other HSC employers. A standard full-time Job Plan will contain ten Programmed Activities. Subject to the provisions in Schedule 7 for recognising work done in Premium Time, a Programmed Activity will have a timetable value of four hours. Programmed Activities may be programmed as blocks of four hours or in half-units of two hours each.
3. The duties and responsibilities set out in a Job Plan will include, as appropriate:
 - Direct Clinical Care duties including on-call work;
 - Supporting Professional Activities;
 - Additional HSC Responsibilities;
 - External Duties;
 - Travelling Time as defined in Schedule 12, paragraphs 10-11.

Job Schedule

4. The Job Plan will include a schedule of Programmed Activities setting out how, when and where the consultant's duties and responsibilities will be delivered. It is expected that Programmed Activities will normally take place at a consultant's principal place of work but there will be flexibility to agree off site working where appropriate. The clinical manager will draw up the schedule after full discussion with the consultant, taking into account the consultant's views on resources and priorities and making every effort to reach agreement.
5. The employer will be responsible for ensuring that a consultant has the facilities, training development and support needed to deliver the commitments in the job plan and will make all reasonable endeavours to ensure that this support conforms with the HR Strategy relating to improving working lives.
6. Non-emergency work after 7pm and before 7am during weekdays or at weekends will only be scheduled by mutual agreement between the consultant and his or her clinical manager. Consultants will have the right to refuse non-emergency work at such times where this has not been mutually agreed as part of the job planning process. Should they do so, there will be no detriment in relation to pay progression or any other matter.

7. Where a consultant is required to participate in an on-call rota, the Job Plan will set out the frequency of the rota.

Managerial Responsibilities

8. The Job Plan will set out the consultant's management responsibilities.

Accountability Arrangements

9. The Job Plan will set out the consultant's accountability arrangements, both professional and managerial, including responsibilities towards other medical staff both junior and senior.

Objectives

10. The Job Plan will include appropriate and identified personal objectives that have been agreed between the consultant and his or her clinical manager and will set out the relationship between these personal objectives and local service objectives. Where a consultant works for more than one HSC employer, the lead employer will take account of any objectives agreed with other employers.
11. The nature of a consultant's personal objectives will depend in part on his or her specialty, but they may include objectives relating to:
 - quality;
 - activity and efficiency;
 - clinical outcomes;
 - clinical standards;
 - local service objectives;
 - management of resources, including efficient use of HSC resources;
 - service development;
 - multi-disciplinary team working.
12. Objectives may refer to protocols, policies, procedures and work patterns to be followed. Where objectives are set in terms of output and outcome measures, these must be reasonable and agreed by the consultant and his or her clinical manager.
13. The objectives will set out a mutual understanding of what the consultant will be seeking to achieve over the annual period that they cover and how this will contribute to the objectives of the employing organisation. They will:
 - be based on past experience and on agreed reasonable expectations of what might be achievable over the next period;
 - where appropriate, reflect different, developing phases in the consultant's career;
 - be agreed on the understanding that delivery of objectives may be affected by changes in circumstances or factors outside the consultant's control, which will be considered at the Job Plan review.

Supporting Resources

14. The consultant and his or her clinical manager will use Job Plan reviews to identify the resources that are likely to be needed to help the consultant carry out his or her Job Plan commitments over the following year and achieve his or her agreed objectives for that year.
15. The consultant and his or her clinical manager will also use Job Plan reviews to identify any potential organisational or systems barriers that may affect the consultant's ability to carry out the Job Plan commitments or to achieve agreed objectives.
16. The Job Plan will set out:
 - agreed supporting resources, which may include reasonable clinical facilities, administrative, clerical or secretarial support, office accommodation, IT resources and other forms of support;
 - any action that the consultant and/or employing organisation agree to take to reduce or remove potential organisational or systems barriers.

Job Plan Review

17. The Job Plan will be reviewed annually. The annual review will examine all aspects of the Job Plan and should be used to consider amongst other possible issues:
 - what factors affected the achievement or otherwise of objectives;
 - adequacy of resources to meet objectives;
 - any possible changes to duties or responsibilities, or the schedule of Programmed Activities;
 - ways of improving management of workload;
 - the planning and management of the consultant's career.
18. The annual review will be informed by the same information systems that serve the appraisal process and by the outcome of the appraisal discussions.
19. The annual Job Plan review may result in a revised prospective Job Plan.
20. In the case of consultants with more than one HSC employer, a lead employer will normally be designated to conduct the Job Plan review on behalf of all the consultant's employers. The lead employer will normally be the employer for whom the consultant provides the majority of his or her programmed activities. The lead employer will take full account of the views of other employers (including for the purposes of Schedule 5) and inform them of the outcome. It is the responsibility of the lead employer to ensure no detriment to the consultant as a result of disagreement on the job plan between the lead and other HSC employer(s).
21. Following the annual Job Plan review, the clinical manager will report the outcome, via the Medical Director, to the Chief Executive and copied to the consultant, setting out for the purposes of decisions on pay thresholds whether the criteria in Schedule 15 have been met.
22. The consultant and clinical manager may conduct an interim review of the Job Plan where duties, responsibilities, accountability arrangements or objectives have

changed or need to change significantly within the year. In particular, in respect of the agreed objectives in the Job Plan, both the consultant and clinical manager will:

- keep progress against those objectives under review;
- identify to each other any problems in meeting those objectives as they emerge;
- propose an interim Job Plan review if it appears that the objectives may not be achieved for reasons outside the consultant's control.

Resolving disagreements over Job Plans

23. The consultant and clinical manager will make every effort to agree any appropriate changes to the Job Plan at the annual or interim review. If it is not possible to reach agreement on the Job Plan, the consultant may refer to facilitation and, if necessary, the appeal mechanism as set out in Schedule 4.

SCHEDULE 4**Facilitation And Appeals**

1. Where it has not been possible to agree a Job Plan or a consultant disputes a decision that he or she has not met the required criteria for a pay threshold in respect of a given year, a facilitation procedure and an appeal procedure are available.

Facilitation

2. The consultant, or (in the case of a disputed Job Plan) the clinical manager, may refer the matter to the Medical Director, or to an agreed designated medical manager if the Medical Director is one of the parties to the initial decision. Where a consultant is employed by more than one HSC organisation, a designated employer will take the lead (in the case of a disputed Job Plan, a lead employer should have already been identified). The purposes of the referral will be to reach agreement if at all possible. The process will be that:
 - the consultant or clinical manager makes the referral in writing within two weeks of the disagreement arising;
 - the party making the referral will set out the nature of the disagreement and his or her position or view on the matter;
 - where the referral is made by the consultant, the clinical manager responsible for the Job Plan review, or (as the case may be) for making the recommendation as to whether the criteria for pay thresholds have been met, will set out the employing organisation's position or view on the matter;
 - where the referral is made by the clinical manager, the consultant will be invited to set out his or her position on the view or matter;
 - the Medical Director (or the agreed designated medical manager) will convene a meeting, normally within four weeks of receipt of the referral, with the consultant and the responsible clinical manager to discuss the disagreement and to hear their views;
 - if agreement is not reached at this meeting, then the Medical Director will decide the matter (in the case of a decision on the Job Plan) or make a recommendation to the Chief Executive (in the case of a decision on whether the criteria for a pay threshold have been met) and inform the consultant and the responsible clinical manager of that decision or recommendation in writing;
 - in the case of a decision on whether the criteria for a pay threshold have been met, the Chief Executive will inform the consultant, the Medical Director and the responsible clinical manager of his or her decision in writing;
 - if the consultant is not satisfied with the outcome, he or she may lodge a formal appeal.

Formal appeal

3. A formal appeal panel will be convened only where it has not been possible to resolve the disagreement using the facilitation process. A formal appeal will be heard by a panel under the procedure set out below.

4. An appeal shall be lodged in writing to the Chief Executive as soon as possible, and in any event within two weeks of the outcome of the Facilitation process being formally advised to both parties. The appeal should set out the points in dispute and the reasons for the appeal. The Chief Executive will, on receipt of a written appeal, convene an appeal panel to meet within four weeks.
5. The membership of the panel will be:
 - a chair nominated by the appellants employing organisation;
 - a second panel member nominated by the appellant consultant;
 - a third member chosen from a list of individuals approved by the DHSSPS and the BMA and BDA. The DHSSPS will monitor the way in which individuals are allocated to appeal panels to avoid particular individuals being routinely called upon. If there is an objection raised by either the consultant or the employing organisation to the first representative from the list, one alternative representative will be allocated. The list of individuals will be regularly reviewed.

No member of the panel should have previously been involved in the dispute.

6. The parties to the dispute will submit their written statements of case to the appeal panel and to the other party one week before the appeal hearing. The appeal panel will hear oral submissions on the day of the hearing. Management will present its case first explaining the position on the Job Plan, or the reasons for deciding that the criteria for a pay threshold have not been met.
7. The consultant may present his or her own case in person, or be assisted by a work colleague or trade union or professional organisation representative, but legal representatives acting in a professional capacity are not permitted.
8. Where the consultant, the employer or the panel requires it, the appeal panel may hear expert advice on matters specific to a speciality.
9. It is expected that the appeal hearing will last no more than one day.
10. The appeal panel will make a recommendation on the matter in dispute in writing to the Board of the employing authority, normally within two weeks of the appeal having been heard and this will normally be accepted. The consultant should see a copy of the recommendation when it is sent to the Board. The Board will make the final decision and inform the parties in writing.
11. No disputed element of the Job Plan will be implemented until confirmed by the outcome of the appeal process. Any decision that affects the salary or pay of the consultant will have effect from the date on which the consultant referred the matter to facilitation or from the time he or she would otherwise have received a change in salary, if earlier.
12. In the case of a job planning appeal from a Medical Director or Director of Public Health, facilitation would take place via an independent Medical Manager at or above the same management level.

SCHEDULE 5

Recognition For Emergency Work Arising From On-Call Duties

1. The expected average amount of time that a consultant is likely to spend on unpredictable emergency work each week whilst on-call and directly associated with his or her on-call duties will be treated as counting towards the number of Direct Clinical Care Programmed Activities that the consultant is regarded as undertaking. This will be up to a maximum average of one Programmed Activity per week until 31 March 2005 and a maximum average of two Programmed Activities per week from 1 April 2005.
2. Where the unpredictable emergency work arising from a consultant's on-call duties significantly exceeds the equivalent of two Programmed Activities on average per week, the clinical manager and the consultant will review the position. In exceptional circumstances, the employing organisation may agree additional arrangements with the consultant to recognise work in excess of this limit, either by additional remuneration or time off. The clinical manager and the consultant should also consider whether some of the work is sufficiently regular and predictable to be programmed into the working week on a prospective basis. If no arrangements are made the default position is to trigger a job plan review.
3. The employing organisation will assess with the consultant, on a prospective basis, the number of Programmed Activities that are to be regarded for these purposes as representing the average weekly volume of unpredictable emergency work arising from a consultant's on-call duties during a period of between one and eight weeks. This will be based on a periodic assessment of the average weekly amount of such work over a prior reference period. The consultant will be the key player in the assessment by maintaining records of his/her activities. The employing organisation will agree the reference period with the consultant.
4. Tables 1 and 2 below set out illustrations of the relationship between the average weekly emergency work arising from on-call duties and the number of Programmed Activities that this work is regarded as representing. The general principle is that an average of four hours of such work per week, or - subject to the provisions in Schedule 7, an average of three hours of such work per week during Premium Time - constitutes for these purposes one Programmed Activity
5. Table 1 illustrates possible ways of allocating Programmed Activities for these purposes where the emergency work in question does not arise during Premium Time.

Table 1

Average emergency work per week likely to arise from on-call duties	Possible allocation of Programmed Activities (PAs)
½ hour	1 PA every 8 weeks, or a half-PA every 4 weeks
1 hour	1 PA every 4 weeks, or a half-PA every 2 weeks
1½ hours	3 PAs every 8 weeks
2 hours	1 PA every 2 weeks, or a half-PA every week
3 hours	3 PAs every 4 weeks
4 hours	1 PA per week
6 hours	1½ PAs per week, or 3 PAs every 2 weeks
8 hours	2 PAs per week

6. Table 2 illustrates possible ways of allocating Programmed Activities for these purposes where the emergency work in question arises during Premium Time.

Table 2

Average emergency work per week likely to arise during Premium Time from on-call duties	Possible allocation of Programmed Activities (PAs)
½ hour	1 PA every 6 weeks, or a half-PA every 3 weeks
1 hour	1 PA every 3 weeks
1½ hours	1 PA every 2 weeks, or a half-PA per week
2 hours	2 PAs every 3 weeks
3 hours	1 PA per week
4 hours	3 PAs every two weeks
6 hours	2 PAs per week

7. Where on-call work averages less than 30 minutes per week, compensatory time will be deducted from normal Direct Clinical Care Programmed Activities on an ad hoc basis and may be accrued.
8. Where a consultant's on-call duties give rise to a different amount of time spent on unpredictable emergency work than assumed in this prospective assessment, the clinical manager and the consultant will review the position at a Job Plan review and, where appropriate, agree adjustments on a prospective basis. Where this results in a reduction in the level of recognition, the new arrangements will take immediate effect without any period of protection. A whole time consultant has the right to maintain a full time salary. Where such a reduction would otherwise result in a working week of fewer than ten Programmed Activities, the consultant should have the option of accepting other duties to maintain a full time salary. Similar protection will apply to part-timers.

SCHEDULE 6**Extra Programmed Activities And Additional Professional Capacity**

1. Where a consultant intends to undertake remunerated clinical work that falls under the definition of Private Professional Services other than such work specified in his or her Job Plan, whether for the HSC, for the independent sector, or for another party, the provisions in this Schedule will apply.
2. Where a consultant intends to undertake such work:
 - the consultant will first consult with his or her clinical manager;
 - the employing organisation may, but is not obliged to, offer the consultant the opportunity to carry out under these Terms and Conditions (including the remuneration arrangements contained in these Terms and Conditions) up to one extra Programmed Activity per week on top of the standard commitment set out in his or her contract of employment, subject to the provisions in paragraph 7 for consultants who held a maximum part-time HSC consultant contract at the time of transfer to the new contract;
 - additional Programmed Activities may be offered on a fixed basis, but where possible the employing organisation will offer them on a mutually agreed annualised basis. Where consultants prospectively agree to extra Programmed Activities these will be remunerated;
 - where possible, the employing organisation will put any such offer to the consultant at the annual Job Plan review but, unless the employing organisation and consultant agree otherwise, no fewer than three months in advance of the start of the proposed extra Programmed Activities, or six months in advance where the work would mean the consultant has to re-schedule external commitments;
 - there will be a minimum notice period of three months for termination of these additional activities. If a consultant ceases to undertake Private Professional Services, he/she may relinquish the additional Programmed Activity subject to a similar notice period;
 - the employing organisation will give all appropriately qualified consultants an equal opportunity to express an interest in undertaking these additional activities. Any offer or acceptance should be made in writing;
 - full-time consultants who are currently working the equivalent of 11 or more Programmed Activities and agree with their clinical manager that the same level of activity should form part of their Job Plan under the new contract will not be expected to offer any additional work on top of this;
 - part-time consultants who wish to use some of their non-HSC time to do private practice will not be expected to offer any more than one extra Programmed Activity on top of their normal working week.
3. If a consultant declines the opportunity to take up additional Programmed Activities that are offered in line with the provisions above, and the consultant subsequently undertakes remunerated clinical work as defined above, this will constitute one of the grounds for deferring a pay threshold in respect of the year in question. If another consultant in the group accepts the work, there will be no impact on pay progression for any consultant in the group.

4. Where a consultant works for more than one HSC employer, the employers concerned may each offer additional Programmed Activities, but the consultant will not be expected to undertake on average any more than one Programmed Activity per week to meet the relevant criterion for pay thresholds. The job planning process should be used to agree for which employing organisation any additional Programmed Activities should be undertaken.
5. Should there be any significant increase in the time a part-time consultant working between seven and nine Programmed Activities devotes to Private Professional Services, the consultant will notify the employing organisation, and the consultant and employing organisation may review the number of Programmed Activities in the consultant's Job Plan.
6. The provisions in this Schedule are without prejudice to the possibility that the consultant and employing organisation may wish to agree extra-programmed activities up to the maximum level consistent with the Working Time Regulations.

Transitional Provisions

7. For the first year under these Terms and Conditions (2004/05), the number of extra Programmed Activities that the employing organisation may offer, for the purposes of the provisions above, to consultants who held a maximum part-time HSC consultant contract at the time of transfer will not exceed an average of one extra Programmed Activity every two weeks. As provided by paragraph 6 above, this does not preclude the possibility of arranging additional Programmed Activities by mutual agreement.

SCHEDULE 7**Premium Time**

1. The following provisions will apply to recognise the unsocial nature of work done in Premium Time and the flexibility required of consultants who work at these times as part of a more varied overall working pattern.

Scheduled Work

2. For each Programmed Activity scheduled during Premium Time there will be a reduction in the timetable value of the Programmed Activity itself to three hours or a reduction in the timetable value of another equivalent Programmed Activity by one hour, i.e. where the work done in Premium Time falls under the definition of Direct Clinical Care the one hour must be deducted from a Direct Clinical Care Programmed Activity.
3. If, by mutual agreement, a Programmed Activity in Premium Time lasts for four hours or more, an equivalent enhancement to payment may be agreed.
4. Where a Programmed Activity falls only partly in Premium Time, the reduction in the timetable value of this or another equivalent Programmed Activity will be on an appropriate pro rata basis. If an enhancement to payment is made this will be applied to the proportion of the Programmed Activity falling within Premium Time.

Unpredictable Emergency Work Arising From On-Call Duties

5. In assessing the number of Programmed Activities needed to recognise unpredictable emergency work arising from on-call duties under the provisions in Schedule 5, the employing organisation will treat three hours of unpredictable emergency work done in Premium Time as equivalent to one Programmed Activity. The provisions of paragraph 3 may also apply.

Work In Premium Time Exceeding Three Programmed Activities Per Week

6. The foregoing provisions are designed to cover situations where work in Premium Time is up to the equivalent of three Programmed Activities per week on average. Where work during Premium Time exceeds this average, the employing organisation and the consultant will agree appropriate arrangements.

SCHEDULE 8**On-Call Rotas****Duty To Be Contactable**

1. Subject to the following provisions, the consultant must ensure that there are clear and effective arrangements so that the employing organisation can contact him or her immediately at any time during a period when he or she is on-call.
2. The only exception to this requirement is where a consultant's on-call duties have been assessed as falling within category B described in Schedule 16 and the employing organisation and the consultant have agreed in advance that the consultant may arrange short intervals during an on-call period during which it will not be possible for him or her to be contacted straight away. In these circumstances, the consultant must ensure that:
 - the intervals in question have been agreed with the employing organisation in advance and clearly recorded;
 - there are arrangements for messages to be taken if the employing organisation contacts the consultant during such an interval;
 - the consultant can and does respond immediately after such an interval.

High Frequency Rotas

3. Where a consultant or consultants are on a rota of 1 in 4 or more frequent, the employing organisation will review at least annually the reasons for this rota and for its high frequency and take any practicable steps to reduce the need for high-frequency rotas of this kind. The views of consultants will be taken into account.
4. Where unusually a consultant is asked to be resident at the hospital or other place of work during his or her on-call period, appropriate arrangements may be agreed locally. A consultant will only be resident during an on-call period by mutual agreement.

Private Professional Services and Fee Paying Services

5. Subject to the following provisions, a consultant will not undertake Private Professional Services or Fee Paying Services (unless the latter involves minimal disruption and the employing organisation agrees that the work can be done) when on on-call duty. The exceptions to this rule are where:
 - the consultant's rota frequency is 1 in 4 or more frequent, his or her on-call duties have been assessed as falling within the category B described in Schedule 16, and the employing organisation has given prior approval for undertaking specified Private Professional Services or Fee Paying Services;
 - the consultant has to provide emergency treatment or essential continuing treatment for a private patient. If the consultant finds that such work regularly impacts on his or her HSC commitments, he or she will make alternative arrangements to provide emergency cover for private patients.

SCHEDULE 9**Provisions Governing the Relationship Between HSC Work and Private Practice**

1. This Schedule should be read in conjunction with the 'Code of Conduct for Private Practice', which sets out standards of best practice governing the relationship between HSC work and private practice.
2. The consultant is responsible for ensuring that their provision of Private Professional Services for other organisations does not:
 - result in detriment to HSC patients;
 - diminish the public resources that are available for the HSC.

Disclosure of information about Private Commitments

3. The consultant will inform his or her clinical manager of any regular commitments in respect of Private Professional Services or Fee Paying Services. This information will include the planned location, timing and broad type of work involved.
4. The consultant will disclose this information at least annually as part of the Job Plan Review. The consultant will provide information in advance about any significant changes to this information.

Scheduling of Work and Job Planning

5. Where a conflict of interest arises or is liable to arise, HSC commitments must take precedence over private work. Subject to paragraphs 10 and 11 below, the consultant is responsible for ensuring that private commitments do not conflict with Programmed Activities.
6. Regular private commitments must be noted in the Job Plan.
7. Circumstances may also arise in which a consultant needs to provide emergency treatment for private patients during time when he or she is scheduled to be undertaking Programmed Activities. The consultant will make alternative arrangements to provide cover if emergency work of this kind regularly impacts on the delivery of Programmed Activities.
8. The consultant should ensure that there are arrangements in place, such that there can be no significant risk of private commitments disrupting HSC commitments, e.g. by causing HSC activities to begin late or to be cancelled. In particular where a consultant is providing private services that are likely to result in the occurrence of emergency work, he or she should ensure that there is sufficient time before the scheduled start of Programmed Activities for such emergency work to be carried out.
9. Where the employing authority has proposed a change to the scheduling of a consultant's HSC work, it will allow the consultant a reasonable period in line with Schedule 6, paragraph 2 to rearrange any private commitments. The employing organisation will take into account any binding commitments that the consultant may have entered into (e.g. leases). Should a consultant wish to reschedule private commitments to a time that would conflict with Programmed Activities, he or she should raise the matter with the clinical manager at the earliest opportunity.

Scheduling Private Commitments Whilst On-Call

10. The consultant will comply with the provisions in Schedule 8, paragraph 5 of these Terms and Conditions.
11. In addition, where a consultant is asked to provide emergency cover for a colleague at short notice and the consultant has previously arranged private commitments at the same time, the consultant should only agree to provide such emergency cover if those private commitments would not prevent him or her returning to the relevant HSC site at short notice to attend an emergency. If the consultant is unable to provide cover at short notice it will be the employing organisation's responsibility to make alternative arrangements and the consultant will suffer no detriment in terms of pay progression as a result.

Use of HSC Facilities and Staff

12. Where a consultant wishes to provide Private Professional Services at an HSC facility he or she must obtain the employing organisation's prior agreement, before using either HSC facilities or staff.
13. The employing organisation has discretion to allow the use of its facilities and will make it clear which facilities a consultant is permitted to use for private purposes and to what extent.
14. Should a consultant, with the employing organisation's permission, undertake Private Professional Services in any of the employing organisation's facilities, the consultant should observe the relevant provisions in the 'Code of Conduct for Private Practice'.
15. Where a patient pays privately for a procedure that takes place in the employing organisation's facilities, such procedures should occur only where the patient has given a signed undertaking to pay any charges (or an undertaking has been given on the patient's behalf) in accordance with the employing organisation's procedures.
16. Private patients should normally be seen separately from scheduled HSC patients. Only in unforeseen and clinically justified circumstances should a consultant cancel or delay an HSC patient's treatment to make way for his or her private patient.
17. Where the employing organisation agrees that HSC staff may assist a consultant in providing Private Professional Services, or provide private services on the consultant's behalf, it is the consultant's responsibility to ensure that these staff are aware that the patient has private status.
18. The consultant has an obligation to ensure, in accordance with the employing organisation's procedures, that any patient whom the consultant admits to the employing organisation's facilities is identified as private and that the responsible manager is aware of that patient's status.
19. The consultant will comply with the employing organisation's policies and procedures for private practice

Patient Enquiries about Private Treatment

20. Where, in the course of his or her duties, a consultant is approached by a patient and asked about the provision of Private Professional Services, the consultant may provide only such standard advice as has been agreed between the employing

organisation and appropriate local consultant representatives for such circumstances.

21. The consultant will not during the course of his or her Programmed Activities make arrangements to provide Private Professional Services, nor ask any other member of staff to make such arrangements on his or her behalf, unless the patient is to be treated as a private patient of the employing organisation.
22. In the course of his/her Programmed Activities, a consultant should not initiate discussions about providing Private Professional Services for HSC patients, nor should the consultant ask other staff to initiate such discussions on his or her behalf.
23. Where an HSC patient seeks information about the availability of, or waiting times for, HSC services and/or Private Professional Services, the consultant is responsible for ensuring that any information he or she provides, or arranges for other staff to provide on his or her behalf, is accurate and up-to-date.

Promoting Improved Patient Access to HSC Care

24. Subject to clinical considerations, the consultant is expected to contribute as fully as possible to reducing waiting times and improving access and choice for HSC patients. This should include ensuring that, as far as is practicable, patients are given the opportunity to be treated by other HSC colleagues or by other providers where this will reduce their waiting time and facilitate the transfer of such patients.
25. The consultant will make all reasonable efforts to support initiatives to increase HSC capacity, including appointment of additional medical staff and changes to ways of working.

SCHEDULE 10**Fee Paying Services**

1. Fee Paying Services are services that are not part of Contractual or Consequential Services and not reasonably incidental to them. Fee Paying Services include:
 - a. work on a person referred by a Medical Adviser of the Department of Social Development, or by an Adjudicating Medical Authority or a Medical Appeal Tribunal, in connection with any benefits administered by an Agency of the Department of Social Development;
 - b. work for the Criminal Injuries Compensation Board, when a special examination is required or an appreciable amount of work is involved in making extracts from case notes;
 - c. work required by a patient or interested third party to serve the interests of the person, his or her employer or other third party, in such non-clinical contexts as insurance, pension arrangements, foreign travel, emigration, or sport and recreation. (This includes the issue of certificates confirming that inoculations necessary for foreign travel have been carried out, but excludes the inoculations themselves. It also excludes examinations in respect of the diagnosis and treatment of injuries or accidents);
 - d. work required for life insurance purposes;
 - e. work on prospective emigrants including X-ray examinations and blood tests;
 - f. work on persons in connection with legal actions other than reports which are incidental to the consultant's Contractual and Consequential Duties, or where the consultant is giving evidence on the consultant's own behalf or on the employing organisation's behalf in connection with a case in which the consultant is professionally concerned;
 - g. work for coroners, as well as attendance at coroners' courts as medical witnesses;
 - h. work requested by the courts on the medical condition of an offender or defendant and attendance at court hearings as medical witnesses, otherwise than in the circumstances referred to above;
 - i. work on a person referred by a medical examiner of HM Armed Forces Recruiting Organisation;
 - j. work in connection with the routine screening of workers to protect them or the public from specific health risks, whether such screening is a statutory obligation laid on the employing organisation by specific regulation or a voluntary undertaking by the employing organisation in pursuance of its general liability to protect the health of its workforce;
 - k. occupational health services provided under contract to other HSC, independent or public sector employers;
 - l. work on a person referred by a medical referee appointed under the Workmen's Compensation (Supplementation) Act (Northern Ireland) 1966;
 - m. work on prospective students of universities or other institutions of further education, provided that they are not covered by Contractual and Consequential Services. Such examinations may include chest radiographs;

- n. Appropriate examinations and recommendations under Parts II and IV of the Mental Health (Northern Ireland) Order 1986 and fees payable to medical members of Mental Health Review Tribunals;
- o. services performed by members of hospital medical staffs for government departments as members of medical boards;
- p. work undertaken on behalf of the Employment Medical Advisory Service in connection with research/survey work, i.e. the medical examination of employees intended primarily to increase the understanding of the cause, other than to protect the health of people immediately at risk (except where such work falls within Contractual and Consequential Services);
- q. completion of Form B (Certificate of Medical Attendant) and Form C (Confirmatory Medical Certificate) of the cremation certificates;
- r. examinations and reports including visits to prison required by the Prison Service which do not fall within the consultant's Contractual and Consequential Services and which are not covered by separate contractual arrangements with the Prison Service;
- s. examination of blind or partially-sighted persons for the completion of form A655, except where the information is required for social security purposes, or by an Agency of the Department of Social Development, or the Employment Service, or the patient's employer, unless a special examination is required, or the information is not readily available from knowledge of the case, or an appreciable amount of work is required to extract medically correct information from case notes;
- t. work as a medical referee (or deputy) to a cremation authority and signing confirmatory cremation certificates;
- u. medical examination in relation to staff health schemes of local authorities and fire and police authorities;
- v. delivering lectures;
- w. medical advice in a specialised field of communicable disease control;
- x. attendance as a witness in court;
- y. medical examinations and reports for commercial purposes, e.g. certificates of hygiene on goods to be exported or reports for insurance companies;
- z. advice to organisations on matters on which the consultant is acknowledged to be an expert.

SCHEDULE 11**Principles Governing Receipt Of Additional Fees**

1. In the case of the following services, the consultant will not be paid an additional fee, or - if paid a fee - the consultant must remit the fee to the employing organisation:
 - any work in relation to the consultant's Contractual and Consequential Services;
 - duties which are included in the consultant's Job Plan, including any additional Programmed Activities which have been agreed with the employing organisation;
 - fee paying work for other organisations carried out during the consultant's Programmed Activities, unless the work involves minimal disruption and the employing organisation agrees that the work can be done in HSC time without the employer collecting the fee;
 - domiciliary consultations carried out during the consultant's Programmed Activities;
 - lectures and teaching delivered during the course of the consultant's clinical duties;
 - delivering lectures and teaching that are not part of the consultant's clinical duties, but are undertaken during the consultant's Programmed Activities.

This list is not exhaustive and as a general principle, work undertaken during Programmed Activities will not attract additional fees.

2. Services for which the consultant can retain any fee that is paid:
 - Fee Paying Services carried out in the consultant's own time, or during annual or unpaid leave;
 - Fee Paying Services carried out during the consultant's Programmed Activities that involve minimal disruption to HSC work and which the employing organisation agrees can be done in HSC time without the employer collecting the fee;
 - domiciliary consultations undertaken in the consultant's own time, though it is expected that such consultations will normally be scheduled as part of Programmed Activities;¹
 - Private Professional Services undertaken in the employing organisation's facilities and with the employing organisation's agreement during the consultant's own time or during annual or unpaid leave;
 - Private Professional Services undertaken in other facilities during the consultant's own time, or during annual or unpaid leave;
 - lectures and teaching that are not part of the consultant's clinical duties and are undertaken in the consultant's own time or during annual or unpaid leave;
 - preparation of lectures or teaching undertaken during the consultant's own time irrespective of when the lecture or teaching is delivered.

¹ And only for a visit to the patient's home at the request of a general practitioner and normally in his or her company to advise on the diagnosis or treatment of a patient who on medical grounds cannot attend hospital.

This list is not exhaustive but as a general principle the consultant is entitled to the fees for work done in his or her own time, or during annual or unpaid leave.

SCHEDULE 12**Other Conditions Of Employment****Outside Employment and Financial Interests**

1. A consultant must declare:
 - any financial interest or relationship with an external organisation he or she may have which may conflict with the policies, business activity and decisions of the employing organisation; and/or
 - any financial or pecuniary advantage he or she may gain whether directly or indirectly as a result of a privileged position within the employing organisation.

Private Residence

2. A consultant is required to reside within a reasonable distance of their principal place of work to be agreed with the employing organisation.
3. A consultant must be contactable by telephone.

Health Assessment

4. Consultants are required to notify their clinical manager as soon as possible of any illness, disease or condition, which prevents them from undertaking their duties or any part thereof.
5. The employer may at any time require a consultant who is unable to perform his or her duties as a consequence of illness to submit to an examination by the organisation's occupational health service. Consultants may also self-refer on a confidential basis.

Research

6. All research must be managed in accordance with the requirements of the DHSSPS Research Governance Framework. Consultants must comply with all reporting requirements, systems and duties of action put in place by the employing organisation to deliver research governance. Consultants must also comply with the GMC guidance 'Good Practice in Research' as from time to time amended.

Publications

7. A consultant shall be free, without prior consent of the employing organisation, to publish books, articles, etc and to deliver any lecture or speak, whether on matters arising out of his or her HSC service or not.

Confidentiality

8. A consultant has an obligation not to disclose any information of a confidential nature concerning patients, employees, contractors or the confidential business of the organisation.

Public Interest Disclosure

9. Should a consultant have cause for genuine concern about an issue (including one that would normally be subject to the above paragraph) and believes that disclosure would be in the public interest, he or she should have a right to speak out and be afforded statutory protection and should follow local procedures² for disclosure of information in the public interest.

Travelling Time

10. Where consultants are expected to spend time on more than one site during the course of a day, travelling time to and from their main base to other site(s) will be included as working time. Such working time (for travel) will be deemed to fall within the same category of Programmed Activity as the work undertaken at the other site(s).
11. Travel to and from work for HSC emergencies, and 'excess travel' will count as working time. 'Excess travel' is defined as time spent travelling between home and a working site other than the consultant's main place of work, after deducting the time normally spent travelling between home and main place of work. Employers and consultants may need to agree arrangements for dealing with more complex working days. Travelling time between a consultant's main place of work and home (for purposes other than emergency work) or private practice premises will not be regarded as part of working time.

² As required under the Public Interest Disclosure Act 1998 (PIDA).

SCHEDULE 13**Basic Salary And Payment For Additional Programmed Activities For Consultants Appointed Before 15 January 2004**

1. This Schedule applies to those whose first appointment as an HSC consultant is before 15 January 2004. Schedule 14 applies to those whose first appointment as a HSC consultant is on or after 15 January 2004. For the purposes of determining whether this Schedule or Schedule 14 applies, the date of appointment will be regarded as the date on which the consultant post was offered.

Date of Transfer

2. Where a consultant subject to this Schedule has given a formal expression of interest to the new contract by 15 January 2004, the consultant will be able to choose one of two options; to either take seniority credit backdated to 1 April 2003, or a combination of pay increases and seniority backdated to 1 October 2003. Where a consultant has given a formal expression of interest to the new contract between 15 January 2004 and 31 March 2004, only backdating of pay increases by three months from the date on which the commitment was given as applicable. In each case, backdating will be conditional upon a job plan being agreed within three months, except where this deadline is not met for reasons beyond the consultant's control. Consultants may choose any shorter period of backdating if they so wish. Where a consultant gives a formal expression of interest to the contract after 1 April 2004, there will be no backdating. A formal expression of interest for these purposes is not legally binding, but consultants are expected to enter into such a commitment in good faith and in the full expectation of taking up the new contract.
3. For consultants subject to this Schedule, progression through pay thresholds (see below) will be on the anniversary of transfer to these Terms and Conditions of Service, subject to being continuously employed in the HSC. Subject to paragraph 2 above, where consultants give a formal commitment to the new contract before 1 April 2004, or the earliest practicable date thereafter, and therefore receive either 12 months seniority credit or 6 months backdated increases in pay and seniority, the date of transfer will be regarded as the date to which increases in seniority are backdated. For other consultants subject to this Schedule, the date of transfer will be the date on which the parties agree that the consultant will transfer to these Terms and Conditions.

Annual Pay Uplift

4. All the rates of pay set out in this Schedule are at 2003/04 rates. This is to facilitate calculation of backpay for 2003/04. The rates will be uplifted annually on 1 April. The rates will be increased by 3.225% from April 2004 and by a further 3.225% from April 2005 subject to this value remaining within 1.5% of RPI(X). Should RPI(X) fall outside these values, the DoH(L) and BMA will either agree on the uplift or refer it to the Review Body on Doctors' and Dentists' Remuneration (DDRB). Thereafter, the rates of uplift will be agreed following the recommendations of the DDRB.

Definition of Seniority

5. Both salary on commencement and eligibility for subsequent pay thresholds will depend on a consultant's seniority (see Annex A). For these purposes, seniority is to be measured as the sum of the number of whole years completed as an HSC consultant, plus the point on the salary scale when appointed (on a scale of 1 to 5),

plus any additional credited seniority (in whole years) to reflect non-HSC consultant level experience or flexible training (see below) plus the year that he/she is currently in. For the avoidance of doubt, seniority may only accrue during an absence on an employment break scheme to reflect the gaining of approved non-HSC consultant level experience.

6. The employing organisation will credit appropriate additional seniority to reflect any consultant level experience gained outwith the HSC consultant system, taking care to ensure that there is no double counting of this and any additional seniority granted at appointment by way of a higher point on the salary scale.
7. Where a consultant's training has been lengthened by virtue of being in a flexible training scheme or because of undergoing dual qualification, the employing organisation will credit appropriate additional seniority where this is necessary to ensure that the consultant is not prevented from reaching the pay threshold they would have attained had they trained on a full time or single qualification basis (e.g. training extended by two years counts as the equivalent of two years' seniority as a consultant on first appointment as a consultant). See separate guidance on part time contracts.

Basic Pay on Commencement

8. On commencement, and subject to the provisions on pay protection set out below, the value of basic salary – and of payments for any additional Programmed Activities – will:
 - for full-time consultants who have previously held a whole-time HSC consultant contract be as set out in Annex A;
 - for full-time consultants who at the time of transfer hold a maximum part-time HSC consultant contract be subject to the provisions in paragraph 17 below;
 - for part-time consultants be pro rata to the levels set out in Annex A, based on the number of agreed weekly Programmed Activities in the consultant's Job Plan as a proportion of the standard ten Programmed Activities for full-time consultants.
9. Where a consultant holds Discretionary Points or a Distinction Award, (or their agreed replacement), there will be a pro rata increase in the payment for an additional Programmed Activity, compared with the rates in Annex A. Where a consultant holds a Distinction Award, (or their agreed replacement) the pro rata increase in the payment for an additional Programmed Activity will be based on the maximum level of Discretionary Points (or their agreed replacement).

Pay Protection

10. The annual rate for an additional Programmed Activity will be 10% of basic salary, where basic salary includes the pay thresholds and any local clinical excellence awards or discretionary points.
11. There will be no financial detriment to any consultants for whom the combined total of their basic pay and any on-call availability supplement (as assessed under the provisions in Schedule 16) would otherwise be less than the combined total of their basic pay and any intensity supplement under their previous HSC contract and terms and conditions. For consultants transferring to these Terms and Conditions in 2003/04, there will be full protection for one year, i.e. taking account of annual pay

uplift for 2004/05 for consultants on the previous national terms and conditions. After this date, protection will be on a mark-time basis (i.e. until the new salary exceeds the salary at the point of transfer).

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

Pay Thresholds

13. Consultants will become eligible for pay thresholds at the intervals set out in Annex A on the anniversary of transfer to the new contract (see paragraph 3 above).
14. The value of pay thresholds for full-time consultants who at the time of transfer hold a whole-time HSC consultant contract will be as set out in Annex A.
15. The value of pay thresholds for part-time consultants will be pro rata to the levels in Annex A, based on the number of agreed weekly Programmed Activities in the consultant's Job Plan as a proportion of the ten minimum required Programmed Activities for full-time consultants.
16. The value of pay thresholds for full-time consultants who have previously held a maximum part-time HSC consultant contract will be as set out in paragraph 18 below.

Former Maximum Part-Time Consultants

17. The basic salary for full-time consultants who at the time of transfer hold a maximum part-time HSC consultant contract will be:
 - for the purposes of backdating pay increases for 2003/04 only, their previous level of salary (including the annual pay uplift to which they would have been entitled had they remained on that contract) plus a third of the difference between this and the level of salary to which they would be entitled – as set out in Annex A - if they had previously held a whole time or part-time HSC consultant contract;
 - in the first year under these Terms and Conditions (2004/05), their previous level of salary (including the annual pay uplifts to which they would have been entitled had they remained on that contract) plus two-thirds of the difference between this and the level of salary to which they would be entitled if they had previously held a whole time or part-time HSC consultant contract;
 - in the second and subsequent years under these Terms and Conditions, the same level of salary as is applicable for any consultant who has previously held a whole time or part-time HSC consultant contract.

Annex A

Pay progression for consultants appointed before 15 January 2004

Pay Scale	Seniority	Pay Threshold	Basic salary (2008/09)	Years after transfer before threshold level changes
M430	30+	7	£88,049	Salary on transfer
		8	£93,508	1 year after transfer
			£98,962	2 years after transfer
M421	21-29	6	£82,590	Salary on transfer
		7	£88,049	1 year after transfer
		8	£93,508	2 years after transfer
M420	20	6	£82,590	Salary on transfer
		7	£88,049	1 year after transfer
		8	£93,508	3 years after transfer
M419	19	6	£82,590	Salary on transfer
		7	£88,049	1 year after transfer
		8	£93,508	3 years after transfer
M418	18	6	£82,590	Salary on transfer
		7	£88,049	2 years after transfer
		8	£93,508	3 years after transfer
M417	17	6	£82,590	Salary on transfer
		7	£88,049	2 years after transfer
		8	£93,508	4 years after transfer
M416	16	6	£82,590	Salary on transfer
		7	£88,049	3 years after transfer
		8	£93,508	4 years after transfer
M415	15	6	£82,590	Salary on transfer
		7	£88,049	3 years after transfer
		8	£93,508	4 years after transfer
M414	14	6	£82,590	Salary on transfer
		7	£88,049	3 years after transfer
		8	£93,508	5 years after transfer
M413	13	6	£82,590	Salary on transfer
		7	£88,049	3 years after transfer
		8	£93,508	5 years after transfer
			£98,962	10 years after transfer

Pay Scale	Seniority	Pay Threshold	Basic salary (2008/09)	Years after transfer before threshold level changes
M412	12	6	£82,590	Salary on transfer
		7	£88,049	3 years after transfer
		8	£93,508	6 years after transfer
		8	£98,962	11 years after transfer
M411	11	6	£82,590	Salary on transfer
		7	£88,049	4 years after transfer
		8	£93,508	7 years after transfer
		8	£98,962	12 years after transfer
M410	10	6	£82,590	Salary on transfer
		7	£88,049	4 years after transfer
		8	£93,508	8 years after transfer
		8	£98,962	13 years after transfer
M409	9	6	£82,590	Salary on transfer
		7	£88,049	4 years after transfer
		8	£93,508	9 years after transfer
		8	£98,962	14 years after transfer
M408	8	6	£82,590	Salary on transfer
		7	£88,049	5 years after transfer
		8	£93,508	10 years after transfer
		8	£98,962	15 years after transfer
M407	7	6	£82,590	Salary on transfer
		7	£88,049	5 years after transfer
		8	£93,508	10 years after transfer
		8	£98,962	15 years after transfer
M406	6	5	£81,444	Salary on transfer
		6	£82,590	1 year after transfer
		7	£88,049	5 years after transfer
		8	£93,508	10 years after transfer
M405	5	*	£98,962	15 years after transfer
		5	£80,298*	Salary on transfer
		6	£81,444	1 year after transfer
		7	£82,590	2 years after transfer
M404	4	6	£88,049	6 years after transfer
		7	£93,508	11 years after transfer
		8	£98,962	16 years after transfer
		3	£75,128	Salary on transfer
M404	4	4	£78,000	1 year after transfer
		5	£80,298	2 years after transfer
		6	£82,590	3 years after transfer
		7	£88,049	6 years after transfer
M404	4	8	£93,508	11 years after transfer
		8	£98,962	16 years after transfer

Pay Scale	Seniority	Pay Threshold	Basic salary (2008/09)	Years after transfer before threshold level changes
M403	3	*	£74,549*	Salary on transfer
			£76,848	1 year after transfer
		4	£80,298	2 years after transfer
		5	£82,590	3 years after transfer
		6	£88,049	7 years after transfer
		7	£93,508	12 years after transfer
		8	£98,962	17 years after transfer
M402	2		£73,976	Salary on transfer
		2	£75,701	1 year after transfer
		4	£80,298	2 years after transfer
		5	£82,590	3 years after transfer
		6	£88,049	8 years after transfer
		7	£93,508	13 years after transfer
		8	£98,962	18 years after transfer
M401	1		£73,403*	Salary on transfer
		*	£74,549	1 year after transfer
		3	£78,000	2 years after transfer
		4	£80,298	3 years after transfer
		5	£82,590	4 years after transfer
		6	£88,049	9 years after transfer
		7	£93,508	14 years after transfer
		8	£98,962	19 years after transfer

* For consultants with seniority of 1, 3 or 5 years on transition, the first pay threshold is for transitional purposes.

SCHEDULE 14**Basic Salary And Payment For Additional Programmed Activities For Consultants Appointed After 15 January 2004**

1. This Schedule applies to all those whose first appointment as an HSC consultant is on or after 15 January 2004 and before 1 April 2004. For these purposes, the date of appointment will be regarded as the date on which the consultant post was offered.
2. For consultants subject to this Schedule, progression through pay thresholds (see below) will be on the anniversary of appointment, subject to being continuously employed in the HSC.

Annual Pay Uplift

3. All the rates of pay set out in this Schedule are at 2003/04 rates. This is to facilitate calculation of backpay for 2003/04. The rates will be uplifted annually on 1 April. The rates will be increased by 3.225% from April 2004 and by a further 3.225% from April 2005 subject to this value remaining within 1.5% of RPI(X). Should RPI(X) fall outside these values the DoH(L) and BMA will either agree on the uplift or refer it to the Review Body on Doctors' and Dentists' Remuneration (DDRB). Thereafter, the rates of uplift will be agreed following the recommendations of the DDRB.

Basic Pay and Pay Thresholds

4. On commencement, basic salary – and payments for any additional Programmed Activities – will be the first of the thresholds set out in Annex B below, subject to paragraphs 5 and 6 below.
5. Basic salary on commencement will be set at a higher threshold to reflect any approved consultant-level experience that a consultant has gained. For the avoidance of doubt, seniority may only accrue during an absence on an employment break scheme to reflect the gaining of approved non-HSC consultant level experience.
6. Where a consultant's training has been lengthened by virtue of being in a flexible training scheme or because of undergoing dual qualification, the employing organisation will set basic salary on commencement at a higher threshold where this is necessary to ensure that the consultant is not prevented from reaching the pay threshold they would have attained had they trained on a full time or single qualification basis (e.g. training extended by two years counts as the equivalent of two years' consultant service where a consultant would not otherwise be able to reach the same pay threshold).
7. The annual rate for an additional Programmed Activity will be 10% of basic salary, where basic salary includes the pay thresholds and any local clinical excellence awards or discretionary points.
8. Consultants will become eligible for additional pay thresholds at the intervals set out in Annex B below on the anniversary of appointment (see paragraph 2 above).
9. The value of pay thresholds for part-time consultants will be pro rata to the levels in Annex B based on the number of agreed weekly Programmed Activities in the consultant's Job Plan as a proportion of the ten standard Programmed Activities for full-time consultants.

10. Where a consultant holds Discretionary Points (or their agreed replacement), there will be a pro rata increase in the payment for an additional Programmed Activity, compared with the rates in Annex B. Where a consultant holds a Distinction Award (or their agreed replacement), the pro rata increase in the payment for an additional Programmed Activity will be based on the maximum level of Discretionary Points (or their agreed replacement).
11. Where Associate Specialists have been paid in their previous regular employment at a basic salary, including any discretionary points, higher or equal to the rate at which they would (were it not for this provision) be paid on taking up their new Consultant appointment, then their starting salary in the new appointment shall be fixed at the threshold in the scale next above that previous rate.

Annex B

Pay progression for consultants appointed on or after 15 January 2004

Payscale	Years completed as a consultant	Threshold	Basic salary 2008/2009	Period before eligibility for next Threshold
M400 Point 00	0	1	£73,403	1 year
M400 Point 01	1	2	£75,701	1 year
M400 Point 02	2	3	£78,000	1 year
M400 Point 03	3	4	£80,298	1 year
M400 Point 04	4	5	£82,590	5 years
M400 Point 05	5		£82,590	4 years
M400 Point 06	6		£82,590	3 years
M400 Point 07	7		£82,590	2 years
M400 Point 08	8		£82,590	1 year
M400 Point 09	9	6	£88,049	5 years
M400 Point 10	10		£88,049	4 years
M400 Point 11	11		£88,049	3 years
M400 Point 12	12		£88,049	2 years
M400 Point 13	13		£88,049	1 year
M400 Point 14	14	7	£93,508	5 years
M400 Point 15	15		£93,508	4 years
M400 Point 16	16		£93,508	3 years
M400 Point 17	17		£93,508	2 years
M400 Point 18	18		£93,508	1 year
M400 Point 19	19	8	£98,962	-

SCHEDULE 15**Pay Thresholds****Criteria for Pay Thresholds**

1. Following the annual Job Plan review, the clinical manager who has conducted the Job Plan review will report the outcome, via the Medical Director, to the Chief Executive and copied to the consultant and the Chief Executive of any other HSC organisation with which the consultant holds a contract of employment, setting out for the purposes of decisions on pay thresholds whether the consultant has:
 - made every reasonable effort to meet the time and service commitments in the Job Plan;
 - participated satisfactorily in the appraisal process;
 - participated satisfactorily in reviewing the Job Plan and setting personal objectives;
 - met the personal objectives in the Job Plan, or where this is not achieved for reasons beyond the consultant's control, made every reasonable effort to do so;
 - worked towards any changes identified in the last Job Plan review as being necessary to support achievement of the employing organisation's objectives;
 - taken up any offer to undertake additional Programmed Activities that the employing organisation has made to the consultant in accordance with Schedule 6 of these Terms and Conditions;
 - met the standards of conduct governing the relationship between private practice and HSC commitments set out in Schedule 9.
2. The Chief Executive, informed by the Medical Director's recommendation, will subsequently decide each year whether the consultant has met the criteria.
3. Where one or more of the criteria are not achieved in any year, the Chief Executive will have the discretion to decide where appropriate, for instance because of personal illness, that the consultant should nonetheless be regarded as having met the criteria for that year.
4. Consultants should not be penalised if objectives have not been met for reasons beyond their control.
5. It will be the norm for consultants to achieve pay progression. Pay progression may only be deferred where the consultant has not met the specified criteria at paragraph 1 of this Schedule. Employing organisations cannot introduce any new criteria. For instance, pay progression cannot be withheld or delayed on the grounds of the employing organisation's financial position. Nor would it be acceptable for HSC organisations to use any system of quotas for pay progression.
6. A consultant has the right of appeal against a decision by the Chief Executive that he or she has not met the criteria in respect of any given year. In the event of an appeal, it will be the responsibility of the employing organisation to show why this decision was taken. The appeal process is at Schedule 4 of these Terms and Conditions.

Process for award of Pay Thresholds

7. When a consultant becomes eligible for a pay threshold by virtue of fulfilling the required number of years' service in Schedule 13 or Schedule 14 of the Terms and Conditions, he or she will receive that pay threshold provided that the Chief Executive agrees that they have met the criteria above in each year since the award of the previous threshold or, in the case of a consultant's first pay threshold, since the commencement of a contract subject to these Terms and Conditions.
8. Where the Chief Executive has decided in any one year that a consultant has not met the necessary criteria, the employing organisation will defer the award of the appropriate pay threshold for one year beyond the date on which they would otherwise have received the threshold. Provided the Chief Executive decides that a consultant has met the criteria in the intervening year, he or she will receive that pay threshold from the start of the following year.

SCHEDULE 16**Pay Supplements****On-Call Availability Supplement**

1. If a consultant is required to participate in an on-call rota, he or she will be paid a supplement in addition to basic salary in respect of his or her availability to work during on-call periods. The supplement will be paid at the appropriate rate set out in Table 1 below.
2. The level of supplement will depend on the consultant's rota frequency and the category of the consultant's on-call duties. The consultant's rota frequency for these purposes will be determined by reference to the number of consultants on the relevant rota and without regard to any alternative arrangements that the consultant may make with colleagues to provide on-call cover
3. The employing organisation will determine the category of the consultant's on-call duties for these purposes by making a prospective assessment of the typical nature of the response that the consultant is likely to have to make when called during an on-call period. This assessment will take into account the nature of the calls that the consultant typically receives whilst on-call. The two categories are:
 - Category A: this applies where the consultant is typically required to return immediately to site when called or has to undertake interventions with a similar level of complexity to those that would normally be carried out on site, such as telemedicine or complex telephone consultations;
 - Category B: this applies where the consultant can typically respond by giving telephone advice and/or by returning to work later.
4. Where there is a change to the consultant's rota frequency or the categorisation of the consultant's on-call duties, the level of the supplement will be amended on a prospective basis. Where this results in a reduction in the level of supplement, there will not be any protection arrangements in relation to previous entitlements. The consultant is entitled to challenge any changes to the assessment of on-call duties through the Job Planning process.
5. The supplement does not alter the amount of basic salary for any other purpose or calculation.

Table 1

Frequency of Rota Commitment	Value of supplement as a percentage of full-time basic salary	
	Category A	Category 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%

6. Basic salary, for these purposes, will include pay thresholds. It will exclude any Discretionary Points, Distinction Awards (or their agreed replacement), recruitment or retention premium, and any other fees, allowances or supplements.
7. Part-time consultants will receive the appropriate percentage of the equivalent full-time salary, provided their responsibilities when on-call are the same as those of full-time consultants on the same rota.

Recruitment and Retention Premia

8. An employing organisation may under certain circumstances decide to award a recruitment or a retention premium in addition to basic salary. The premium may be paid either as a single sum, or on recurrent basis but for a time-limited period. If the latter, the period in question will not typically last for more than four years.
9. Employing organizations will determine the value of any such premium and may adjust its value from time to time to take account of changing circumstances. The value of the premium will not typically exceed 30% of the normal starting salary for a consultant post.

Other Payments and Allowances

10. A consultant may be entitled to certain other payments and allowances at the discretion of the employing authority.

Directors of Public Health

11. Directors of Public Health will be entitled to supplements in addition to basic salary (in line with the provisions in Schedule 13 or Schedule 14) within the range as specified from time to time in letters advising national rates of pay. These supplements will depend on the band within which their post falls and the weight of the post as assessed by their employing organisation. Band A applies to regional posts, irrespective of population. The definition of the relevant bands is set out below:

Band A:	Regional Director of Public Health	N/A
Band B:	Population over 450,000	Eastern Board
Band C:	Population 250,000 - 449,999	Northern, Southern and Western Boards
Band D:	Population 50,000 - 249,999	N/A

12. Supplements shall be an element of remuneration and shall be superannuable.
13. Population shall be reviewed annually at 1 April. The relevant population for this purpose shall be the Registrar General's estimate of the home population for the employing organisation at the previous 30 June.

14. If the home population for the employing organisation increases to a higher population band for one year only, this shall have no effect on the minimum supplement. If the rise to a higher population band is confirmed by the next year's estimate, a review of the supplement payable should be completed within six months. Payment of any increased supplement following such a review shall be made with retrospective effect from 1 April of the previous year.
15. If the home population for the employing organisation falls to a lower population band for one year only, this shall have no effect on the minimum supplement. If the fall in population is confirmed by the next year's estimate, a review of the supplement payable should be completed within six months. Where this would result in a reduction in the value of the supplement, an officer shall retain the cash value of his or her existing supplement for so long as that remains more favourable.

SCHEDULE 17**Pension Arrangements**

1. The consultant will be eligible for membership of the HPSS Superannuation Scheme, the provisions of which are set out in the HPSS Superannuation Regulations (Northern Ireland) 1995 (as amended). The Scheme is a final salary scheme with benefits based on the best of the last three years pensionable pay.
2. The following will be pensionable in the HPSS Superannuation Scheme:
 - the consultant's basic salary (up to ten Programmed Activities), including pay thresholds;
 - enhancements to basic salary by way of any Discretionary Points, Distinction Awards or their agreed replacement;
 - any on-call availability supplement; and
 - fees for domiciliary visits not undertaken during Programmed Activities.
3. The following will not be pensionable in the HPSS Superannuation Scheme:
 - travelling, subsistence, and other expenses paid as a consequence of the consultant's work for the employing organisation or the wider HSC;
 - any recruitment or retention premium;
 - any payments for additional Programmed Activities; and
 - any payments for work the consultant undertakes for Local Authorities, subject to local agreements to the contrary.

Employment after Retirement

4. Once a consultant has retired, and taken his or her HPSS pension benefits, any salary paid to the consultant in any re-employment will not be pensionable in the HPSS Superannuation Scheme.

Removal or Downgrading of a Distinction Award or their agreed replacement

5. If a Distinction Award, or their agreed replacement, is removed or downgraded, the consultant will normally continue to be paid the value of the award he or she received at the time this decision was made. This will be taken into account in the calculation of the consultant's pension in the normal way.
6. In exceptional circumstances, a consultant may lose the value of the award as well as the award itself. This may affect the value of the consultant's pension depending on the date on which this deduction was made.

Mental Health Officer Status

7. There will be no effect on the Mental Health Officer status of consultants transferring to these Terms and Conditions.

SCHEDULE 18**Leave and Public Holidays****A. Annual Leave and Public Holidays****Annual Leave**

1. Consultants employed on a full-time contract are entitled to annual leave at the following rates per year, exclusive of public holidays and extra statutory days:

Year	Number of Years of Completed Service as a Consultant	
	Up to Seven Years	Seven Or More Years
Until 31 March 2004	Six weeks	Six weeks
1 April 2004 – 31 March 2005	Six weeks	Six weeks + one day
From 1 April 2005	Six weeks	Six weeks + two days

2. The leave year runs from 1 April in any year to 31 March the following year. No detriment to the consultant will arise from the leave year adjustment.
3. Annual leave should be discussed at the annual Job Plan review.

Public Holidays

4. The leave entitlements of consultants in regular appointments are additional to ten public holidays and two statutory holidays or days in lieu thereof. The two statutory holidays may, by local agreement, be converted to a period of annual leave.
5. In addition, a consultant who in the course of his or her duty is required to be present in hospital or other place of work between the hours of midnight and 9am on statutory or public holidays should receive a day off in lieu.

Carry Over of Annual Leave

6. Annual leave may be carried over subject to Section 1, paragraphs 10-14 of the General Terms and Conditions of Service.
7. The employing organisation will not ordinarily make payment in lieu of annual leave.

Sickness During Annual Leave

8. In accordance with the employers sickness/absence policy if a consultant falls sick during annual leave and produces a statement to that effect, he or she will be regarded as being on sick leave from the date of the statement. A self-certificate may cover days 1 to 7 of the period of sickness. The consultant must obtain a medical certificate for subsequent days. Further annual leave will be suspended from the date of the first statement.

B. Professional and Study Leave**Definition**

9. Professional and study leave (which is separate from and in addition to those activities covered by the definition of Supporting Professional Activities) includes:
- study, usually but not exclusively or necessarily on a course or programme;
 - research;
 - undergoing a period of teaching;
 - examining or taking examinations;
 - visiting clinics and attending professional conferences;
 - participation in personal training.

Proposing Professional or Study Leave

10. A consultant may be allowed professional or study leave for approved postgraduate purposes.

Conditions

11. Any grant of leave is subject to the need to maintain HSC services.
12. Where leave with pay is granted, the consultant must not undertake any other paid work during the leave period without the employing organisation's prior permission.

Period of Leave

13. Subject to the conditions in paragraph 16, professional or study leave will normally be granted to the maximum extent consistent with maintaining essential services in accordance with the recommended standards, or may exceptionally be granted under the provisions of paragraphs 14 and 15. The recommended standard for consultants is leave with pay and expenses within a maximum of thirty days in any period of three years for professional purposes within the United Kingdom.

Additional Periods of Professional and Study Leave in the United Kingdom

14. Authorities may at their discretion grant professional or study leave in the United Kingdom above the period recommended in paragraph 13 with or without pay and with or without expenses or with some proportion thereof.

Professional and Study Leave outside the United Kingdom

15. Authorities may at their discretion grant professional or study leave outside the United Kingdom with or without pay and with or without expenses or with any proportion thereof.

Conditions

16. The following conditions shall apply:

- i. where a consultant is employed by more than one HSC organisation, the leave and the purpose for which it is required must be approved by all the organisations concerned;
- ii. where leave with pay is granted, the consultant must not undertake any remunerative work without the special permission of the lead employer;
- iii. where an application is made under paragraphs 14 and 15 for a period of leave with pay, and this exceeds three weeks, it shall be open to the lead employer to require that one half of the excess over three weeks shall be counted against annual leave entitlement, the carry forward or anticipation of annual leave within a maximum of three weeks being permitted for this purpose.

C. Sabbaticals

17. A consultant may apply for sabbatical leave in accordance with the employing organisation's current arrangements. Any proposal for sabbatical leave should be made before the annual appraisal and considered in the annual Job Plan review.

D. Sick Absence

Scale of Allowances

18. A consultant absent from duty owing to illness (including injury or other disability) shall, subject to the provisions of paragraphs 2 to 15, be entitled to receive an allowance in accordance with the following table:

Table1: Consultant Sick Absence Entitlement

During the first year of service	One month's full pay and (after completing four months' service) two months' half pay.
During the second year of service	Two months' full pay and two months' half pay.
During the third year of service	Four months' full pay and four months' half pay.
During the fourth and fifth years of service	Five months' full pay and five months' half pay
After completing five years of service	Six months' full pay and six months' half pay.

19. The employer shall have the discretion to extend the provision of sick pay in an exceptional case. A case of a serious nature in which a period of sick leave on full pay in excess of the period outlined above would, by relieving anxiety, materially assist recovery of health, shall receive special consideration by the employer.
20. To aid rehabilitation the employer has discretion to allow a consultant to return to work on reduced hours or to be encouraged to work from home without loss of pay. Any such arrangements need to be consistent with statutory sick pay rules.
21. For the purposes of these calculations all periods of service (without any break of twelve months or more) for any HSC Organisation, any Local Authority, Her

Majesty's Armed Forces, the Civil Service or the teaching service shall be aggregated

Calculation of Allowances

22. The rate of allowance, and the period for which it is to be paid in respect of any period of absence due to illness, shall be ascertained by deducting from the period of benefit (under paragraph 18) appropriate to the consultant's service on the first day of absence the aggregate for the period of absence due to illness during the twelve months immediately preceding the first day of absence. In aggregating the periods of absence, no account shall be taken of:
- i. unpaid sick absence; or
 - ii. injuries or diseases sustained to members of staff in the actual discharge of their duties through no fault of their own; or
 - iii. injury resulting from a crime of violence not sustained on duty but connected with or arising from the consultant's employment or profession, where the injury has been the subject of payment by the Criminal Injuries Compensation Agency; or
 - iv. due to injury as at sub-paragraph ii. above which has not been the subject of payment by the Agency on grounds that it has not given rise to more than three weeks' loss of earnings, or was not one for which compensation above the minimum would arise.
23. The employer may at its discretion also take no account of the whole or part of the periods of absence due to injury (not on duty) resulting from a crime of violence not arising from or connected with the consultant's employment or profession.

Previous Qualifying Service

24. For the purpose of ascertaining the appropriate allowance of paid sick absence under paragraph 18, previous qualifying service shall be determined in accordance with a consultant's statutory rights and all periods of service, without any break of twelve months or more (unless undertaking voluntary service), with a HSC employer shall be aggregated.

Limitation of Allowance when Insurance or Other Benefits are Payable

25. The sick pay paid to a consultant when added to any statutory sickness, injuries or compensation benefits, including any allowances for adult or child dependants, must not exceed full pay.

Submission of Doctor's Statements

26. A consultant who is incapable of doing his or her normal work because of illness shall immediately notify the employer according to the employer's procedures.
27. Any absence of more than seven days shall be certified by a doctor other than the sick consultant. Statements shall be submitted according to the employer's procedures.

Accident Due to Sport or Negligence

28. An allowance shall not normally be paid in a case of accident due to active participation in sport as a profession, or in a case in which contributory negligence is proved, unless the employer decides otherwise.

Injury Sustained on Duty

29. (i) An absence due to injury sustained by a consultant in the actual discharge of his or her duty, for which the consultant was not liable, shall not be recorded for the purposes of these provisions.
- (ii) The injury Allowance provisions will apply as set out in Section 22 of the NHS Terms and Conditions of Service Handbook, and should be read alongside the accompanying guidance issued by NHS Employers.¹

Recovering of Damages from Third Party

30. A consultant who is absent as a result of an accident is not entitled to sick pay if damages are received from a third party. Employers may agree to advance to a consultant a loan, not exceeding the amount of sick pay under these provisions, providing the consultant repays to the employer when damages are received, the full amount or portion thereof corresponding to the amount in respect of loss of remuneration including the damages received. Once received the absence shall not be taken into account for the purposes of the scale set out in Table 1.

Medical Examination

31. The employer may at any time require a consultant who is unable to perform his or her duties as a consequence of illness to submit to an examination by a medical practitioner nominated by the employer. Any expense incurred in connection with such an examination shall be met by the employer.

Termination of Employment

32. After investigation, consultation and consideration of other alternative posts, and where there is no reasonable prospect of the consultant returning to work, employers will have the option to terminate employment before the employee has reached the end of the contractual period of sick leave, provided that the consultant will receive his or her entitlement in accordance with Table 1.

Procedures and Payment When Injuries are Connected With Other Insured Employment

33. Notification procedures and payment of sick pay when injuries are connected with other insured employment will be for local determination.

E. Special Leave With or Without Pay

34. Special leave for any circumstances may be granted (with or without pay) at the discretion of the employer. Where a consultant is required to attend court as a

witness, as a result of the normal course of delivering his or her HSC duties, such attendance will be classified as Contractual and Consequential Services.

F. Maternity Leave and Pay

- 35. The provisions of Schedule 24 shall apply.
- 36. Not allocated.

SCHEDULE 19**Termination of Employment****Period of Notice**

1. Where termination of employment is necessary, an employing organisation will give a consultant three months notice, in writing.
2. Consultants are required to give their employing organisation three months written notice if they wish to terminate their employment.
3. Shorter or longer notice may apply where agreed between both parties in writing and signed by both.

Grounds for Termination of Employment

4. A consultant's employment may be terminated for the following reasons:
 - failure to hold or maintain a requisite qualification, registration or licence to practice;
 - in order to comply with statute or other statutory regulation;
 - redundancy;
 - where there are concerns which have been upheld by agreed procedures in respect of conduct and capability (see circular HSS(TC8) 6/2005).
5. Should the application of any disciplinary or capability procedures result in the decision to terminate a consultant's contract of employment, he or she will be entitled to an appeal.
6. In cases where employment is terminated, a consultant may be required to work his or her notice, or, if the employing authority considers it more appropriate, a consultant may be paid in lieu of notice, or paid through the notice period but not be required to attend work.
7. Where a case of gross misconduct or gross negligence has been upheld, or where a consultant's registration as a medical practitioner (and/or their registration as a dental practitioner) has been removed or has lapsed without good reason, employment may be terminated without notice.

Termination of Employment upon Re-Organisation

8. Where a re-organisation of local health services involves displacement of, or significant disturbance to, the services provided by a consultant, the employing organisation will use reasonable endeavours to render effective assistance to the consultant with a view to his or her obtaining comparable work elsewhere in the HPSS.

Termination of Employment by Redundancy

9. If a consultant's employment is terminated because of redundancy within the meaning of section 174 of the Employment Rights (Northern Ireland) Order 1996, or

the circumstances described in Section 45 of the General Terms and Conditions of Service, then provided that he or she has two years or more continuous service, entitlement to redundancy payment will be in accordance with Section 45 of the General Terms and Conditions of Service.

SCHEDULE 20**Incorporated General Terms and Conditions Of Service**

This Schedule lists those General Terms and Conditions of Service that apply under the contract, except where otherwise indicated in these Terms and Conditions.

Section	Subject
1	Annual Leave Entitlement
2	Statutory and Public Holidays
7.	Equal Opportunities
8.	Harassment at Work
9.	Child Care
10.	Retainer / Career break scheme
11.	Job Sharing
22.	Subsistence Allowances
23.	Travelling Expenses
24.	Official Vehicles, Mileage Allowances and Associated Provisions
26.	Removal Expenses and Associated Provisions
38.	Facilities for Staff Organisations
39.	Joint Consultation Machinery
41.	Health Awareness for HPSS staff
42.	Disciplinary and Disputes Procedures
45.	Arrangements for Redundancy Payments
46.	Payment of Superannuation and Compensation Benefits on Premature Retirement
48.	Protection of Pay and Conditions of Service
52.	Position of Employees Elected to Parliament
53.	Membership of District Councils
54.	Payment of Annual Salaries
55.	Preparation for Retirement
57.	Statutory Sick Pay: Qualifying Days
59.	HSS Trusts - Continuity of Service
61.	Annual Leave and Sick Pay Entitlements on Re-entry and Entry into HPSS Employment

NB – Please note that Maternity Leave and Pay arrangements are now covered in temporary Schedule 24.

SCHEDULE 21**Model Provisions for Expenses – HSC Consultants**

These model provisions are designed to serve as the basis for agreements about the payment of consultant expenses for medical consultants employed by the HSC or contracted on an honorary basis. HSC employers and consultants may agree alternative provisions.

General

1. Travelling, subsistence, and other expenses incurred in the service of the employer shall be reimbursed to meet actual costs. Expenses do not form part of a consultant's pay and are not pensionable.

Submission of Claims

2. In preparing claims, consultants shall indicate adequately the nature of the expenses involved and submit valid receipts; claims shall be submitted normally at intervals of not more than one month (unless for good reason), and as soon as possible after the end of the period to which the claim relates.

Travelling Expenses and Mileage Allowances

3. The provisions of Section 23 (except paragraphs 2.4 and 4) of the General Terms and Conditions of Service shall apply. In these provisions "principal place of work" shall be understood to mean "the hospital or other base from which the consultant conducts his or her main duties". Where a consultant has a joint contract with more than one employing organisation, the term "principal place of work" shall be interpreted as meaning the base from which the consultant conducts his or her main duties within that joint contract, irrespective of employing organisation.

Mileage Allowances Payable

4. Except where a consultant has been allocated a Lease Car (paragraphs 31 to 53 and subject to paragraph 34 of these provisions) mileage allowances shall be payable in accordance with the rates specified at paragraphs 14 to 25 of these provisions, as appropriate, where consultants use their private vehicle for any official journey on behalf of their employing organisation, including travel in connection with domiciliary consultations.
5. No allowance shall be payable for their normal daily journey between their home and their principal place of work, except as provided for in paragraphs 6 to 11.

Emergency Visits

6. Consultants called out in an emergency shall be entitled to mileage allowance in respect of any journey they are required to undertake, including the distance between their home and principal place of work.

Home-to- Principal Place of Work Mileage**Official Journeys Beginning at Home**

7. Mileage allowance will be paid for official journeys on behalf of the employing organisation where consultants travel by private car between their home and places other than their principal place of work, subject to a maximum of the distance between the consultant's principal place of work and the place visited, plus the agreed home to base mileage, for each single journey (doubled for a return journey).
8. For consultants in public health medicine, for official journeys between 6pm and 8am and on Saturdays, Sundays, statutory and public holidays only between 8am and 6pm, the base for the calculation of mileage allowance shall be the doctor's own home.

Subsequent Official Journeys

9. In addition, consultants may claim mileage allowance for one return journey daily between their home and their principal place of work up to the maximum of their agreed home to base mileage on days when they subsequently use their car for an official journey.

Liability to Make Emergency Visits

10. Consultants with commitments under the same contract to visit more than one place of work which includes a liability to make emergency visits to subsidiary hospitals, other institutions, or domiciliary visits, may, if the employing organisation decides that their liability is so extensive as to make it desirable that their car should always be available at their principal place of work, claim mileage allowances for normal daily journeys between their home and principal place of work up to the agreed home to base mileage.

Scattered Hospitals

11. Where, in exceptional circumstances, consultants are required by their employing organisation, as a condition of their contract, to live within a specified area at a distance of more than ten miles by road from their principal place of work in order to provide adequate emergency cover to a group of widely scattered hospitals or other institutions, mileage allowance at the approved rate shall be paid for the whole of the journey between their home and their principal place of work.

Part-time consultants

12. In the case of part-time consultants to whom paragraphs 7 to 11 do not apply, journeys between their place of residence and any place of work where they are employed, other than their principal place of work, shall be regarded as a journey in the service of the employing organisation, provided that no expenses shall be allowed for any such journey or part of such journey which would have been undertaken by the consultant, irrespective of their duties for the employer.
13. Where a part-time consultant travels between their place of residence and their principal place of work before and/or after an official journey, expenses shall be payable for the agreed home to base mileage.

Locum Consultants

14. Where a locum consultant travels between his or her home (or temporary accommodation) and principle place of work, expenses shall be payable in respect of any distance by which the journey exceeds 10 miles.

Rates of Mileage Allowance: Regular User Allowances

15. Allowances at regular user rates shall be paid to consultants who:
- i. are classified by the employing organisation as regular or essential users and choose not, or are unable, to avail themselves of a Lease Car in accordance with paragraphs 31 to 39; or
 - ii. are new appointees to whom the employing organisation has deemed it uneconomic, or is unable, to offer a Lease Car in accordance with paragraphs 31 to 39; and
 - iii. are required by their employing organisation to use their own car on HSC business and, in so doing, either:
 - a. travel an average of more than 3,500 miles a year; or
 - b. travel an average of at least 1,250 miles a year, and either:
 - i) necessarily use their car on an average of three days a week; or
 - ii) spend an average of at least 50% of their time on such travel, including the duties performed during the visits; or
 - iv. are consultants who are classified as essential users.

Essential Users Allowance

16. Essential users are consultants who:
- travel on average at least 1,250 miles (other than normal travel between their home or their practice premises and their principal place of work) each year; and
- i. either have ultimate clinical responsibility, or on-call responsibility normally controlled by a rota system, for the diagnosis and treatment of patients in hospital with emergency conditions which require them to be immediately available for recall; and are expected to be recalled to hospital in emergency at an average rate (taken over the year, but excluding periods of leave) of twice or more during a working week; or
 - ii. whose duties require them to pay frequent visits to places away from their principal place of work (e.g. to clinics, schools, residential establishments and other places, for instance, in connection with the control of infectious diseases and food poisoning), or who are liable to be called out in an emergency in connection with statutory duties relating to the control of communicable disease and food poisoning or the compulsory removal to suitable premises of persons in need of care and attention.

Change in Circumstances

17. If there is a change in a consultant's duties, or if the official mileage falls below that on which a regular or essential user classification was based and which is likely to continue, the application to the consultant of the regular user agreement should be reconsidered. Any decrease in the annual official mileage or the frequency of travel, etc. which is attributable to circumstances such as prolonged sick leave or the temporary closure of one place of duty should be ignored for this purpose.

Non-Classification as Regular User

18. Where an employing organisation does not consider that a consultant, other than one to whom paragraph 34 of these provisions applies, should be classified as a regular or essential user, and if this gives rise to any serious difficulty, the consultant shall have recourse to local grievance procedures.

Payment of Lump Sums

19. Payment of the annual lump sum allowance shall be made in equal monthly instalments over a period from 1 April in any year to 31 March in the succeeding year.
20. In the case of a consultant who takes up an appointment with an employing organisation or leaves the employment of his or her employing organisation after 1 April in any year, allowances shall be paid pro rata. The calculation of the mileage allowance should thus be in accordance with the following procedure:
- i. the mileage allowance to be paid at the higher rate would, at 9,000 miles per annum, be equivalent to 750 miles per month of service. The excess over 750 miles per month of service would be paid at the intermediate, and, if appropriate, the lower rate. For example, where the total service in the period 1 April in any year to 31 March in the succeeding year is five months, then up to 3,750 miles would be paid at the higher rate and any excess at the intermediate, and, if appropriate, the lower rate. Similarly, the lump sum should be divided into twelve monthly payments.
 - ii. when a consultant leaves the employment of an employing organisation, a calculation shall be made in respect of his or her entitlement for the portion of the year served with the employing organisation and any adjustments made thereafter.

Part Months of Service

21. Part months of service shall be regarded as complete months for the purposes of paragraph 18. However, a regular user who leaves the service of one employing organisation and enters the employment of another during the same month shall receive only one lump sum instalment for that month, payable by the former employing organisation.

Cars Out Of Use

22. When a consultant entitled to the regular user allowance does not use his or her car as a result of a mechanical defect or absence through illness:
- i. the lump sum payment should be paid for the remainder of the month in which the car was out of use and for a further three months thereafter. For the following three months, payment should be made at the rate of 50% of the

- lump sum payment. No further payments should be made if the car is out of use for six months or longer;
- ii. during the period when the car is "off the road" for repairs, out-of-pocket expenses in respect of travel by other forms of transport should be borne by the employing organisation, in accordance with the provisions of paragraph 2 of Section 23 of the General Terms and Conditions of Service.

Standard Mileage Rates

23. Mileage allowances at standard rates will be paid to consultants who use their own vehicles for official journeys, other than in the circumstances described in paragraphs 14, 23 and 34 of these provisions, provided that a consultant may opt to be paid mileage allowances at standard rates, notwithstanding his or her entitlement to payment at regular user rates.

Public Transport Mileage Rate

24. The foregoing rates shall not apply if a consultant uses a private motor vehicle in circumstances where travel by a public service (e.g. rail, bus) would be appropriate. For such journeys, an allowance at the public transport rate shall be paid, unless this is higher than the rate that would be payable at the standard, regular user or special rate. Further guidance on the application of the public transport mileage rate is attached at Annex B.

Passenger Allowances

25. Where other employees or members of an employing organisation are conveyed in the same vehicle, other than a Lease Car, on the business of the HSC and their fares by a public service would otherwise be payable by the employing organisation, passenger mileage allowance shall be paid.

Garage Expenses, Tolls and Ferries

26. Subject to the production of vouchers wherever possible, consultants using their private motor vehicles on an official journey at the standard, regular user or special rate of mileage allowance shall be refunded reasonable garage and parking expenses and charges for tolls and ferries necessarily incurred, except that charges for overnight garaging or parking shall not be reimbursed, unless the consultant is entitled to night subsistence allowance for overnight absence. Similar expenses may also be refunded to consultants only entitled to the public transport rate of mileage allowance, provided that the total reimbursement for an official journey does not exceed the cost, which would otherwise have been incurred on public transport, including the fares of any official passengers.

Loans for Car Purchase

27. The provisions of this paragraph apply to consultants who qualify for the first time as essential car users in the HSC, other than those who are offered, or provided with, a suitable Lease Car.
28. Such consultants are entitled to a loan at 2½% flat rate of interest, provided that the request for the loan is made within three months of such classification, or of taking up the post (whichever is the later).

29. Loans shall be made in accordance with the provisions of paragraphs 22 to 27 of Section 24 of the General Terms and Conditions of Service.
30. In determining whether a car is "suitable" for the purposes of these provisions, various factors may need to be taken into account, such as the total official mileage to be driven, reliability, the need to carry heavy or bulky equipment and local road conditions, etc.

Pedal Cycles

31. Consultants using pedal cycles for official journeys may be reimbursed at the rate set out in Annex A, Table 1.

Lease Cars

Allocation

32. For the purposes of paragraphs 32 to 53, a "Lease Car" is any vehicle owned or contract-hired by an employing organisation.
33. Employing organisations may offer Lease Cars for individual use on official business where they deem it economic (see also paragraph 50 of these provisions) or otherwise in the interest of the service to do so.
34. Consultants who are required to travel on HSC business and have been classified by the employing organisation as regular or essential users may continue to receive the regular user lump sum payments and allowances set out in Annex A, Table 1 for so long as they remain in the same post or until they voluntarily accept the offer of a Lease Car.

New Appointees

35. A consultant who was a new appointee after 1 April 2003 (including a consultant who voluntarily moves post within the same employing organisation, or to a different employing organisation) and who is required to travel on HSC business and who chooses to use his or her own car, rather than to accept the employing organisation's offer of a Lease Car, shall not receive the allowances specified in paragraph 33 of these provisions, but shall be reimbursed at the special rate. The special rate will be equivalent to the current 9,001 to 15,000 miles rate for over 2,000cc for regular and standard users, regardless of the vehicle's engine size.
36. A consultant who initially refused an offer of a Lease Car will continue to be eligible for one, providing there has been no change in the consultant's duties.
37. A consultant who has been allocated a Lease Car for individual use on HSC business is entitled to private use of the car, subject to the conditions set out in paragraphs 40 to 53 of these provisions.
38. The offer of a Lease Car constitutes the offer of a base vehicle, which should in no case exceed 1800cc. Unless the consultant and the employing organisation agree to the allocation of a smaller vehicle, it shall be at least 1500cc. In determining the operational needs of a post for assessing the base vehicle requirement, employing organisations shall have regard, in consultation with the consultants concerned or their representatives, to:

- i. the clinical commitments of the postholder, including the nature, frequency and urgency of the journeys to be undertaken;
 - ii. the distances to be travelled;
 - iii. the road, traffic and climatic conditions;
 - iv. the physical requirements of the postholder; and
 - v. the need to transport equipment.
39. A Lease Car, which is no longer required by an individual member of staff, may be allocated to another for the remaining term of the contract (or notional contract). In that event, the charges for private use will be based on the fixed annual charges determined when the employing organisation first obtained the vehicle.
40. Employing organisations shall ensure that proper arrangements are made for the economic servicing, repair, maintenance in a roadworthy condition and replacement of Lease Cars.

Conditions of Use

41. Following consultation with the representatives of the professions locally, an employing organisation's conditions of use shall set out the consultant's obligations in respect of the Lease Car and shall state the effect of the following events on the contract and any subsequent financial liability on the consultant:
- i. breach of conditions of use;
 - ii. disqualification from driving;
 - iii. wilful neglect;
 - iv. termination of the consultant's contract of employment, on: disciplinary grounds; voluntary resignation; transfer to another employing organisation (where practicable, reciprocal arrangements should be made);
 - v. change of duties resulting in the consultant no longer being required to drive on official business;
 - vi. substantial reduction in annual business mileage;
 - vii. prolonged absence on annual, study, special or maternity leave.

Charges for Private Use

42. The basis of charges for private use set out in this paragraph assumes that Lease Cars are provided on a contract-hire basis. Where this is not the case, charges for private use are to be based on the notional cost to the employing organisation of providing Lease Cars on a contract-hire basis. Notional contract-hire charges at current rates are to be used, and the fixed charge to the consultant for agreed private mileage determined on this basis is to remain unaltered for the period for which the contract would have remained in force (e.g. three years).
43. A consultant will be required to pay one composite annual charge for private use. This will comprise the sum of the items listed in Annex A, Table 2. The composite annual charge will be paid by monthly deduction from salary of one twelfth of the total.

44. The basis of the fixed charge for agreed private mileage shall be the consultant's estimate to the nearest thousand miles of his or her annual private mileage, as agreed by the employing organisation and multiplied by the rate per thousand miles, determined in accordance with the formula set out in Annex A, Table 2, Paragraph B.
45. In the event that a consultant underestimates his or her annual private mileage, an excess charge will be levied by the employing organisation, based on the contract-hirer's excess charge to the employing organisation for the particular car hired to the consultant. In the event that a consultant overestimates his or her annual private mileage, any sum recoverable by the employing organisation from the contract-hirer in respect of the overestimate will be refundable to the consultant. If no recovery is available to the employing organisation, no refund will be made to the consultant.
46. A consultant shall meet the cost to the employing organisation of the fitting of any optional extras the consultant requires, and the contract between the employing organisation and the consultant should specify whether such extras will become the property of the contract-hirer or the consultant. In the latter case, the consultant shall be liable for the cost of making good any damage caused to the car by the removal of such fittings at the end or on early termination of the contract. However, if such alterations are required because the consultant has a certified disability, then the costs shall be met by the employing organisation.
47. In the event of a consultant's death in service or an early termination of the consultant's contract on the grounds of ill health, there shall be no financial penalty to the consultant or the consultant's estate on account of the early termination of the contract for private use of the Lease Car.
48. In the event of a consultant's absence from work for an extended period on maternity, sick, study or special leave, a consultant who has contracted for private use of a Lease Car may choose to continue the private use at the contracted charge or to return the vehicle to the employing organisation. In the latter case, there shall be no financial penalty to the consultant on account of early termination of the contract.

Alternative Vehicle

49. Subject to the agreement of the employing organisation, which shall not be unreasonably withheld, a consultant who wishes to contract for private use of a Lease Car may choose a larger or more expensively equipped vehicle than that offered. In this event, the consultant shall be responsible for meeting the additional costs to the employing organisation by means of an addition to the composite annual charge, which shall be paid by monthly deduction from salary of one twelfth of the total determined. The rate for reimbursement of petrol used on official business shall be that of the appropriate base vehicle.

Reimbursement of Petrol and Other Costs

50. A consultant who has been allocated a Lease Car will be responsible for purchasing all petrol, whether for business or private mileage.
51. HSC business mileage costs will be reimbursed by reference to a claim form or diary showing daily visits on HSC business signed by the consultant. HSC business mileage costs include journeys for which a mileage allowance would be payable under paragraphs 7 to 13 of these provisions.

52. The rate per mile will be determined according to the following formula:

$$\frac{\text{Cost of one gallon of premium unleaded petrol}^*}{\text{Base Vehicle's mileage on urban cycle}}$$

* The price of petrol will be as recommended from time to time by the Department of Health, Social Services and Public Safety or any new employers' body to whom this function may in future be delegated. The mileage on the urban cycle will be as quoted by manufacturers from officially approved tests under the Passenger Car Fuel Consumption Order 1983.

53. The provisions of paragraph 25 of these provisions shall apply to expenses incurred by a consultant using a Lease Car on official business.

Carriage of Passengers

54. Liability for compensation of authorised official passengers injured while being carried in a Lease Car will be borne by the employing organisation. It is for each employing organisation to reach a view and issue advice to consultants on the carriage of official passengers.

Other Expenses

Subsistence Allowances

55. The provisions of Section 22 of the General Terms and Conditions of Service shall apply, with the following provisos:
56. For the purposes of this guidance the term "principal place of work" shall be understood to mean "the HSC facility where the consultant's principal duties lie", except in the case of consultants who work occasional sessions with the Blood Transfusion Service Special Agency in which case the regional headquarters of the Blood Transfusion Service Special Agency shall be considered to be the principal place of work for any such sessions.
57. No day allowance shall be payable in respect of any period spent at an HSC facility as part of the Programmed Activities of the consultant concerned.

Postage etc

58. Any expenditure necessarily incurred by a consultant on postage or telephone calls in the service of an employing organisation shall be reimbursed, through the periodical claim for travelling and subsistence.

Expenses of Candidates for Appointments

59. The provisions of this paragraph shall apply where an employing organisation summons a consultant to appear before a selection board or invites a short-listed consultant to attend in connection with his or her application for appointment.
- i. reimbursement of eligible expenses shall be made by the prospective employing organisation;
 - ii. where a consultant holds a paid or honorary appointment with an employing organisation and applies for a new post with his or her own or another

- employing organisation, the consultant is entitled to travelling expenses in accordance with paragraph 3 of these provisions and to subsistence allowance in accordance with paragraphs 54 to 56;
- iii. where a consultant to whom sub-paragraph ii. does not apply provides general medical or dental services under Part VI of the Health and Personal Social Services (Northern Ireland) Order 1972, or is an assistant to such a consultant, he or she is entitled to travelling expenses and subsistence allowance at the higher rate applicable under paragraphs 54 to 56 of these provisions;
 - iv. a consultant to whom sub-paragraphs ii. and iii. do not apply may at the discretion of the employing organisation be reimbursed travelling expenses and subsistence allowance, subject, unless the circumstances warrant exceptional treatment, to the maximum that would have been payable had those provisions applied;
 - v. a candidate for a consultant appointment shall not be reimbursed for more than three attendances. Where an employing organisation invites such a candidate to attend prior to short-listing, it may reimburse the candidate's expenses provided that he or she is subsequently short-listed, but not otherwise;
 - vi. a candidate to whom sub-paragraph v. does not apply shall not be reimbursed for more than two attendances.
60. A consultant to whom sub-paragraph 58ii. applies and who is summoned to appear before a selection board while on holiday shall be reimbursed for:
- i. travelling expenses from the consultant's holiday address, but limited in the case of travel from abroad to expenses from the port of entry to Northern Ireland, provided that the consultant returns to his or her holiday address after interview; for this purpose, travel from Great Britain, the Isle of Man and the Channel Islands shall not be regarded as travel from abroad; and
 - ii. subsistence allowance at the appropriate rate, unless the consultant is able to stay at his or her own home and it is reasonable to expect the consultant to do so.
61. Reimbursement shall not be made to a consultant who refuses the offer of the appointment as advertised on grounds which the employing organisation considers inadequate.

Removal Expenses

62. The provisions of Section 26 of the General Terms and Conditions of Service shall apply.

Annex A**Allowances and Charges for Private Use****Table 1: Mileage Allowances**

- Public transport rate: 23p per mile.

- Regular user rates:

Motor cars:

Engine capacity	(cc)	501 to 1000	1,001 to 1,500	1,501 to 2,000	over 2,000
Lump sum	(£)	399.00	475.00	580.00	580.00
Up to 9,000 miles	(p)	29.7	36.9	40.0	40.0
9,001 - 15,000 miles	(p)	16.5	19.7	22.7	25.5
Thereafter	(p)	17.8	20.1	20.5	20.5

- Standard rates:

Motor cars:

Engine capacity	(cc)	501 to 1000	1,001 to 1,500	1,501 to 2,000	over 2,000
Up to 3,500 miles	(p)	34.0	43.0	53.0	53.0
3,501 – 9,000 miles	(p)	23.0	28.2	33.5	41.0
9,001 - 15,000 miles	(p)	16.5	19.7	22.7	25.5
Thereafter	(p)	16.2	18.3	20.5	20.5

- Other motor vehicles:

Engine capacity	(cc)	Up to 125	Over 125
Up to 5,000 miles	(p)	16.2	25.3
Over 5,000 miles	(p)	6.1	9.0

- Passenger allowance:

Each passenger: 2p per mile

- Pedal cycles: 6.2p per mile

Table 2: Lease Cars Charges For Private Use Of Allocated Lease Cars

A.	The current rates of:	£
	Road Fund Licence	e.g. 55
	Insurance for Private Use * (National call-off contract)	e.g. 88
	Including cover for private use:	e.g. 28
	Handling charge	95

- B. Fixed Annual Charge per 1,000 private miles (for each year of the contract or notional contract), determined as follows:

$$\frac{(\text{Cost of Contract Hire at } \text{)} - (\text{Cost of Contract Hire at } \text{)}}{(\text{maximum quoted mileage}) - (\text{minimum quoted mileage})} \times 1000$$

Plus total excess costs for non-base vehicle, where appropriate.

Plus VAT on total charge to consultant (A+B).

- NB: Where the cost to the employing organisation of hiring the car includes Road Fund Licence and/or Insurance, these items should be extracted and the net cost used in calculating the charge per 1,000 miles.

Lease Cars, while used solely on HSC business, do not require to be taxed or insured for the purposes of the Road Traffic Act 1972; any private mileage requires that the vehicle be taxed and insured.

Annex B**Application of the Public Transport User Rate**

1. This annex provides further guidance on the application of the public transport user rate instead of the standard mileage rate, under the provisions set out in paragraph 22 of the main body of this guidance.
2. If mileage allowance is payable, the public transport rate (set out in Annex A, Table 1) should be paid where travel by a public service is appropriate, but the consultant prefers to use a private means of transport instead. In all other circumstances, the standard or regular user rates apply.
3. Employers should use the following criteria in deciding whether the public transport rate should apply:
 - the nature of the consultant's duties;
 - the length and complexity of journeys (including the number of changes and likely waiting times);
 - the availability of public transport;
 - personal safety;
 - the time of day;
 - relative journey times (public transport compared with private vehicle);
 - any other relevant factors, for example, equipment or luggage to be carried.
4. In particular, employers should take into account the variable times at which consultants start and finish work when public transport may not be a viable way of travelling.

SCHEDULE 22**Locum Consultants**

1. The provisions of these terms and conditions shall apply to locum consultants, subject to the provisions set out below.
2. Locum consultants should ordinarily be included on the General Medical Council's, or the General Dental Council's, Specialist Register. Where, exceptionally, doctors or dentists not included on either Specialist Register are appointed to locum consultant posts, terms and conditions shall – subject to the provisions below – be on the same basis as for other locum appointments.

Appointment and Tenure of Post

3. Locum appointments should be made in line with guidance issued by the Department of Health, Social Services and Public Safety. Locum appointments are not permanent posts; tenure will be as agreed on appointment.

Basic Salary

4. Locum consultants who have not at any time held a substantive consultant post shall be remunerated at the equivalent rate to the first point on the salary scale, subject to the provisions for pay progression set out below and subject to recognising any approved non-HSC consultant level experience. Where a locum consultant's training has been lengthened by virtue of being in a flexible training scheme or because of undergoing dual qualification (required for the locum post concerned), the employing organisation will, where necessary, credit appropriate additional seniority to ensure that the locum consultant is not prevented from reaching the pay threshold they would have attained had they trained on a full time or single qualification basis (e.g. training extended by two years counts as the equivalent of two years' consultant level experience where a locum consultants would not otherwise be able to reach the same pay threshold).
5. Locum consultants who hold a substantive consultant post (either within the employing organisation, or with another HSC employer) and will continue to hold such a post beyond the tenure of the locum post shall be remunerated at a rate consistent with their current pay threshold including any Distinction Award, Discretionary Points or Clinical Excellence Awards.
6. Locum consultants who do not currently hold a substantive consultant post (e.g. retired consultants) or consultants taking up a locum post with an employer other than their substantive employer shall be remunerated at a rate consistent with their most recent pay threshold as a substantive consultant or, for those who have not previously held employment under these Terms and Conditions, their calculated seniority, subject to the provisions for pay progression set out below.

Pay Progression

7. A locum in post for a period of six months will become subject to the Job Planning process. Where a locum doctor is covered by the Job Planning process and has completed twelve months' locum service, whether continuous or cumulative, there shall be an assessment of whether he or she has met the criteria set out in Schedule 15 for pay progression in respect of that year's service. Subject to meeting the

criteria in respect of the relevant year(s), locums shall receive pay progression in the same way as substantive consultants.

8. Where a locum consultant is approaching the completion of twelve months' service, the current employing organisation is responsible for making a decision as to whether the criteria for pay progression have been met in respect of that year. Where part of the previous twelve months' service has been for one or more other HSC employing organisations, the current employing organisation shall ensure that they receive an assurance as to whether the criteria have been met in respect of this other service.
9. Where Associate Specialists have been paid in their previous regular employment at a basic salary, including any discretionary points, higher or equal to the rate at which they would (were it not for this provision) be paid on taking up their new locum consultant appointment, then their starting salary in the new appointment shall be fixed at the threshold in the scale next above that previous rate.²

SCHEDULE 23

Guidance Notes For The Employment Of Joint Appointment Consultants within HSC

Preamble

- i) This guidance applies to all HSC Joint Appointment Consultants. It is intended to inform both the HSS employing organisation and University employer in the management of a joint appointment consultant who is employed on comparable terms to the Consultant Terms and Conditions of Service (Northern Ireland) 2004.
- ii) Associated documentation is set out below:

Document	Purpose
Joint Appointment Consultant - Principles for Applying the Consultant Contract	A policy document setting out principles for applying the HSC consultant contract to joint appointment Consultants in Northern Ireland. The document was agreed between the DHSS&PS, the NICC, MASC(NI), the Universities and Colleges Employers Association and the HSC Employers. This document does not in itself form part of the contract documentation, but its agreed principles have underpinned the development of the contract documentation for joint appointments.
Joint Appointment Consultant Contract (NI) Suggested Clauses	Agreed clauses that should be incorporated into the substantive contract issued to a joint appointment (normally by a University). These clauses enable parity with the HSC pay arrangements to be achieved.
Consultant Terms and Conditions of Service (NI) 2004	The Terms and Conditions, associated with the consultant contract, were agreed between NICC, the HSC Employers and DHSS&PS in March 2004. This document forms the basis for the employment of HSC consultants and applies to joint appointment contract holders, subject to the provisions of Schedule 23 of the Terms and Conditions.

- iii) The special nature of the joint appointment consultant's job derives from its two major components, academic and clinical, which are of equal importance and together make up the integrated workload. The integrated commitments require the joint appointment consultant to give equal priority to University and HSC activity within a contractual framework that supports flexible working practices.
- iv) The contract documentation for joint appointment consultants has been agreed in the spirit of joint working between stakeholders. The two parts of the contract and this guidance are based on the agreed 'Joint Appointment Consultant – Principles for

Applying the Consultant Contract' and the principles in the recommendations of the Follett report³. In particular:

- HSC and University organisations involved in medical education and research should be 'working together to integrate separate responsibilities'; and
 - Universities and HSC bodies should formally make all joint appointment consultants fully aware to whom they are accountable for the separate facets of their job.
- v) These principles are embodied in the concept of job planning and the single integrated Job Plan that will be agreed for a joint appointment consultant. The integrated job planning process ensures that all stakeholders have clarity about the duties that have been agreed for an individual joint appointee. The integrated process also ensures joint working between the University and the HSC employers.

³ "A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties" A report to the Secretary of State for Education and Skills, by Professor Sir Brian Follett and Michael Paulson-Ellis, September 2001.

Appointment

1. All appointments should be made jointly by the employers having regard to guidance on joint recruitment to be issued by UCEA. This guidance is based on the key Follett report recommendation⁴ that:
 - the job descriptions for new and replacement Joint Appointment consultant posts with academic and clinical duties should be jointly prepared and formally agreed by both partners prior to advertisement.
2. In order to serve in the HSC, a joint appointment consultant must be included on the appropriate registers held by the General Medical Council or the General Dental Council, and hold a valid license to practice.
3. On appointment a jointly agreed induction programme should be arranged by the employing organisations.

Joint Appointment Consultants Employed By More Than One HSC Organisation

4. In some cases a joint appointment consultant may undertake work for a number of HSC organisations under the provisions of their contract. Where this is the case:
 - (i) a lead HSC employer should hold the HSC joint appointment contract and represent all the HSC organisations involved for the purposes of the integrated Job Plan review;
 - (ii) it should be clear from an individual's joint appointment contract that he or she is expected to undertake work for other employers. To ensure this, the duties for all HSC employers, including locations, should be specified in the integrated Job Plan;
 - (iii) it should be clear at all times where liability falls (i.e. which HSC organisation will take responsibility under the Clinical Negligence Scheme for Trusts); and
 - (iv) the other HSC organisations should agree to indemnify the lead employer for any losses or liability that the lead employer might otherwise incur as a result of negligence. These indemnities could be given in correspondence, or an appropriately worded Service Level Agreement signed by all the HSC employers involved.

Duties And Responsibilities

5. All duties for joint appointment consultants should be expressed as Programmed Activities in the integrated Job Plan. A Programmed Activity is a period of activity, typically equivalent to 4 hours' work, although in some cases activities will be included in the integrated Job Plan as part Programmed Activities⁵. A full-time joint appointment consultant will normally be contracted for a total of 10 Programmed Activities per week.
6. All of a joint appointment consultant's duties involving Direct Clinical Care should be included in a work schedule that will normally cover a week, or a number of weeks.

⁴ "A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties" A report to the Secretary of State for Education and Skills, by Professor Sir Brian Follett and Michael Paulson-Ellis, September 2001.

⁵ Note also that the length of Programmed Activities may be varied where they are undertaken during Premium Time.

For some activities, such as research, other academic activities and emergency work while on-call, that are often undertaken at irregular times, the Programmed Activity may be a prospective estimate of the amount of time that will be allocated to these duties over a longer period of time. It is recognised that some activities, such as research, may be undertaken in a flexible way. Where a joint appointment consultant finds that in practice the amount of time worked on a particular activity differs from the number of Programmed Activities allocated to it, the integrated job planning process will be used to address this. Programming of duties should ensure compliance with the Working Time Regulations.

7. Direct Clinical Care duties include, but are not limited to:
 - a dental teaching clinic where patients are treated under the direct supervision of the joint appointment consultant as part of the patient's ongoing clinical care, or where organised for dental teaching.
 - a medical outpatient clinic where patients are treated as part of their ongoing clinical care, with students in attendance.

Job Planning

8. The duties of a joint appointment consultant will be set out in a single, integrated Job Plan. The integrated Job Plan will cover all of the joint appointee's professional duties. Although the integrated Job Plan may be agreed with a lead HSC employer acting on behalf of a number of HSC organisations, the Job Plan will include duties undertaken for all HSC organisations. The integrated Job Plan will be expressed in terms of Programmed Activities.
9. A provisional integrated Job Plan should be jointly agreed between the HSC and University employers in advance of the formal job planning meeting. In most cases a representative of both employers will be present at a Job Plan meeting. However, in exceptional cases and with the agreement of all parties, one individual may represent both employers and agree the integrated Job Plan with the joint appointee.
10. The integrated Job Plan must be reviewed at least annually and any party may propose amendment at any time.
11. In line with the key recommendations of the Follett report, a joint appointee's management and accountability arrangements for both employers should be set out in the integrated Job Plan.
12. Joint Appointment Consultants will not be expected to carry out work that has not been agreed in the job plan.
13. Detailed guidance on job planning is available at www.dhsspsni.gov.uk/hpss/hrd.

Job Planning Flexibilities

14. The contractual arrangements for joint appointment consultants allow, by agreement between joint appointment consultants and employers, for flexible timetabling of commitments over a period. Flexible timetabling (annualisation) could help meet varying service needs by allowing adjustment to working patterns at different times of the year and facilitate teaching and research requirements. Examples could include:
 - offering the flexibility for a consultant to focus on an intensive research project for part of the year or to alternate clinical and teaching duties across the year;

- term time working; and/or
 - consultant of the week arrangements.
15. The allocation of programmed activities for a full time joint appointment consultant for Direct Clinical Care and Supporting Professional Activities will typically be divided equally between the HSC and the University. However there will be scope for agreed local variation of the Job Plan to take account of individual circumstances and University or HSC service needs; for example, in terms of management, research and development and teaching duties. The proportion of Programmed Activities allocated to Direct Clinical Care compared with Supporting Professional Activities will typically be 3 to 1. There are flexibilities in the contract to agree a different ratio for individual joint appointment consultants. Supporting Professional Activities will need to be available from both HSC and University Employers to allow the Joint Appointment Consultant to undertake those Supporting Professional Activities which are specific to each employment.

Facilitation And Appeals

16. Where a dispute arises from the integrated job planning process or decisions about pay progression, a joint appointment consultant will be entitled to an appeal, subject to facilitation having failed. Any appeal will be jointly conducted by both employers, and the appeals panel will include representation from both employers and a representative acting on behalf of the consultant. An Appeals Framework is set out at Annex E of the Joint Appointment Consultant Contract.

On-call

17. Joint appointment consultants can agree to participate in an on-call rota as part of their duties under their joint appointment contract. Participation in an on-call rota will attract a pay supplement, as defined in the contract of employment and Schedule 17 of the Consultant Terms and Conditions of Service (NI) 2004.

Additional Programmed Activities

18. Joint appointment consultants may agree to undertake additional Programmed Activities on behalf of either employer. If they do so, these will be remunerated at the standard HSC rate applicable to the time of day. The University will not require Joint Appointment consultants to undertake any additional programmed activities in the completion of their academic work.
19. In some cases, where it is agreed with both employers and the Joint Appointment Consultant, all additional Programmed Activities may be contracted for with one employer.

Additional Programmed Activities and Additional Professional Capacity

20. Where a Joint Appointment consultant undertakes privately remunerated work outside the terms of his or her contract that has not been expressly agreed in the integrated Job Plan, he/she may be asked by either employer to undertake one additional Programmed Activity. The employer responsible for reimbursing this additional activity should be agreed between the employers prior to engagement with the individual consultant. In the above circumstances, agreeing to undertake an additional Programmed Activity, if asked to do so, will form part of the criteria for pay

progression. Where an additional Programmed Activity is undertaken it will be remunerated at the standard HSC rate applicable to the time of day.

21. Either employer may offer additional Programmed Activities to a joint appointment consultant under the private practice rules referred to in paragraph 20. The split of any agreed additional Programmed Activities that are to be undertaken for either employer will be agreed as part of the integrated job planning process. Where a full-time joint appointment consultant who is currently working the equivalent of 11 Programmed Activities or more transfers to the new contract and it is agreed that the same level of activity should form part of their integrated Job Plan under the new contract, he/she will not be expected to offer any additional work on top of this.

Fee Paying Services

22. Where any separate duties for which fees are payable are undertaken explicitly on behalf of either employer, the conditions applying to such work will be agreed between the employers and the joint appointment consultant. For all other Fee Paying Services the provisions of Schedule 10 of the Consultant Terms and Conditions of Service (NI) 2004 will apply.

Intellectual Property

23. It is recognised that both HSC organisations and academic institutions have policies relating to intellectual property rights. These procedures will be in line with any agreed documentation on the management of Intellectual Property produced by the HSC or the University. There should be a local agreement between the employers and the joint appointment consultant concerning the intellectual property rules that will apply to a particular job, or research project, where the development of intellectual property may occur as a result of both parts of a joint appointment consultant's duties. Local agreements will also address any potential conflicts between the policies of HSC organisations and academic institutions.

Research Governance

24. Joint appointment consultants are expected to comply with their employers' procedures for research governance. Local agreements will also address any potential conflicts between the policies of HSC organisations and academic institutions.

Basic Salary

Commencement Of Service

25. In setting starting salary employers are expected to take into account all previous HSC service in the consultant grade and any equivalent experience in another EEA member-state. Employers may also, at their discretion, take into account service outside the HPSS, for example including:
 - service outside the EEA;
 - voluntary service;
 - service in the independent sector;
 - service in HM armed forces; and

- employment in an academic institution other than that subject to the current contract .

Salary should be agreed between both employers. The employer organisations should credit starting salary with additional 'seniority' to take account of any relevant (equivalent) experience and retain discretion to take account of any relevant academic qualifications.

Pay Uplift

26. A Joint Appointment Consultant contract is based on parity in arrangements with the HSC, and a joint appointment's basic salary is linked to the pay scale for substantive HSC consultants. The rates of pay, including pay thresholds and consequential rates of payment for additional Programmed Activities, will be uplifted in line with that for HSC consultants. The rates will be uplifted from 1 April.
27. The rates will be increased by 3.225 per cent from April 2004 and by a further 3.225 per cent from April 2005 subject to this value remaining within 1.5% of RPI(x).

Recruitment or Retention Premia

28. The University and HSC employers may jointly agree to pay either a recruitment or a retention premium. Any such payments will be agreed as part of the offer of contract. Payments may be made as a single sum, or on a recurrent basis, but for a time limited period. If the latter, the period in question will not typically last for more than four years. Such premia will not exceed more than 30% of the normal starting salary for a consultant post.

Pay Progression

29. Representatives of both employers will jointly agree decisions on pay progression. Pay progression will be in accordance with Schedule 15 of the Consultant Terms and Conditions of Service (NI) 2004. Neither employer will be able to add additional criteria.
30. As with disputes arising from job planning, a joint appointment consultant will be entitled to appeal against a decision on pay progression. Such an appeal can be lodged with either employer.

Pay Supplements

Premium Time

31. The provisions relating to contracted work undertaken in Premium Time are contained in Schedule 7 of the Consultant Terms and Conditions of Service (NI) 2004.

On-call Availability Supplements

32. On-call availability supplements will also be payable in accordance with Schedule 17 of the Consultant Terms and Conditions of Service (NI) 2004.

Distinction Awards, Discretionary Points (or their agreed replacement)

33. Joint appointment consultants will continue to be eligible for HSC Distinction and Meritorious Service Awards and Discretionary Points (or their agreed replacement).

Pension

34. Joint appointment consultants who are continuing contributors to the HPSS Superannuation Scheme retain the option to contribute to the Universities Superannuation Scheme or to remain in the HPSS Superannuation Scheme, subject to the terms of that scheme.
35. The HPSS Superannuation Scheme is a final salary scheme with benefits based on the best of the last three years' pensionable pay. The following will be pensionable in the HPSS Superannuation Scheme:
- the joint appointment's basic salary (up to ten Programmed Activities), including pay thresholds;
 - enhancements to basic salary by way of any discretionary points or distinction awards (or their agreed replacement);
 - any on-call availability supplement;
 - fees for domiciliary visits not undertaken during Programmed Activities.
36. The following will not be pensionable in the HPSS Superannuation Scheme:
- travelling, subsistence, and other expenses paid as a consequence of the consultant's work for the employing organisation or the wider HSC;
 - any recruitment or retention premium;
 - any payments for additional Programmed Activities;

Annual and Special Leave

37. Annual leave entitlement for joint appointment consultants will be determined by both employers, but should be no less favourable than those agreed for substantive HSC consultants. HSC consultants normally receive 6 weeks' annual leave, with an extra two days' leave awarded in recognition of sustained commitment to the HSC for consultants with more than seven years' seniority.
38. From April 2005, joint appointment consultants, like substantive HSC consultants, will become entitled to an extra 2 days leave which will replace 2 existing statutory days which HSC consultant staff currently receive. The 2 statutory days being replaced are the day taken as July 13, and the third day at Christmas. This will give all consultants with less than seven years seniority 6 weeks and 2 days of annual leave a year from April 2005, plus 10 public holidays. Consultants with more than seven years seniority will have an entitlement to 6 weeks and 4 days of annual leave from April 2005 plus 10 public holidays.
39. Arrangements for study, sabbatical and other kinds of leave must be agreed by both employers following appropriate consultation.

40. Where a joint appointment consultant intends to take annual leave, the timing should be agreed in advance with an employer where it will affect contractual duties. Annual leave will not be unreasonably withheld by either employer. Wherever possible, provisions for taking annual leave will be agreed as part of the integrated job planning process.

Disciplinary Matters

41. Wherever possible, any issues relating to conduct and competence should be identified and resolved without recourse to formal procedures. Where disciplinary action is taken against a joint appointment consultant, the disciplinary procedures used will be determined by which employer initiated the action.
42. Should either employer contemplate taking disciplinary action against a joint appointment consultant, the joint appointment consultant should be given the opportunity to respond to the matter raised as part of the preliminary investigation. If it is deemed necessary to proceed to a disciplinary hearing, the initiating employer should inform the other joint employer (or the lead employer if a joint appointment consultant holds contracts with more than one HSC employer) and keep them informed at all stages of the process.
43. Should either employer terminate the contract, this may have implications for the other contracting employer.

Termination of Contract

44. Should either employer choose to terminate their contract with the individual, there should be a review of the other employing contract.

Schedule 24**Maternity Leave and Pay (Temporary Schedule)****Introduction**

1. All employees will have the right to take 52 weeks of maternity leave.
2. Paragraphs 7 to 54 of this Schedule set out the maternity leave and pay entitlements of HSC employees under the HSC contractual maternity leave scheme.
3. Paragraphs 55 to 59 give information about the position of staff who are not covered by this scheme because they do not have the necessary service or do not intend to return to HSC employment.
4. Paragraphs 60 to 64 define the service that can be counted towards the twelve month continuous service qualification set out in paragraph 7 (i) below and which breaks in service may be disregarded for this purpose.
5. Paragraph 65 explains how to get further information about employees' statutory entitlements.
6. Where locally staff and employer representatives agree arrangements which provide benefits to staff, beyond those provided by this section, those local arrangements will apply.

Eligibility

7. An employee working full-time or part-time will be entitled to paid and unpaid maternity leave under the HSC contractual maternity pay scheme if:
 - i. she has twelve months continuous service (see paragraphs 60 to 64) with one or more HSC employers at the beginning of the eleventh week before the expected week of childbirth;
 - ii. she notifies her employer in writing before the end of the 15th week before the expected date of childbirth (or if this is not possible, as soon as is reasonably practicable thereafter):
 - (a) of her intention to take maternity leave;
 - (b) of the date she wishes to start her maternity leave - she can choose when to start her maternity leave – this can usually be any date from the beginning of the 11th week before the baby is born (but see paragraph 8 below);
 - (c) that she intends to return to work with the same or another HSC employer for a minimum period of three months after her maternity leave has ended;
 - (d) and provides a MATB1 form from her midwife or GP giving the expected date of childbirth.

Changing the Maternity Leave Start Date

8. If the employee subsequently wants to change the date from which she wishes her leave to start she should notify her employer at least 28 days beforehand (or, if this is not possible, as soon as is reasonably practicable beforehand).

Confirming Maternity Leave and Pay

9. Following discussion with the employee, the employer should confirm in writing:
 - i. the employee's paid and unpaid leave entitlements under this agreement (or statutory entitlements if the employee does not qualify under this agreement);
 - ii. unless an earlier return date has been given by the employee, her expected return date based on her 52 weeks paid and unpaid leave entitlement under this agreement; and
 - iii. the length of any period of accrued annual leave which it has been agreed may be taken following the end of the formal maternity leave period (see paragraphs 49 and 50 below);
 - iv. the need for the employee to give at least 28 days notice if she wishes to return to work before the expected return date.

Keeping in Touch

10. Before going on leave, the employer and the employee should also discuss and agree any voluntary arrangements for keeping in touch during the employee's maternity leave including:
 - i. any voluntary arrangements that the employee may find helpful to help her keep in touch with developments at work and, nearer the time of her return, to help facilitate her return to work;
 - ii. keeping the employer in touch with any developments that may affect her intended date of return.

Work During the Maternity Leave Period**Keeping in Touch Days**

11. To facilitate the process of Keeping in Touch Days (KIT days) it is important that the employer and employee have early discussion to plan and make arrangements for KIT days before the employee's maternity leave takes place.
12. To enable employees to take up the opportunity to work KIT days employers should consider the scope for reimbursement of reasonable childcare costs or the provision of childcare facilities.
13. KIT days are intended to facilitate a smooth return to work for women returning from maternity leave.
14. An employee may work for up to a maximum of 10 KIT days without bringing her maternity leave to an end. Any days of work will not extend the maternity leave period.
15. An employee may not work during the two weeks of compulsory maternity leave immediately after the birth of her baby.
16. The work can be consecutive or not and can include training or other activities which enable the employee to keep in touch with the workplace.

17. Any such work must be by agreement and neither the employer nor the employee can insist upon it.
18. The employee will be paid at their basic daily rate, for the hours worked less appropriate maternity leave payment for KIT days worked.
19. Working for part of any day will count as one KIT day.
20. Any employee who is breastfeeding must be risk assessed and facilities provided in accordance with paragraph 34.

Paid Maternity Leave

Amount of Pay

21. Where an employee intends to return to work the amount of contractual maternity pay receivable is as follows:
 - (i) for the first eight weeks of absence, the employee will receive full pay, less any Statutory Maternity Pay or Maternity Allowance (including any dependants' allowances) receivable;
 - (ii) for the next 18 weeks, the employee will receive half of full pay plus any Statutory Maternity Pay or Maternity Allowance (including any dependants' allowances) receivable, providing the total receivable does not exceed full pay.
 - (iii) for the next 13 weeks, the employee will receive any Statutory Maternity Pay or Maternity Allowance that they are entitled to under the statutory scheme.
22. By prior agreement with the employer occupational maternity pay may be paid in a different way, for example a combination of full pay and half pay or a fixed amount spread equally over the maternity leave period.

Calculation of Maternity Pay

23. Full pay will be calculated using the average weekly earnings rules used for calculating Statutory Maternity Pay entitlements, subject to the following qualifications:
 - (i) in the event of a pay award or annual increment being implemented before the paid maternity leave period begins, the maternity pay should be calculated as though the pay award or annual increment had effect throughout the entire Statutory Maternity Pay calculation period. If such a pay award was agreed retrospectively, the maternity pay should be re-calculated on the same basis;
 - (ii) in the event of a pay award or annual increment being implemented during the paid maternity leave period, the maternity pay due from the date of the pay award or annual increment should be increased accordingly. If such a pay award was agreed retrospectively, the maternity pay should be re-calculated on the same basis;
 - (iii) in the case of an employee on unpaid sick absence or on sick absence attracting half pay during the whole or part of the period used for calculating

average weekly earnings in accordance with the earnings rules for Statutory Maternity Pay purposes, average weekly earnings for the period of sick absence shall be calculated on the basis of notional full sick pay.

Unpaid Contractual Leave

24. Employees are also entitled to take a further 13 weeks as unpaid leave to bring the total of leave to 52 weeks. However, this may be extended by local agreement in exceptional circumstances for example, where employees have sick pre-term babies or multiple births.

Commencement and Duration of Leave

25. An employee may begin her maternity leave at any time between eleven weeks before the expected week of childbirth and the expected week of childbirth provided she gives the required notice.

Sickness Prior to Childbirth

26. If an employee is off work ill, or becomes ill, with a pregnancy related illness during the last four weeks before the expected week of childbirth, maternity leave will normally commence at the beginning of the fourth week before the expected week of childbirth or the beginning of the next week after the employee last worked, whichever is the later. Absence prior to the last four weeks before the expected week of childbirth, supported by a medical statement of incapacity for work, or a self-certificate, shall be treated as sick leave in accordance with normal leave provisions.
27. Odd days of pregnancy related illness during this period may be disregarded if the employee wishes to continue working till the maternity leave start date previously notified to the employer.

Pre-term Birth

28. Where an employee's baby is born alive prematurely the employee will be entitled to the same amount of maternity leave and pay as if her baby was born at full term.
29. Where an employee's baby is born before the eleventh week before the expected week of childbirth and the employee has worked during the actual week of childbirth, maternity leave will start on the first day of the employee's absence.
30. Where an employee's baby is born before the eleventh week before the expected week of childbirth and the employee has been absent from work on certified sickness absence during the actual week of childbirth, maternity leave will start the day after the day of birth.
31. Where an employee's baby is born before the eleventh week before the expected week of childbirth and the baby is in hospital the employee may split her maternity leave entitlement, taking a minimum period of two weeks' leave immediately after childbirth and the rest of her leave following her baby's discharge from hospital.

Still Birth

32. Where an employee's baby is born dead after the 24th week of pregnancy the employee will be entitled to the same amount of maternity leave and pay as if her baby was born alive.

Miscarriage

33. Where an employee has a miscarriage before the 25th week of pregnancy normal sick leave provisions will apply as necessary.

Health and Safety of Employees Pre and Post Birth

34. Where an employee is pregnant, has recently given birth or is breastfeeding, the employer must carry out a risk assessment of her working conditions. If it is found, or a medical practitioner considers, that an employee or her child would be at risk were she to continue with her normal duties the employer should provide suitable alternative work for which the employee will receive her normal rate of pay. Where it is not reasonably practicable to offer suitable alternative work the employee should be suspended on full pay.
35. These provisions also apply to an employee who is breastfeeding if it is found that her normal duties would prevent her from successfully breastfeeding her child.

Return to Work

36. An employee who intends to return to work at the end of her full maternity leave will not be required to give any further notification to the employer, although if she wishes to return early she must give at least 28 days' notice.
37. An employee has the right to return to her job under her original contract and on no less favourable terms and conditions.

Returning on Flexible Working Arrangements

38. If at the end of maternity leave the employee wishes to return to work on different hours the HSC employer has a duty to facilitate this wherever possible, with the employee returning to work on different hours in the same job. If this is not possible the employer must provide written, objectively justifiable reasons for this and the employee should return to the same grade and work of a similar nature and status to that which they held prior to their maternity absence.
39. If it is agreed that the employee will return to work on a flexible basis, including changed or reduced hours, for an agreed temporary period this will not affect the employee's right to return to her job under her original contract at the end of the agreed period.

Sickness Following the End of Maternity Leave

40. In the event of illness following the date the employee was due to return to work normal sick leave provisions will apply as necessary.

Failure to Return to Work

41. If an employee who has notified her employer of her intention to return to work for the same or a different HSC employer in accordance with paragraph 7 (ii) (c) above fails to do so within 15 months of the beginning of her maternity leave she will be liable to refund the whole of her maternity pay, less any Statutory Maternity Pay, received. In cases where the employer considers that to enforce this provision would cause undue hardship or distress the employer will have the discretion to waive their rights to recovery.

Miscellaneous Provisions**Fixed – Term Contracts**

42. Employees subject to fixed-term contracts which expire after the eleventh week before the expected week of childbirth and who satisfy the conditions in paragraphs 7 (i), 7 (ii)(a), 7 (ii)(b) and 7 (ii) (d) shall have their contracts extended so as to allow them to receive the 52 weeks which includes paid contractual and statutory maternity pay and the remaining 13 weeks of unpaid maternity leave.
43. Absence on maternity leave (paid and unpaid) up to 52 weeks before a further HSC appointment shall not constitute a break in service.
44. If there is no right of return to be exercised because the contract would have ended if pregnancy and childbirth had not occurred the repayment provisions set out in paragraph 41 above will not apply.
45. Employees on fixed-term contracts who do not meet the twelve months continuous service condition set out in paragraph 7 (i) above may still be entitled to Statutory Maternity Pay.
46. Unallocated

Contractual rights

47. During maternity leave (both paid and unpaid) an employee retains all of her contractual rights except remuneration.

Increments

48. Maternity leave, whether paid or unpaid, shall count as service for annual increments and for the purposes of any service qualification period for additional annual leave.

Accrual of Annual Leave

49. Annual leave will continue to accrue during maternity leave, whether paid or unpaid, provided for by this agreement.
50. Where the amount of accrued annual leave would exceed normal carry over provisions, it may be mutually beneficial to both the employer and employee for the employee to take annual leave before and/or after the formal (paid and unpaid) maternity leave period. The amount of annual leave to be taken in this way, or carried over, should be discussed and agreed between the employee and employer.

Payment in lieu may be considered as an option where accrual of annual leave exceeds normal carry over provisions.

Pensions

51. Pension rights and contributions shall be dealt with in accordance with the provisions of the HPSS Superannuation Regulations.

Antenatal Care

52. Pregnant employees have the right to paid time off for antenatal care. Antenatal care includes relaxation and parent-craft classes as well as appointments for antenatal care.

Post-natal Care and Breastfeeding Mothers

53. Women who have recently given birth should have paid time off for post-natal care e.g. attendance at health clinics.
54. Employers are required to undertake a risk assessment and to provide breastfeeding women with suitable private rest facilities. The Health and Safety Executive Guidance recommends that employers provide:
 - o a clean, healthy and safe environment for women who are breastfeeding,
 - o suitable access to a private room to express and store milk in an appropriate refrigerator.

Employers are reminded that they should consider requests for flexible working arrangements to support breastfeeding women at work.

Employees Not Returning to HSC Employment

55. An employee who satisfies the conditions in paragraph 7, except that she does not intend to work with the same or another HSC employer for a minimum period of three months after her maternity leave is ended, will be entitled to pay equivalent to Statutory Maternity Pay, which is paid at 90% of her average weekly earnings for the first six weeks of her maternity leave and to a flat rate sum for the following 33 weeks.

Employees With Less Than Twelve Months Continuous Service

56. If an employee does not satisfy the conditions in paragraph 7 for occupational maternity pay she may be entitled to Statutory Maternity Pay. Statutory Maternity Pay will be paid regardless of whether she satisfies the conditions in paragraph 7.
57. If her earnings are too low for her to qualify for Statutory Maternity Pay, or she does not qualify for another reason, she should be advised to claim Maternity Allowance from her local Job Centre or Social Security Office.
58. All employees will have a right to take 52 weeks of maternity leave whether they return to HSC Employment or not.
59. Paragraph 65 contains further information on statutory maternity entitlements.

Continuous Service

60. For the purposes of calculating whether the employee meets the twelve months continuous service with one or more HSC employers qualification set out in paragraph 7 (i) the following provisions shall apply:
- (i) HSC employers include HSS Boards, HSC Trusts, Special Agencies and employment in the NHS;
 - (ii) a break in service of three months or less will be disregarded (though not count as service).
61. The following breaks in service will also be disregarded (though not count as service);
- (i) employment under the terms of an honorary contract;
 - (ii) employment as a locum with a general practitioner for a period not exceeding twelve months;
 - (iii) a period of up to twelve months spent abroad as part of a definite programme of postgraduate training on the advice of the Postgraduate Dean or College or Faculty Advisor in the speciality concerned;
 - (iv) a period of voluntary service overseas with a recognised international relief organisation for a period of twelve months which may exceptionally be extended for twelve months at the discretion of the employer which recruits the employee on her return;
 - (v) absence on a employment break scheme in accordance with the provisions of Schedule 25;
 - (vi) absence on maternity leave (paid or unpaid) as provided for under this agreement.
62. Employers may at their discretion extend the period specified in paragraphs 60 (ii) and 61.
63. Employment as a trainee with a General Medical Practitioner in accordance with the provisions of the Trainee Practitioner Scheme shall similarly be disregarded and count as service.
64. Employers have the discretion to count other previous HSC service or service with other employers.

Information about Statutory Maternity/Adoption and Paternity Maternity Leave and Pay

65. There are occasions when employees are entitled to other statutory benefits/allowances and Information about all statutory maternity/adoption and paternity rights can be found using the following links:

<http://www.dti.gov.uk/employment/workandfamilies/maternityleave-pay/guidance/page21116.html>

http://www.dwp.gov.uk/lifeevent/benefits/statutory_maternitypay.asp

http://jobcentreplus.gov.uk/JCP/Customers/WorkingAgeBenefits/Dev_008115.xml.html

Information about Health and Safety for new and expectant mothers at work can be found using the following link:-

www.hse.gov.uk

SCHEDULE 25**Employment break scheme (temporary schedule)****General**

1. HSC employers should provide all staff with access to an employment break scheme.
2. The scheme should be agreed between employers and local staff representatives.
3. The scheme should be viewed with others, particularly those relating to flexible working, balancing work and personal life, and provisions for carers, as part of the commitment to arrangements which enable employees to balance paid work with their other commitments and responsibilities.
4. The scheme should also enable employers to attract and retain the experience of staff consistent with the HSC commitment to the provision of high quality healthcare.
5. The scheme should provide for people to take a longer period away from work than that provided for by the parental leave and other leave arrangements.

Scope

6. The scheme should explicitly cover the main reasons for which employment breaks can be used, including childcare, eldercare, care for another dependant, training, study leave or work abroad. It should also indicate that other reasons will be considered on their merits.
7. People on employment breaks will not normally be allowed to take up paid employment with another employer except where, for example, work overseas or charitable work could broaden experience. In such circumstances written authority from the employer would be necessary.

Eligibility

8. The employment break scheme should normally be open to all employees who have a minimum of twelve months' service.
9. Applications should be submitted in writing and notice periods should be clearly stated in an agreement between the employee and employer.

Length of break

10. The maximum length of break should be five years.
11. Breaks should be able to be taken either as a single period or as more than one period.
12. The minimum length of break should be three months.
13. The length of any break should balance the needs of the applicant with the needs of the service.
14. The scheme should have provision for breaks to be extended with appropriate notice, or for early return from breaks.

15. All breaks should be subject to an agreement between the employer and applicant before the break begins. The agreement should cover:
- the effect of the break on various entitlements related to length of service;
 - a guarantee that, if the applicant returns to work within one year, the same job will be available, as far as is reasonably practicable;
 - if the break is longer than one year, the applicant may return to as similar a job as possible;
 - return to work at the equivalent salary level, reflecting increases awarded during the break;
 - the notice period required before the return to work should be two months if the break is less than a year and six months if the break is more than a year;
 - arrangements for keeping in touch during the break;
 - requirements on the applicant to keep up to date with their relevant professional registration needs, including attendance at specified training courses and conferences, and any assistance the employer may give in the support of this;
 - training arrangements for re-induction to work;
 - any other conditions required either by the employer or the applicant.

Return to work

16. Applicants should not have to resign to take an employment break, although there will be a change to the contract of employment.
17. The period of the break should count toward continuous employment for statutory purposes.
18. Other provisions depending upon length of service, i.e. pensions, contractual redundancy payments, leave entitlements etc, should be suspended for the period of the break.

Appeals

19. Applicants should be entitled to a written reason for the refusal of any application.
20. Applicants may resort to the grievance procedure if a request for a break is refused.

Monitoring and review

21. All records of applications and decisions should be kept for a minimum of twelve months.

22. The operation of the scheme should be monitored annually by employers in partnership with local staff representatives. This will include consideration of diversity data³

SCHEDULE 26

Caring for Children and Adults (Temporary Schedule)

General

1. All HSC employers must have a carer's policy to address the needs of people with caring responsibilities and to meet the requirements of the "right to request" flexible working legislation for carers of children and dependant adults (see Employment Relations (NI) Order 1999 for definition of "carer"). This policy should emphasise the benefits of employment breaks, flexible working arrangements and balancing work and personal life as set out in Schedules 25, 27 and 28.
2. The policy should seek to balance the requirements of delivering a first class service with the needs of employees, to find the most effective means of supporting those with carer responsibilities as part of a wider commitment by the HSC to improve the quality of working life.
3. Many of the policies related to child and dependant care will have relevance to other forms of care. For example the planning process for checking out what would help eligibility criteria and ensuring equality of access. These should be considered when drawing up a carers policy.

Child and Dependant Care

4. Childcare covers a range of care choices for children from birth up to age 14 years.
5. Dependant care covers a range of options to meet the needs of dependant adults, including the needs of dependant young people over the age of 14, where an employee is involved in substantial and regular care sufficient for them to seek a change in their permanent contract of employment.⁴
6. The policy should be drawn up jointly between employers and local staff side representatives. This should cover:
 - the child and dependant care needs of people relative to matters such as place of work, working patterns (including shift patterns) and hours worked;
 - policy on child and dependant care support particularly related to specific difficulties in recruiting and retaining people in certain job categories;
 - equality of access to child and dependant care and affordability, respecting the diversity of personal domestic circumstances;
 - guidelines on eligibility;
 - how the policy relates to other Schedules, in particular those covering leave and flexible working arrangements;

- the range of options open to carers, i.e. crèche facilities, childminders, workplace nurseries, allowances, school and holiday play schemes, term-time contracts etc. The policy should be clear as to why certain options are available;
 - partnership options with other employers and trade unions;
 - allocation of senior management responsibility for the operation and monitoring of the policy.
7. Where a decision is taken not to offer particular forms of support, the policy should indicate where other arrangements are available to help people with caring responsibilities, and what alternative ways of working exist.⁵
 8. Applications and outcomes should be monitored annually, in partnership with local staff representatives.
 9. Monitoring information should be analysed and used to review and revise policies and procedures to ensure their continuing effectiveness.
 10. Applications and outcomes, from both employer and employees should be recorded and kept for a minimum of one year.

SCHEDULE 27

Flexible Working Arrangements

General

1. HSC employers in partnership with staff organisations will develop positive flexible working arrangements which allow people to balance work responsibilities with other aspects of their lives.
2. Employers are required to consider flexible working options as part of their duty to make reasonable adjustments for disabled staff, staff with dependants and job applicants applications under the Disability Discrimination (NI) Order 2006 and staff who are returning from maternity leave (see Schedule 24).⁶
3. New working arrangements should only be introduced by mutual agreement, whether sought by the employee or the employer.
4. Flexible working should be part of an integrated approach to the organisation of work and the healthy work/life balance of staff.
5. Policies for flexible working should be made clear to all employees.
6. Employers should develop policies on flexible working which, as far as is practicable, should include:
 - part-time working, where a person works to a pattern and number of hours by mutual agreement;
 - job sharing, where two or more people share the responsibilities of one or more full-time job(s), dividing the hours, duties and pay between them;
 - flexi-time, where employees can choose their own start and finish time around fixed core hours;
 - annual hours contracts, where people work a specific number of hours each year, with the hours being unevenly distributed throughout the year;
 - flexible rostering, using periods of work of differing lengths within an agreed overall period;
 - term-time working, where people work during the school term but not during school holidays;
 - school-time contracts;
 - teleworking, where people work from home for all or part of their hours with a computer or telecommunication link to their organisation;
 - voluntary reduced working time, where people work reduced hours by agreement at a reduced salary;
 - fixed work patterns, where, by agreement, days off can be irregular to enable, for example, access by separated parents to their children and flexible rostering.
 - Flexible retirement
7. Flexible working arrangements should be available to all employees.

8. All jobs should be considered for flexible working. If this is not possible the employer must provide written, objectively justifiable reasons for this and give a clear, demonstrable operational reason why this is not practicable.
9. There should be a clear procedure for application for flexible working, agreed by employers and local staff representatives.
10. All people with flexible working arrangements should have access to standard terms and conditions of employment, on an equal or pro-rata basis, unless different treatment can be justified for operational reasons.

Monitoring and Review

11. Applications and outcomes should be monitored annually, in partnership with local staff representatives.
12. Monitoring information should be analysed and used to review and revise policies and procedures to ensure their continuing effectiveness.
13. Applications and outcomes, from both employer and employees, should be recorded and kept for a minimum of one year.

SCHEDULE 28**Balancing Work and Personal Life****General**

1. HSC employers should provide employees with access to leave arrangements which support them in balancing their work responsibilities with their personal commitments.
2. Leave arrangements should be part of an integrated policy of efficient and employee friendly employment practices, and this Schedule should be seen as operating in conjunction with other provisions particularly the Employment Break Scheme, Flexible Working Arrangements and the Caring for Children and Adults Schedules.
3. Arrangements should be agreed between employers and local staff representatives.
4. A dependant is someone who is married to, or is a partner or civil partner, "a near relative" or someone who lives at the same address as the employee. A relative for this purpose includes: parents, parents-in-law, adult children, adopted adult children, siblings (including those who are in-laws), uncles, aunts, grandparents and step relatives or is someone who relies on the employee in a particular emergency.

FORMS OF LEAVE

Parental Leave

5. This should be a separate provision from either maternity or maternity support leave and should provide a non-transferable individual right to at least 18 weeks' leave.⁷ Leave is normally unpaid, but may be paid by local agreement.
6. Parental leave should be applicable to any employee in the HSC who has nominated caring responsibility for a child under age 14 (18 in cases of adoption or disabled children).
7. Leave arrangements need to be as flexible as possible, so that the leave may be taken in a variety of ways by local agreement. Parental leave can be added to periods of maternity support or maternity leave.
8. Notice periods should not be unnecessarily lengthy and should reflect the period of leave required. Employers should only postpone leave in exceptional circumstances and give written reasons. Employees may also postpone or cancel leave that has been booked with local agreement.
9. During parental leave the employee retains all of his or her contractual rights, except remuneration and should return to the same job after it. Pension rights and contributions shall be dealt with in accordance with HPSS Superannuation Regulations. Periods of parental leave should be regarded as continuous service.
10. It is good practice for employers to maintain contact (within agreed protocols) with employees while they are on parental leave.

Maternity support (Paternity) Leave and Pay and Ante-Natal Leave

11. This will apply to the father of the child (including adoptive fathers), the mother's husband or partner (whether opposite or same sex), or nominated carer.
12. HSC organisations have scope for agreeing locally more favourable arrangements where they consider it necessary, or further periods of unpaid leave.

Maternity support (paternity) leave

13. All employees are entitled to two weeks' of ordinary maternity support (paternity) leave which can be taken around the time of the birth or the placement of the child for adoption.
14. In addition, employees may be entitled to take up to twenty six weeks of additional maternity support (paternity) leave if their partner has returned to work, the leave can be taken between 20 weeks and one year after the child is born or placed for adoption.
15. To qualify for additional maternity support (paternity) leave the employee and their partner must first meet certain qualification criteria. Details of the qualifying conditions and the notification requirements can be found at <http://www.nidirect.gov.uk/index/information-and-services/employment.htm>

Occupational pay during maternity support (paternity) leave

16. There will be an entitlement to two weeks' occupational ordinary maternity support (paternity) pay. Full pay will be calculated on the basis of the average weekly earnings rules used for calculating occupational maternity pay entitlements. The employee will receive full pay less any statutory paternity pay receivable. Only one period of occupational maternity support (paternity) pay is ordinarily available when there is a multiple birth.
17. Eligibility for the two weeks of occupational maternity support (paternity) pay will be 12 months' continuous service with one or more HSC employer at the beginning of the week in which the baby is due.
18. Employees who are not eligible for the two weeks of occupational maternity support (paternity) pay may still be entitled to statutory paternity pay subject to meeting the qualifying conditions. Details of the qualifying conditions can be found at <http://www.nidirect.gov.uk/index/information-and-services/employment.htm>

Statutory pay during maternity support (paternity) leave

19. To qualify for statutory pay in the additional maternity support (paternity) leave period, the employee and their partner must first meet certain qualifying conditions. Details of the criteria and the notification requirements can be found at <http://www.nidirect.gov.uk/index/information-and-services/employment.htm>

Rights during additional maternity support (paternity) leave

20. Employees who are entitled to additional maternity support (paternity) leave/pay will be entitled to take up to 10 keeping in touch days during the course of the additional maternity support (paternity) leave period. The criteria for keeping in touch days is set out in Schedule 24 and is based on those used for statutory maternity leave and pay.
21. Employees who have taken additional maternity support (paternity) leave will have the right to return to the same job under their original contract and on no less favourable terms and conditions.

Ante-natal leave

22. Reasonable paid time off to attend ante-natal classes will also be given⁸.

Adoption Leave and Pay

- 23⁹. All employees are entitled to take 52 weeks adoption leave.
24. There will be entitlement to paid occupational adoption leave for employees wishing to adopt a child who is newly placed for adoption.
25. It will be available to people wishing to adopt a child who has primary carer responsibilities for that child.
26. Where the child is below the age of 18 adoption leave and pay will be in line with the maternity leave and pay provisions as set out in this agreement.
27. Eligibility for occupational adoption pay will be twelve months' continuous HSC service ending with the week in which they are notified of being matched with the child for adoption. This will cover the circumstances where employees are newly matched with the child by an adoption agency.
28. If there is an established relationship with the child, such as fostering prior to the adoption, or when a step-parent is adopting a partner's children there is scope for local arrangements on the amount of leave and pay in addition to time off for official meetings.
29. If the same employer employs both parents the period of leave and pay may be shared. One parent should be identified as the primary carer and be entitled to the majority of the leave. The partner of the primary carer is entitled to occupational paternity leave and pay.
30. Reasonable time off to attend official meetings in the adoption process should also be given.
31. Employees who are not eligible for occupational adoption pay, may still be entitled to Statutory Adoption Pay (SAP) subject to the qualifying conditions. The rate of SAP is the same as for Statutory Maternity Pay.

Keeping in Touch**Work during the Adoption Leave Period****Keeping in Touch Days**

32. Employees will be entitled to Keep in Touch Days (KIT) in line with the maternity leave and pay provisions as set out in Schedule 24.

Leave/Time Off for Domestic Reasons

33. This form of leave should cover a range of needs, from genuine domestic emergencies through to bereavement.
34. These provisions should cover all employees.
35. Payment may be made by local agreement, but the expectation is that relatively short periods of leave for emergencies will be paid.
36. If the need for time off continues, other options may be considered, such as a career break.
37. Applicants for the above forms of leave should be entitled to a written explanation if the application is declined.
38. Appeals against decisions to decline an application for leave should be made through the Grievance Procedure.

Monitoring and Review

39. All applications and outcomes should be recorded, and each leave provision should be annually reviewed by employers in partnership with local staff representatives.
40. Applications and outcomes should be monitored annually, in partnership with local staff representatives.
41. Monitoring information should be analysed and used to review and revise policies and procedures to ensure their continuing effectiveness.
42. Applications and outcomes, from both employer and employees should be recorded and kept for a minimum of one year.

SCHEDULE 29**Redundancy Pay (Temporary Schedule)**

1. This section sets out the arrangements for redundancy pay for employees dismissed by reason of redundancy who, at the date of termination of their contract, have at least 104 weeks of continuous full-time or part-time service. These take effect from 1 October 2006. It also sets out the arrangements for early retirement on grounds of redundancy and in the interests of the service for those who are members of the HPSS Superannuation Scheme and have at least two years continuous full-time or part-time service and two years qualifying membership in the Scheme. Pension changes take effect from 1 December 2006¹⁰.

Definition of Redundancy

2. The Employment Rights (Northern Ireland) Order 1996 Article 174 states that redundancy arises when employees are dismissed in the following circumstances:
 - “where the employer has ceased, or intends to cease, to carry on the business for the purposes of which the employee was employed; or where the employer has ceased, or intends to cease, to carry on the business in the place where the employee was so employed; or
 - where the requirements of the business for employees to carry out work of a particular kind, in place where they were so employed, have ceased or diminished or are expected to cease or diminish”.

Qualification for a Redundancy Payment

3. To qualify for a redundancy payment, the member of staff must be an employee, working under a contract of employment for a HSC employer. ‘HSC employer’ means HSS Boards, HSC Trusts, Special Agencies and employment in the NHS. Non executive directors of HSC organisations do not qualify. Contracts of employment may be written or verbal, and can be for a fixed period or be continuous. In law, employees have a contract as soon as they start work and in accepting and undertaking the work required they accept the terms and conditions offered by the employer. To qualify for a redundancy payment the employee must also have at least 104 weeks of continuous full-time or part-time service.

Definition of Continuous Service

4. “Continuous service” means full-time or part-time employment with the present or any previous HSC employer. If with more than one HSC employer, there must not have been a break of more than a week (measured Sunday to Saturday) between employments.

Definition of Reckonable Service

5. “Reckonable service” for the purposes of a HSC redundancy payment, which is calculated on the basis of the service up to the date of termination of the contract, means continuous full-time or part-time employment with the present or any previous HSC employer but with the following additions:
- where there has been a break in service of 12 months or less the period of employment prior to the break will count as reckonable service;
 - periods of employment as a trainee with a general medical practitioner in accordance with the provisions of the Trainee Practitioner Scheme will count as reckonable service;
 - at employer discretion, any period or periods of employment with employers outside the HSC where these are judged to be relevant to HSC employment can be included in reckonable service.
6. The following employment will not count as reckonable service:
- employment that has been taken into account for the purposes of a previous redundancy, or loss of office payment by a HSC employer;
 - where the employee has previously been given pension benefits, any employment that has been taken into account for the purposes of those pension benefits.

Definition of a Month’s Pay

7. “Month’s pay” means whichever is the more beneficial of the following calculations:
- 4.35 times a week’s pay calculated in accordance with the provisions of Sections 17 to 25 of the Employment Rights (Northern Ireland) Order 1996;
 - an amount equal to 1/12th of the annual salary in payment at the date of termination of employment.

Calculation of Redundancy Payment

8. The redundancy payment will take the form of a lump sum, dependent on the employee’s reckonable service at the date of termination of employment. The lump sum will be calculated on the basis of one month’s pay for each complete year of reckonable service subject to a minimum of two years (104 weeks) continuous service and a maximum of 24 year’s reckonable service being counted.
9. Fractions of a year of reckonable service will not be taken into account.

Early Retirement on Grounds of Redundancy for Employees entitled top pension benefits**Qualification Criteria**

10. Members of the HPSS Superannuation Scheme who are made redundant and meet the conditions set out above in paragraphs 3 to 6, may choose to retire early without reduction in the value of pension benefits as an alternative to receiving the full lump sum benefit set out in paragraph 8. To qualify for early retirement the member of staff must:

- be a member of the HPSS Superannuation Scheme;
- have at least two years' continuous service and two years' qualifying membership;
- have reached the minimum pension age. The Finance Act 2004 allows for protection of a minimum pension age of 50 for members who had the right to take reduced benefits at that age on 5 April 2006. This protection may continue as long as members retiring early after 6 April 2010 take all their benefits payable under scheme rules. In the HPSS Superannuation Scheme, for those without this protection, members who first joined and some who returned to the scheme after 6 April 2006, minimum pension age will change from 50 to 55 from 6 April 2010.^{§₁₁₎}

Definition of Qualifying Membership

11. 'Qualifying membership' is membership that counts towards entitlement for benefits. Pensionable membership is membership that counts when benefits are calculated. This may be different from reckonable service for the purposes of a redundancy payment as it can include pensionable service from previous periods of employment with the HSC or another employer and periods of part-time working.

Use of Redundancy Payment to pay for Early Retirement

12. If the redundant member of staff chooses to take early retirement with an unreduced pension under these arrangements, they will receive immediately the full value of their qualifying pension benefits at the point of redundancy without the actuarial reduction that would occur with voluntary early retirement. Their employer will pay the relevant HPSS Superannuation Scheme a sum equivalent to the capitalised cost of paying the pension and lump sum early; either as one payment or in five instalments.**
13. This sum will be paid from the lump sum redundancy payment that otherwise would have been paid to the employee. If the cost to the employer of paying by single payment for early retirement is less than the value of the redundancy payment that the member would have received under paragraph 8 then the redundant employee will also receive from the employer a redundancy payment equivalent to the difference between the two sums. The cost to the employer would therefore normally be the same as if the employee had chosen to take a redundancy payment without unreduced early retirement. However, if the cost of early retirement is more than the redundancy payment due, the employer will pay the additional cost. If the employer chooses to pay in five instalments, the employer is responsible for the additional interest charge.

¹¹

** It is open to qualifying members to take early retirement under the normal scheme arrangements for voluntary early retirement or normal age retirement.

Treatment of Concurrent Pensionable Employment

14. Where there is concurrent pensionable employment, members may choose between:
- ceasing all pensionable employment and taking early retirement on the terms set out below in respect of each employment in which case they cannot be pensionable again in the current scheme (normal pension age of 60). (An employment may continue if it is not more than 16 hours a week, without affecting the payment of enhanced benefits, but it will not be pensionable in the scheme); and
 - taking benefits only in respect of the employment that is being terminated, in which case they can continue being pensionable in other employments. After 6 April 2010, this will not apply if taking benefits under the age of 55.¹²
15. Members with concurrent practitioner and non-practitioner employments, who choose to cease all pensionable employments, will receive only their non-practitioner benefits on redundancy grounds. Where appropriate, benefits for practitioner membership may be taken on an early retirement basis with an actuarial reduction or preserved for payment at age 60.^{††}
16. The employer who authorises early retirement will be responsible for the pension costs accruing from other terminating employment. If a member returns to work after taking their pension, their pension will be abated, if the combined value of their pension and salary is greater than they earned prior to retirement. This will continue until they reach their normal pension age.

Exclusion from eligibility

17. Employees shall not be entitled to redundancy payments or early retirement on grounds of redundancy if:
- they are dismissed for reasons of misconduct, with or without notice; or
 - at the date of the termination of the contract have obtained without a break, or with a break not exceeding four weeks, suitable alternative employment with the same or another HSC employer; or
 - unreasonably refuse to accept or apply for suitable alternative employment with the same or another HSC employer; or
 - leave their employment before expiry of notice, except if they are being released early (see paragraphs 20 to 21 below); or

^{††} Where practitioner membership ended 12 months or more before the date of non-practitioner retirement on redundancy, and all other posts have ceased, practitioner benefits will be paid at the same time as the redundancy benefits and associated pension costs will be met by the HSC employer authorising retirement.

[‡] Practitioners are general medical and general dental practitioners.

- are offered a renewal of contract (with the substitution of the new employer for the previous HSC one);
- where their employment is transferred to another public service employer who is not a HSC employer.

Suitable alternative employment

18. Employers have a responsibility before making a member of staff redundant or agreeing early retirement on grounds of redundancy to seek suitable alternative employment for that person, either in their own organisation or through arrangements with another HSC employer. Employers should avoid the loss of staff through redundancy wherever possible to retain valuable skills and experience where appropriate within the local health economy.
19. 'Suitable alternative employment', for the purposes of paragraph 17, should be determined by reference to Articles 173 and 176 of the Employment Rights (Northern Ireland) Order 1996. In considering whether a post is suitable alternative employment, regard should be had to the personal circumstances of the employee. Employees will, however, be expected to show some flexibility.
20. For the purposes of this scheme any suitable alternative employment must be brought to the employee's notice in writing or by electronic means agreed with the employee before the date of termination of contract and with reasonable time for the employee to consider it. The employment should be available not later than four weeks from that date. Where this is done, but the employee fails to make any necessary application, the employee shall be deemed to have refused suitable alternative employment. Where an employee accepts suitable alternative employment the 'trial period' provisions in Article 173(3) of the Employment Rights (Northern Ireland) Order 1996 will apply.

Early release of redundant employees

21. Employees who have been notified of the termination of their employment on grounds of redundancy, and for whom no suitable alternative employment in the HSC is available, may, during the period of notice, obtain other employment outside the HSC.
22. If they wish to take this up before the period of notice of redundancy expires the employer will, unless there are compelling reasons to the contrary, release such employees at their request on a mutually agreeable date. That date will become the revised date of redundancy for the purpose of calculating any entitlement to a redundancy payment under this agreement.

Claim for redundancy payment

23. Claims for redundancy payment or retirement on grounds of redundancy must be submitted within six months of date of termination of employment. Before payment is made the employee will certify that:

- they had not obtained, been offered or unreasonably refused to apply for or accept suitable alternative Health Service employment within four weeks of the termination date;
- they understand that payment is made only on this condition and undertake to refund it if this condition is not satisfied.

Retrospective Pay Awards

24. If a retrospective pay award is notified after the date of termination of employment then the redundancy payment and/or pension will be recalculated, and any arrears due paid.

Disputes

25. An employee who disagrees with the employer's calculation of the amount of redundancy payment or the rejection of a claim for redundancy payment should make representations to the employer via local grievance procedures. See also paragraph 22 about making a claim for a redundancy payment.

Early Retirement in the Interests of the Efficiency of the Service

26. Members of the HPSS Superannuation Scheme will receive payment of benefits without reduction if they retire early in the interests of the efficiency of the service, and they satisfy the qualifying conditions set out in paragraph 10. Retiring early in the interests of the service is a flexibility available at employer discretion. In these cases, no redundancy payment is due. In agreeing to retirement in the interests of the service, the employer undertakes to pay the costs of paying the pension and lump sum early. Employers will need to ensure that they exercise this discretion appropriately and will be conscious of the implications of any potential discrimination on grounds of age, gender, gender identity or gender expression, pregnancy or maternity, marriage or civil partnership, race, religion or belief, disability, or sexual orientation¹³
27. These arrangements are aimed at employees who have give valuable HSC service in the past but are no longer capable of doing so. This might be because of new or expanded duties or a decline in the ability to perform existing duties efficiently but not so as to qualify them for ill health retirement. Employers would be expected to consider alternatives before agreeing to early retirement, including reasonable adjustments to an existing role or potential suitable alternatives¹⁴
28. The relevant HPSS Superannuation Scheme certifies the grounds on which early retirement is taking place. The scheme does so, on the basis of the information provided by the employer. In each case, therefore, an appropriate senior manager should authorise the early retirement, ensuring that the relevant criteria have been met.

Employer Responsibilities

29. Employer contributions to the HPSS Superannuation Scheme do not cover the costs of early retirement benefits. There is a requirement for HSC employers to pay these

costs if they retire staff early on grounds of redundancy or in the interests of the service¹⁵.

**CONSULTANT TERMS AND CONDITIONS OF SERVICE
(NORTHERN IRELAND) 2004
*(May 2008 issue)***

Record of Amendments

Amendments to this handbook will normally be notified in the form of replacement pages attached to a Circular. Revised material will be indicated by a vertical marginal line. Please make amendments immediately they are received and keep the following record of amendments up to date.

Amendment number	Circular number	Date inserted
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		

Amendment number	Circular number	Date inserted
21		
22		
23		
24		
25		
26		
27		
28		
29		
30		
31		
32		
33		
34		
35		
36		
34		
38		
39		
40		

HEALTH AND PERSONAL SOCIAL SERVICES

**HOSPITAL MEDICAL AND DENTAL STAFF AND DOCTORS IN PUBLIC
HEALTH MEDICINE AND THE COMMUNITY HEALTH SERVICE
(NORTHERN IRELAND)**

TERMS AND CONDITIONS OF SERVICE

Department of Health, Social Services and Public Safety

Version 1	October 2006
Version 2	June 2008

**HOSPITAL MEDICAL AND DENTAL STAFF AND DOCTORS IN PUBLIC HEALTH
MEDICINE AND THE COMMUNITY HEALTH SERVICE (NORTHERN IRELAND)****TERMS AND CONDITIONS OF SERVICE****CONTENTS**

Subject	Paragraphs
Introduction	i-x
Rates of Pay	1-2
Appointments to, and tenure of, Posts	3-12
Basis of Contract	13-28
Contractual Duties of Practitioners	30-38
Payment of Fees: Doctors in Public Health Medicine and the Community Health Service	39
Private Practice	40-43
Clinical and Senior Clinical Medical Officers: Additional Work	44
Medical Superintendents and Deputy Medical Superintendents	49
Chief Officers of Health Authorities	50-51
Part-time Appointments	61-69
Job-Sharing	70
Multiple Appointments	71-76
Non-HPSS Employment	77
Teaching and Research	78-86
General Practitioner Hospital Units	87-93
Appointments held only by Part-time Practitioners	94-105
Arrangements for cover during absences and Locum Tenens	106-110
Locum Practitioners: Basis of Contract	111
Acting-up Allowances	112
Remuneration of Locum Practitioners	113-116
Application of the Terms and Conditions of Service to Locum Practitioners	117
Registration of Locum Practitioners	118
Starting Salaries and Incremental Dates	121
Counting of Previous Service	122-125
Increments on First Appointment to a Grade	126-131
Protection	132
Promotion Increase	133
Hard to Fill Consultant Posts	134
Interpretation of Paragraphs 121 to 134	135-136
Domiciliary Consultations	140-149
Exceptional Consultations	155-157
Lecture Fees	165-166
Charges for Residence	173-182
Medical Examination on Appointment	186-188
Disciplinary Procedures	189
Termination of Employment	190-198
Retiring Age	200-201
Annual Leave	205-217
Sick Leave	225-244
Study Leave	250-254
Special Leave	260-262
Expenses – General Provisions	275-276

Subject	Paragraphs
Travelling Expenses and Mileage Allowances	277-303
Crown Cars	304-308
Other Expenses	311-313
Removal Expenses	314-315
Miscellaneous	330-342
Application	343-344
SUPPLEMENT	Terms and conditions of service for doctors undertaking sessional work in the community health service, providing medical services to social services departments, medical examinations of prospective health service employees and notification of infectious diseases and food poisoning
APPENDIX I	See latest pay circular that deals with pay and conditions of service.
APPENDIX II	Applications of General Whitley Council Agreements.
APPENDIX III	Application of General Whitley Council Agreements by Subject Matter.
APPENDIX IV	See latest pay circular that deals with fees and allowances for sessional work.
APPENDIX V	Index to examples of Category 1 and Category 2 work
APPENDIX VI	(Temporary Insertion) Maternity Leave and Pay
APPENDIX VII	(Temporary Insertion) Employment Break Scheme
APPENDIX VIII	(Temporary Insertion) Caring for Children and Adults
APPENDIX IX	(Temporary Insertion) Flexible Working Arrangements
APPENDIX X	(Temporary Insertion) Balancing Work and Personal Life
APPENDIX XI	(Temporary Insertion) Redundancy Pay
INDEX	Index to terms and Conditions by subject Matter
RECORD OF AMENDMENTS	Record of Amendments Incorporated

INTRODUCTION

- i. This handbook sets out the terms and conditions of service of hospital medical and dental staff and doctors in public health medicine and the community health service in Northern Ireland. It supersedes the handbook issued in 2003 and incorporates all amendments agreed between the Department and the medical and dental professions as at 1 December 2005.
- ii. The terms and conditions of service set out in this handbook have been determined by the Department under paragraph 12 of Part II of Schedule 1 to the Health and Personal Social Services (Northern Ireland) Order 1972 (S.I. 1972/1265 (N.I.14)).
- iii. The terms and conditions of service set out in this handbook shall incorporate, and be read subject to, any amendments which are from time to time the subject of negotiation by appropriate negotiating bodies and are determined by the Department after considering the results of such negotiations. The record of amendments, at the back of this handbook, should be kept up-to-date.
- iv. The approved provisions of this handbook are the terms and conditions determined from time to time for the purposes of the contracts of hospitals medical and dental staff and doctors in public health medicine and the community health service and have been so determined by the Department for the purpose of those contracts requiring Departmental determination. The fees and allowances set out in Appendix IV do not form part of these terms and conditions of service, and are included solely for the convenience of users.
- v. Where reference is made in these terms and conditions of service to the Department, this shall be taken to mean the Department of Health, Social Services and Public Safety for Northern Ireland.
- vi. The term “clinical” should be taken to include hospital medical and dental work and work in public health medicine and the community health service.
- vii. This handbook should be read in conjunction with the General Council Terms and Conditions of Service Handbook. Those sections of the General Council Conditions of Service which apply to medical and dental staff are listed in Appendices II and III to this handbook.
- viii. The following abbreviations for grades have been used:

SHMO/SHDO:	Senior hospital medical/dental officer
AS:	Associate Specialist
SG:	Staff Grade
SCMO:	Senior Clinical Medical Officer
CMO:	Clinical Medical Officer
SpR:	Specialist Registrar
StR:	Specialty Registrar
StR(FT):	Specialty Registrar (Fixed Term)
SHO:	Senior House Officer
FHO2:	Foundation House Officer (Post-Registration)
FHO1:	Foundation House Officer (Pre-Registration)
LAT:	Locum Appointment for Training
LAS:	Locum Appointment for Service (HPSS appointments)
HO:	House Officer
PRHO:	Pre-Registration House Officer

- ix. All provisions apply to both medical and dental staff, except where the text specifically indicates the contrary.

- x. The term “regular appointment” excludes “locum appointment”.
- xi. The term “training grades” is used as an inclusive term for doctors in the grades of SpR, StR, StR(FT), SHO, PRHO, HO, FHO1 and FHO2 including locums for training.

RATES OF PAY

1.
 - a. Practitioners shall be paid at the rates set out in Appendix I.
 - b. Consultants who have reached the maximum of the salary scale shall be paid discretionary points where the employing authority has agreed at the rates given in Appendix I.
 - c. Distinction awards shall be payable where these have been recommended for an individual consultant by the Distinction and Meritorious Service Awards Committee, at the rates given in Appendix I. The detailed provisions governing criteria for granting awards, the process for deciding them, and the review of awards, together with other information about the distinction awards scheme and how it operates, are set out in the *Guide to the HPSS Consultants Distinction Awards Scheme* published annually by the Distinction and Meritorious Service Awards Committee.
 - d. *With effect from 1 April 2005, discretionary points and distinction awards have been replaced with a new Clinical Excellence Awards Scheme. Guidance on the operation of the new scheme is available on the Clinical Excellence Awards website at: <http://www.dhsspsni.gov.uk/clinicaexcellence>.*
 - e. Associate specialists who have reached the maximum of the salary scale shall be paid Discretionary Points where the employing authority has agreed, at the rates given in Appendix I.
 - f. Staff Grade practitioners who have reached the maximum point possible on the incremental salary scale shall be paid optional points where the employing authority has agreed, at the rates given in Appendix I.
2. Payments relating to sessional employment and item of service fees in the community health service are set out in the supplement to these terms and conditions of service.

APPOINTMENT TO, AND TENURE OF, POSTS**Consultant**

3. Consultants holding medical posts must be fully registered medical practitioners: consultants holding dental posts must be registered dental practitioners or fully registered medical practitioners.

Closed Grades

4.
 - a. Entry to the career grades of Senior Hospital Medical and Dental Officer is closed.
 - b. Entry to the career grades of Clinical and Senior Clinical Medical Officer is closed. The terms of service of these practitioners are, unless otherwise specified, those of Associate Specialists (or, in the case of practitioners who do not fulfil the conditions of paragraphs 5.a - d below, those of Staff Grade practitioners).
 - c. Entry to the grades of PRHO and HO are closed for medical practitioners. Entry to the grade of SpR is closed from 31 December 2006.
 - d. From 31 July 2007 entry to the grade of SHO is closed.

Associate Specialist

5.
 - a. A medical practitioner appointed to the AS grade should have served for a minimum of four years in the staff grade or a training grade higher than SHO, and/or in the clinical and/or senior clinical medical officer grades, at least two of which have been in the appropriate specialty. Equivalent service is also acceptable, with the agreement of the relevant specialty adviser of the Northern Ireland Council for Postgraduate Medical and Dental Education;
 - b. The practitioner should have completed 10 years medical work (either a continuous period or in aggregate) since obtaining a primary medical qualification that is (or would at the time have been) acceptable by the GMC for full, limited or temporary (but not provisional) registration. Placement on the overseas list will not by itself count towards the qualifying period.
 - c. A dental practitioner appointed to the AS grade should have served for a minimum of four years in the registrar or staff grade, at least two of which have been in the appropriate specialty. Equivalent service is also acceptable, with the agreement of the relevant specialty adviser of the Northern Ireland Council for Postgraduate Medical and Dental Education;
 - d. The practitioner should have completed 10 years dental work since obtaining a primary dental qualification that is acceptable for registration by the General Dental Council.
 - e. Appointments shall be for one year in the first instance, except for experienced SCMOs.

Hospital Practitioner Grade

6.
 - a. Appointments to the grade of hospital practitioner shall be in accordance with HSS(TC8) 13/79, as amended by HSS(TC8) 2/94. A practitioner appointed to the grade shall be a principal providing general medical or dental services under Part VI of the Health and Personal Social Services (Northern Ireland) Order 1972. A medical practitioner appointed to the grade shall have been fully registered for at least four years; a dental practitioner shall have been registered for at least five years.
 - b. Appointments shall be for one year in the first instance, except where a practitioner had previously occupied a post as part-time medical or dental officer or as an AS in the same unit.
 - c. A medical practitioner shall have full registration and a dental practitioner shall be registered.
 - d. Posts shall be limited to a maximum of five notional half-days each week.

Staff Grade

7.
 - a. Subject to such manpower controls as may be exercised from time to time by the Department:
 - i. employing authorities may offer whole or part-time appointments in the Staff Grade; and

- ii. exceptionally, and subject to the approval of the Department, an employing authority may offer an appointment for a limited term. Appointments shall otherwise be held for one year in the first instance, save where a practitioner has previously held a regular appointment, other than in the HO grade, in the same unit and specialty.
- b. A medical practitioner appointed to the grade:
 - i. shall have full registration; and
 - ii. shall have completed at least three years' aggregate full-time hospital service in SHO, FHO2 or higher grades since first obtaining full or limited registration, including adequate experience in the relevant specialty; or
 - iii. shall have had equivalent experience.
- c. A dental practitioner appointed to the grade:
 - i. shall be registered; and
 - ii. shall have completed at least four years' full-time hospital service since first obtaining registration, including adequate experience in the SHO, FHO2 or a higher grade in the relevant specialty; or
 - iii. shall have had equivalent experience.

Tenure of post

- 8.
 - a. Appointments in the grade of consultant, SHMO, SHDO, and appointments in the grade of AS and hospital practitioner, if confirmed after the first year where this is appropriate, may be held until retirement age under paragraph 200 unless terminated under the provisions of paragraph 190 to 192 or 195 to 198; provided that an appointment as hospital practitioner shall cease if the practitioner ceases to be a principal in general medical or dental practice.
 - b. Subject to confirmation after the first year where appropriate, an appointment to the Staff Grade may be held until retirement age under paragraph 200, unless offered for a limited term, or terminated in accordance with paragraphs 191, 192 and 195 to 198.
- 9. Unallocated.

Specialist Registrar or Specialty Registrar

- 10. On appointment to the grade through the requisite appointments procedure run by the Postgraduate Dean a specialist or specialty registrar appointed to a full programme will be allocated a National Training Number guaranteeing a continued place in a training programme. Training placements will be arranged by the Postgraduate Dean in consultation with employers culminating in the award of a Certificate of Completion of Specialist Training (CCST) or Certificate of Completion of Training (CCT) or permanent removal from a place in a training programme. The final placement will end 6 months after the completion of training, or 6 months after notification of completion of training, whichever is the later. In certain circumstances the Postgraduate Dean will recommend a new fixed term contract. A practitioner appointed to a post of Specialty Registrar (Fixed Term) shall be appointed for a fixed period of one year (or the equivalent for a practitioner appointed on a less than full time basis) and will not be allocated a National Training Number.

10A. Unallocated

Senior House Officer

11. On appointment as SHO a medical practitioner shall have at least twelve months' postgraduate experience in hospital posts; and shall have full registration or, if provisionally registered, shall obtain full registration within fourteen days of taking up the appointment; or shall have limited registration. A dental practitioner shall normally have been registered for at least one year. Posts shall normally be held for one year.

House Officer/Foundation House Officer

12. A medical practitioner may have full, limited or provisional registration; a dental practitioner must be registered. Posts shall normally be held for 12 or 24 months, but may include rotations (including rotations between different employing authorities) for shorter periods within that period.

BASIS OF CONTRACT

Consultant, SHMO/SHDO and AS

13. a. When a whole-time consultant or AS appointment is made in the Health Service it may be held on either a whole-time or maximum part-time basis. Practitioners who opt for the maximum part-time contract are, like whole-time practitioners in these grades, expected to devote substantially the whole of their professional time to their duties in the HS. Subject to any controls that may be exercised from time to time by the Department, employing authorities may offer part-time appointments to be held by consultants and ASs; and by any SHMO or SHDO who is already employed by them.
- b. A maximum part-time practitioner is paid ten elevenths of the whole-time salary (including any Discretionary Points granted) set out in Appendix I and of a distinction award if applicable. Such a practitioner has a minimum work commitment equivalent to ten notional half-days, which should be assessed on the basis set out in paragraphs 61 and 62. Any such consultant in post on 31 December 1979 electing to do so may retain a personal maximum part-time contract paid at nine elevenths of the whole-time salary.
- c. A part-time practitioner is paid on the basis set out in paragraphs 61 to 69.

Additional session

14. a. Subject to sub-paragraphs c, d, e and f below, in exceptional circumstances an authority may, at their discretion, enter into a separate contract with practitioners in any of these grades, for an extra notional half-day or fraction thereof to undertake work which is not part of their normal contractual duties (including their obligations under paragraph 106). Such contracts shall be reviewed not less often than annually and will be terminable at three months' notice on either side without formality. The provisions of paragraphs 190 and 191 do not apply to notional half-days contracted for under these arrangements. The notional half-day shall be remunerated at the rate of one eleventh of the appropriate whole-time salary including any Discretionary Point(s) granted. Where a consultant is in receipt of a Distinction Award, the notional half-day shall be remunerated in all cases as if the individual had reached point 8 on the Discretionary Point Scale. For consultants who receive a Distinction Award for

the first time, temporary additional notional half-days should be remunerated at this rate from 1 April of that year. Locum practitioners will be eligible for this session on the same basis as other practitioners, subject only to the period of notice for the additional session not exceeding that of their locum contract.

- b. When family planning work undertaken by gynaecologists consists largely of counselling or examination, then, subject to the agreement of the employing authority, and irrespective of the nature of their contract, they may be contracted for extra sessions (in addition to existing contracted sessions) to carry out such work. These sessions should be assessed in accordance with paragraph 61 below.
- c. An authority may, at their discretion, award an additional session to maximum part-time consultants without prejudice to their private practice rights where they are:
 - i. appointed as a part-time general manager and their clinical sessions have not been reduced sufficiently to take full account of their general manager duties; or
 - ii. the immediate colleague of a consultant appointed part-time general manager, and is called upon to take on additional work to cover clinical sessions temporarily relinquished by the general manager.
- d. An authority may, at their discretion, and for clinical tutor duties on the advice of the postgraduate dean, enter into a separate contract with a consultant for a temporary additional notional half-day or fraction thereof, or where such duties are particularly onerous, for up to two temporary additional notional half-days or fraction thereof, where the practitioner has taken on significant responsibilities which are not part of his or her normal contractual duties, either in management in one of the following fields:
 - i. in co-ordinating the development and the operation of medical audit in a hospital or district;
 - ii. as a clinical director or with equivalent management responsibility;
 - iii. in leadership of the Resource Management Initiative;or as a clinical tutor.

Any contract agreed under this sub-paragraph will be agreed as part of the job plan of the consultant, and will take effect from the date of agreement of the job plan. The provisions of sub-paragraph a above shall also apply.

- e. Alternatively, where another consultant is the immediate colleague of a consultant who has taken on such significant management responsibilities or clinical tutor responsibilities as defined in sub-paragraph d above, and agrees to take on additional work to cover clinical sessions relinquished by that consultant, the authority may instead enter into a contract with that colleague for a temporary additional notional half-day or fraction thereof. Where the duties of the consultant who has taken on such management responsibilities or clinical tutor responsibilities are particularly onerous so as to justify two additional notional half-days and the consultant opts to relinquish one clinical session and receive one temporary additional notional half-day under sub-paragraph d above, the authority may also enter into a separate contract for a temporary additional notional half-day or fraction thereof with the immediate colleague who agrees to take on the clinical session thus relinquished. Any contract

agreed under this sub-paragraph will be agreed as part of the job plan. The provisions of sub-paragraph a above shall also apply.

- f. An authority may, at their discretion, enter into a separate contract with an associate specialist for a temporary additional notional half-day or fraction thereof where the practitioner is considered by the authority to have particularly onerous contractual duties or, exceptionally, up to 2 temporary additional notional half-days. Such a contract may be made with a maximum part-time associate specialist, without prejudice to the practitioner's private practice rights, or with any other part-time associate specialist. The provisions of sub-paragraph a. above shall otherwise apply.
- g. The total number of temporary additional notional half-days awarded to a consultant under sub-paragraphs a to e shall not normally exceed two, except in very exceptional circumstances (where consultants are undertaking work that is clearly in addition to their normal duties agreed under their inclusive professional contract).

Staff Grade

- 15. A whole-time practitioner shall be remunerated at the basic rate set out in Appendix I. Such a practitioner contracts for:
 - i. a minimum average work commitment of ten sessions a week, each session being equivalent to four hours' work; and
 - ii. liability to deputise for absent colleagues in accordance with paragraph 108; and
 - iii. such exceptional irregular commitments outside normally rostered duties as are essential for continuity of patient care; and
 - iv. exceptionally, duty in occasional emergencies and unforeseen circumstances.

Sessional assessment

- 16. a. A whole-time practitioner may be contracted for such sessions or part sessions as required to meet the needs of the service and may be remunerated at the rate of one-tenth or pro-rata for part sessions of the appropriate basic rate for each session. The allocation of sessions or part sessions, including any additional sessions deemed necessary, shall be determined in accordance with paragraphs 16 b to e below, taking account of any guidance issued by the Department.
- b. The average weekly number of sessions allocated will be assessed by reference to the work commitment specified in the practitioner's job plan and should take account of any assessment under paragraph 16 d. Contributions in the following areas should be taken into account in drawing up the job plan: out-patient clinics, ward rounds, operating procedures, investigative work, administration, teaching, participation in clinical audit, emergency visits, on-call duties. This list is not intended to be prescriptive.
- c. The assessment should exclude time attributable to:
 - i. the practitioner's commitment under paragraph 15ii to iv; and to
 - ii. travelling time between the practitioner's place of residence and his or her principal place of work.

The assessment shall be rounded up to the nearest whole number of sessions, and shall be deemed to continue throughout the year regardless of the practitioner's absence on leave.

- d. In assessing the allocation of sessions or part sessions for out of hours work the following factors should be taken into account:
 - i. where in effect staff grade doctors work for the whole time that they are on duty out-of-hours (whether compulsorily resident or not), the allocation should be no less than 1 session per 4-hour session actually worked
 - ii. staff grade doctors should not have their personal freedom unnecessarily restricted by being required to be compulsorily resident on-call where there is no legitimate service reason for such a requirement
 - iii. where a staff grade doctor is compulsorily resident on-call the allocation should normally be no less than 1 session per 4-hour session of on-call duty
 - iv. where in effect staff grade doctors work for a substantial proportion of the time that they are on duty out-of-hours, but where paragraphs d(i) or d(iii) do not apply, the allocation should be no less than 1 session per 6 hours of duty.
- e. The sessional assessment should be reviewed not less than annually via a job plan review. Where appropriate, the allocation should be revised, in consultation with the consultant and the practitioner concerned, in accordance with paragraph 16b. The salary payable shall be recalculated from the date of change, and any protection of pay shall be determined in accordance with Section 48 of the General Council Conditions of Service. In the event of failure to agree on a sessional assessment, the practitioner shall be entitled to appeal, via a local mechanism set up by the employing authority.

17. Unallocated

Practitioners in the Training Grades

18. a. Practitioners in the training grades contract for:
 - i. 40 hours per week (see paragraph 65 for part-time practitioners);
 - ii. such further contracted hours as are agreed with the employing authority subject to the controls set out in paragraph 20 below;
 - iii. exceptionally, duty in occasional emergencies or unforeseen circumstances (see paragraph 110).
- b. Practitioners in these grades work on an on-call rota, partial shift, 24-hour partial shift, full shift or hybrid working arrangement. Controls on the contracted hours of duty for each of these working arrangements are set out in paragraph 20 below and employing authorities shall ensure that these controls are met. They shall keep the working and contractual arrangements under review to ensure that they remain in line with the demands of the post. Hours of duty include periods of formal and organised study (other than study leave), training, all rest while on duty, and prospective cover where applicable.

DEFINITIONS

19. For the purposes of paragraph 20 below the following definitions shall apply:

On-call rotas

- a. Practitioners on on-call rotas usually work a set working day on weekdays, from Monday to Friday. The out-of-hours duty period is covered by practitioners working “on call” in rotation. Practitioners are rostered for duty periods of more than 24 hours. The frequency of on-call depends on the number of practitioners providing cover and is normally expressed as 1 in 4, 1 in 5, etc. Practitioners working on on-call rotas shall have adequate rest during a period of duty.

Partial shifts

- b.
 - i. On most weekdays practitioners on partial shifts work a normal day. But, at intervals, one or more practitioners will work a different duty for a fixed period of time, eg. evening or night shifts. Practitioners can expect to work for a substantial proportion of the out-of-hours duty period, during which time they will expect to achieve some rest in addition to natural breaks. Practitioners will be rostered for duty periods of not more than 16 hours. Practitioners working on partial shifts shall have adequate rest during a period of duty;
 - ii. 24 hour partial shifts: Weekdays are usually worked as normal days. In rotation, a duty period is rostered, not exceeding 24 hours including handovers, for the weekend and out-of-hours cover. Practitioners will be rostered for duty periods of more than 16 hours, but less than or equal to 24 hours. Practitioners working 24-hour partial shifts shall have adequate rest during a period of duty.

Full shifts

- c. A full shift will divide the total working week into definitive time blocks with practitioners rotating around the shift pattern. Practitioners can expect to be working for the whole duty period, except for natural breaks. Practitioners will be rostered for duty periods that do not exceed 14 hours. Practitioners working on full shifts shall have adequate rest during a period of duty.

Hybrids

- d. Working arrangements of two or more distinct working arrangements described in subparagraphs 19.a, b, c above. The different working arrangements must be worked either concurrently in the same rota or alternately within a time limit of up to one month. Practitioners working on hybrids shall have adequate rest during a period of duty.

CONTROLS ON HOURS

- 20. The following controls on hours of duty shall apply to practitioners in the training grades working on-call rotas, partial shifts, 24 hour partial shifts, full shifts or hybrids (except in circumstances where they are acting up as a consultant):
 - a. On-call rotas

- i. Employing authorities shall ensure that the maximum average contracted hours of duty for practitioners working on on-call rotas do not exceed 72 per week, including handovers at the start and finish of duty periods.
 - ii. Practitioners in higher specialist training may contract for duty for up to a maximum average of 83 hours per week when it would be to the benefit of their training and they wish to do so, providing the proper supporting staff structure exists and providing the duties are not harmful either to the trainees or to patients.
 - iii. Employing authorities shall ensure that no period of continuous duty for practitioners working on-call rotas is longer than 32 hours during the week and 56 hours at the weekend, except that for a transitional period of two years from 1 September 2002 practitioners in public health medicine may, in consultation with organisers of training schemes in public health medicine, choose to continue to work for a week on-call, provided that the average hours of work do not exceed 48 and they can expect to receive 11 hours of continuous rest between 9pm and 8am on at least 75% of nights when on-call. Practitioners undertaking a week on-call meeting the above criteria shall not be entitled to Band 3.
 - iv. Employing authorities shall ensure that practitioners working on on-call rotas have a minimum period of 12 hours off duty between periods of duty and one minimum continuous period off duty of 62 hours and one minimum continuous period off duty of 48 hours in every period of 21 days.
- b. Partial Shifts and 24 Hour Partial Shifts: Employing authorities shall ensure that:
- i. The maximum average contracted hours of duty for practitioners working a partial shift or 24 hour partial shift do not exceed 64 per week, including handovers at the start and finish of shifts.
 - ii. No period of continuous duty for practitioners working partial shifts is longer than 16 hours, including the time required for handovers.
 - iii. No period of continuous duty for practitioners working 24-hour partial shifts is longer than 24 hours, including the time required for handovers.
 - iv. Practitioners working partial shifts and 24 hour partial shifts have a minimum period of 8 hours off-duty time between shifts; do not work more than 13 days without a minimum period of 48 hours of continuous off-duty time; and have one minimum continuous period off-duty of 62 hours and one minimum continuous period off-duty of 48 hours in every period of 28 days.
- c. Full Shifts: Employing authorities shall ensure that:
- i. The maximum average contracted hours of duty for practitioners working a full shift do not exceed 56 per week including handovers at the start and finish of shifts.
 - ii. No period of continuous duty for practitioners working full shifts is longer than 14 hours, including the time required for handovers.
 - iii. Practitioners working full shifts have a minimum period of 8 hours off duty between shifts; do not work more than 13 days without a minimum period of 48 hours of continuous off-duty time; and have one minimum continuous

period off duty of 62 hours and one minimum continuous period off duty of 48 hours in every period of 28 days.

- d. Hybrids: Employing authorities shall ensure that the maximum average contracted hours of duty for practitioners working a hybrid arrangement do not exceed a point, calculated as a proportion of the part that each arrangement makes to the hybrid, between the average maximum contracted hours of duty for each of the working arrangements which comprise the hybrid arrangement.
- e. Hours protection: Following the changes in contractual terms on 1 December 2000, any substantive change to the working arrangement of any existing post which might lead to an increase in the number of hours of work can only be introduced with the agreement of the practitioner in post and the approval of the Improving Junior Doctors' Working Lives Implementation Support Group (ISG). The nature of the approval system is described in guidance "A general guide to the new pay system", issues on 19 October 2000.
- f. Not allocated.
- g. Not allocated.
- h. Employing authorities shall ensure that practitioners in the training grades comply with the relevant controls on hours of duty. Practitioners and their employing authority shall agree to work together to identify appropriate working arrangements or other organisational changes in working practice to ensure the controls on hours of duty, actual work and rest described in sub-paragraphs 18.b, 20.a to d above and 22.a below are met for practitioners in all training grades, and to comply with reasonable changes following these discussions; changes to working arrangements shall be monitored by regional improving junior doctors working lives action team's (or equivalents).

Payment

- 21. a. Full-time practitioners in the training grades receive a base salary. Part time practitioners in these grades receive as base salary a proportion of the full-time base salary based on average weekly hours of actual work. An additional supplement will be paid according to one of the pay bands, in accordance with the assessment of their post as described in paragraph 22 below, at the rates set out in Appendix I.
- b. For practitioners contracted to work 40 or more hours of duty per week, pensionable pay for contributions purposes must be based on the practitioner's actual whole-time basic pay (1.0) only. Pay supplements over and above base salary are non-pensionable.

Pay protection at transition

- c. Pay protection in compliant posts will apply from 1 December 2000 to any junior doctor whose total pay under the ADH system (at current ADH percentages) in the post they are occupying on 1 December 2000, or in any post in a rotation accepted before 1 December 2000, where a formal ADH assessment has been made, would be higher than that due under the proposed new contractual arrangements.

- d. Until 1 December 2003 pay protection will also apply to any post or placement in a rotation accepted before 1 December 2000 where no formal ADH assessment was made but where the post, at the time the junior doctor accepted the rotation, was paid at a higher rate under the ADH system than is the case under the new contractual arrangements when the junior doctor takes up the post.
- e. On 1 December 2000, where a post attracts a higher rate ADH payment in recognition of excessive intensity, under HSS(TC8) 11/96 or HSS(TC8) 14/98, then the post shall attract the same overall salary for so long as it is more favourable until the intensity problem has been shown to be resolved. This shall also apply where a claim with full supporting evidence has been lodged by 30 November 2000 in accordance with these circulars.

Principles of pay protection

- f. The principle of pay protection applies to practitioners in all bands for the duration of the post/placement or within a rotation subject to the conditions set out in subparagraphs 21.h to m.
- g. Pay protection applies to the base salary on the scale plus the supplement in payment at the time the post or placement is rebanded. The salary shall be increased only to take account of increments in the base salary on the old scale.

Pay protection in New Deal compliant posts

- h. Where a practitioner reaches agreement with his or her employing authority on a new or revised contract on or after 1 December 2000, the practitioner's post shall be reassessed in accordance with paragraphs 19 to 23, effective from the date of the change. For so long as it is more favourable, and so long as the practitioner remains in the same post, the practitioner shall retain the overall salary applicable to the band he or she was placed in immediately before the change. The salary shall be increased only to take account of increments in the base salary on the old scale.
- i. If a practitioner in a rotational appointment has accepted appointment to a future post in that rotation for which a New Deal compliant pay band assessment has been made at the time of appointment to the rotation and the duties of that future post have been changed before the practitioner actually takes it up, then sub-paragraph 21.h shall apply, and the practitioner shall be treated as if he or she had already been occupying the post at the time of the change. If no assessment of the pay band has been made at the time of appointment then sub-paragraphs 21.c, d and e apply.

Pay protection in New Deal non-compliant posts

- j. Where a New Deal non-compliant post/placement (pay band 3) becomes compliant before 1 December 2002, the practitioner shall retain the overall salary protected at the pay band 3 rate applicable at the time of rebanding, for so long as it is more favourable and for the duration of the post/placement. The salary shall be increased only to take account of increments in the base salary on the old scale.

- k. Where a New Deal non-compliant post/placement (pay band 3) becomes compliant on or after 1 December 2002, the practitioner shall have their salary protected at the pay band 2A rate applicable at the time of rebanding, for so long as it is more favourable and for the duration of the post/placement. The salary shall be increased only to take account of increments in the base salary on the old scale.
- l. Where a future post/placement in a rotation, which has been accepted by the practitioner at pay band 3, becomes compliant before 1 December 2002, the practitioner when they take up that post/placement shall retain the overall salary protected at the pay band 3 rate applicable at the time of the rebanding, for so long as it is more favourable and for the duration of that post/placement. The salary shall be increased only to take account of increments in the base salary on the old scale.
- m. Where a future post/placement in a rotation, which has been accepted by the practitioner at pay band 3, becomes compliant on or after 1 December 2002, the practitioner when they take up that post/placement shall have their salary protected at the pay band 2A rate applicable at the time of the rebanding, for so long as it is more favourable and for the duration of that post/placement. The salary shall be increased only to take account of increments in the base salary on the old scale.

Definition

- n. For these purposes a rotation is a series of posts or placements forming part of a training programme, which might be in any training grade. Such a rotation may involve the trainee having a series of different employing trusts and contracts, but will not involve a new appointment panel.

Backdating of pay on re-banding after monitoring

- o. When following a change of house a rota is properly monitored to be in a higher band than demonstrated by previous valid monitoring, backdating of pay will apply to those doctors currently in post and will not apply to former postholders regardless of when previous monitoring took place, unless former postholders have formally raised concerns and requested monitoring but where that has not taken place. In such cases where the later valid monitoring confirms the concerns of the former postholders, they should receive back pay at the higher rate from the date of the request for monitoring to the end of the placement.
- p. In the event of a rota, without any change in working pattern, being shown to belong in a higher pay band as a result of a valid monitoring round, pay at the higher level shall be backdated to the point three calendar months after the first day of the previous successful monitoring round, ie. that which most recently showed the lower pay band, except:
 - where there are postholders who have taken up their posts after the previous valid monitoring round, for whom the most recent round is also their first one in their current post, in which case their pay increase will be backdated to their first day in the post; or

- when there have been intervening attempts by the trust to monitor, which the trust can demonstrate to have been done in accordance with good practice guidelines and which have not been successful despite the proven best efforts of the trust, in which case pay shall be backdated to the first day of the valid monitoring exercise which led to the rota being shown for the first time to belong to a higher pay band; or
- where a valid monitoring round which has been requested by the doctors in post demonstrates an increase in the pay band, when backdating will be to the date of the request to monitor if this is less than three calendar months from the first day of the previous successful monitoring round.

Notification of posts becoming compliant

- q. Where a previously non-compliant rota is shown on valid monitoring to fall into a compliant pay band, an employer shall notify the doctors on that rota of the change in writing, and salaries at the protected level of band 2A shall be paid from the first day of the month following that in which notification was made. An employer cannot require repayment of any salary paid at the higher band prior to the last day of the month in which formal notification was given.

Assessment of Pay Supplements

22. Subject to paragraph 24 below, the assessment of pay supplements for staff in the training grades shall be made as follows:
- a. Band 3 shall apply to full-time and part-time practitioners in posts which do not comply with the controls on hours of duty described in paragraph 20 above or with the controls on hours of work or rest described below (refer HSS(TC8) 6/99 and “Junior Doctors’ hours monitoring: principles and guidance” issued on 12 October 2000 including agreement to modify weekend rest requirements for on-call rotas) applicable to their working pattern.
 - i. That practitioners working any of the working arrangements defined in paragraph 19 above, work on average no more than 56 hours of actual work per week;
 - ii. That practitioners working on on-call rotas have rest equivalent to at least one half of the out-of-hours duty period, with a minimum of 5 hours continuous rest between 10pm and 8am, on 75% of occasions when on-call;
 - iii. For practitioners working at weekends on an on-call rota, if the agreed total rest expectation of 50% of the out-of-hours duty period within the duty period is achieved (see paragraph 22a.(ii) above), this is acceptable. For a weekend duty period of 9am Saturday to 5pm Monday, this would mean a total of 24 hours rest during that period; or
 - iv. For practitioners working at weekends on an on-call rota, if the rest requirement equivalent to that for a weekday is achieved (8 hours for 24 hour period, 5 continuous between 10pm and 8am, on at least 75%

of duty periods - see paragraph 22a.(ii) above), but the total rest does not meet the requirement for the weekend (at least 50% of the out of hours duty period on 75% of occasions – see paragraph 22a.(ii) above), the requirements for the controls on hours governing weekend rest will still be met if: - “equivalent paid rest” is built into the rota for each weekend worked, in the form of working days or half days (to count as a day or half day on duty for total hours purposes – see Junior Doctors Contract: A general guide to the new pay system,). This rest should be taken by the end of the Monday of the following week (ie. within 8 days). However, in exceptional circumstances, the period of equivalent paid rest built into the rota may be taken at another time in the rota cycle. This must be with the agreement of the individual trainee and apply to no more than 25% of weekends worked; and the employing authority clearly demonstrates that the post is fully compliant with all other aspects of the New Deal, including the 56 hours of actual work limit.

- v. That practitioners working partial shifts have rest for at least one quarter of the out-of-hours duty period on at least 75% of occasions; and where there is no out-of-hours duty that practitioners have natural breaks at any time during the whole of each duty period.
 - vi. That practitioners working 24 hour partial shifts have 6 hours rest during the duty period with a minimum of 4 hours continuous rest between 10pm and 8am on at least 75% of occasions; and that practitioners are not on duty for more than four hours following the 16 hour period of out-of-hours duty, and the next duty period should not start until at least the beginning of the next normal working day.
 - vii. That practitioners working full shifts shall have natural breaks as minimum rest during the whole of each duty period with at least 30 minutes continuous rest after approximately 4 hours continuous duty.
 - viii. That practitioners working a hybrid arrangement shall receive the appropriate controls on hours described in paragraphs 20 and 22 above that applies to each of the working arrangements that comprise the hybrid arrangement.
- b. Band 2A shall apply to full-time and part-time practitioners who work within the controls on hours applicable to their working arrangement as described in paragraphs 20 and 22.a above, and who work on average more than 48 but less than or equal to 56 hours of actual work per week; and:
- i. to practitioners on on-call rotas who either work an on-call rota of 1 in 6 including prospective cover or more frequently, or who work 1 in 3 weekends or more frequently; and who have an expectation that, for 50% or more of their out-of-hours duty periods, either they will work after 7pm and will be required, for clinical or contractual reasons, to be resident at their place(s) of work when on-call, or they will be non-resident and required to work, for clinical or contractual reasons, for 4 hours or more after 7pm; or
 - ii. to practitioners on partial or full shifts or hybrid arrangements for whom one third of their hours of duty fall outside the period 7am to

7pm Monday to Friday; or who work 1 in 3 weekends or more frequently.

- c. Band 2B shall apply to full-time and part-time practitioners who work within the controls on hours applicable to their working arrangement as described in paragraphs 20 and 22.a above, and who work on average more than 48 but less than or equal to 56 hours of actual work per week; and who do not fulfil the criteria for Band 2A described in sub-paragraph 22.b above.
- d. Band 1A shall apply to full-time and part-time practitioners who work within the controls on hours applicable to their working arrangement as described in paragraphs 20 and 22.a above, and who work on average 48 hours or less of actual work per week; and:
 - i. to practitioners on on-call rotas who work an on-call rota of 1 in 6 including prospective cover or more frequently; or
 - ii. to practitioners on on-call rotas who either work an on-call rota of 1 in 8 including prospective cover or more frequently, or who work 1 in 4 weekends or more frequently; and who have an expectation that, for 50% or more of their out-of-hours duty periods, either they will work after 7pm and will be required, for clinical or contractual reasons, to be resident at their place(s) of work when on duty out-of-hours, or they will be non-resident and required to work, for clinical or contractual reasons, for 4 hours or more after 7pm; or
 - iii. to practitioners on partial or full shifts or hybrid arrangements for whom one third of their hours of duty fall outside the period 7am to 7pm Monday to Friday; or who work 1 in 4 weekends or more frequently.
- e. Band 1C shall apply to full-time and part-time practitioners who work within the controls on hours applicable to on-call rotas as described in sub-paragraphs 20.a and 22.a above, and who work on average 48 hours or less of actual work per week and, for part-time practitioners, more than 40 hours; and who work an on-call rota of 1 in 8 without prospective cover or less frequently and are not required to be resident, for clinical or contractual reasons, at their place(s) of work when on duty out-of-hours.
- f. Band 1B shall apply to full-time and part-time practitioners who work within the controls on hours applicable to their working arrangement as described in paragraphs 20 and 22.a above, and who work on average 48 hours or less of actual work per week and, for part-time practitioners, more than 40 hours; and who do not fulfil the criteria for Band 1A or 1C described in sub-paragraphs 22.d and e above.
- g. Band FA shall apply to part-time practitioners who work within the controls on hours applicable to their working arrangement as described in paragraphs 20 and 22.a above, and who work on average less than 40 hours of actual work per week; and
 - i. to practitioners who work an on-call rota of 1 in 10 including prospective cover or more frequently; or
 - ii. to practitioners on on-call rotas who work either an on-call rota of 1 in 13.5 including prospective cover or more frequently, or who work 1 in

- 6.5 weekends or more frequently; and who have an expectation that, for 50% or more of their out-of-hours duty periods, either they will work after 7pm and will be required, for clinical or contractual reasons, to be resident at their place(s) of work when on duty out-of-hours or they will be non-resident and required to work, for clinical or contractual reasons, for 4 hours or more after 7pm; or
- iii. to practitioners on partial or full shifts or hybrid arrangements for whom one third of their hours of duty fall outside the period 7am Monday to Friday; or who work 1 in 6.5 weekends or more frequently.
- h. Band FC shall apply to part-time practitioners who work within the controls on hours applicable to their working arrangement as described in paragraphs 20 and 22.a above, and who work on average less than 40 hours of actual work per week; and who work an on-call rota of 1 in 13.5 without prospective cover or less frequently and are not required to be resident, for clinical or contractual reasons, at their place(s) of work when on duty out-of-hours.
- i. Band FB shall apply to part-time practitioners who work within the controls on hours applicable to their working arrangement as described in paragraphs 20 and 22.a above, and who work on average less than 40 hours of actual work per week; and who do not fulfil the criteria for Band FA or FC as described in sub-paragraphs 22.h and 22.i above.
- j. No supplement shall be payable to:
- i. full-time practitioners who work within all the controls on hours applicable to their working arrangement as described in paragraphs 20 and 22.a above, and who work on average 40 hours or fewer all between 8am to 7pm, Monday to Friday;
 - ii. part-time practitioners who work within all the controls on hours applicable to their working arrangements as described in paragraphs 20 and 22.a above, and who work on average less than 40 hours per week all between 7am to 7pm Monday to Friday.
- k. For the purposes of the assessment of pay supplements as described in sub-paragraphs 22.a to j above, the following definitions shall apply:
- i. Actual work: All hours of duty when practitioners are carrying out tasks for the employer, including periods of formal study/teaching. For the purposes of defining actual work after 7pm, work begins when a doctor is disturbed from rest and ends when that rest is resumed. This includes, for example, time spent waiting to perform a clinical activity and time spent giving advice on the telephone.
 - ii. Rest: All time on duty when not performing or waiting to perform a clinical or administrative task, and not undertaking a formal educational activity; but including time spent sleeping. Natural breaks do not count as rest;
 - iii. Weekend: When the practitioner is on duty at any time during the period from 7pm Friday to 7am Monday;

- iv. 1 in x on-call rota: For example: if six practitioners share a rota equally between them, but locums are employed for leave, this is a 1 in 6 rota without prospective cover. This means each practitioner will, for the whole duration of their contract or placement, work less than one-sixth of all on-call duty periods unless they do not take any leave. If, for example, six practitioners share a rota equally between them and cover each other's leave, this is a 1 in 6 with prospective cover. The contribution of non-training grades and flexible trainees in the frequency of on-call rotas should be taken into consideration.
- v. Prospective cover: When the practitioner is contracted to provide internal cover for colleagues when they are on annual and/or study leave, ie. if no locums are provided. Prospective cover is also in operation when on-calls are required to be swapped when taking leave or when leave is fixed in advance. When a practitioner not on the rota acts as a "floater", ie. covering any practitioners on the rota who are away on holiday, prospective cover is not in operation.
- I. Where either the employing authority or the practitioner rejects the opinion of the regional improving junior doctors working lives action team (or equivalent) in any case where there is a dispute regarding the allocation of posts to pay bands or in cases where the regional improving junior doctors working lives action team (or equivalent) finds it necessary to intervene, there is a right of appeal:
 - i. Appeals shall be heard by a local committee that shall be convened as soon as possible and employing authorities shall be expected to do so while the practitioner remains in post;
 - ii. The appeal panel shall be constituted of the following, none of whom shall have been involved in the earlier decision: two representatives of the employing authority nominated by the chief executive or medical director of the employing authority (one of whom shall chair the panel); a representative from the SR, SpR, R, SHO or HO grades from the same employing authority conversant with the working arrangements applicable to the case; a representative from a regional list supplied by the BMA's Junior Doctors Committee; an independent external assessor nominated by the regional improving junior doctors working lives action team (or equivalent).
 - iii. Decisions of the appeals panel which confirm the appellant(s) had been underpaid shall lead to the practitioner(s) receiving appropriate reimbursement backdated to the date of the change, or to 1 December 2000, whichever is applicable.
 - iv. Decisions of the appeals panel which confirm the trust's original decision shall lead to the trust receiving appropriate reimbursement backdated to the date of the change, or to 1 December 2000, whichever is applicable.
- m. The process for reallocating posts to new pay bands due to changes in working practice shall be as follows:
 - i. Stage one – to institute a change in working practice, the employer must:

- consult the post holders and obtain the agreement of the majority participating in the rota;
 - obtain agreement from the clinical tutor for education purposes;
 - submit details of the new rota to the ISG for information and invited comment.
- ii. Stage two – monitoring of working pattern. Such monitoring must comply with the principles set out in “Junior Doctors’ hours monitoring: principles and guidance” and be subject to validation by local junior doctor representatives and the ISG.
- iii. Stage three – written notification of monitoring outcome.
- iv. Stage four – approval mechanism to change band. The following information must be sent to the ISG:
- details of the change in working practice;
 - monitoring data;
 - agreement of postholder;
 - agreement of clinical tutor.
- v. Stage five – appeals mechanism (see sub-paragraph 22.I above).

Full Pay

23. The total remuneration calculated on the basis of paragraph 22 represents full pay for the purpose of the agreements relating to leave in these Terms and Conditions of Service and of the General Council Conditions of Service. Provisions as to other rates of pay should be construed accordingly.

Retention of Existing Contracts

24. Where contracts had been entered into before 1 February 1992 on the basis of the then current paragraphs of the Terms and Conditions of Service relating to the assessment of workload, that basis shall continue in force until the expiry or negotiated revision of that contract.

EMERGENCY ROTA ALLOWANCES

25. a. Where a doctor in public health medicine and the community health service (other than a public health physician or trainee in public health medicine) who has the appropriate experience and training, deputises for a public health physician who acts as medical officer for environmental health in regard to his or her responsibilities for communicable diseases and food poisoning on the 24 hour rota, he or she shall each half year receive an allowance at the rate given in Appendix I. Each week should be regarded as consisting of 9 duties, ie 7 nights plus the days of Saturday and Sunday. Statutory and general national holidays should be treated in the same way as Saturdays and Sundays. The allowance should be assessed and paid at the end of each half-year ending 30 June and 31 December. The allowance is superannuable.
- b. Where a clinical or senior clinical medical officer is on a 24 hour rota for work at a designated customs airport or for a constituted port health authority, he or she shall receive an allowance, at the same rate as that payable under

paragraph 25(a), except in the circumstances specified in sub-paragraph (c) below.

- c. If such a doctor is on a rota which requires him or her simultaneously to be on duty for environmental health and for port health work (as defined in (b) above) and he or she is eligible for an allowance under sub-paragraphs (a) and (b) above, only one such allowance will be payable, at 150 percent of the rate set out in Appendix I, in respect of each duty during which he or she was on call for both rotas.
- d. A doctor who receives an allowance under sub-paragraph (b) or (c) above may also receive an allowance under sub-paragraph (a) for nights when he or she is on call for Communicable Disease and Food Poisoning only but not port health.

ASSOCIATE SPECIALIST

Minimum Time Off-Duty

- 26. Provided that the needs of patients permit, the following assured periods of time off-duty, including freedom from on-call liability, or the equivalent of these periods taken at other times, shall be made available as a minimum to practitioners in whole-time or maximum part-time appointments as AS:
 - i. one afternoon a week;
 - ii. two nights off in three (from Monday to Thursday);
 - iii. two weekends off in three being the nights of Friday, Saturday and Sunday and the days of Saturday and Sunday.

27.- 29. Unallocated.

CONTRACTUAL DUTIES OF PRACTITIONERS

- 30. a. A practitioner's duties under his or her contract of employment should be agreed in that contract or its associated job description. The duties will include work relating to the prevention, diagnosis or treatment of illness which forms part of the services provided by the practitioner's employing authority under Articles 5(1), 5(2), 7(1) and 8(1) of the Health and Personal Social Services (Northern Ireland) Order 1972, including services provided to patients who have elected to receive services under Article 31(1). They may also include work related to services provided under the following provisions:
 - i. under Article 5(1) (relating to contraceptive services);
 - ii. for Government Departments and public bodies under Article 68(1) (in connection with their functions relating to social services, education and public health and in relation to staff health schemes);
 - iii. under Article 3 of the Health and Medicines (Northern Ireland) Order 1988 (relating to the provision of services to third parties).
- b. The work will also include the provision of reports, which are reasonably incidental to the practitioner's work. Illustration of such work (for which

charges may not be made) are set out in Category 1 of the Schedule (paragraph 36), while illustrations of work which is regarded as not related to services provided under these sections and therefore is not part of the practitioner's duties under his or her contract are set out in Category 2 of the Schedule (paragraph 37): see also paragraph 33.

- c. A hospital consultant has continuing clinical responsibility for any patient admitted under his or her care. A consultant and the general manager responsible for the management of the consultant's contract shall agree a job plan for the performance of duties under the contract of employment. For the purpose of drawing up a job plan, the authority shall take the following duties into account: out-patient clinics, ward rounds, operating procedures, investigative work, administration, teaching, participation in medical audit, management commitments (for example as clinical director), emergency visits, on-call rota commitments, and so on, including occasional visits to outlying hospitals or other institutions for consultation, diagnosis or operative work. The authority shall also take into account time given, for example, as consultant adviser to the authority on special branches of the service or by way of "pastoral visits" to outlying hospitals.
- d. The job plan will identify the nature and timing of the consultant's fixed commitments. Fixed commitments are to be assessed and worked in notional half-days or fractions thereof, and for a whole-time or maximum part-time consultant shall normally account for between 5 and 7 NHDs, depending on specialty. For consultants on other part-time contracts, including honorary contracts, at least half of the NHDs specified in the contract shall normally be accounted for by fixed commitments. The number of fixed commitments may be varied with the agreement of the consultant and the general manager, taking account of the other components of the job plan. Except in an emergency, the consultant shall fulfil fixed commitments unless the local general manager has agreed otherwise; such agreement is not to be unreasonably withheld. The job plan will be subject to review each year and revisions may be proposed by either the general manager or the consultant, who shall use their best endeavours to reach agreement on any revised job plan. If agreement is not reached and the health authority notifies the consultant of its intention to amend the job plan, the consultant may appeal against the proposed amendment. Where an appeal is made in relation to matters governed by this paragraph or paragraph 30.c, the employing authority shall establish an appeal panel. The panel will be chaired by the Director of Public Health or a senior medical or dental officer of the authority, and will include a lay member of the authority and a senior officer of the authority. If either party judges that it would be helpful a medical or dental adviser acceptable to each party will be co-opted to the panel. The panel will submit its advice to the authority, which shall then determine the appeal.

Article 3 of the Health and Medicines (Northern Ireland) Order 1988

- 31. Where an employing authority proposes to provide services to a third party under Article 3 of the Health and Medicines (Northern Ireland) Order 1988 which will involve a practitioner, then the prior agreement of that practitioner should be obtained. The practitioner may negotiate separately with, and obtain fees from, a third party for any such medical or dental work the practitioner undertakes; such fees will count as part of the practitioner's gross income from private practice for the purposes of sub-paragraph 42.a. Alternatively, by mutual consent, a sessional assessment may be made within the practitioner's HS contract.

Fees payable by employing authorities

32. A practitioner shall receive fees from his or her employing authority for undertaking the following work, provided it does not form part of the practitioner's duties under paragraph 30:
- a. work related to the services referred to under sub-paragraphs 30.a. and b.;
 - b. radiology and pathology tests required as part of examinations and reports illustrated in Category 1(c)(vi) of the Schedule in paragraph 36, where either time is not allocated to such work in a practitioner's contract or the volume of work does not justify a separate arrangement. The fee for this work is shown in Appendix I.

Retention of other fees

33. Provided that it would not in the opinion of the practitioner's employing authority interfere with other hospital activities, or with the proper discharge of the practitioner's contractual duties, and the person or third party concerned accepts that a fee is payable, a practitioner may undertake and retain fees for the following work, whether at a hospital or elsewhere:
- a. examination, reports, etc. (illustrations of which are set out in Category 2) which do not fulfil any of the conditions referred to in Category 1 of the Schedule or fall within the definition of private practice; and
 - b. general practitioner services given by a hospital medical officer under Part VI of the Health and Personal Social Services (Northern Ireland) Order 1972 to members of the hospital staff who are on his or her list.

Use of hospital facilities

34. a. Where, in carrying out work referred to in sub-paragraph 33a, hospital facilities are used the charge made by the practitioner to the person or third party shall represent two elements:
- i. payment for professional services; and
 - ii. payment for HS services, accommodation and facilities.
- b. The employing authority shall determine and make such charges for the use of its services, accommodation or facilities, after discussions with the practitioners concerned, as it considers reasonable. It may also decide not to make any such charges. Any charge made for such use shall be collected by the employing authority, with the agreement of the practitioner concerned, either:
- i. from the person or third party commissioning the work, in which case the authority must remit to the practitioner the professional fee collected on his or her behalf and make an administrative charge to the practitioner where appropriate, or
 - ii. from the practitioner, in which case it will be the responsibility of the practitioner to collect the charge from the person or third party

commissioning the work and make an administrative charge to the authority where appropriate.

Alternatively either party may collect its own fees by arrangement with the third party concerned.

- c. All charges in respect of professional services shall be a matter of agreement between the practitioner and the person or third party concerned.
35. a. No absolute definition is possible of the service (mainly examinations and reports), that fall under Category 1 or 2. Broadly, Category 1 work is reasonably incidental to a practitioner's duties under his or her contract of employment and its associated job description or job plan. Those duties include work relating to the prevention, diagnosis or treatment of illness which forms part of the services provided by the practitioner's employing authority under Articles 5(1) and 8(1) of the Health and Personal Social Services (Northern Ireland) Order 1972. Such contractual duties may also include services provided under other Articles of the Order (see paragraph 30). Examinations and reports that are not part of, or reasonably incidental to, normal contractual duties fall within Category 2. This distinction is illustrated further in paragraphs 36 and 37 below by means of **examples** of items of service that fall within one or other of the Categories. As it is not possible to construct a definitive list of every type of work, these examples should be regarded as illustrating general principles, the application of which shall determine to which Category other similar services belong, and consequently whether or not the work is or may be part of the practitioner's contractual duties.
- b. An index to the examples of Category 1 and 2 items of service is attached at Appendix V to this Handbook.

36. **CATEGORY 1:** work undertaken by hospital medical and dental staff which is reasonably incidental to contractual duties and for which charges may not be made. For convenience, such work has been divided into five sub-sections, which are set out below (Categories 1a-1e), with accompanying illustrative examples:

CATEGORY 1.a: The examination, diagnosis and provision of related reports on a person referred to the health services from a medical source for a second opinion. For this purpose, reference "from a medical source" means reference from a medical or dental practitioner (including, for example, a medical board) who, having clinically examined a person, requires a second opinion in connection with the prevention, diagnosis or treatment of illness. It does not include reference for examination included in Category 2 or reference from an administrative medical officer who has not clinically examined the person referred.

Examples of Category 1.a examinations and reports include those on:

- i. a person referred by a general practitioner;
- ii. members of HM Armed Forces (including members of overseas forces serving on duty in the UK) and their families, referred by medical officers who are treating them;
- iii. persons referred in connection with diagnosis or treatment by a medical practitioner in the Community Health Service; (**but** examinations of and

reports required on employees or prospective employees for the purpose of, for example, superannuation schemes, fall within Category 2.)

- iv. a person referred by an occupational health physician or employment medical adviser following an accident or incident which may give rise to occupational disease or where an employment medical adviser, following a clinical examination of a person or persons, suspects the possibility of occupational disease and seeks an investigation and a second medical opinion;
- v. a person referred by a medical officer of a Medical Boarding Centre (Respiratory Diseases) of the Department for Social Development for the purposes of diagnosis and treatment; (**but** when the second opinion is required solely in connection with a compensation or social security claim, this falls within Category 2.a.)
- vi. a person referred by a medical interviewing committee set up by the Department for Social Development to advise the Disablement Advisory Service of the Department for Education and Learning on the working capacity of disabled persons.

CATEGORY 1.b: The provision of a medical or dental report **either** to a patient currently under hospital observation or treatment **or**, with his or her consent, to an interested third party, when the information required is reasonably incidental to such observation and treatment and can be given readily from knowledge of the case without a separate examination or without an appreciable amount of work in extracting information from case notes. (**but** if a special examination of the patient is required, or the information requested cannot be given readily from knowledge of the case, or an appreciable amount of work is required to extract medically correct information from case notes, the work falls within Category 2, unless it is specifically included in the practitioner's contractual duties as provided by paragraph 30 above.)

Examples of Category 1.b services are:

- i. doctors' statements given to the patient for social security purposes;
- ii. reports required by the Department for Social Development on a person who is under hospital observation or treatment;
- iii. reports required by the Disablement Advisory Service of the Department for Education and Learning on the working capacity of disabled patients;
- iv. reports required by employers (including government departments and local authorities) on employees who are under observation or treatment, eg. reports required in connection with sick leave or premature retirement on health grounds; (**but** information required primarily to serve the interests of the person or his or her employer in such non-clinical contexts as insurance, superannuation, foreign travel or emigration would fall within Category 2.)

CATEGORY 1.c: Examinations and reports on persons for the purposes of the prevention of illness, under arrangements approved by the Department after consultation with the profession. (**but** examinations and reports required by a person or third party primarily to serve the interests of the person, his or her employer or other third party, in such non-clinical contexts as insurance, superannuation, foreign travel, or emigration, fall within Category 2.)

Examples of Category 1.c. examinations and reports include those:

- i. where it is necessary, as a preventative measure, to investigate the contacts of a patient with a transmissible or epidemic disease, such as typhoid or a sexually transmitted disease;
- ii. in respect of transmissible disease on entrants to teacher training colleges, applicants for teaching posts, teachers, and any other persons whose course of training, prospective occupation or occupation brings them into close or prolonged contact with children;
- iii. on employees or prospective employees (not otherwise covered by sub-paragraph 1.c.ii. above) of Health and Social Services Boards and Trusts, Education and Library Boards and environmental health departments who may be at particular risk of acquiring or spreading transmissible diseases by reason of the nature of their employment or prospective employment. This includes voluntary workers and employees of voluntary bodies similarly at risk;
- iv. in connection with individual screening measures (eg. cervical cytology) for the benefit of particular people who, by reason of age, sex, constitutional or other factors not related to the nature of their employment, are particularly at risk of developing specific diseases; (**but** routine screening of workers, including screening made necessary by the nature of the working environment, is covered **either** by subparagraph 1.c.vi below or Category 2.k or 2.m.)
- v. where the defined duties of the practitioner specifically includes such work, examinations and reports on prospective employees of Health and Social Services Boards and Trusts and local authorities (other than those covered in sub-paragraph 1.c.ii and 1.c.iii above);
- vi. where the defined duties of the practitioner specifically includes such work, examinations and reports in connection with the routine screening of employees of Health and Social Services Boards and Trusts and local authorities, to such extent as may be approved by the Department after consultation with the profession. (**but** this excludes work under sub-paragraph 1.c.iii and 1.c.iv above; see also paragraph 32.)

CATEGORY 1.d: Recommendations under Part II of the Mental Health Order 1986:

- i. if given by a doctor on the staff of the hospital where the patient is an in-patient;
- ii. if given following examination at an outpatient clinic;
- iii. if given as a result of a domiciliary consultation carried out at the request of a general practitioner.

CATEGORY 1.e: Attendance at court hearings as a witness as to fact by a practitioner giving evidence on his or her own behalf or on behalf of his or her employing authority in connection with a case with which the practitioner is professionally concerned. (**but** attendance at coroners' courts is normally work falling within Category 2).

37. **CATEGORY 2:** When work undertaken by hospital medical and dental staff on examinations, reports etc does not fulfil any of the qualifying conditions for Category 1 as set out in paragraph 36 above, it falls within Category 2 and charges may be made. Examples of Category 2 examinations and/or reports include those:
- a. on a patient not under observation or treatment at the hospital at the time the report is requested, or a report which involves a special examination of the patient, or an appreciable amount of work in making extracts from case notes - other than in circumstances referred to in Category 1;
 - b. on a person referred by a Medical Adviser of the Department for Social Development, or by an Adjudicating Medical Authority or a Medical Appeal Tribunal, in connection with any benefits administered by the Department for Social Development;
 - c. for the Criminal Injuries Compensation Board, when a special examination is required or an appreciable amount of work is involved in making extracts from case notes;
 - d. required by a patient or interested third party to serve the interests of the person, his or her employer or other third party, in such non-clinical contexts as insurance, superannuation, foreign travel, emigration, or sport and recreation. (This includes the issue of certificates confirming that inoculations necessary for foreign travel have been carried out, but excludes the inoculations themselves. It also excludes examinations in respect of the diagnosis and treatment of injuries or accidents);
 - e. required for life insurance purposes;
 - f. on prospective emigrants including X-ray examinations and blood tests;
 - g. on persons in connection with legal actions other than reports that can be given under Category 1.b and reports associated with cases referred to in Category 1.b;
 - h. for coroners, as well as attendance at coroners' courts as medical witnesses;
 - i. requested by the courts on the medical condition of an offender or defendant and attendance at court hearings as medical witnesses, otherwise than in the circumstances referred to in Category 1.e;
 - j. on a person referred by a medical examiner of HM Armed Forces Recruiting Organisation;
 - k. in connection with the routine screening of workers to protect them or the public from specific health risks, whether such screening is a statutory obligation laid on the employer by specific regulation or a voluntary undertaking by the employer in pursuance of the employer's general liability to protect the health of its workforce;
 - l. on a person referred by a medical referee appointed under the Workmen's Compensation (Supplementation) Act (Northern Ireland) 1966;

- m. on prospective students of universities or other institutions of further education, provided that they are not covered by Category 1.c.ii. Such examinations may include chest radiographs;
- n. examinations and recommendations under Part II of the Mental Health Order 1986 (except where this falls within Category 1.d):
 - i. if given by a doctor who is not on the staff of the hospital where the patient is examined; or
 - ii. if the recommendation is given as a result of a special examination carried out at the request of a local authority officer at a place other than a hospital or clinic administered by a hospital authority.

Where fees are payable under i or ii above, they will be paid where the practitioner has carried out a special examination whether or not, as a result, he or she completes a recommendation;

- o. services performed by members of hospital medical staffs for government departments as members of medical boards;
 - p. work undertaken on behalf of the employment medical advisory service in connection with research/survey work, ie. the medical examination of employees intended primarily to increase the understanding of the cause, other than to protect the health of people immediately at risk (except where such work falls within Category 1.a.iv);
 - q. completion of Form B (Certificate of Medical Attendant) and Form C (Confirmatory Medical Certificate) of the cremation certificates;
 - r. examinations and reports including visits to prison required by the Prison Service which do not fall within Category 1 and which are not covered by separate contractual arrangements between the Practitioner and the Prison Service;
 - s. examination on blind or partially sighted persons for the completion of form A655 (except where this falls within Category 1.b);
 - t. in respect of sub paragraph s. above, when payment is due in connection with registration with a HSS Trust this will be made by the HSS Trust under the arrangements for sessional work in the community health service in accordance with the appropriate schedule of fees.
38. For the avoidance of doubt, and in accordance with the requirements at Article 98(1) of the Health and Personal Social Services (Northern Ireland) Order 1972, a practitioner shall not otherwise than pursuant to these Terms and Conditions of Service demand or accept any fee or other remuneration for the provision of the services which the practitioner is required to provide by virtue of his or her contract of employment.

Payment of Fees: Doctors in Public Health Medicine and the Community Health Service

- 39. a. A doctor in public health medicine and the community health service employed under these terms and conditions of service may, unless it would,

in the opinion of the employing authority, interfere with the proper discharge of his or her normal duties and provided it does not form part of his or her normal duties, undertake and receive payment for work other than that referred to in paragraph 39.b., including services to a local or public authority of a kind not provided by a HSS Board or Trust under the arrangements for sessional work in the community health service, such as:

- i. work as a medical referee (or deputy) to a cremation authority and signing confirmatory cremation certificates;
 - ii. medical examination in relation to staff health schemes of local authorities and fire and police authorities and to driving licence;
 - iii. lectures to other than HS staff;
 - iv. medical advice in a specialised field of communicable disease control, eg. membership of a Departmental panel for an infectious disease;
 - v. attendance as a witness in court (other than in the course of an officer's normal duties);
 - vi. medical examinations and reports for commercial purposes eg. certificates of hygiene on goods to be exported or reports for insurance companies;
 - vii. advice to organisations (including HSS Boards), other than the doctor's employing authority, on matters which the doctor is acknowledged to be an expert;
 - viii. examinations and recommendations under Part II of the Mental Health (Northern Ireland) Order 1986.
- b. A doctor in public health medicine and the community health service employed under these terms and conditions of service, whether whole-time or part-time, shall not accept a fee from a local or public authority or from a HSS Board or Trust for the provision of advice or services of a kind which a HSS Board or Trust provides under the arrangements for collaboration between health authorities and local and public authorities in accordance with Section 26 of the National Health Service Act 1977, including:
- i. advice and services relating to social services, education and environmental health (including control of communicable disease);
 - ii. advice in relation to staff health schemes of local authorities and driving licences (but see paragraph 39.a.ii);
 - iii. advice to a HSS Board or Trust other than under paragraph 39.a.iv. or viii.

PRIVATE PRACTICE

Definition

40. The expression "private practice" in these Terms and Conditions of Service includes:

- a. the diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972, excluding however work of the kind referred to in paragraph 33; and
- b. work in the general medical, dental or ophthalmic services under Part VI of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited "list", eg. members of the hospital staff).

Entitlement to undertake private practice

41. Subject to the limits set out in paragraph 42 below, all practitioners (including locums) may undertake private practice or other work, provided that practitioners in grades other than consultant may undertake it only outside the times for which they are contracted to an employing authority.

Limitation on earnings from private practice and work performed on NHS patients by separate arrangement outside the practitioner's principal contract of employment

- 42.
- a. Whole-time practitioners in the grades of consultant and associate specialist must certify annually (if their employing authority requests this, by the production of fully audited accounts) that their gross income from private practice (excluding any payments made for the use of HS hospital facilities) and from work performed on HS patients by separate arrangement outside the practitioner's principal contract of employment in accordance with paragraph 43 below does not exceed 10% of their gross salary (including any distinction award or discretionary point(s) held, but excluding any other fees, whether payable under these Terms and Conditions of Service or otherwise).
 - b. Where whole-time consultants' or associate specialists' certified private practice and paragraph 43 income exceeds 10% of their gross salary (as defined) for two consecutive years beginning 6 April, their contract will automatically be deemed to be a maximum part-time contract and their remuneration adjusted accordingly, with effect from 1 April in the year following, unless by that date they can show that they have taken effective steps to reduce their private practice and paragraph 43 commitments to enable them to comply with sub-paragraph 42.a. and this is substantially confirmed by their earnings return due at that time.
 - c. When consultants or associate specialists have been regraded under 42.b. above, they will not be able to exercise an option to return to whole-time status until two consecutive years have passed in which they can show that their private practice and paragraph 43 earnings have not exceeded the limit of 10%.
 - d. Unallocated.
 - e. Where private practice and paragraph 43 work is undertaken by whole-time practitioners outside the HS hospitals where they are contracted to provide a service, it shall be so limited that significant amounts of their time are not taken up in travelling to and from private commitments.
 - f. An employing authority may interpret failure to provide a certificate that a practitioner's private practice and paragraph 43 earnings have not exceeded

10% of the practitioner's whole-time HS salary within three months of request as evidence that the practitioner concerned has private practice and paragraph 43 income in excess of 10% of his or her salary.

Treatment of earnings from work performed on HS patients by separate arrangement outside the practitioner's principal contract of employment

43. Earnings from work performed on HS patients by separate arrangement outside the practitioner's principal contract of employment, eg. work under a contract between a practitioner and a GP fund holder, or work under a contract between a practitioner and an employing authority which is not subject to these terms and conditions of service, shall be added to the income from any private practice for the purposes of the 10% earnings limit specified in paragraph 42 above. Income from the supply of family planning services under the terms of HSS(TC8) 3/77 is not included under this provision and should not be counted.

CLINICAL AND SENIOR MEDICAL OFFICERS: ADDITIONAL WORK

44. An employing authority may permit a full-time senior medical officer (community medicine), senior clinical medical officer or clinical medical officer to undertake additional work remunerated on a sessional basis, provided the authority is satisfied that this does not conflict with the performance of his or her normal duties. In the case of SCMOs such work may represent managerial duties or highly specialist professional responsibilities.

45-48. Unallocated.

MEDICAL SUPERINTENDENTS AND DEPUTY MEDICAL SUPERINTENDENTS

49. a. Medical superintendents or deputy medical superintendents graded as consultant, SHMO or AS who are normally engaged for at least thirty-two hours a week in clinical work shall be remunerated in respect of the whole of their duties at the appropriate rate for their grade.
- b. An allowance shall be paid to a clinician (whether whole-time or part-time) who holds an appointment as medical superintendent of one or more psychiatric hospitals or an appointment the duties of which require him or her to be the chief officer of such hospital or hospitals for the whole of the therapeutic sphere. This allowance will be superannuable. A deputy medical superintendent shall receive no part of this allowance.
- c. The salaries of a medical superintendent and a deputy medical superintendent engaged wholly or partly in administrative duties who are not covered by sub-paragraph a. above shall be determined on an individual basis by the Department in consultation with the British Medical Association. A medical superintendent whose duties are partly clinical and partly administrative and who holds an appointment of the kind specified in sub-paragraph b. shall be entitled to the additional allowance under that sub-paragraph.

DIRECTOR OF PUBLIC HEALTH

50. a. A Director of Public Health shall receive a supplement within the range set out in Appendix 1, depending on the band within which his or her post falls and

the weight of the post as assessed by his or her employing authority. The definition of the relevant bands is set out below:

Band A	Regional Director of Public Health	-
Band B	Population over 450,000	Eastern Board
Band C	Population 250,000-449,999	Northern, Southern and Western Board
Band D	Population 50,000 – 249,000	-

- b. Supplements shall be an element of remuneration and shall be superannuable.
 - c. Population shall be reviewed annually at 1 April. The relevant population for this purpose shall be the Registrar General's estimate of the home population for the employing authority at the previous June.
 - i. If the home population for the employing authority increases to a higher population band for one year only, this shall have no effect on the minimum supplement. If the rise to a higher population band is confirmed by the next year's estimate, a review of the supplement payable should be completed within 6 months. Payment of any increased supplement shall be made with retrospective effect from 1 April of the previous year.
 - ii. If the home population for the employing authority falls to a lower population band for one year only, this shall have no effect of the minimum supplement. If the fall in population is confirmed by the next year's estimate, a review of the supplement payable should be completed within 6 months. Where this would result in a reduction on the value of the supplement, an officer shall retain the cash value of his or her existing supplement for so long as that remains more favourable.
51. The incremental supplements for 1991-92, together with the supplement to DsPH of areas designated for teaching are set out in HSS(TC8) 8/92. They will not be subject to revaluation.

52-60. Unallocated.

PART-TIME APPOINTMENTS

Assessment of Duties

61. For part-time practitioners in the grades of consultant, AS, SHMO, SHDO, hospital practitioner and part-time medical or dental officers (paragraph 94 or paragraph 105 appointments), the employing authority shall make a general assessment, in terms of notional half-days and fractions thereof, of the average time per week required by an average practitioner in the grade and specialty to perform the duties of the post. A notional half-day is regarded as the equivalent of a period of 3½ hours flexibly worked. In making this assessment, the employing authority shall take into account such duties as are set out at paragraph 30.c above. They should also take into account time necessarily required in travelling between home or private consulting-room, whichever is the nearer, and the hospital(s) or other place(s) of work served (unless the journey is one which the practitioner would undertake irrespective of his or her work for the employing authority), subject, unless the circumstances warrant

exceptional treatment, to a maximum of half an hour each way in respect of journeys to the practitioner's main hospital or principal place of work. There should be excluded from the computation any element of time for committee work other than on behalf of the employing authority, and care of private patients under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972. There shall also be excluded time required for domiciliary consultations (for which special fees are payable), and any time contracted for, and remunerated separately, under the provisions of paragraph 14. This paragraph shall also be used as the basis for assessing the minimum work commitment of maximum part-time practitioners - see sub-paragraph 13.b.

Rounding Up

62. Where a practitioner's appointment is with a single employing authority and in one grade only, any fraction of a notional half-day resulting from the assessment made in accordance with paragraph 61 above shall count as a notional half-day, so that the notional half-days resulting from the general assessment of duties of the practitioner's appointment shall always be in terms of whole numbers of notional half-days.

Remuneration of Part-Timers

63. The salary of a part-time practitioner in the grades of consultant, SHMO, SHDO and AS shall be one eleventh of the appropriate whole-time salary for each notional half day, together, in the case of a part-time consultant, with the same proportion of any distinction award held, subject to the maximum in paragraph 69. In the case of a consultant or AS this should include a proportion of any Discretionary Point(s) granted.

Part-Time Appointments in the Staff Grade

64. A part-time practitioner shall be remunerated at one-tenth of the appropriate basic rate for each session. Such a practitioner contracts for an average work commitment equivalent to no more than 9 sessions a week, to be assessed in accordance with paragraph 17.

Part-Time Practitioners in the Training Grades

65. a. A practitioner in the training grades may contract with one or more employing authorities for an aggregate of less than 40 hours of duty per week.
- b. Details of remuneration for a part time practitioner in these grades can be found at paragraphs 21 and 22.
- c. i. Pensionable pay for contributions purposes will be the appropriate proportion of actual whole-time basic pay (1.0). However, contributions must also be paid on any additional hours of duty a practitioner works between their contracted hours and a maximum of 40 hours per week.
- ii. The employing authority must make arrangements to track and record these additional hours for pension purposes.

- 66-68. Unallocated.

Maximum remuneration of part-time appointments

69. a. The maximum remuneration for part-time appointments shall be that appropriate to:
- i. five notional half-days for practitioners in the HP grade and practitioners, other than those specified in sub-paragraph 69.a.ii, holding appointments under paragraphs 94 and 105;
 - ii. nine notional half-days for practitioners in the grades of consultant, AS, SHMO and SHDO, and for practitioners holding appointments under paragraphs 94 and 105 who also provide general medical or dental services under Articles 56 and 61 of the Health and Personal Social Services (Northern Ireland) Order 1972;
 - iii. nine sessions for practitioners in the Staff Grade.
- b. Where a practitioner holds part-time appointments with more than one authority, these maxima shall apply to the aggregate remuneration from all the authorities concerned.
- c. These maxima shall not include payments made for an additional notional half-day contracted under paragraph 14 or in respect of exceptional consultations performed for an authority with whom the practitioner is not in contract, payment made in respect of work as locum tenens, payments for domiciliary consultations, fees paid for items of service related to family planning, payments for an additional session under sub-paragraph 16.b, and any allowance paid to practitioners holding appointments as medical superintendents of psychiatric hospitals.

JOB SHARING

70. Subject to the provisions of these Terms and Conditions of Service where appropriate, arrangements for the job sharing of a post in any grade shall be determined in accordance with the provisions of temporary Appendix IX.

MULTIPLE APPOINTMENTS

71. Where a practitioner holds appointments in more than one grade other than the training grades and/or with more than one authority, the practitioner's remuneration in respect of each appointment shall be calculated in accordance with the method set out in paragraphs 72 to 75. However, a notional half-day arising from an additional session contracted under the terms of paragraph 14 or an additional session under sub-paragraph 16.b. shall not be included in the calculation.

Multiple appointments in one grade

72. Where a practitioner holds appointments in one grade only:
- a. each authority shall assess the number of notional half-days or sessions and fractions thereof per week in respect of the contract with that authority;

- b. the total number of notional half-days or sessions so assessed shall be aggregated. Where the aggregate number of half-days includes a fraction of a half-day the total shall be rounded up to the next whole number;
- c. the remuneration due under each contract shall be a fraction of the total salary calculated accordingly: the fraction being the number of notional half-days or sessions assessed by the authority under sub-paragraph 72.a. divided by the total number of notional half-days or sessions aggregated under sub-paragraph 72.b. before any fraction of a half-day in the total has been rounded up.

Multiple appointments in more than one grade

- 73. Where a practitioner holds appointments in more than one grade (whether with one employing authority or more), the practitioner's remuneration shall be calculated as follows;
 - a. the total number of notional half-days or sessions shall be assessed as in subparagraphs 72.a. and b.;
 - b. for each grade in which a contract is held the notional total salary that would be payable if all the contracts were in that grade shall be calculated;
 - c. the remuneration due under each contract shall be a fraction of each notional total salary calculated as in sub-paragraph 73.a.; the fraction being determined as in subparagraph 72.c.
- 74. Not allocated. |

Discounting of notional half-days or sessions in excess of limit

- 75. If the number of notional half-days or sessions for separate appointments (or groups of appointments) when added together exceeds the limit for that type of appointment, there shall be excluded from the calculation (at all its stages) such number of notional half-days or sessions and fractions thereof as may be necessary to ensure that the limit is not exceeded, the practitioner being entitled to determine under which contract or contracts these notional half-days or sessions and fractions thereof shall be discounted.

Medical and dental staff holding more than one contract of employment in the HPSS

- 76. a. A consultant or AS who holds under these Terms and Conditions of Service two or more appointments, one or more of which is with a HSS Trust established under the Health and Personal Social Services (Northern Ireland) Order 1991 and which taken together constitute whole-time employment under these Terms and Conditions of Service, shall be treated as a whole-time practitioner. Where a consultant or an AS holds such appointments, he or she may opt to be treated as either a whole-time or a maximum part-time practitioner, and the employing authority(ies) shall not unreasonably withhold agreement. The employing authority(ies) shall agree with the Trust(s) the appropriate adjustment to the practitioner's salary (and distinction award or discretionary point(s), if applicable) in accordance with paragraph 13, and the provisions of paragraphs 13 and 40-42 shall apply.

- b. If a consultant or AS holds two or more appointments, one or more of which is with a HSS Trust but is not under these Terms and Conditions, the employing authority shall:
 - i. determine whether the practitioner holds the appointments taken together on a whole-time, maximum part-time, or other part-time basis; where the practitioner holds the appointments on a whole-time or maximum part-time basis, he or she may exercise the option in paragraph 13, subject to the provisions of paragraphs 40-42, and the authority shall not unreasonably withhold agreement;
 - ii. where the practitioner is treated as a whole-time practitioner under i. above, apply the provisions of paragraphs 40-42; and for this purpose the gross salary referred to in paragraph 42 shall be regarded as the equivalent of the gross salary of a whole-time consultant or AS employed wholly under these Terms and Conditions of Service (including any distinction award or discretionary point(s), but excluding any other fees, whether payable under these Terms and Conditions of Service or otherwise).

The 10/11ths provision in paragraph 13.b shall be 10/11ths of the salary (and any distinction award or discretionary point(s)) payable for the commitment under these Terms and Conditions of Service.

NON-HPSS EMPLOYMENT

- 77. Practitioners in the grades of SR, SpR, R, SHO, HO and PRHO who are required as part of their approved training programme to work in non-HPSS organisations shall be guaranteed continuity of service for employment purposes.

TEACHING AND RESEARCH

Joint Appointments

- 78. Where a consultant holds appointments with one employing authority or more and with a University, which together constitute whole-time employment (excluding any notional half-day contracted for under paragraph 14), the consultant shall be treated as though he or she were employed jointly on a full-time basis.

79-81. Unallocated.

Whole-time posts

- 82. Whole-time joint appointees shall receive the full value of any distinction award or discretionary point(s) made to them according to the average time per week for which they are engaged in clinical work, as follows:

Average number of hours of clinical work per week**Proportion of award payable**

21 or more	The full amount
17½ or more but less than 21	80%
14 or more but less than 17½	65%
10½ or more but less than 14	50%
7 or more but less than 10½	35%
3½ or more but less than 7	25%
An assessable amount of clinical work but less than 3½ hours	15%

Practitioners engaged in private practice

83. Whole-time joint appointees who are permitted to engage in private practice and to retain the fees therefrom, or to receive a consolidated sum in return for handing these fees to their employer, shall, for the purpose of determining the amount of any distinction award or discretionary point(s) payable, be treated as part-time joint appointee and the provisions of paragraph 84 shall apply to them.

Part-time posts

84. Part-time joint appointees shall be paid fractions of any awards made to them on the same basis as part-time clinicians according to the amount of time spent in clinical work, subject to a maximum of that appropriate for nine notional half-days.

Teaching duties undertaken by part-time consultants

85. Consultants who hold paid part-time appointments with an authority and who undertake teaching duties concomitantly with their clinical work shall be permitted to retain any remuneration they may receive from the University or School in recognition of their teaching duties.
86. Not allotted.

GENERAL PRACTITIONER HOSPITAL UNITS**Staff Fund**

87. The employing authority shall create a staff fund in respect of each hospital in which medical services are provided by general practitioners where they take full clinical responsibility for their patients. The fund shall be shared among the general practitioner staff as they may themselves determine.

In-patients

88. A payment should be made to the fund for each eligible bed (other than private pay-beds and maternity beds) in the hospital or unit. An eligible bed shall be defined as follows:
- in a hospital or unit in which average bed occupancy during the preceding calendar year exceeded 70%, the average number of staffed available beds during that year;

- b. in a hospital or unit in which average bed occupancy during the previous calendar year was 70% or less, the average daily number of occupied beds during the preceding calendar year multiplied by 1.2.

Beds under the control of a consultant

89. Where beds in these hospitals or units are under the control of a consultant, the beds shall:
- a. be included in computing the staff fund if, in the absence of the consultant, responsibility for attending the patients is shared by the general practitioner staff;
 - b. be excluded from the calculation if one or more general practitioners or other medical staff hold contracts with the health authority whole-time or for a certain number of notional half-days for the purpose of attending to the patients in these beds, under the direction of the consultant.

Casualty work

90. Where an employing authority decides:
- a. that it is necessary to maintain a casualty service in a hospital in which general practitioners have beds under their control, or exceptionally, where they do not; and
 - b. that the casualty service can be most appropriately staffed by relying at all times at which service is offered upon general practitioners organising the service themselves and acting on their own clinical responsibility payment should be made through the staff fund for such casualty work.

Basis of payment

91. Except where the number of casualties seen is very small (for which, see paragraph 93 below) payment into the fund shall consist of:
- a. a flat-rate payment, to reflect the availability of the service; this being at the higher rate if the authority wish a twenty-four hour service to be provided and at the lower rate if a service is offered only for twelve hours or less (ie., only by day or only by night). Payment shall be made pro-rata to the appropriate rate if a service is not offered every day of the week;
 - b. a sum calculated according to the annual number of notional half-days of actual clinical work required by the authority in order to provide the casualty service. A notional half-day shall be assessed in accordance with paragraphs 61 and 62 of these Terms and Conditions of Service.

Limit on number of sessions

92. The number of sessions under which payment is made under sub-paragraph 91.b. above shall not exceed 9 sessions a week where a 12 hour (or less) service is provided and 18 sessions per week for a 24 hour service, unless the Department after consultation with the profession's representatives shall otherwise direct.

Very small casualty units

93. Where the number of new casualty attendances is expected to be less than two hundred a year, a sum shall be paid into the fund for each new attendance seen by a member of the staff participating in the fund.

APPOINTMENTS HELD ONLY BY PART-TIME PRACTITIONERS**Part-time medical officers**

94. a. In convalescent homes, general practitioner maternity hospitals or other types of hospital where no other rate is appropriate, including general practitioner hospital units in respect of work not covered by payments into the staff fund, payment shall be made at the rates set out in Appendix I for each weekly notional half-day or less a year, the notional half-days being assessed as in paragraph 61.
- b. Where a practitioner holds appointments under this paragraph with more than one authority or holds one or more appointments under this paragraph and one or more part-time appointments under paragraph 61, the practitioner's remuneration in respect of each appointment shall be calculated in accordance with the methods set out in paragraphs 71 to 75.

95-103. Unallocated.

Occasional work in the Blood Transfusion Service

104. Where a practitioner is not in contract with an employing authority and undertakes occasional work for the Blood Transfusion Service but is not engaged sufficiently frequently to make a part-time appointment under paragraph 94 appropriate payment shall be made, irrespective of the qualifications of the practitioner, on a sessional basis at the rates set out in Appendix I.

Part-time General Dental Practitioners

105. The remuneration of part-time general dental practitioner appointments shall be as provided for part-time medical officers in paragraph 94.

ARRANGEMENTS FOR COVER DURING ABSENCES AND LOCUM TENENS**Consultant, SHMO/SHDO and AS**

106. Subject to paragraphs 112 and 113, practitioners shall be expected in the normal run of their duties to deputise for absent colleagues in these grades so far as is practicable, even if on occasions this should involve interchange of staff between hospitals. However, where the normal duties of an AS colleague involve sharing a duty rota with staff in the training grades, then consultants, SHMOs and SHDOs will not be expected to cover that part of the AS colleague's duties. Where appropriate these will fall to the AS's colleagues on the rota under sub-paragraph 110.c. When deputising is not practicable the authority (and not the practitioner) shall be responsible for the engagement of a locum tenens, but the practitioner shall have the responsibility of bringing the need to their notice. The authority shall assess the number of notional half-days required, a notional half-day being regarded as the

equivalent of three and a half hours, the basis of the assessment being as in paragraphs 61 and 62.

Hospital Practitioner

107. A practitioner who holds a hospital practitioner post under the provisions of sub-paragraph 69 a. may also act as a locum in a hospital practitioner post, provided that the total number of locum sessions shall not exceed twenty-five in any one financial year.

Staff Grade

108. a. Subject to paragraph 112, practitioners are liable so far as is practicable to deputise for absent colleagues in the same or other grades who participate in the same duty roster. Such liability is confined to absences due to:
- i. annual and study leave; or to
 - ii. other forms of leave and unfilled vacancies not exceeding two weeks.

Where no liability arises, deputising shall be subject to the practitioner's agreement. Where deputising is not practicable, the authority, and not the practitioner, shall be responsible for the engagement of a locum tenens. The authority shall assess the number of sessions required, each session being regarded as four hours and the basis of the assessment being as in paragraph 17.

- b. Where practitioners undertake duty in accordance with this paragraph that falls outside their normal contracted hours and their commitments under sub-paragraph 15.iii and iv, the authority shall, where practicable, allocate an equivalent off-duty period. If it appears to the authority that such allocation has not been or is unlikely to be made within six months, or by the terminal date of the practitioner's contract if sooner, payment shall be made retrospectively for the actual amount of duty undertaken. Payment shall be at one-tenth of the weekly locum rate set out in Appendix I for each session, subject to a maximum of fifty sessions in any one financial year.

109. Unallocated.

Training Grades

110. a. Subject to paragraphs 112 and 113, and to sub-paragraphs b. to g. below, practitioners in the training grades shall be expected in the normal run of their duties, and within their contract and job description, to cover for the occasional brief absence of colleagues as far as is practicable (for the purposes of paragraph 110, a colleague is another practitioner participating in the same duty rota or shift).
- b. Sick colleagues will normally be covered only for short periods of absence. Any additional cover required for sickness shall be provided under the terms of subparagraph e. below.
- c. Account should necessarily be taken in the job description of the need to provide cover for annual and study leave of colleagues, provided always that the resulting increase in duties does not cause a practitioner's average

weekly hours to exceed the limits set out in paragraph 20. Such prospective cover shall not extend to other forms of leave or to vacant posts.

- d. In addition, practitioners will be prepared to perform duties in occasional emergencies and unforeseen circumstances without additional remuneration but may be granted time off in lieu at the discretion of the employing authority. Commitments arising in such circumstances are, however, exceptional and practitioners should not be required to undertake work of this kind for prolonged periods or on a regular basis.
- e. In circumstances other than those in b. to d. above, eg., where cover is required for a practitioner on maternity leave or for a temporarily vacant post, the employing authority (and not the practitioner) shall be responsible for the engagement of a locum tenens to undertake work which in their view must be carried out, but the practitioner shall have the responsibility of bringing the need to their notice. The employing authority shall assess the number of hours required.
- f. Arrangements for engaging locums shall, wherever practicable, be made in advance of need.
- g. Practitioners on a 1 in 2 rota shall not be obliged to contract prospectively to cover for a colleague during the latter's absence on annual or study leave. Where cover is required, every effort should be made to obtain a locum under the terms of subparagraph 111.d. Where such a locum cannot be obtained, the employing authority may contract with a practitioner to provide locum cover under the terms of subparagraph 111.c.

LOCUM PRACTITIONERS: BASIS OF CONTRACT

- 111. a. Practitioners in the training grades may be employed on a locum tenens basis by their own employing authority but not within the hours for which they are already contracted and provided that such employment does not cause their average weekly hours to exceed the limits set out in paragraph 20 (except in circumstances where they are acting up as a consultant).
- b. Practitioners in the training grades shall not undertake locum medical or dental work for any other employer where such work would cause their contracted hours to breach the controls set out in paragraph 20. (except in circumstances where they are acting up as a consultant).
- c. A practitioner employed in a training grade (except Locum Appointments for Training) accepting an appointment as on a locum basis (cf. sub-paragraph 110.f) in any of these grades, in a hospital identified in the job description applicable to the practitioner's main employment, will contract for each hour in such appointments at the standard hourly rate in accordance with the pay banding arrangements with effect from 1 December 2000 as set out in Table 2 of Appendix I, or shall be entitled to receive a days leave for each week night (the night of Friday/Saturday being classed as a week night) or complete Saturday (including the night of Saturday/Sunday) or Sunday (including up to the start of normal duty on Monday morning) of additional duty. The taking of such leave shall be subject to the needs of the service and to the authority's approval. Any such leave that has not been taken within twelve months or by the end of the practitioner's contract, whichever is the earlier, shall be relinquished. Payment shall be made retrospectively under

the terms of this sub-paragraph for the actual amount of additional duty undertaken at the time and for which the practitioner has not otherwise been paid and has been unable to take leave in compensation.

- d. A practitioner engaged as a locum for a week or less in a training grade (except Locum Appointments for Training) in circumstances other than those described in c. shall be paid at the standard hourly rate in accordance with the pay banding arrangements with effect from 1 December 2000 as set out in Table 2 of Appendix I.
- e. A practitioner engaged as a locum for less than 40 hours of duty per week in a training grade (except Locum Appointments for Training) in circumstances other than those described in c. above, shall contract for hours on the basis set out in paragraph 65 and, in accordance with the pay banding arrangements with effect from 1 December 2000, at the rates set out in Table 2 of Appendix I.

ACTING UP ALLOWANCES

112. An acting-up allowance shall be payable to a practitioner who with the approval of the authority takes over the full range of duties and responsibilities of a grade senior to his or her own, subject to the following provisions:

- a. when a consultant is absent for more than a qualifying period of fourteen days other than on annual or professional leave within the recommended standard for the senior grade, and arrangements cannot be made either for cover by other consultants or for a locum to be engaged, a practitioner below the grade of consultant shall be paid for acting-up if the authority consider it is practicable for the practitioner to take over the full range of duties and responsibilities of the absent consultant without supervision;
- b. the allowance shall be such as to bring the practitioner's rate of pay to the rate of pay he or she would receive on promotion to the senior grade;
- c. payment of the allowance shall have effect from the first day of the qualifying period;
- d. for the purposes of paragraphs 1, 15 to 24, 27 and 28, 49, 121 to 134, 140 to 149, 165 and 166, 205 and 206, 277 to 284 and 311, periods acting-up in a grade shall be treated as service in that grade. Paragraphs 190 and 191 shall not apply to a practitioner in respect of an appointment in which he or she is acting-up. Provision for protection of salary in paragraph 132 excludes acting-up allowances;
- e. continuity of a period of acting-up will not be broken by days on which the practitioner is not required to be on duty; continuity will normally be broken by absence on leave of any kind of more than fourteen days and a further qualifying period of fourteen consecutive days will be required after such absence. Where a practitioner acts-up for a long period, he or she will be entitled to take in addition, without breaking continuity, whatever annual leave in excess of fourteen days the practitioner has earned in the grade in which he or she is acting up;
- f. exceptionally, a practitioner may be paid for acting-up in a post below the grade of consultant where the health authority, in consultation with the

responsible consultant, finds that no other means of reallocating the duties and responsibilities of a post are practicable.

REMUNERATION OF LOCUM PRACTITIONERS

Consultants

113. a. Payment shall be made to a locum engaged to fill a consultant post at the rates set out in Appendix I. The higher rate is payable to a retired consultant, who before his or her retirement was paid at the maximum point of the salary scale. In this context, a retired consultant is a practitioner who does not hold any regular paid appointment under these Terms and Conditions of Service and whose last regular appointment as a consultant (whether paid or honorary) came to an end either:
- i. when the practitioner was at or over the minimum age at which the practitioner could receive an age retirement pension under his or her scheme; or
 - ii. as a result of compulsory redundancy, irrespective of the age at which this occurred.
- b. A locum consultant may receive domiciliary consultation fees.
- c. Such a locum must have full registration.

Associate specialists

114. Payment shall be made to a locum AS at the rate set out in Appendix I.

Other posts

115. a. Subject to paragraph 108, locum practitioners in the Staff Grade shall be paid at the rate set out in Appendix I. The maximum remuneration shall be that appropriate to thirteen sessions for whole-time appointments and to nine sessions for part-time appointments. Sub-paragraph 16.b shall apply to locum practitioners, provided that the period of notice shall not exceed the term of the contract.
- b. Locum practitioners engaged to fill posts in other grades shall, subject to paragraph 111, be paid at the rates set out in Appendix I.

Maximum remuneration for part-time locum consultants, AS and SHMO/SHDO

116. The maximum remuneration (excluding fees) of a locum practitioner engaged on a part-time basis in these grades shall be that appropriate to nine notional half-days a week.

APPLICATION OF TERMS AND CONDITIONS OF SERVICE TO LOCUM PRACTITIONERS

117. The following paragraphs of these Terms and Conditions of Service do not apply to practitioners engaged as a locum tenens: 1 to 11, 190 and 191, 196 to 198 and 201 to 210.

Paragraph 315 (removal expenses) shall only apply at the discretion of the employing authority. All other provisions of these Terms and Conditions of Service apply to locums, subject to the provisions of paragraphs 147, 211 to 213, 241 and 289.

REGISTRATION OF LOCUM PRACTITIONERS

118. A medical practitioner engaged as a locum consultant shall be fully registered. A medical practitioner engaged as a locum for any other grade of staff shall have full or limited registration, save that a medical practitioner with provisional registration may be engaged as a locum in an FHO1 or HO post that is normally occupied by a doctor with such registration. A dental practitioner engaged as a locum consultant should be a registered dental practitioner or a fully registered medical practitioner. For dental posts other than consultant, practitioners appointed as locums should be either registered or temporarily registered dental practitioners, or fully or limited registered medical practitioners.

119-120. Unallocated.

STARTING SALARIES AND INCREMENTAL DATES

121. Except as provided elsewhere in these Terms and Conditions of Service, practitioners shall on appointment be paid at the minimum point of the scale for a post in the grade to which they are appointed; and their incremental date shall be the date of taking up their appointment.

COUNTING OF PREVIOUS SERVICE**Regular appointments**

122. a. Where practitioners are appointed to a post in a grade having already given regular service in one or more posts in that grade or a higher grade (measured in terms of the current maximum rate of whole-time or full-time salary), all such service shall be counted in full in determining their starting salary and their incremental date, provided that service:
- i. in the consultant grade prior to 1 April 1975; or
 - ii. in the AS grade, or in grades treated as equivalent thereto, prior to 1 April 1978, shall count at the rate of one half.

General Practitioners

122. b. On entry to a post under these terms and conditions of service a general practitioner who has been vocationally trained and has 4 years experience as a principal in general practice, or a general practitioner who has at least 8 years post-registration experience including at least 5 years as a principal in general practice, shall have entitlement to protection either of his or her superannuable income in his or her last complete year of practice uprated by

the factor determined for the purpose of regulation 64(2)(a) of the Health and Personal Social Services (Superannuation) Regulations (Northern Ireland) 1984 (SR 1984 No 336) or at the current rate of the second incremental point on the consultant scale, whichever is the lower.

Locum posts

123. a. Where practitioners have held a regular appointment in a grade or higher grade, all subsequent locum service in that grade (or higher grade) shall count towards incremental credit as though it had been service in a regular post.
- b. Except as provided for below, all locum service in other cases of three or more continuous months' duration (as defined in paragraph 213) in the same or a higher grade shall count towards incremental credit at the rate of one half on regular appointment to that grade.
- c. Service before 1 April 1975 as a locum consultant or before 1 April 1978 in a locum capacity as an AS, or in a grade treated as equivalent thereto, shall, subject to the conditions in sub-paragraph b. above, count at the rate of one quarter.

Counting of service while on leave

124. Absence on leave with pay under paragraphs 205 to 211, 214 to 242 and 250 to 262, or absence on leave without pay in the circumstances referred to in paragraph 192, shall count for incremental purposes.

Service outside HS hospitals, public health medicine and the community health services

125. Employing authorities will in determining the starting salaries of medical and dental staff employed under these Terms and Conditions of Service take into account equivalent service or service in a higher grade outside HS hospitals, public health medicine and the community health services, other than as locum tenens, subject to any guidance issued by the Department.

INCREMENTS ON FIRST APPOINTMENT TO A GRADE**Consultants**

126. When a consultant is appointed, the starting salary shall be determined in accordance with paragraphs 121 to 125. Where a consultant with less than two years' equivalent service (paragraph 125) is first appointed to the grade, authorities shall have discretion to fix the starting salary at either of the two next incremental points above the minimum by reason of:
- i. equivalent service; or
- ii. any or all of the following - service in HM Forces, or in a developing country, special experience, qualifications, provided the total salary does not exceed the second incremental point of the scale.

Associate specialist

127. When an AS is appointed to the grade, the starting salary shall be determined in accordance with paragraphs 121 to 125, provided that:
- i. all but the first two years of completed registrar service or service in a higher grade or their equivalent (paragraph 125) may be counted for incremental purposes, subject to paragraphs 122 to 124;
 - ii. where the starting salary so determined is at the minimum or first incremental point, the authority shall have discretion to fix the starting salary at the first or second incremental point by reason of age, special experience and qualifications taken as a whole.

Staff Grade

128. Employing authorities may appoint a staff grade practitioner at any point on the scale, including the optional points. In determining the starting salary, the employing authority shall make reference to the appropriate guidance issued by the Department and take account of the skills, experience and qualifications of the practitioner including:
- i. time spent in HS employment, including periods of locum appointment;
 - ii. equivalent service outside the HS;
 - iii. relevant qualifications obtained in postgraduate education and experience gained through research and teaching.

129. Unallocated.

Specialist/Specialty Registrar

130. On first appointment as a SpR or StR, one increment and one only shall be given for any year or part of a year in excess of two spent previously in the SHO and/or FHO2 grade.

Hospital Practitioner

131. Authorities shall have discretion to fix the starting salary of a hospital practitioner on first appointment to any of the three next incremental points above the minimum of the scale by reason of age, special experience and qualifications taken as a whole.

Protection

132. Where a practitioner in a career grade takes an appointment in a training grade which is recognised by the appropriate authority as being for the purpose of obtaining approved training (which may include training to enable the practitioner to follow a career in another specialty) and the practitioner has given continuous service in a career grade post or posts for at least 13 months immediately prior to re-entering training, the practitioner shall, while in the training grade, continue to receive a salary protected on the incremental point or the threshold the practitioner had reached in his or her previous career grade appointment. Such a practitioner shall receive the

benefit of any general pay awards. On reappointment to a career grade post, the practitioner's starting salary should be assessed as if the period spent in the approved training post had been continuing service in the previous career grade. Where a practitioner re-entering training from a career grade has held a recognised training post (or equivalent service overseas) in the 13 months of contracted employment prior to re-entering training, the intervening period spent in the career grade shall be taken as continuing service in the training grade, and the practitioner will be re-appointed on the appropriate incremental point of the training grade scale. Where pay in the earlier training post was already protected under these provisions, such protection shall continue. Practitioners whose previous appointment was in Great Britain, Isle of Man or Channel Islands hospital service are eligible for protection of salary under the terms of this paragraph.

Promotion Increase

133. a. Subject to sub-paragraph b. below, where practitioners have been paid in their previous regular appointment at a rate of salary higher than or equal to the rate at which they would (were it not for this provision) be paid on taking up their new appointment, then their starting salary in the new appointment shall be fixed at the point in the scale next above that previous rate, or at the maximum if that previous rate were higher.
- b. Where the previous appointment was as a part-time medical or dental officer under paragraph 94 or 105, sub-paragraph a. shall apply only where that appointment has been held for twelve months or more.
- c. Where a practitioner has been paid on one of Points 1, 2, 3, 4 or 5 of the Senior House Officer scale for a period of five months or more in their last appointment prior to promotion to Specialist Registrar, their starting salary shall be determined as under sub-paragraph a. above and they shall retain their existing incremental date.
- d. Where a practitioner is appointed to the Specialty Registrar grade from the SHO grade transitional arrangements will be set out in Circular HSS (TC8) 3/2007.

Hard to Fill Consultant Posts

134. If a consultant post has been vacant for at least a year and has been unsuccessfully advertised at least twice, an employing authority may advertise the post at the maximum of the salary scale excluding Discretionary Point(s). When such a post is filled, other consultants whose principal commitment is in the same hospital and specialty as the principal commitment of the advertised post shall be entitled to be advanced to the maximum of the salary scale from the date that their new colleague takes up post.

INTERPRETATION

135. For the purposes of paragraphs 121 to 134:
 - a. the rate of salary for a part-time practitioner shall be taken to be the corresponding point in the salary scale, except for a practitioner employed as a part-time medical or dental officer under paragraphs 94 or 105, for whom it shall be the maximum amount appropriate to nine notional half-days.

- b. service in a part-time or honorary appointment shall count in exactly the same way as service in a whole-time appointment;
- c. the rate of salary in the previous post shall be taken to be the present rate of remuneration for such a post, whether or not this rate was in fact paid;
- d. the rate of salary in the previous post of a practitioner shall be inclusive of any allowance paid for acting as Medical Superintendent and of the allowance to SHMOs or SHDOs occupying posts graded as consultants. It shall exclude extra duty allowance, or other fees payable by the health authority or allowances for junior doctors in peripheral hospitals;
- e. A practitioner entitled to protection under paragraph 132 shall continue to receive the leave entitlement of his or her previous post and shall receive the appropriate training grade salary plus the supplement or his or her protected salary, whichever is the greater, except that where the salary is protected at a point on the training grade scales the supplement for the new post shall be paid in any case. The appropriate training grade salary shall be determined as the point on the training grade incremental scale previously reached, plus recognition of service in the same or a higher grade subject to the provisions of paragraph 123 and such guidance as may be published from time to time. For career grade practitioners entering a training grade, the basic salary paid in the previous appointment shall also, for protection purposes, not include any payments for an additional notional half-day under paragraph 14, additional sessions under paragraph 16, payments for additional Programmed Activities, out of hours or on-call, or a salary supplement, as appropriate, for which the practitioner was contracted in that career grade appointment. The practitioner will, however, be entitled to have total pay in the training post calculated as if the duties contracted for in the training post had been carried out under the relevant terms of the career grade contract held before re-entry to training.
- f. Unallocated

136. For the purposes of paragraphs 121 to 134, service in the hospital service of Great Britain, the Isle of Man and the Channel Islands shall count as a service in the equivalent grade in a HS hospital.

137-139. Unallocated.

DOMICILIARY CONSULTATIONS

Definition

140. A domiciliary consultation shall, for the purposes of these Terms and Conditions of Service, be understood to mean a visit to the patient's home, at the request of the general practitioner and normally in his or her company, to advise on the diagnosis or treatment of a patient who on medical grounds cannot attend hospital. Visits not falling within this definition include:
- a. a visit made at the instance of a hospital or specialist to review the urgency of a proposed admission to hospital or to continue or supervise treatment initiated or prescribed at a hospital or clinic;

- b. a visit for which a separate fee is payable as part of work undertaken in the community health services;
- c. in the case of dental staff, a visit undertaken as part of a practitioner's responsibilities within the community dental services.

Fees

141. a. Subject to the provisions of b. below and paragraphs 143 to 145 and 148, a fee shall be paid for each consultation at the standard rate set out in Appendix I.
- b. Where a practitioner is called for domiciliary consultation and sees on the same occasion in the same residence or institution more than one clinically related case, a consultation fee shall be payable at the standard rate for the first such case seen, and at the intermediate rate for up to three such further cases. Where more than four clinically related cases are seen, no additional fees shall be payable for such subsequent cases.

Additional fees

142. An additional fee shall be payable:
- a. at the intermediate rate where an operative procedure other than obstetrics is undertaken or where the practitioner uses his or her own electrocardiograph, portable x-ray or ultra-sonography apparatus, or portable audiometer;
 - b. at the standard rate for an obstetric operation, or for the administration of a general anaesthetic for any operative procedure.

Series of consultations

143. Where:
- a. a pathologist carries out a series of domiciliary consultations in connection with anticoagulant therapy, or to supervise treatment with cytotoxic drugs; or
 - b. exceptionally, a psychiatrist and an anaesthetist jointly carry out a series of domiciliary consultations to administer electro-convulsive therapy, fees at the standard rate (plus any additional fee or fees where appropriate) shall be payable for each consultation. Unless a general practitioner, for clinical reasons, considers that a patient requires more than three visits, the payment shall be limited to an overall maximum of three consultation fees during any one illness.

144. Unallocated.

Ophthalmologists

145. Where an ophthalmologist completes form A655 under the arrangements for sessional work in the community health service, in the course of or following a domiciliary visit for hospital purposes, ie. without a further visit being necessary, a combined fee shall be paid (by his or her employing authority).

Long distance payment

146. The authority shall make a payment in respect of travelling time, additional to the fees set out above and to the normal travelling and subsistence expenses, at the lower rate for a journey to a place over twenty and up to forty road miles distance, with an additional fee at the lower rate for every further twenty miles outward.

Locum tenens

147. Locum consultants shall receive fees for domiciliary consultations in the same way as consultants holding permanent appointments.

Maximum number of visits

148. a. A practitioner shall not receive fees for more than 300 domiciliary consultations in a year.
- b. Where a practitioner is called for domiciliary consultation and sees on the same occasion in the same residence or institution more than one clinically related case, this shall count as a single domiciliary consultation for the purpose of a. above.

Replacement of drugs

149. Where an anaesthetist provides his or her own consumable drugs in the course of domiciliary visits, he or she shall be entitled on request to secure replacement of these drugs free of charge through the hospital service, except where he or she is paid an additional fee.

150-154. Unallocated.

EXCEPTIONAL CONSULTATIONS**Consultants**

155. A consultant who has no contract with the employing authority but who is called in exceptionally for a special visit (eg. because of his or her unusual experience or interest) shall be paid a fee (see Appendix I), to include any operative work, etc. This, however, shall not apply in respect of calls of this kind made on the services of retired consultants who hold honorary (unpaid) appointments.

156. Unallocated.

General practitioners

157. A general practitioner not on the staff of a hospital, but called in exceptionally to render a specific service in emergency, shall be paid a fee (see Appendix I), unless the service rendered falls within his or her terms of service under Part VI of the Health and Personal Social Services (Northern Ireland) Order 1972.

158-164. Unallocated.

LECTURE FEES**Lectures to non-medical or non-dental staff**

165. Fees for lectures to nurses and other non-medical and non-dental staff shall be at the rates set out in Appendix 1. Any fees shall be limited to the number of lectures authorised for the subject in question.

Lectures to doctors or dentists

166. Where a practitioner gives a lecture on a professional subject to a group of doctors and/or dentists - whether or not general practitioners or other professional staff are present - a fee shall be payable to the lecturer by the authority which employs the majority of the hospital staff expected to attend, or, where this does not apply, by the authority employing the lecturer, subject to the following conditions:
- a. the lecture shall form part of a programme of postgraduate education approved by the employing authority; and
 - b. a fee shall not be payable by some other body in respect of the same lecture; and
 - c. a fee shall not be payable to a practitioner for teaching, during the course of the practitioner's clinical duties, other practitioners who are working under his or her clinical supervision.

Where a fee is payable, travelling and subsistence expenses may also be paid where appropriate.

167-172. Unallocated.

CHARGES FOR RESIDENCE**Compulsorily resident practitioners**

173. a. A practitioner who is required, whether as a condition of his/her appointment, or statutorily, to reside in a hospital shall be provided with accommodation without charge. Should the practitioner elect to occupy alternative accommodation for which a rent is payable, the employing authority shall abate the rental charge up to the cost of the accommodation which would otherwise have been provided.
- b. Where any other practitioner, other than one to whom paragraphs 174 and 175 apply, is required to stay overnight in the hospital while as part of an on-call rota or partial shift system, no charge shall be made for his/her necessary accommodation.

Voluntary resident practitioners

174. Where a practitioner resides in hospital voluntarily a charge for the accommodation should be made and, provided consent is given, deducted from his/her remuneration. Lodging charges for existing accommodation will be increased at the same time, and by the same percentage, as increases in junior doctors pay. Lodging charges may, where appropriate, be further increased by reasonable amounts to be determined by local negotiation and agreement, in order to phase a move towards charges that reflect the standard of accommodation provided and notional local market value. Lodging charges for new accommodation will be determined by local negotiation and

agreement to reflect the standard of accommodation provided and notional market value.

Abatement of voluntary lodging charges *(effective from 1 February 2001)*

175. a. Charges made for accommodation should reflect the standard and amenities provided. Should those standards fall below the minimum stipulated in Annex A of HSS(TC8) 1/2000 employers should consider providing the accommodation free of charge until such time as improvements have been completed.
- b. Practitioners who are required to stay overnight in hospital as part of an on-call rota or partial shift system one night in seven or more often, but who are not eligible for free accommodation under paragraph 173, shall pay the following proportion of the lodging charge:

Required to stay overnight	Proportion
One night in three	0%
One night in four	35%
One night in five	55%
One night in six or seven	75%

Charges during annual leave

176. The charges set out in paragraph 174 are calculated on the basis that the practitioner has the use of the accommodation for fifty-two weeks. Subject to paragraphs 177 and 178, the charges should be deducted pro rata from the practitioner's remuneration over the whole period during which the practitioner has the use of the accommodation. No charge should be made for any continuous period of seven days or more during which the accommodation is vacated.

Charges during sick leave

177. Residence charges shall not be abated during the first week of sick leave, but thereafter, if a practitioner is suffering from an illness for which hospital treatment as an in-patient is required, or is absent from hospital accommodation on sick leave, no charge shall be made.

Charges during study or special leave

178. No charge shall be made when a practitioner is absent on study leave or special leave for more than a week and is not being paid any expenses in respect of his/her subsistence away from the hospital.

179-181. Unallocated.

Charges for meals

182. All practitioners, whether resident or non-resident and whether on-duty or off-duty shall, other than in exceptional circumstances, pay for meals and other refreshments provided by the employing authority.

183-185. Unallocated.

MEDICAL EXAMINATION ON APPOINTMENT

186. The passing of a medical examination shall be a condition of appointment of all practitioners within the scope of the Health Service Superannuation Scheme, other than those who were transferred under the Health Services Act (Northern Ireland), 1948, or who held hospital appointments at 4 July 1948. The fee for examination shall be paid by the appointing employing authority, except that, where, at the instance of a candidate who has failed to pass the first examination, a second examination is carried out by one or more doctors approved by the appointing authority, any fee for such examination shall be paid by the candidate.

Form of certificate

187. The examining doctor shall be asked to certify that the candidate is "free from any disease or physical defect which now impairs his or her capacity satisfactorily to undertake the duties of the post for which he or she is a candidate".

House Officers

188. Despite the foregoing requirement, a medical or dental practitioner who fails to pass the medical examination shall not be refused an appointment as HO, FHO1 or FHO2 unless the practitioner's employment is likely to be prejudicial to the health of his or her patients or colleagues. In the case of practitioners so appointed, however, the passing of a medical examination shall be an essential condition of appointment to a post in any grade other than HO, FHO1 or FHO2.

DISCIPLINARY PROCEDURES

189. Wherever possible, any issues relating to conduct and capability should be identified and resolved without recourse to formal procedures. However should an employing authority consider that a practitioner's conduct and capability may be in breach of the authority's code of conduct, or that the practitioner's professional competence has been called into question, the matter will be resolved through the 'Maintaining high professional Standards in the Modern HPSS' framework (effective from 1 December 2005). Any allegations of misconduct against, or capability concerns about, a doctor or dentist in a recognised training grade should be considered initially as a training issue and dealt with via the educational supervisor with close involvement of the postgraduate dean from the outset.
190. Unallocated

ALTERNATIVE EMPLOYMENT

191. It is understood that, where a local change of organisation in the hospital and specialist services involves displacement or serious disturbance of the services of a practitioner to whom paragraphs 7 or 190 apply, the employing authority recognises that it has a moral obligation to render the greatest possible assistance to the practitioner with a view to his or her obtaining comparable work elsewhere in the HS.

APPOINTMENT FOR LIMITED PERIOD

192. Where an employing authority grants leave without pay to a practitioner to permit the practitioner to accept a short-term appointment of not more than three years in an overseas university or other position of similar standing, the vacancy so created may be filled by another appointment for a limited period. Paragraphs 190 and 191 shall not apply to a practitioner appointed for a limited period in these circumstances in respect of the termination of his or her appointment at the end of that period. If the practitioner is in the appropriate grade, the procedure set out in paragraph 190 shall apply if his or her appointment is being terminated in other circumstances.

193-194. Unallocated.

STATUTORY MINIMUM PERIOD OF NOTICE

195. An employing authority shall give as the minimum period of notice to terminate the employment of a practitioner (unless the period specified in paragraph 196 is longer) who has been continuously employed for at least four weeks:

- a. one week's notice if the period of continuous employment is less than two years;
- b. one week's notice for each year of continuous employment if the period of continuous employment is at least two but less than twelve years;
- c. twelve weeks' notice if the period of continuous employment is twelve years or more.

The minimum period of notice to be given to his or her employing authority by a practitioner who has been continuously employed for at least four weeks shall be one week.

The period of continuous employment shall be computed in accordance with Schedule 1 of the Contracts of Employment and Redundancy Payments Act (Northern Ireland) 1965 (as amended by the Industrial Relations (Northern Ireland) Order 1976.

CONTRACTUAL MINIMUM PERIOD OF NOTICE

196. The agreed minimum period of notice by both sides for practitioners in regular appointments shall, unless the statutory minimum periods specified in paragraph 195 are longer, be as follows:

FHO1 or HO	two weeks
FHO2, StR(FT) or SHO	one month
SpR or StR	three months
Part-time medical or dental officer (paragraphs 94 and 105)	two months
All other practitioners	three months

Application of minimum periods

197. These arrangements shall not prevent:
- a. an employing authority or a practitioner from giving, or agreeing to give, a longer period of notice than the minimum set out in paragraph 195;

- b. both parties to a contract agreeing to a period different from that set out in paragraph 196;
- c. either party waiving its rights to notice on any occasion, or accepting payment in lieu of it; or
- d. either party treating the contract as terminable without notice, by reason of such conduct by the other party as enables it so to treat it at law.

Pay during notice

198. For the minimum period of notice appropriate to the practitioner's case set out in paragraph 195, reference shall be made to the rights available to the practitioner under Schedule 2 of the Contracts of Employment and Redundancy Payments Act (Northern Ireland) 1965 as substituted by the Industrial Relations (Northern Ireland) Order 1976. This applies whether the employing authority gives notice to the practitioner or whether the practitioner gives notice to his or her employing authority.

199. Unallocated.

RETIRING AGE

200. Unallocated.

Honorary or emeritus contracts

201. In the case of a consultant or SHMO or SHDO who has been filling a post graded as consultant, the authority may on the practitioner's retirement allow him or her an honorary (unpaid) contract.

202-204. Unallocated.

ANNUAL LEAVE

205. The following practitioners shall be entitled to leave at the rate of 6 weeks a year:

Consultants
 SHMOs
 SHDOs
 SpRs, StRs and StRs (FT)s on the third or higher incremental points of their scale
 Practitioners appointed under the terms of paragraphs 94 or 105
 SCMOs
 Senior medical officers (community health medicine)
 CMOs on or above the 6th point of the salary scale
 Hospital Practitioners
 ASs

Practitioners in the staff grade who have completed two years' service in the grade or who had an entitlement to six weeks' leave a year in their immediately previous appointments.

CMOs who have served 5 years in the grade before transfer to staff grade as part of the assimilation into a combined child health service between 1 February 1994 and 31 January 1995.

206. The following practitioners shall be entitled to leave at the rate of 5 weeks a year:

Registrars

SpRrs on the minimum, 1st or 2nd incremental points of their payscale

SHOs

CMOs on the first 5 points of the salary scale

Practitioners in the staff grade other than those mentioned in paragraph 205.

207. Unallocated.

Part-time staff

208. Annual leave entitlements shall be the same for part-time as for whole-time staff, as set out in paragraphs 205 and 206 above.

Leave years

209. With the exception of CMOs on the first five points of the salary scale and practitioners in the staff grade other than those mentioned in paragraph 205, whose leave year will run from 1 November to 31 October, the leave year of practitioners (other than locums) referred to in paragraphs 205 and 206 shall run from their incremental date for salary purposes, or its anniversary where the practitioners are on the maximum of the scale, or the anniversary of the date of the appointment where there is no incremental progression. Practitioners previously conditioned to a different leave year may retain existing arrangements for the duration of their current post.

FHO1s and HOs

210. FHO1s and HOs are entitled to leave at the rate of five weeks a year. The leave period of an FHO1 and HO shall correspond with the period of tenure of a post. Not more than four days' leave may be carried forward from one post into subsequent appointments, or may be anticipated from such subsequent appointments.

Locum tenens: leave entitlement

211. Subject to paragraph 212, practitioners acting as locums shall be entitled to leave at the rate applicable to the substantive grade of the acting post per twelve months' continuous locum service except that practitioners acting as locums in the run-through StR grade shall be entitled to leave at the rate of six weeks per twelve months' continuous locum service regardless of previous service in the substantive grade.

Locum tenens: leave arrangements

212. The following conditions shall govern the taking of leave by locums:

- a. the taking of leave shall be subject to the needs of the employing authority;
- b. wherever possible, leave shall be taken during the occupancy of the post. Where this is not possible, leave may be carried forward to the next succeeding appointment, or payment in lieu of leave earned and not taken may be made;

- c. the total leave taken in any one period of twelve months shall not exceed the annual leave entitlement.

Continuous locum service

213. For the purposes of paragraphs 123, 211, 212 and 243, "continuous locum service" shall be taken to mean service as a locum in the employment of one or more authorities uninterrupted by the tenure of a regular appointment or by more than two weeks during which the practitioner was not employed in the HS.

Public holidays

214. The leave entitlements of practitioners in regular appointments are additional to ten public holidays and two statutory holidays or days in lieu thereof. The two statutory holidays may, by local agreement, be converted to a period of annual leave. In addition, a practitioner who in the course of his or her duty was required to be present in hospital or other place of work between the hours of midnight and 9am on a statutory or public holiday should receive a day off in lieu. Where the needs of the service permit, locums should be allowed statutory and general national holidays or days in lieu in the same way as practitioners in regular appointments.

General

215. Practitioners shall notify their employing authority when they wish to take annual leave, and the granting of such leave shall be subject to approved arrangements having been made for their work to be done during their absence. Paragraphs 106 to 111 provide for the employment of locums where it is not possible for practitioners to deputise for an absent colleague. Subject, however, to suitable arrangements having been made, consultants, SHMOs and SHDOs may take short periods of up to two days of their annual leave without seeking formal permission beforehand, provided that they give notification when they take this leave.

GENERAL COUNCIL CONDITIONS

216. The provisions of Section 1 of the General Council Conditions of Service shall apply to practitioners in regular appointments, save that, where a practitioner has arranged to go overseas on a rotational appointment or on an appointment which is considered by the Northern Ireland Council for Postgraduate Medical and Dental Education (if necessary, with the advice of the consultant) to be part of a suitable programme of training, or to undertake voluntary service, the practitioner may carry forward any outstanding annual leave to the next regular appointment, provided that:
- a. the next regular appointment is known in advance of the practitioner leaving the HS to go overseas; and
 - b. the practitioner takes no other post outside the HS during the break of service, apart from limited or incidental work during the period of the training appointment or voluntary service.

CHANGES OF GRADE

217. Where a practitioner moves between grades carrying different leave entitlements, the leave allowance for the year in which the move occurs shall be determined on a proportionate basis.

218-224 Unallocated.

SICK LEAVE

Scale of allowances

225. A practitioner absent from duty owing to illness, injury or other disability shall, subject to the provisions of paragraphs 226 to 244, be entitled to receive an allowance in accordance with the following scale:

During the first year of service:	One month's full pay and (after completing four months' service) two months' half pay
During the second year of service:	Two months' full pay and two months' half pay.
During the third year of service:	Four months' full pay and four months' half pay.
During the fourth and fifth years of service	Five months' full pay and five months' half pay.
After completing five years of service:	Six months' full pay and six months' half pay.

The authority shall have discretion to extend the application of the foregoing scale in an exceptional case. A case of a serious character, in which a period of sick leave on full pay in excess of the period of benefit stipulated above would, by relieving anxiety, materially assist a recovery of health, shall receive special consideration by the employing authority.

House Officers who have not passed a medical examination

226. The application of the above scale of allowances in the case of a practitioner appointed as FHO1, FHO2 or HO who has failed to pass the medical examination and has been employed under the terms of paragraph 188 shall be subject to an overriding maximum period of paid sick leave on the basis of one week for each completed month of service.

Calculation of allowances

227. The rate of allowance, and the period for which it is to be paid in respect of any period of absence due to illness, shall be ascertained by deducting from the period of benefit (under paragraph 225) appropriate to the practitioner's service on the first day of absence the aggregate for the period of absence due to illness during the twelve months immediately preceding the first day of absence. In aggregating the periods of absence, no account shall be taken of any absence:

- a. on unpaid sick leave; or
- b. due to injury resulting from a crime of violence not sustained on duty but connected with or arising from the practitioner's employment or profession, where the injury has been the subject of payment by the Criminal Injuries Compensation Agency or under the Northern Ireland Criminal Injuries Compensation Scheme 2002: or

- c. due to injury as at b. above which has not been the subject of payment by the Criminal Injuries Compensation Agency or under the Northern Ireland Criminal Injuries Compensation Scheme 2002 on grounds that it has not given rise to more than three weeks' loss of earnings, or was one for which compensation of less than the minimum provided for under the Scheme would be given (subject in such cases to the provision of satisfactory proof that the injury was sustained as a result of a crime of violence).

The employing authority may at its discretion also take no account of the whole or part of the periods of absence due to injury (not on duty) resulting from a crime of violence not arising from or connected with the practitioner's employment or profession.

Previous qualifying service

- 228. a. For the purpose of ascertaining the appropriate allowance of paid sick leave under paragraph 225, all periods of service (without any break of twelve months or more, subject to sub-paragraph b. below) under any employing authority constituted under the Health Service Acts of 1948, or any local authority, or in the Civil Service or the teaching service, or any other service approved by the Secretary of State for the purposes of Regulation 75(1) of the Health and Personal Social Services (Superannuation) Regulations (Northern Ireland) 1984, shall be aggregated.
- b. Where a practitioner has broken his or her regular service in order to go overseas on a rotational appointment, or on an appointment which is considered by the Northern Ireland Council for Postgraduate Medical and Dental Education (if necessary, with the advice of the consultant) to be part of a suitable programme of training, or to undertake voluntary service, the practitioner's previous HS or approved service, as set out in sub-paragraph a. above, shall be taken fully into account in assessing entitlement to sick leave allowance, provided that:
 - i. the practitioner has not undertaken any other work outside the HS during the break in service, apart from limited or incidental work during the period of the training appointment or voluntary service; and
 - ii. the authority considers that there has been no unreasonable delay between the training or voluntary service abroad ending and the commencement of the HS post.

Limitation of allowance when Insurance or other benefits are payable

- 229. The allowance made to a practitioner during absence on sick leave when added to:
 - a. the amount of sickness benefit, severe disablement allowance, invalidity benefit or statutory sick pay receivable under the Social Security Acts (Northern Ireland);
 - b. compensation payments under the Workmen's Compensation Acts, where the right to compensation arises in respect of an accident sustained before 5 July 1948;

- c. any element in compensation payments under the Employers Liability (Defective Equipment and Compulsory Insurance (Northern Ireland) Order 1972 or under common law which is attributable to immediate loss of remuneration; and
- d. the dependency element of any amount received as a treatment allowance from the Department for Social Development (the personal element of this allowance will not be taken into account)

shall not exceed the practitioner's normal salary for the period, and the occupational sick leave allowance shall be restricted accordingly where necessary, except that no deduction shall be made under a. above in the case of a practitioner on whose behalf the employing authority makes no National Insurance contributions.

Sums to be taken into account

230. The benefits, compensation payments and allowances to be taken into account under paragraph 229 shall be those for the practitioner's own incapacity, including allowances for adult and child dependants.

Practitioners on half pay

231. Where a practitioner is entitled to an occupational sick pay allowance equivalent to half pay and to statutory sick pay, the occupational sick pay allowance shall be increased by an amount equivalent to the amount of statutory sick pay due, except that the sum of the occupational sick pay allowance and statutory sick pay payable shall not exceed the practitioner's normal pay for the period.

232. Unallocated.

Married Women

233. A married woman who chooses not to pay standard rate National Insurance contributions (ie, chooses to pay reduced Class 1 contributions) shall, for the purposes of this agreement, be deemed to be receiving the full rate of social security benefits that would have been receivable had she chosen to pay standard rate National Insurance contributions.

Definition of "one month"

234. For the purpose of calculation of allowance, twenty-six working days shall be deemed to be equivalent to "one-month".

Submission of doctor's statements

235. A practitioner who is incapable of doing his or her normal work because of illness shall immediately notify the employing authority in the manner laid down by them. If an absence because of sickness continues beyond the third calendar day, the practitioner shall submit a statement of the nature of the illness within the first seven calendar days of absence. Further statements shall be submitted to cover any absence extending beyond the first seven calendar days. These further statements shall not normally be submitted more frequently than once every succeeding seven calendar days. Unless the authority otherwise prescribes, they shall take the form of medical certificates completed by a doctor other than the sick practitioner.

Exceptionally, the authority may, in a particular case, require statements to be submitted at more frequent intervals.

Practitioners admitted to hospital

236. A practitioner entering a hospital or similar institution shall submit a doctor's statement on entry and on discharge in substitution for periodical statements, unless the period of absence from duty does not exceed seven calendar days. If the period of absence is seven calendar days or less, the practitioner shall submit a self-certificate, as under paragraph 235.

Accident due to sport or negligence

237. An allowance shall not be paid in a case of accident due to active participation in sport as a profession, or in a case in which contributory negligence is proved, unless the employing authority decide otherwise.

Injury sustained on duty

238. A period of absence due to injury sustained by a practitioner in the actual discharge of his or her duty and without the practitioner's own default shall not be recorded for the purposes of this scheme.

Recovering of damages from third party

239. A practitioner who is absent as a result of an accident shall not be entitled to an allowance if damages are recoverable from a third party in respect of such accident. In this event, the employing authority may, having regard to the circumstances of the case, advance to the practitioner a sum not exceeding the sickness allowance which would have been payable under these provisions but for this condition, subject to the practitioner undertaking to refund to the authority the total amount of such allowance or a portion thereof corresponding to the amount in respect of loss of remuneration including the damages received. Any period of absence in such a case where a refund of the monies advanced is made in full shall not count against the practitioner's sick leave entitlement. Where, however, the refund is made in part only, the employing authority may, at its discretion, decide to what extent, if any, the period of absence may be taken into account. This paragraph does not apply to compensation awarded by the Criminal Injuries Compensation Agency or under the Northern Ireland Criminal Injuries Compensation Scheme 2002.

Medical examination

240. The employing authority may at any time require a practitioner who is unable to perform his or her duties as a consequence of illness to submit to an examination by a medical practitioner nominated by the authority. Any expense incurred in connection with such examination shall be met by the employing authority.

Termination of employment

241. The sick leave provisions of these Terms and Conditions or Service shall cease to apply to a practitioner on the termination of employment by reasons of permanent ill-health or infirmity of mind or body, of resignation, of age, or any other reason; provided that, where a practitioner is in receipt of sick leave allowance at the time of expiry of a contract in a regular appointment in a training grade, that allowance shall be paid during the practitioner's illness, subject as a maximum to his or her entitlement to allowances under the provisions of paragraph 225 and 226.

Forfeiture of rights

242. If it is reported to the employing authority that a practitioner has failed to observe the conditions of this scheme, or has been guilty of conduct prejudicial to his or her recovery, and the authority is satisfied that there is substance in the report, the payment of the allowance shall be suspended until the authority has made a decision thereon, provided that, before making a decision, the employing authority shall advise the practitioner of the terms of the report, and shall afford the practitioner an opportunity of submitting his or her observations thereon and of appearing or being represented before the authority or its appropriate committee. If the employing authority decide that the practitioner has failed without reasonable excuse to observe the conditions relating to the granting of sick leave, or has been guilty of conduct prejudicial to his or her recovery, then the practitioner shall forfeit his or her right to any further payment of allowance in respect of that period of absence.

Locum tenens

243. For the purpose of sick leave allowances, a practitioner's service shall be taken to include locum service. A practitioner who has reached age sixty-five, and who does not hold a contract under paragraph 200.a, shall not be entitled to sick leave allowance, unless immediately beforehand the practitioner has completed at least three months' continuous locum service; three months' continuous locum service having the meaning assigned to it in paragraph 213.

Appointments under paragraph 87 to 93

244. Practitioners holding appointments under paragraphs 87 to 93 shall not be eligible to receive occupational sick pay under the terms of paragraphs 225 to 243. Section 57 of the General Council Conditions of Service shall not apply to these practitioners.

245-249. Unallocated.

STUDY LEAVE**Definition**

250. Professional or study leave is granted for postgraduate purposes approved by the employing authority, and includes study (usually, but not exclusively or necessarily, on a course), research, teaching, examining or taking examinations, visiting clinics and attending professional conferences.

Recommended standard for professional and study leave in the United Kingdom

251. Subject to the conditions in paragraph 254, professional or study leave will normally be granted to the maximum extent consistent with maintaining essential services in accordance with the recommended standards, or may exceptionally be granted under the provisions of paragraph 252. The recommended standards are:
- a. Consultants
SHMOs and SHDOs
ASs
Staff Grade
Hospital practitioners
SCMOs
Senior medical officers (community medicine)

Leave with pay and expenses, within a maximum of thirty days (including off-duty days falling within the period of leave) in any period of three years for professional purposes within the United Kingdom.

- b. Not allocated. |
- c. SpRs
StRs
StR (FT)s
CMOs
SHOs
FHO2s
HOs |
- i. Either: day release with pay and expenses for the equivalent of one day a week during university terms; or leave with pay and expenses within a maximum calculated at the rate of thirty days in a year (the year for this purpose being counted from 1 October); or leave with pay and expenses to attend approved full or part-time academic courses; and payment of expenses for attendance at approved conferences or seminars (including those held in the evenings and weekends). This allowance may accumulate over the period of the appointment, provided that the total amount due in the period of the appointment is not taken until one year of the appointment has been served. Attainment of an MSc in public health medicine or other similar courses should form a separate part of the employment contract.
- ii. Such practitioners should, for a maximum of two occasions, also receive leave with pay and expenses (other than examination fees) for the purpose of sitting an examination for a higher qualification where it is necessary as part of a structured training programme.
- iii. Such practitioners may also receive leave with pay and expenses (other than examination fees) for the purpose of sitting other examinations for a higher qualification, except where the authority considers that this would be contrary to the interests of the individual or the service, leave may be refused (for example, repeated sitting and failing of the same examination could be held to be an unjustifiable use of the paid leave).
- d. FHO1s and pre-registration HOs should be allowed reasonable time within working hours for attending, within the hospital, clinico-pathological conferences and ward rounds with other firms. |

Additional periods of professional and study leave in the United Kingdom

252. Authorities may at their discretion grant professional or study leave in the United Kingdom above the period recommended in paragraph 251 with or without pay and with or without expenses or with some proportion thereof.

Professional and study leave outside the United Kingdom

253. Authorities may at their discretion grant professional or study leave outside the United Kingdom with or without pay and with or without expenses or with any proportion thereof.

Conditions

254. The following conditions shall apply:
- a. where a practitioner is employed by more than one employing authority, the leave and the purpose for which it is required must be approved by all the employing authorities concerned;
 - b. where leave with pay is granted, the practitioner must not undertake any remunerative work without the special permission of the leave-granting employing authority;
 - c. where an application is made under paragraphs 252 or 253 for a period of leave with pay, and this exceeds three weeks, it shall be open to the employing authority to require that one half of the excess over three weeks shall be counted against annual leave entitlement, the carry forward or anticipation of annual leave within a maximum of three weeks being permitted for this purpose (this condition shall not be applied to practitioners attending certain courses of specialist training notified to employing authorities for this purpose by the Department).
- 255-259. Unallocated.

SPECIAL LEAVE**Special leave with and without pay**

260. Special leave for any circumstances may be granted (with or without pay) at the discretion of the employing authority, with the following qualifications:
- a. Attendance at court as witness: For practitioners attending court as medical or dental witnesses such attendance is governed by paragraphs 30 to 37 and 40 to 42.
 - b. Not allocated.
 - c. Contact with notifiable diseases: In general, the situation will not arise in the case of medical practitioners because of their professional position.

Maternity leave

261. The provisions listed temporarily at Appendix VI shall apply.

Special leave for domestic, personal and family reasons

262. The provisions listed temporarily at Appendix X shall apply.

263 -274. Unallocated.

EXPENSES**General**

275. Travelling, subsistence, and other expenses shall be paid to meet actual disbursements of practitioners engaged in the service of authorities, and shall not be regarded as a source of emolument or reckoned as such for the purposes of pension.

Submission of claims

276. In preparing claims, practitioners shall indicate adequately the nature of the expenses involved; claims shall be submitted normally at intervals of not more than one month, and as soon as possible after the end of the period to which the claim relates.

TRAVELLING EXPENSES AND MILEAGE ALLOWANCES**General Council Conditions Applied**

277. The provisions of Section 23 (except paragraphs 2.4 and 4) of the General Council Conditions of Service shall apply to all grades. In the General Conditions of Service and in paragraphs 278-308, 311 and 315 the terms "headquarters" and "principal hospital" shall be understood to mean "the hospital or other base from which the practitioner conducts his or her main duties" and the term "hospital" shall be understood to mean "hospital or other place to which the practitioner is required to make official journeys". Where a practitioner has a joint contract with more than one employing authority, the terms "headquarters" and "principal hospital" shall be interpreted as meaning the base from which the doctor conducts his or her main duties within that joint contract, irrespective of employing authority.

Mileage allowances payable to all practitioners

278. Except where a practitioner has been allocated a Crown Car (paragraphs 304 to 308) and subject to sub-paragraph 304.d mileage allowances shall be payable in accordance with the rates specified in paragraphs 290 to 301, as appropriate, where practitioners use their private vehicle for any official journey on behalf of their employing authority, including travel in connection with domiciliary consultations. No allowance shall be payable for their normal daily journey between their home, or their practice premises, and their principal hospital, except as provided for in paragraphs 279 to 286 and 289, which also specify the rules for payment of allowances for journeys between their home and other places (including subsidiary hospitals).

Emergency visits

279. Practitioners called out in an emergency shall be entitled to mileage allowance in respect of any journey they are required to undertake.

Home-to-Hospital Mileage: Practitioners in the grades of Consultant, SHM, SHDO and AS**Official journeys beginning at home**

280. a. Mileage allowance will be paid for official journeys on behalf of the employing authority where practitioners in these grades travel by private car between their home or their practice premises and places other than their principal hospital, subject to a maximum of the distance between the practitioner's principal hospital and the place visited, plus ten miles, for each single journey (twenty miles for a return journey).
- b. For consultants in public health medicine, for official journeys between 6pm and 8am and on Saturdays, Sundays, statutory and public holidays only between 8am and 6pm, the base for the calculation of mileage allowance shall be the doctor's own home.

Subsequent official journeys

281. In addition, practitioners in these grades may claim mileage allowance for one return journey daily between their home or their practice premises and their principal hospital, up to a maximum of ten miles in each direction, on days when they subsequently use their car for an official journey.

Liability to make emergency visits

282. Practitioners in these grades with commitments under the same contract to visit more than one hospital which includes a liability to make emergency visits to subsidiary hospitals or other institutions, or a consultant or SHMO with a liability to make emergency domiciliary visits, may, if the employing authority decide that their liability is so extensive as to make it desirable that their car should always be available at their principal hospital, claim mileage allowances for normal daily journeys between their home and principal hospital up to a maximum of ten miles in each direction.

Scattered hospitals

283. Where, in exceptional circumstances, consultants are required by their employing authority, as a condition of their contract, to live within a specified area at a distance of more than ten miles by road from their principal hospital in order to provide adequate emergency cover to a group of widely scattered hospitals or other institutions, mileage allowance at the approved rate shall be paid for the whole of the journey between their home and their principal hospital.

Journeys Beginning or Ending at Home: Other Staff

(ie. practitioners in the grades of SG, CMO, HP, or any training grade, or employed under paragraphs 94 or 105).

Full-time staff

284. a. Subject to sub-paragraph 284.b, where full-time practitioners in these grades travel between their home and principal hospital before and/or after an official journey, or journey direct from their home to the place visited and/or return direct to their home from the place visited, mileage allowance shall be payable for the whole distance travelled, subject to a maximum based on the return journey from their principal hospital to the place visited, plus twenty miles. Mileage allowance shall be paid for the distance equal to the return journey between the principal hospital and the place visited. The additional (maximum) twenty miles shall be paid for as follows:
- i. if the practitioner is the holder of a current season ticket for travelling between their home and their principal hospital, mileage allowance in accordance with paragraphs 290 to 298.
 - ii. if the practitioner is not a season ticket holder, mileage allowance less the public transport rate.
- b. No allowance shall be paid in respect of home to principal hospital mileage to fulltime practitioners in these grades whose normal practice is to travel from their home to their principal hospital by private car even when the car is not required for the purpose of making an official journey.
- c. For training grades in public health medicine, for official journeys between 6pm and 8am and on Saturdays, Sundays, statutory and public holidays only between 8am and 6pm, the base for the calculation of mileage allowance shall be the doctor's own home.

Application of paragraph 284

285. Paragraph 284 shall be applied as follows:
- a. full-time practitioners in these grades who travel by car only on the days when they require it to make an official journey which attracts mileage allowance, other than at the public transport rate, shall be paid mileage allowance calculated in accordance with sub-paragraph 284.a;
 - b. except as provided in sub-paragraph 285.c, practitioners whose normal practice is to travel to their principal hospital by car shall, if they use it on any day to make an official journey, be paid mileage allowance by reference to the excess, if any, of the total distance travelled over the normal return journey between their home and their principal hospital;
 - c. practitioners whose normal practice is to use their car to travel to their principal hospital, but who satisfy both the following requirements, may, if the employing authority by resolution so decide, be treated as in sub-paragraph 285.a., ie. they may, in respect of the days on which they actually use the car to make an official journey that attracts mileage allowance, other than at the public transport rate, be paid mileage allowance in accordance with sub-paragraph 284.a. Practitioners to whom this arrangement apply are those who have a claim to special consideration because:
 - i. they have a definite commitment to make an official journey every day for which the use of their car is justified, or, alternatively, their duties

are such that they are liable to be called upon to make official journeys by car which cannot be arranged in advance, and that liability is so extensive and the journeys in practice so frequent as to make it desirable that their car should always be available at their principal hospital; and

- ii. they would not otherwise require to travel to their principal hospital by car;
- d. in the foregoing, "car" means any private motor vehicle in respect of which mileage allowance is authorised;
- e. subject to the agreement of the employing authority, the maximum of twenty miles (additional to the return journey from the practitioner's principal hospital to the place visited) referred to in sub-paragraph 284.a. shall not apply if:
 - i. the practitioner is in a training grade and owned the home before taking up the appointment; or
 - ii. the home is within ten miles of one of the hospitals involved in a rotational appointment, or is conveniently situated for several of the hospitals in the rotation, but is more than ten miles from one or more of them.

Part-time practitioners

- 286. a. In the case of part-time practitioner to whom paragraphs 280 to 284 and 287 do not apply, journeys between their practice premises or place of residence and any hospital where they are employed, other than their principal hospital, shall be regarded as a journey in the service of the authority, provided that no expenses shall be allowed for any such journey or part of such journey which would have been undertaken by the practitioner, irrespective of their employment with the authority.
- b. Where a part-time practitioner travels between their practice premises or place of residence and their principal hospital before and/or after an official journey, expenses shall be payable for the whole distance, provided that, for journeys to and from their principal hospital, no expenses shall be paid for any distance exceeding ten miles each way, unless the circumstances warrant exceptional treatment.

Part-time Practitioners in all grades: Reserved Rights

- 287. A part-time practitioner who at 31 December 1959 was receiving expenses for journeys between their home or private consulting room and their principal hospital shall continue for the time being to receive expenses in accordance with the Terms and Conditions of Service then in force.

288. Unallocated.

Locum Tenens

- 289. Where practitioners engaged as locums tenens travel (including, where they take up

temporary accommodation at or near the hospital, their initial and final journeys) between their practice premises or place of residence (whichever is the nearer) and their principal hospital, expenses shall be payable in respect of any distance by which the journey exceeds ten miles each way, unless the application of the rules in paragraphs 279 to 286 is more favourable.

Rates of Mileage Allowance: Regular user allowances

290. Allowances at regular user rates shall be paid to practitioners who at the date on which this agreement comes into operation:

- a. are classified by the employing authority as regular or essential users and choose not, or are unable, to avail themselves of a Crown car in accordance with paragraph 304; or
- b. are new appointees to whom the employing authority has deemed it uneconomic, or is unable, to offer a Crown car in accordance with paragraph 304; and
- c. are required by their employing authority to use their own car on HS business and, in so doing, either:
 - i. travel an average of more than 3,500 miles a year; or
 - ii. travel an average of at least 1,250 miles a year, and:
 - iii. necessarily use their car on an average of three days a week; or
 - iv. spend an average of at least 50% of their time on such travel, including the duties performed during the visits; or
- d. are consultants who are classified as essential users.

Essential users (consultants)

291. Essential users are consultants who:

- a. travel on average at least 1,250 miles (other than normal travel between their home or their practice premises and their principal hospital) each year; and
- b. either have ultimate clinical responsibility, or on-call responsibility normally controlled by a rota system, for the diagnosis and treatment of patients in hospital with emergency conditions which require them to be immediately available for recall; and are expected to be recalled to hospital in emergency at an average rate (taken over the year, but excluding period of leave) of twice or more during a working week;
- c. or whose duties require them to pay frequent visits to places away from their principal place of work (eg. to clinics, schools, residential establishments and other places, for instance, in connection with the control of infectious diseases and food poisoning), or who are liable to be called out in an emergency in connection with statutory duties relating to the control of communicable disease and food poisoning or the compulsory removal to suitable premises of persons in need of care and attention.

Change in circumstances

292. If there is a change in a practitioner's duties, or if the official mileage falls below that on which a regular or essential user classification was based and which is likely to continue, the application to the practitioner of the regular user agreement should be reconsidered. Any decrease in the annual official mileage or the frequency of travel, etc. which is attributable to circumstances such as prolonged sick leave or the temporary closure of one place of duty should be ignored for this purpose.

Non-classification as Regular User

293. Where an authority does not consider that a practitioner, other than one to whom subparagraph 304.d applies, should be classified as a regular or essential user, and if this gives rise to any serious difficulty, the practitioner shall have the right to request that the Department should be consulted. The Department will seek the views of the British Medical Association on the appropriate solution.

Payment of lump sums

294. a. Payment of the annual lump sum allowance shall be made in equal monthly instalments over a period from 1 April in any year to 31 March in the succeeding year.
- b. In the case of a practitioner who takes up an appointment with an employing authority or leaves the employment of his or her authority after 1 April in any year, the total allowance payable should be so calculated that the amount payable is directly proportionate to a full year's allowance. The calculation of the mileage allowance should thus be in accordance with the following procedure:

The mileage allowance to be paid at the higher rate would, at 9,000 miles per annum, be equivalent to 750 miles per month of service. The excess over 750 miles per month of service would be paid at the intermediate, and, if appropriate, the lower rate. For example, where the total service in the period 1 April in any year to 31 March in the succeeding year is five months, then up to 3,750 miles would be paid at the higher rate and any excess at the intermediate, and, if appropriate, the lower rate. Similarly, the lump sum should be divided into twelve monthly payments.

When a practitioner leaves the employment of an employing authority, a calculation shall be made in respect of his or her entitlement for the portion of the year served with the authority and any adjustments made thereafter.

Part months of service

295. Part months of service shall be regarded as complete months for the purposes of paragraph 294. However, a regular user who leaves the service of one authority and enters the employment of another during the same month shall receive only one lump sum instalment for that month, payable by the former employing authority.

Cars out of use

296. When a practitioner entitled to the regular user allowance does not use his or her car as a result of a mechanical defect or absence through illness:
- a. the lump sum payment should be paid for the remainder of the month in which the car was out of use and for a further three months thereafter. For the following three months, payment should be made at the rate of 50% of the lump sum payment. No further payments should be made if the car is out of use for six months or longer;
 - b. during the period when the car is "off the road" for repairs, out-of-pocket expenses in respect of travel by other forms of transport should be borne by the employing authority, in accordance with the provisions of paragraph 2 of Section 23 of the General Council Conditions of Service.

Protection of existing standard rates

297. a. Practitioners referred to in paragraph 290 who prior to 30 May 1975¹ received mileage allowance calculated by reference to the standard rate of allowance may continue to claim payment of their expenses in accordance with these arrangements, but at the following rates, for so long as they remain in the same grade and in the employment of the same employing authority as on 30 May 1975*;

	Up to 1,000cc	1,000 to 1,750cc	Over 1,750cc
Rate per mile (p)	14.2	16.5	18.8

- b. In addition, where practitioners transferred under the Health and Personal Social Services (Northern Ireland) Order 1972 and in post on 30 May 1975 (30 March 1976 for practitioners holding part-time appointments on 30 March 1976), other than in a training post, subsequently take up their first substantive post in the reorganised Health Service, similar protection shall last for so long as they remain in the grade appropriate to that post and in the employment of the authority making that substantive appointment.

Standard mileage rates

298. Mileage allowances at standard rates will be paid to practitioners who use their own vehicles for official journeys, other than in the circumstances described in paragraphs 290, 297, 299 and 304.d; provided that a practitioner may opt to be paid mileage allowances at standard rates, notwithstanding his or her entitlement to payment at regular user rates.

Public transport mileage rate

¹ 30 March 1976 for practitioners holding part-time appointments on 30 March 1976.

299. The foregoing rates shall not apply if a practitioner uses a private motor vehicle in circumstances where travel by a public service (eg. rail, steamer, bus) would be appropriate. For such journeys, an allowance at the public transport rate shall be paid, unless this is higher than the rate that would be payable at the standard, regular user or special rate.

Passenger allowances

300. Where other employees or members of an employing authority are conveyed in the same vehicle, other than a Crown Car, on the business of the National Health Service and their fares by a public service would otherwise be payable by the authority, passenger mileage allowance shall be paid.

Garage expenses, tolls and ferries

301. Subject to the production of vouchers wherever possible, practitioners using their private motor vehicles on an official journey at the standard, regular user or special rate of mileage allowance shall be refunded reasonable garage and parking expenses and charges for tolls and ferries necessarily incurred, except that charges for overnight garaging or parking shall not be reimbursed, unless the practitioner is entitled to night subsistence allowance for overnight absence. Similar expenses may also be refunded to practitioners only entitled to the public transport rate of mileage allowance, provided that the total reimbursement for an official journey does not exceed the cost that would otherwise have been incurred on public transport, including the fares of any official passengers.

Loans For Car Purchase

302. a. The provisions of sub-paragraph 302.b apply to practitioners who qualify for the first time as regular car users in the HS, other than those who are offered, or provided with, a suitable Crown Car or who, prior to 1 April 1980, have been paid the rates of mileage allowances which are protected under the provisions of paragraph 297.
- b. Such practitioners are entitled to a loan at 2½ % flat rate of interest, provided that the request for the loan is made within three months of such classification, or of taking up the post (whichever is the later).
- c. Loans shall be made in accordance with the provisions of paragraphs 22 to 27 of Section 24 of the General Council Conditions of Service.
- d. In determining whether a car is "suitable" for the purposes of this paragraph, various factors may need to be taken into account, such as the total official mileage to be driven, reliability, the need to carry heavy or bulky equipment and local road conditions, etc.

Pedal cycles

303. Employees using pedal cycles for official journeys may be reimbursed at the rate set out in Table 4 of Appendix I.

CROWN CARS**Allocation**

304. a. For the purposes of paragraphs 304 to 308 and the Road Traffic Act, a "Crown Car" is any vehicle owned or contract-hired by an employing authority.
- b. Employing authorities may offer Crown Cars for individual use on official business where they deem it economic (see also paragraph 307.b) or otherwise in the interest of the service to do so.
- c. Practitioners in post who, at the date on which this agreement comes into operation, are required to travel on HS business and have been classified by the employing authority as regular or essential Users may continue to receive the regular user lump sum payments and allowances set out in paragraph 2 of Table 4 of Appendix I for so long as they remain in the same post or until they voluntarily accept the offer of a Crown Car.

New Appointees

- d. A practitioner who is a new appointee after the date on which this agreement comes into operation (including a first time appointee, a practitioner who voluntarily moves to a different post with the same employing authority and a practitioner who moves to a new post with another employing authority) and who is required to travel on HS business and who chooses to use his or her own car, rather than to accept the employing authority's offer of a Crown Car, shall not receive the allowances specified in sub-paragraph 304.c, but shall be reimbursed at the special rate. The special rate will be equivalent to the current 9,001 to 15,000 miles rate for over 2,000cc for regular and standard users, regardless of the vehicle's engine size.
- e. A practitioner who initially refused an offer of a "Crown Car" will continue to be eligible for one, providing there has been no change in the practitioner's duties.
- f. A practitioner who has been allocated a Crown Car for individual use on HS business is entitled to private use of the car, subject to the conditions set out in paragraphs 305 to 308.
- g. The offer of a Crown Car constitutes the offer of a base vehicle that should in no case exceed 1800cc. Unless the practitioner and the employing authority agree to the allocation of a smaller vehicle, it shall be at least 1500cc in the case of consultants or Associate Specialists and for others it shall be at least 1100cc or equivalent. In determining the operational needs of a post for assessing the base vehicle requirement, employing authorities shall have regard, in consultation with the practitioners concerned or their representatives, to :
- i. the clinical commitments of the postholder, including the nature, frequency and urgency of the journeys to be undertaken;
 - ii. the distances to be travelled;

- iii. the road, traffic and climatic conditions;
- iv. the physical requirements of the postholder;
- v. the need to transport equipment.
- h. A Crown Car, which is no longer required by one officer, may be allocated to another for the remaining term of the contract (or notional contract). In that event, the charges for private use will be based on the fixed annual charges determined when the authority first obtained the vehicle.
- i. Employing authorities shall ensure that proper arrangements are made for the economic servicing, repair, maintenance in a roadworthy condition and replacement of Crown Cars.

Conditions of Use

305. Following consultation with the representatives of the professions locally, an authority's conditions of use shall set the practitioner's obligations in respect of the Crown Car and shall state the effect of the following events on the contract and any subsequent financial liability on the practitioner:
- i. breach of conditions of use;
 - ii. disqualification from driving;
 - iii. wilful neglect;
 - iv. termination of the practitioner's contract of employment, on: disciplinary grounds; voluntary resignation; transfer to another employing authority (where practicable, reciprocal arrangements should be made);
 - v. change of duties resulting in the practitioner no longer being required to drive on official business;
 - vi. substantial reduction in annual business mileage;
 - vii. prolonged absence on annual, study, special or maternity leave.

Charges for Private Use

306. a. The basis of charges for private use set out in this paragraph assumes that Crown Cars are provided on a contract-hire basis. Where this is not the case, charges for private use are to be based on the notional cost to the authority of providing Crown Cars on a contract-hire basis. Notional contract-hire charges at current rates are to be used, and the fixed charge to the practitioner for agreed private mileage determined on this basis is to remain unaltered for the period for which the contract would have remained in force (eg., three years).
- b. A practitioner will be required to pay one composite annual charge for private use. This will comprise the sum of the items listed in Table 5 of Appendix I. The composite annual charge will be paid by monthly deduction from salary of one twelfth of the total.

- c. The basis of the fixed charge for agreed private mileage shall be the practitioner's estimate to the nearest thousand miles of his or her annual private mileage, as agreed by the authority and multiplied by the rate per thousand miles, determined in accordance with the formula set out in paragraph B of Table 5 of Appendix I.
- d. In the event that a practitioner underestimates his or her annual private mileage, an excess charge will be levied by the authority, based on the contract-hirer's excess charge to the authority for the particular car hired to the practitioner. In the event that a practitioner overestimates his or her annual private mileage, any sum recoverable by the authority from the contract-hirer in respect of the overestimate will be refundable to the practitioner. If no recovery is available to the authority, no refund will be made to the practitioner.
- e. A practitioner shall meet the cost to the authority of the fitting of any optional extras the practitioner requires, and the contract between the authority and the practitioner should specify whether such extras will become the property of the contract-hirer or the practitioner. In the latter case, the practitioner shall be liable for the cost of making good any damage caused to the car by the removal of such fittings at the end or on early termination of the contract.
- f. In the event of a practitioner's death in service or an early termination of the practitioner's contract on the grounds of ill health, there shall be no financial penalty to the practitioner or the practitioner's estate on account of the early termination of the contract for private use of the Crown Car.
- g. In the event of a practitioner's absence from work for an extended period on maternity, sick, study or special leave, a practitioner who has contracted for private use of a Crown Car may choose to continue the private use at the contracted charge or to return the vehicle to the authority. In the latter case, there shall be no financial penalty to the practitioner on account of early termination of the contract.

Alternative Vehicle

- h. Subject to the agreement of the employing authority, which shall not be unreasonably withheld, a practitioner who wishes to contract for private use of a Crown Car may choose a larger or more expensively equipped vehicle than that offered. In this event, the practitioner shall be responsible for meeting the additional costs to the authority by means of an addition to the composite annual charge, which shall be paid by monthly deduction from salary of one twelfth of the total determined. The rate for reimbursement of petrol used on official business shall be that of the appropriate base vehicle.

Reimbursement of Petrol and other Costs

- 307. a. A practitioner who has been allocated a Crown Car will be responsible for purchasing all petrol, whether for business or private mileage.
- b. HS business mileage costs will be reimbursed by reference to a claim form or diary showing daily visits on HS business signed by the practitioner. HS business mileage costs include journeys for which a mileage allowance would be payable under paragraphs 280 to 284, 286 to 289 or 315.

- c. The rate per mile will be determined according to the following formula:

$$\frac{\text{Cost of one gallon of 4 Star petrol*}}{\text{Base Vehicle's mileage on urban cycle}}$$

* The price of petrol will be as notified from time to time by the Department. The mileage on the urban cycle will be as quoted by manufacturers from officially approved tests under the Passenger Car Fuel Consumption Order 1983.

- d. The provisions of paragraph 301 shall apply to expenses incurred by a practitioner using a Crown Car on official business.

Carriage Of Passengers

308. Liability for compensation of authorised official passengers injured while being carried in a Crown vehicle will be borne by the Crown. It is for each employing authority to reach a view and issue advice to practitioners on the carriage of official passengers.

309-310. Unallocated.

OTHER EXPENSES

Subsistence allowances

311. The provisions of Section 22 of the General Council Conditions of Service shall apply, with the following provisos:
- a. The terms "headquarters" shall be understood to mean, "the hospital where the practitioner's principal duties lie", except in the case of practitioners who work occasional sessions with the Blood Transfusion Services (see c. below);
 - b. no day allowance shall be payable in respect of any period spent at a hospital as part of the regular duties of the practitioner concerned;
 - c. where a practitioner is engaged in accordance with paragraph 94 or paragraph 104 for the purpose of working occasional sessions in the Blood Transfusion Service, the practitioner's headquarters shall be regarded as being the Regional Headquarters of the Blood Transfusion Service.

Postage etc

312. Any expenditure necessarily incurred by a practitioner on postage or telephone calls in the service of an authority shall be reimbursed, through the periodical claim for travelling and subsistence.

Expenses of candidates for appointments

313. a. The provisions of this paragraph shall apply where an employing authority summons a practitioner to appear before a selection board or invites a

shortlisted practitioner to attend in connection with an his or her application for appointment.

- i. Reimbursement of eligible expenses shall be made by the prospective employing authority.
 - ii. Where a practitioner holds a paid or honorary appointment with an employing authority or is employed as a trainee in general practice, and applies for a new post with his or her own or another authority, the practitioner is entitled to travelling expenses in accordance with paragraph 277 and to subsistence allowance in accordance with paragraph 311 at the rate appropriate to the post the practitioner already holds.
 - iii. Where a practitioner to whom sub-paragraph 313.a.ii does not apply provides general medical or dental services under Part VI of the Health and Personal Social Services (Northern Ireland) Order 1972, or is an assistant to such a practitioner, he or she is entitled to travelling expenses and subsistence allowance at the higher rate applicable under paragraph 311.
 - iv. A practitioner to whom sub-paragraphs 313.a.ii. and iii. do not apply may at the discretion of the authority be reimbursed travelling expenses and subsistence allowance, subject, unless the circumstances warrant exceptional treatment, to the maximum that would have been payable had those provisions applied.
 - v. A candidate for a consultant appointment shall not be reimbursed for more than three attendances. Where an authority invites such a candidate to attend prior to shortlisting, it may reimburse the candidate's expenses provided that he or she is subsequently shortlisted, but not otherwise.
 - vi. A candidate to whom sub-paragraph 313.a.v. does not apply shall not be reimbursed for more than two attendances unless they are seeking to enter a specialist registrar training programme (see d below) in which case further attendances may be reimbursed with the prior agreement of the authority.
- b. A practitioner to whom sub-paragraph 313 a.ii. applies and who is summoned to appear before a selection board while on holiday shall be reimbursed for:
- i. travelling expenses from the practitioner's holiday address, but limited in the case of travel from abroad to expenses from the port of entry in Great Britain, provided that the practitioner returns to his or her holiday address after interview; for this purpose, travel from the Isle of Man and the Channel Islands shall not be regarded as travel from abroad;
 - ii. Subsistence allowance at the appropriate rate, unless the practitioner is able to stay at his or her own home and it is reasonable to expect the practitioner to do so.

- c. Reimbursement shall not be made to a practitioner who refuses the offer of the appointment as advertised on grounds that the authority considers inadequate.
- d. Where candidates intending to apply to enter a specialist registrar training programme make pre-interview or pre-application visits to placements in the training programme, they may, with the prior agreement of the employing authority, be reimbursed travelling expenses and subsistence allowance subject, unless the circumstances warrant exceptional treatment, to the maximum that would have been payable under sub-paragraph 313.a.ii or iii as appropriate.

Removal Expenses

314. The provisions of Section 26 of the General Council Conditions of Service shall apply.
315. Practitioners who are required to move house during a rotational training programme may receive reimbursement of removal expenses in accordance with Section 26 of the General Council Conditions of Service. Practitioners who might be reimbursed for moving house in such circumstances may, however, choose not to move home on taking up the second or subsequent posts in a rotation but to travel daily the greater distance between their home and the hospital. Similarly if the practitioner has a home convenient to the hospital in which the second or subsequent post in the rotational appointment is to be held the practitioner may elect to travel the extra distance to the hospital in which the previous post or posts are held. In such cases, the practitioner may be paid excess travelling expenses at the appropriate rate according to the circumstances in which the practitioner's vehicle is used.
- 316-329. Unallocated.

MISCELLANEOUS**Publications, lectures, etc**

330. A practitioner shall be free, without prior consent of the employing authority, to publish books, articles, etc., and to deliver any lecture or speak, whether on matters arising out of his or her hospital service or not.

Equal opportunities

331. The provisions of Section 7 of the General Council Conditions of Service shall apply.

Harassment at work

332. The provisions of Section 8 of the General Council Conditions of Service shall apply.

Child care

333. The provisions of temporary Appendix VIII shall apply.

Retainer schemes

334. The general provisions of temporary Appendix VII shall apply.

Disputes procedures

335. The provisions of Section 32 of the General Council Conditions of Service shall apply.

Health awareness for HPSS staff

336. The provisions of Section 41 of the General Council Conditions of Service shall apply.

Arrangements for redundancy payments

337. The provisions of Section 45 of the General Council Conditions of Service shall apply.

Position of employees elected to Parliament

338. The provisions of Section 52 of the General Council Conditions of Service shall apply.

Membership of District Councils

339. The provisions of Section 53 of the General Council Conditions of Service shall apply.

Payment of annual salaries

340. The provisions of Section 54 of the General Council Conditions of Service shall apply.

HSC Trusts - continuity of service

341. The provisions of Section 59 of the General Council Conditions of Service shall apply.

Annual leave and sick pay entitlements on re-entry and entry into HS employment

342. The provisions of Section 61 of the General Council Conditions of Service shall apply.

APPLICATION

343. All salary scales and conditions of service apply equally to men and women, provided that the practitioner has full, limited or provisional registration as a medical practitioner with the General Medical Council, or is registered as a dental practitioner with the General Dental Council.

Former trainees in general practice

344. Where a practitioner's immediately previous post was as a trainee in general practice, the practitioner should be treated for the purpose of these Terms and Conditions of Service as if the post had been a regular post in the hospital service. The practitioner's salary shall be taken to have been the point on the scale in Appendix I to which the salary payable under paragraph 38.6(e) of the Statement of Fees and Allowances corresponds (ie. after deduction of the addition for out-of-hours commitments). This provision does not apply to practitioners who were Principals or Assistants in general practice.

SUPPLEMENT**TERMS AND CONDITIONS OF SERVICE FOR DOCTORS UNDERTAKING SESSIONAL WORK IN THE COMMUNITY HEALTH SERVICES, PROVIDING MEDICAL SERVICES TO SOCIAL SERVICES DEPARTMENTS AND UNDERTAKING MEDICAL EXAMINATIONS OF PROSPECTIVE HS EMPLOYEES**

1. These terms and conditions of service do not form part of the terms and conditions of service for doctors in community medicine and the community health service. Doctors covered by the terms and conditions of service set out in this supplement are entitled only to the fees and allowances at the rates contained in the schedule annexed to this Supplement.
2. Where an employing authority has requested a doctor to carry out a domiciliary visit for which a fee is payable and the examination cannot be carried out because the patient is not at home at the pre-arranged time, the doctor shall be reimbursed at the rate of 50% of the appropriate fee.
3. In the Schedule, unless otherwise indicated, "full session" means a session of normally 1½ to 2½ hours, including, where necessary, allowance for travelling time; "short session" means a session not normally exceeding one hour.

SESSIONAL FEES (Schedule paragraph 1)

4. Not allotted.
5. Attendance at case conferences arranged by Social Services Departments (but not at the volition of the attending medical practitioner) should be treated as sessions, except where such attendance would be part of the practitioner's normal duties, eg as part of a multidisciplinary team, and a fee paid in accordance with the length of the conference.
6. Sessional fees are also payable for emergency attendances. They are repeated for ease of reference at paragraphs 5.a.iv. and 5.a.v. of the Schedule.

EXAMINATION OF BLIND OR PARTIALLY- SIGHTED PERSONS FOR THE COMPLETION OF FORM A655 (Schedule paragraph 2)

7. These fees are payable if the doctor has taken steps to ascertain that the patient is not already registered, or where it is proposed to recommend that a registered patient be transferred from one category of register to another, and it has been decided in consultation with the employing authority concerned (by telephone if necessary) that the examination should be carried out other than in the course of sessional arrangements. The fees for re-examination should be paid if the previous A655 is available at the time of the re-examination.
8. Where Form A655 is completed in the course of or following a domiciliary consultation for hospital purposes without a further visit being necessary, the combined fee should be paid by his employing authority at the rate shown in Appendix I (paragraph 145) to the Hospital Medical and Dental Staff Terms and Conditions of Service.

PSYCHIATRIC EXAMINATION UNDER ARTICLES 4, 13(3), 18 AND 23(2)(a) OF THE MENTAL HEALTH (NORTHERN IRELAND) ORDER 1986 (Schedule paragraph 3)

9. These fees should be paid in all cases where the practitioner has carried out the examination, whether or not a recommendation is made.

CHILDREN IN CARE, ADOPTION AND FOSTERING (Schedule paragraph 4)

10. Fees for completion of BAAF forms 3-4 should be settled locally with the doctor concerned if their use is necessary.

OTHER EXAMINATIONS AND REPORTS (Schedule paragraph 5)

11. Except where a fee for a particular service is specified elsewhere in the Schedule, reports required by Social Services Departments will be covered by the fees in paragraph 5.a of the Schedule. Where an employing authority is in doubt whether this is the appropriate fee for the service, the matter should be referred to the Department for advice.

VISITING MEDICAL OFFICERS TO ESTABLISHMENTS MAINTAINED BY TRUSTS AND EDUCATION AND LIBRARY BOARDS (Schedule paragraph 6)

12. The types of establishment covered by this scale are as follows:
- a. Day nurseries accommodating children aged 5 years and under.
 - b. Nursery schools accommodating children 2-5 years.
 - c. Residential special schools and boarding homes accommodating handicapped children of various types.
 - d. Boarding schools.
 - e. Community homes.
 - f. Mother and baby homes.
 - g. Residential accommodation provided under Article 15 of the Health and Personal Social Services (Northern Ireland) Order 1972.
 - h. Reception centres for accommodating person without a settled way of living.
 - i. Teacher Training and other residential colleges.
13. Fees are payable only for work that is not covered by general medical services under the Health and Personal Social Services (Northern Ireland) Order 1972. Remuneration for regular and routine attendances for such non-GMS work shall be by annual salary or sessional fee at the discretion of the employing authority. Where the sessional basis is adopted, fees shall be paid in accordance with paragraph 1 of the Schedule. Where the salary basis is adopted the remuneration shall be based on the number of hours per week spent at the establishment and shall be in accordance with paragraph 6.a of the Schedule.

14. The number of hours per week to which the annual salary is related shall be a matter for agreement from time to time between the employing authority and the doctor concerned. Agreements embodying periods of half an hour or any other period of less than an hour (with proportionate rate of payment) are not precluded.
15. A doctor remunerated by annual salary shall be responsible for providing a locum, at his own expense, when he is unable to carry out the duties himself.
16. A visit carried out in an emergency at the special request of the establishment and outside the regular and routine attendances and which falls outside the provision of general medical services shall be entitled to a fee in accordance with paragraph 6.b of the Schedule.

MISCELLANEOUS FEES (Schedule paragraph 7)

17. The fee for the notification of infectious diseases or food poisoning (paragraph 7.b) is payable to all notifying doctors except for those serving in the Armed Forces of the Crown or in any Women's Service administered by the Defence Council.
18. The fee shown at paragraph 7.c of the Schedule is for elementary lectures (normally of 60 minutes duration) to the lay public on first-aid to the injured, home nursing, childcare or hygiene.

MILEAGE ARRANGEMENTS

19. A doctor whose principle employment is subject to the terms and conditions of service for hospital, medical and dental staff and who is also remunerated by the same employing authority in respect of work referred to in the annex shall receive mileage allowances as if the work had been undertaken as part of his principal employment. All other doctors shall receive travelling expenses, and standard rate mileage allowances, and passenger allowances in accordance with Sections 23 and 24 of the General Council Conditions of Service provided that the doctor is entitled to allowances for travel between his practice premises or his home, whichever is the nearer, and the clinic or other premises visited.

SUPERANNUATION

20. Fees for work done for Social Services Departments will not normally be regarded as superannuable remuneration in the Health Services Superannuation Scheme. Fees for work in the community health service will normally be superannuable under the scheme. Exceptions to these generalisations include where a previous agreement to the contrary exists.

APPENDIX I

See latest pay circular which deals with pay and condition of service of hospital medical and dental staff and doctors in public health medicine and the community health service at the Department of Health's website at www.dhsspsni.gov.uk.

APPENDIX II

This Appendix sets out by reference to the General Council Handbook which General Council agreements have been applied to hospital medical and dental staff and doctors in public health medicine and the community health service and in what way.

Section	Subject	Paragraph
1	Annual Leave Entitlement (except that this section does not apply to locums, and subject to the further qualifications set out in paragraph 216)	216
2	Statutory And Public Holidays (subject to the qualifications set out in paragraph 214)	214
7	Equal Opportunities	331
22	Subsistence Allowances (subject to the qualifications set out in paragraphs 311)	311
23	Travelling Expenses (subject to the qualifications set out in paragraphs 277 to 303)	277-303
26	Removal Expenses And Associated Provisions (subject to the qualifications set out in paragraph 315)	314-315
32	Disputes Procedures	335
38	Facilities for Staff Organisations	
39	Joint Consultation Machinery	
41	Health Awareness For HPSS Staff	336
46	Payment of Superannuation and Compensation Benefits on Premature Retirement	
47	Protection of Pay and Conditions of Service	
52	Position of Employees Elected to Parliament	338
53	Membership of District Councils	339
54	Payment of Annual Salaries	340
55	Preparation for Retirement	
57	Statutory Sick Pay: Qualifying Days (subject to the qualifications set out in paragraph 244)	244
58	HPSS Reorganisation 1973 – Continuity of Employment	
59	HSC Trusts – Continuity of Service	341

61	Annual Leave and Sick Pay Entitlements on re-entry and entry to HS employment	342
62	HPSS Reorganisation – Staffing Arrangements	
74	HPSS Reorganisation – Protection of Pay and Terms and Conditions of Service	

NB - Please note that maternity leave and pay arrangements are now covered in temporary Appendix VI.

NB - irrelevant redacted by the USI
[Redacted text block]

NB - Please note that the Employment Break Scheme arrangements are now covered by Temporary Appendix VII.

NB - Please note that Caring for Children and Adults is now covered by Temporary Appendix VIII.

NB - Please note that Flexible Working Arrangements are now covered by Temporary Appendix IX.

NB - Please note that Balancing Work and personal Life is now covered by Temporary Appendix X.

APPENDIX III

This Appendix sets out by reference to the subject matter the General Council agreements that apply to hospital medical and dental staff and doctors in public health medicine and the community health service.

Subject	Section(s) of General Council Handbook
Annual Leave	1*
Annual Leave and Sick Pay Entitlements on re-entry and entry to HS employment	61
Disputes Procedures	32
District Councils – membership of	53
Equal Opportunities	7
Facilities for Staff Organisations	38
Health Awareness for HPSS staff	41
Joint Consultation Machinery	39
Mileage Allowance	23*
HPSS Reorganisation	58, 62, 74
HSC Trusts – Continuity of service	59
Parliament, position of employees elected to	52
Premature retirement	46
Protection of pay and conditions of service	47
Redundancy payments	45
Removal expenses	26*
Retirement, preparation for	55
Salaries, payment of	54
Statutory and Public holidays	2*
Statutory sick pay, qualifying days	57*
Subsistence allowances	22*
Travelling expenses	23*

*: see note in Appendix II

NB - Please note that maternity leave and pay arrangements are now covered in temporary Appendix VI.

NB - irrelevant redacted by the USI

APPENDIX IV

Please see the latest pay circular, which deals with fees and allowances payable to doctors for sessional work in the community health service, medical examinations of prospective HPSS employees and notification of infectious diseases and food poisoning

APPENDIX V

INDEX TO EXAMPLES OF CATEGORY 1 AND 2 ITEMS OF SERVICE

The following alphabetical index to the examples of category 1 and 2 items of service set out in paragraphs 36 and 37 is provided for the convenience of users of these terms and conditions of service. It is not a substitute for those terms and conditions, which should always be read before a decision is made as to which Category a particular item of service belongs.

Subject Reference	Paragraph (Category)	Sub paragraph
Armed Forces		
-Members of HM Armed Forces and or overseas forces in the UK, and their families	36 (1)	a.ii
-Referrals from HM Armed Forces Recruiting Organisations	37 (2)	j
Cervical cytology, screening for	36 (1)	c.iv
Children, close contact with	36 (1)	c.ii
Community Health Services practitioner, referral from	36 (1)	a.iii
Court hearings, including at coroners' courts E	36 (1) 37 (2)	E h.i
Courts, reports for (including coroners' courts	36 (1) 37 (2)	B g, h, I
Cremation certificates	37(2)	Q
Criminal Injuries Compensation Agency, referrals from	37(2)	C
Social Security Agency		
- statements or reports for social security purposes	36(1) 37(2)	b. i, b.ii b
- referrals about disabled persons' working capacity	36(1)	a.vi
- referrals from Medical Boards and Medical	36(1)	a.v b
- Appeal Tribunals	37(2)	
Disabled persons, working capacity of	36(1)	a.vi
Disablement resettlement officers, reports for	36(1)	a.vi

Emigration	37(2)	d, f
Employees and prospective employees, report on		
- of HPSS employing authorities and Education and Library Boards, social services and environmental health departments	36(1)	c.ii, c.iii
- other HPSS employees where specified in contract	36(1)	c.v
- routine screening of HPSS employees, where specified in contract	36(1)	c.vi
- already under observation or treatment, for sick leave purposes etc	36(1)	b.iv
- routine screening of the workforce	37(2)	k
Employment Medical Adviser, referral from	36(1)	a.iv
Employment Service	36(1) 37(2)	a.vi, b.iii p
Epidemic disease, patient with	36(1)	c.i
Extracts from case notes	36(1) 37(2)	b a
Foreign travel, including inoculations	37(2)	d
Form A655 (certificate of blindness)	37(2)	s
General practitioner, referral from for second opinion	36(1)	a.i
Insurance reports, including life insurance	37(2)	d,e
Legal Actions	36(1) 37(2)	e g,h,i
Medical Boards		
- membership of	37(2)	o
- referral from, for a second opinion	36(1)	a
Mental Health Order (Northern Ireland) 1986	36(1) 37(2)	d n
Occupational health physician, referral from	36(1)	a.iv
Teachers, prospective teachers and trainee teachers, in respect of transmissible disease	36(1)	c.ii

Transmissible disease, patient with	36(1)	c.i, c.ii, c.iii
Venereal disease, patient with	36(1)	c.i
Voluntary workers and employees of voluntary bodies	36(1)	c.iii
Workman's Compensation (Supplementation) Act (NI) 1966, referral by a medical referee	37(2)	1

APPENDIX VI
(Temporary Appendix)**MATERNITY LEAVE AND PAY****Introduction**

1. All employees will have the right to take 52 weeks of maternity leave.
2. Paragraphs 7 to 54 of this Schedule set out the maternity leave and pay entitlements of HPSS employees under the HPSS contractual maternity leave scheme.
3. Paragraphs 55 to 59 give information about the position of staff who are not covered by this scheme because they do not have the necessary service or do not intend to return to HPSS employment.
4. Paragraphs 60 to 64 define the service that can be counted towards the twelve month continuous service qualification set out in paragraph 7 (i) below and which breaks in service may be disregarded for this purpose.
5. Paragraph 65 explains how to get further information about employees' statutory entitlements.
6. Where locally staff and employer representatives agree arrangements which provide benefits to staff, beyond those provided by this section, those local arrangements will apply.

Eligibility

7. An employee working full-time or part-time will be entitled to paid and unpaid maternity leave under the HPSS contractual maternity pay scheme if:
 - (i) she has twelve months continuous service (see paragraphs 60 to 64) with one or more HPSS employers at the beginning of the eleventh week before the expected week of childbirth;
 - (ii) she notifies her employer in writing before the end of the 15th week before the expected date of childbirth (or if this is not possible, as soon as is reasonably practicable thereafter):
 - (a) of her intention to take maternity leave;
 - (b) of the date she wishes to start her maternity leave – she can choose when to start her maternity leave – this can usually be any date from the beginning of the 11th week before the baby is born (but see paragraph 8 below);
 - (c) that she intends to return to work with the same or another HPSS employer for a minimum period of three months after her maternity leave has ended;
 - (d) and provides a MATB1 form from her midwife or GP giving the expected date of childbirth.

Changing the Maternity Leave Start Date

8. If the employee subsequently wants to change the date from which she wishes her leave to start she should notify her employer at least 28 days beforehand (or, if this is not possible, as soon as is reasonably practicable beforehand).

Confirming Maternity Leave and Pay

9. Following discussion with the employee, the employer should confirm in writing:
- (i) the employee's paid and unpaid leave entitlements under this agreement (or statutory entitlements if the employee does not qualify under this agreement);
 - (ii) unless an earlier return date has been given by the employee, her expected return date based on her 52 weeks paid and unpaid leave entitlement under this agreement; and
 - (iii) the length of any period of accrued annual leave which it has been agreed may be taken following the end of the formal maternity leave period (see paragraphs 49 and 50 below);
 - (iv) the need for the employee to give at least 28 days notice if she wishes to return to work before the expected return date.

Keeping in Touch

10. Before going on leave, the employer and the employee should also discuss and agree any voluntary arrangements for keeping in touch during the employee's maternity leave including:
- (i) any voluntary arrangements that the employee may find helpful to help her keep in touch with developments at work and, nearer the time of her return, to help facilitate her return to work;
 - (ii) keeping the employer in touch with any developments that may affect her intended date of return.

Work During the Maternity Leave Period**Keeping in Touch Days**

11. To facilitate the process of Keeping in Touch Days (KIT days) it is important that the employer and employee have early discussion to plan and make arrangements for KIT days before the employee's maternity leave takes place.
12. To enable employees to take up the opportunity to work KIT days employers should consider the scope for reimbursement of reasonable childcare costs or the provision of childcare facilities.

13. KIT days are intended to facilitate a smooth return to work for women returning from maternity leave.
14. An employee may work for up to a maximum of 10 KIT days without bringing her maternity leave to an end. Any days of work will not extend the maternity leave period.
15. An employee may not work during the two weeks of compulsory maternity leave immediately after the birth of her baby.
16. The work can be consecutive or not and can include training or other activities which enable the employee to keep in touch with the workplace.
17. Any such work must be by agreement and neither the employer nor the employee can insist upon it.
18. The employee will be paid at their basic daily rate, for the hours worked less appropriate maternity leave payment for KIT days worked.
19. Working for part of any day will count as one KIT day.
20. Any employee who is breastfeeding must be risk assessed and facilities provided in accordance with paragraph 34.

Paid Maternity Leave

Amount of Pay

21. Where an employee intends to return to work the amount of contractual maternity pay receivable is as follows:
 - (i) for the first eight weeks of absence, the employee will receive full pay, less any Statutory Maternity Pay or Maternity Allowance (including any dependants' allowances) receivable;
 - (ii) for the next 18 weeks, the employee will receive half of full pay plus any Statutory Maternity Pay or Maternity Allowance (including any dependants' allowances) receivable, providing the total receivable does not exceed full pay.
 - (iii) for the next 13 weeks, the employee will receive any Statutory Maternity Pay or Maternity Allowance that they are entitled to under the statutory scheme.
22. By prior agreement with the employer occupational maternity pay may be paid in a different way, for example a combination of full pay and half pay or a fixed amount spread equally over the maternity leave period.

Calculation of Maternity Pay

23. Full pay will be calculated using the average weekly earnings rules used for calculating Statutory Maternity Pay entitlements, subject to the following qualifications:

- (i) in the event of a pay award or annual increment being implemented before the paid maternity leave period begins, the maternity pay should be calculated as though the pay award or annual increment had effect throughout the entire Statutory Maternity Pay calculation period. If such a pay award was agreed retrospectively, the maternity pay should be re-calculated on the same basis;
- (ii) in the event of a pay award or annual increment being implemented during the paid maternity leave period, the maternity pay due from the date of the pay award or annual increment should be increased accordingly. If such a pay award was agreed retrospectively, the maternity pay should be re-calculated on the same basis;
- (iii) in the case of an employee on unpaid sick absence or on sick absence attracting half pay during the whole or part of the period used for calculating average weekly earnings in accordance with the earnings rules for Statutory Maternity Pay purposes, average weekly earnings for the period of sick absence shall be calculated on the basis of notional full sick pay.

Unpaid Contractual Leave

24. Employees are also entitled to take a further 13 weeks as unpaid leave to bring the total of leave to 52 weeks. However, this may be extended by local agreement in exceptional circumstances for example, where employees have sick pre-term babies or multiple births.

Commencement and Duration of Leave

25. An employee may begin her maternity leave at any time between eleven weeks before the expected week of childbirth and the expected week of childbirth provided she gives the required notice.

Sickness Prior to Childbirth

26. If an employee is off work ill, or becomes ill, with a pregnancy related illness during the last four weeks before the expected week of childbirth, maternity leave will normally commence at the beginning of the fourth week before the expected week of childbirth or the beginning of the next week after the employee last worked, whichever is the later. Absence prior to the last four weeks before the expected week of childbirth, supported by a medical statement of incapacity for work, or a self-certificate, shall be treated as sick leave in accordance with normal leave provisions.
27. Odd days of pregnancy related illness during this period may be disregarded if the employee wishes to continue working till the maternity leave start date previously notified to the employer.

Pre-term Birth

28. Where an employee's baby is born alive prematurely the employee will be entitled to the same amount of maternity leave and pay as if her baby was born at full term.

29. Where an employee's baby is born before the eleventh week before the expected week of childbirth and the employee has worked during the actual week of childbirth, maternity leave will start on the first day of the employee's absence.
30. Where an employee's baby is born before the eleventh week before the expected week of childbirth and the employee has been absent from work on certified sickness absence during the actual week of childbirth, maternity leave will start the day after the day of birth.
31. Where an employee's baby is born before the eleventh week before the expected week of childbirth and the baby is in hospital the employee may spilt her maternity leave entitlement, taking a minimum period of two weeks' leave immediately after childbirth and the rest of her leave following her baby's discharge from hospital.

Still Birth

32. Where an employee's baby is born dead after the 24th week of pregnancy the employee will be entitled to the same amount of maternity leave and pay as if her baby was born alive.

Miscarriage

33. Where an employee has a miscarriage before the 25th week of pregnancy normal sick leave provisions will apply as necessary.

Health and Safety of Employees Pre and Post Birth

34. Where an employee is pregnant, has recently given birth or is breastfeeding, the employer must carry out a risk assessment of her working conditions. If it is found, or a medical practitioner considers, that an employee or her child would be at risk were she to continue with her normal duties the employer should provide suitable alternative work for which the employee will receive her normal rate of pay. Where it is not reasonably practicable to offer suitable alternative work the employee should be suspended on full pay.
35. These provisions also apply to an employee who is breastfeeding if it is found that her normal duties would prevent her from successfully breastfeeding her child.

Return to Work

36. An employee who intends to return to work at the end of her full maternity leave will not be required to give any further notification to the employer, although if she wishes to return early she must give at least 28 days' notice.
37. An employee has the right to return to her job under her original contract and on no less favourable terms and conditions.

Returning on Flexible Working Arrangements

38. If at the end of maternity leave the employee wishes to return to work on different hours the HPSS employer has a duty to facilitate this wherever possible, with the employee returning to work on different hours in the same job. If this is not possible the employer must provide written, objectively justifiable reasons for this and the

employee should return to the same grade and work of a similar nature and status to that which they held prior to their maternity absence.

39. If it is agreed that the employee will return to work on a flexible basis, including changed or reduced hours, for an agreed temporary period this will not affect the employee's right to return to her job under her original contract at the end of the agreed period.

Sickness Following the End of Maternity Leave

40. In the event of illness following the date the employee was due to return to work normal sick leave provisions will apply as necessary.

Failure to Return to Work

41. If an employee who has notified her employer of her intention to return to work for the same or a different HPSS employer in accordance with paragraph 7 (ii) (c) above fails to do so within 15 months of the beginning of her maternity leave she will be liable to refund the whole of her maternity pay, less any Statutory Maternity Pay, received. In cases where the employer considers that to enforce this provision would cause undue hardship or distress the employer will have the discretion to waive their rights to recovery.

Miscellaneous Provisions

Fixed – Term Contracts or Training Contracts

42. Employees subject to fixed-term or training contracts which expire after the eleventh week before the expected week of childbirth and who satisfy the conditions in paragraphs 7 (i), 7 (ii) (a), 7 (ii) (b) and 7 (ii) (d) shall have their contracts extended so as to allow them to receive the 52 weeks which includes paid contractual and statutory maternity pay and the remaining 13 weeks of unpaid maternity leave.
43. Absence on maternity leave (paid and unpaid) up to 52 weeks before a further HPSS appointment shall not constitute a break in service.
44. If there is no right of return to be exercised because the contract would have ended if pregnancy and childbirth had not occurred the repayment provisions set out in paragraph 41 above will not apply.
45. Employees on fixed-term contracts who do not meet the twelve months continuous service condition set out in paragraph 7 (i) above may still be entitled to Statutory Maternity Pay.

Rotational Training Contracts

46. Where an employee is on a planned rotation of appointments with one or more HPSS employers as part of an agreed programme of training, she shall have the right to return to work in the same post or in the next planned post irrespective of whether the contract would otherwise have ended if pregnancy and childbirth had not occurred. In such circumstances the employee's contract will be extended to enable the practitioner to complete the agreed programme of training.

Contractual rights

47. During maternity leave (both paid and unpaid) an employee retains all of her contractual rights except remuneration.

Increments

48. Maternity leave, whether paid or unpaid, shall count as service for annual increments and for the purposes of any service qualification period for additional annual leave.

Accrual of Annual Leave

49. Annual leave will continue to accrue during maternity leave, whether paid or unpaid, provided for by this agreement.
50. Where the amount of accrued annual leave would exceed normal carry over provisions, it may be mutually beneficial to both the employer and employee for the employee to take annual leave before and/or after the formal (paid and unpaid) maternity leave period. The amount of annual leave to be taken in this way, or carried over, should be discussed and agreed between the employee and employer. Payment in lieu may be considered as an option where accrual of annual leave exceeds normal carry over provisions.

Pensions

51. Pension rights and contributions shall be dealt with in accordance with the provisions of the HPSS Superannuation Regulations.

Antenatal Care

52. Pregnant employees have the right to paid time off for antenatal care. Antenatal care includes relaxation and parent-craft classes as well as appointments for antenatal care.

Post-natal Care and Breastfeeding Mothers

53. Women who have recently given birth should have paid time off for post-natal care e.g. attendance at health clinics.
54. Employers are required to undertake a risk assessment and to provide breastfeeding women with suitable private rest facilities. The Health and Safety Executive Guidance recommends that employers provide:
- o a clean, healthy and safe environment for women who are breastfeeding,
 - o suitable access to a private room to express and store milk in an appropriate refrigerator.

Employers are reminded that they should consider requests for flexible working arrangements to support breastfeeding women at work.

Employees Not Returning to HPSS Employment

55. An employee who satisfies the conditions in paragraph 7, except that she does not intend to work with the same or another HPSS employer for a minimum period of three months after her maternity leave is ended, will be entitled to pay equivalent to Statutory Maternity Pay, which is paid at 90% of her average weekly earnings for the first six weeks of her maternity leave and to a flat rate sum for the following 33 weeks.

Employees With Less Than Twelve Months Continuous Service

56. If an employee does not satisfy the conditions in paragraph 7 for occupational maternity pay she may be entitled to Statutory Maternity Pay. Statutory Maternity Pay will be paid regardless of whether she satisfies the conditions in paragraph 7.
57. If her earnings are too low for her to qualify for Statutory Maternity Pay, or she does not qualify for another reason, she should be advised to claim Maternity Allowance from her local Job Centre or Social Security office.
58. All employees will have a right to take 52 weeks of maternity leave whether they return to HPSS Employment or not.
59. Paragraph 65 contains further information on statutory maternity entitlements.

Continuous Service

60. For the purposes of calculating whether the employee meets the twelve months continuous service with one or more HPSS employers qualification set out in paragraph 7 (i) the following provisions shall apply:
- (i) HPSS employers includes HSS Boards, HSC Trusts and Special Agencies and employment in the NHS;
 - (ii) a break in service of three months or less will be disregarded (though not count as service).
61. The following breaks in service will also be disregarded (though not count as service);
- (i) employment under the terms of an honorary contract;
 - (ii) employment as a locum with a general practitioner for a period not exceeding twelve months;
 - (iii) a period of up to twelve months spent abroad as part of a definite programme of postgraduate training on the advice of the Postgraduate Dean or College or Faculty Advisor in the speciality concerned;
 - (iv) a period of voluntary service overseas with a recognised international relief organisation for a period of twelve months which may exceptionally be extended for twelve months at the discretion of the employer which recruits the employee on her return;

- (v) absence on a employment break scheme in accordance with the provisions of Appendix VII;
 - (vi) absence on maternity leave (paid or unpaid) as provided for under this agreement.
62. Employers may at their discretion extend the period specified in paragraphs 60 (ii) and 61.
63. Employment as a trainee with a General Medical Practitioner in accordance with the provisions of the Trainee Practitioner Scheme shall similarly be disregarded and count as service.
64. Employers have the discretion to count other previous HPSS/NHS service or service with other employers.

Information about Statutory Maternity/Adoption and Paternity Maternity Leave and Pay

65. There are occasions when employees are entitled to other statutory benefits/allowances and information about all statutory maternity/adoption and paternity rights can be found using the following links:

<http://www.dti.gov.uk/employment/workandfamilies/maternity-leave-pay/guidance/page21116.html>

http://www.dwp.gov.uk/lifeevent/benefits/statutory_maternity_pay.asp

http://jobcentreplus.gov.uk/JCP/Customers/WorkingAgeBenefits/Dev_008115.xml.htm
I

Information about Health and Safety for new and expectant mothers at work can be found using the following link:-

www.hse.gov.uk

EMPLOYMENT BREAK SCHEME**General**

1. HPSS employers should provide all staff with access to an employment break scheme.
2. The scheme should be agreed between employers and local staff representatives.
3. The scheme should be viewed with others, particularly those relating to flexible working, balancing work and personal life, and provisions for carers, as part of the commitment to arrangements which enable employees to balance paid work with their other commitments and responsibilities.
4. The scheme should also enable employers to attract and retain the experience of staff consistent with the HPSS commitment to the provision of high quality healthcare.
5. The scheme should provide for people to take a longer period away from work than that provided for by the parental leave and other leave arrangements.

Scope

6. The scheme should explicitly cover the main reasons for which employment breaks can be used, including childcare, eldercare, care for another dependant, training, study leave or work abroad. It should also indicate that other reasons will be considered on their merits.
7. People on employment breaks will not normally be allowed to take up paid employment with another employer except where, for example, work overseas or charitable work could broaden experience. In such circumstances written authority from the employer would be necessary.

Eligibility

8. The employment break scheme should normally be open to all employees who have a minimum of twelve month's service.
9. Applications should be submitted in writing and notice periods should be clearly stated in an agreement between the employee and employer.

Length of Break

10. The maximum length of break should be five years.
11. Breaks should be able to be taken either as a single period or as more than one period.
12. The minimum length of break should be three months.
13. The length of any break should balance the needs of the applicant with the needs of the service.

14. The scheme should have provision for breaks to be extended with appropriate notice, or for early return from breaks.
15. All breaks should be subject to an agreement between the employer and applicant before the break begins. The agreement should cover:
 - the effect of the break on various entitlements related to length of service;
 - a guarantee that, if the applicant returns to work within one year, the same job will be available, as far as is reasonably practicable;
 - if the break is longer than one year, the applicant may return to as similar a job as possible;
 - return to work at the equivalent salary level, reflecting increases awarded during the break;
 - the notice period required before the return to work should be two months if the break is less than a year and six months if the break is more than a year;
 - arrangements for keeping in touch during the break;
 - requirements on the applicant to keep up to date with their relevant professional registration needs, including attendance at specified training courses and conferences, and any assistance the employer may give in the support of this;
 - training arrangements for re-induction to work;
 - any other conditions required either by the employer or the applicant.

Return to Work

16. Applicants should not have to resign to take an employment break, although there will be a change to the contract of employment.
17. The period of the break should count toward continuous employment for statutory purposes.
18. Other provisions depending upon length of service, ie. pensions, contractual redundancy payments, leave entitlements etc, should be suspended for the period of the break.

Appeals

19. Applicants should be entitled to a written reason for the refusal of any application.
20. Applicants may resort to the grievance procedure if a request for a break is refused.

Monitoring and Review

21. All records of applications and decisions should be kept for a minimum of twelve months.
22. The operation of the scheme should be monitored annually by employers in partnership with local staff representatives.

APPENDIX VIII
(Temporary Appendix)**CARING FOR CHILDREN AND ADULTS****General**

1. All HPSS employers must have a carer's policy to address the needs of people with caring responsibilities and to meet the requirements of the "right to request" flexible working legislation for carers of children and dependant adults (see Employment Relations (NI) Order 1999 for definition of "carer"). This policy should emphasise the benefits of employment breaks, flexible working arrangements and balancing work and personal life as set out in Temporary Appendices VII, IX and X.
2. The policy should seek to balance the requirements of delivering a first class service with the needs of employees, to find the most effective means of supporting those with carer responsibilities as part of a wider commitment by the HPSS to improve the quality of working life.
3. Many of the policies related to child and dependant care will have relevance to other forms of care. For example the planning process for checking out what would help eligibility criteria and ensuring equality of access. These should be considered when drawing up a carers policy.

Child and Dependant Care

4. Childcare covers a range of care choices for children from birth up to age 14 years.
5. Dependant care covers a range of options to meet the needs of dependant adults, where an employee is involved in substantial and regular care sufficient for them to seek a change in their permanent contract of employment.
6. The policy should be drawn up jointly between employers and local staff side representatives.
This should cover:
 - the child and dependant care needs of people relative to matters such as place of work, working patterns (including shift patterns) and hours worked;
 - policy on child and dependant care support particularly related to specific difficulties in recruiting and retaining people in certain job categories;
 - equality of access to child and dependant care and affordability, respecting the diversity of personal domestic circumstances;
 - guidelines on eligibility;
 - how the policy relates to other Appendices, in particular those covering leave and flexible working arrangements;
 - the range of options open to carers, i.e. crèche facilities, childminders, workplace nurseries, allowances, school and holiday play schemes, term-time contracts etc. The policy should be clear as to why certain options are available;
 - partnership options with other employers and trade unions;

- allocation of senior management responsibility for the operation and monitoring of the policy
- 7. Where a decision is taken not to offer particular forms of childcare, the policy should indicate where other arrangements are available to support people with childcare responsibilities, and what alternative ways of working exist.
- 8. Applications and outcomes should be monitored annually, in partnership with local staff representatives.
- 9. Monitoring information should be analysed and used to review and revise policies and procedures to ensure their continuing effectiveness.
- 10. Applications and outcomes, from both employer and employees should be recorded and kept for a minimum of one year.

APPENDIX IX
(Temporary Appendix)**FLEXIBLE WORKING ARRANGEMENTS****General**

1. HPSS employers in partnership with staff organisations will develop positive flexible working arrangements which allow people to balance work responsibilities with other aspects of their lives.
2. Employers are required to consider flexible working options as part of their duty to make reasonable adjustments for disabled staff and job applicants under the Disability Discrimination (NI) Order 2006, and staff returning from maternity leave (see Appendix VI).
3. New working arrangements should only be introduced by mutual agreement, whether sought by the employee or the employer.
4. Flexible working should be part of an integrated approach to the organisation of work and the healthy work/life balance of staff.
5. Policies for flexible working should be made clear to all employees.
6. Employers should develop policies on flexible working which, as far as is practicable, should include:
 - part-time working, where a person works to a pattern and number of hours by mutual agreement;
 - job sharing, where two or more people share the responsibilities of one or more full-time job(s), dividing the hours, duties and pay between them;
 - flexi-time, where employees can choose their own start and finish time around fixed core hours;
 - annual hours contracts, where people work a specific number of hours each year, with the hours being unevenly distributed throughout the year;
 - flexible rostering, using periods of work of differing lengths within an agreed overall period;
 - term-time working, where people work during the school term but not during school holidays;
 - school-time contracts;
 - teleworking, where people work from home for all or part of their hours with a computer or telecommunication link to their organisation;
 - voluntary reduced working time, where people work reduced hours by agreement at a reduced salary;
 - fixed work patterns, where, by agreement, days off can be irregular to enable, for example, access by separated parents to their children and flexible rostering;

- Flexible retirement
7. Flexible working arrangements should be available to all employees.
 8. All jobs should be considered for flexible working. If this is not possible the employer must provide written, objectively justifiable reasons for this and give a clear, demonstrable operational reason why this is not practicable.
 9. There should be a clear procedure for application for flexible working, agreed by employers and local staff representatives.
 10. All people with flexible working arrangements should have access to standard terms and conditions of employment, on an equal or pro-rata basis, unless different treatment can be justified for operational reasons.

Monitoring and Review

11. Applications and outcomes should be monitored annually, in partnership with local staff representatives.
12. Monitoring information should be analysed and used to review and revise policies and procedures to ensure their continuing effectiveness.
13. Applications and outcomes, from both employer and employees, should be recorded and kept for a minimum of one year.

**APPENDIX X
(Temporary Appendix)****BALANCING WORK AND PERSONAL LIFE****General**

1. HPSS employers should provide employees with access to leave arrangements which support them in balancing their work responsibilities with their personal commitments.
2. Leave arrangements should be part of an integrated policy of efficient and employee friendly employment practices, and this Schedule should be seen as operating in conjunction with other provisions particularly the Employment Break Scheme, Flexible Working Arrangements and the Caring for Children and Adults Appendices.
3. Arrangements should be agreed between employers and local staff representatives.
4. A dependant is someone who is married to, or is a partner or civil partner, "a near relative" or someone who lives at the same address as the employee. A relative for this purpose includes: parents, parents-in-law, adult children, adopted adult children, siblings (including those who are in-laws), uncles, aunts, grandparents and step relatives or is someone who relies on the employee in a particular emergency.

FORMS OF LEAVE**Parental Leave**

5. This should be a separate provision from either maternity or maternity support leave and should provide an untransferable individual right to at least 13 weeks' leave (18 weeks if child is disabled). Leave is normally unpaid, but may be paid by local agreement.
6. Parental leave should be applicable to any employee in the HPSS who has nominated caring responsibility for a child under age 14 (18 in cases of adoption or disabled children).
7. Leave arrangements need to be as flexible as possible, so that the leave may be taken in a variety of ways by local agreement. Parental leave can be added to periods of maternity support or maternity leave.
8. Notice periods should not be unnecessarily lengthy and should reflect the period of leave required. Employers should only postpone leave in exceptional circumstances and give written reasons. Employees may also postpone or cancel leave that has been booked with local agreement.
9. During parental leave the employee retains all of his or her contractual rights, except remuneration and should return to the same job after it. Pension rights and contributions shall be dealt with in accordance with HPSS Superannuation Scheme. Periods of parental leave should be regarded as continuous service.
10. It is good practice for employers to maintain contact (within agreed protocols) with employees while they are on parental leave.

Maternity Support (Paternity) Leave and Pay and Ante-Natal Leave

11. This will apply to biological and adoptive fathers, nominated carers and same sex partners.
12. There will be an entitlement to two weeks' occupational maternity support pay. Full pay will be calculated on the basis of the average weekly earnings rules used for calculating occupational maternity pay entitlements. The employee will receive full pay less any statutory paternity pay receivable. Only one period of occupational paternity pay is ordinarily available when there is a multiple birth. However, HPSS organisations have scope for agreeing locally more favourable arrangements where they consider it necessary, or further periods of unpaid leave.
13. Eligibility for occupational paid maternity support pay will be twelve months' continuous service with one or more HPSS employers at the beginning of the week in which the baby is due. More favourable local arrangements may be agreed with staff representatives and/or may be already in place.
14. Local arrangements should specify the period during which leave can be taken and whether it must be taken in a continuous block or may be split up over a specific period.
15. An employee must give his or her employer a completed form SC3 "Becoming a Parent" at least 28 days before they want leave to start. The employer should accept later notification if there is good reason.
16. Reasonable paid time off to attend ante-natal classes will also be given.
17. All employees are entitled to two weeks maternity support leave. Employees who are not eligible for occupational maternity support pay may still be entitled to Statutory Paternity Pay (SPP) subject to the qualifying conditions. The rate of SPP is the same as for Statutory Maternity Pay (SMP).

Adoption Leave and Pay

18. All employees are entitled to take 52 weeks adoption leave.
19. There will be entitlement to paid occupational adoption leave for employees wishing to adopt a child who is newly placed for adoption.
20. It will be available to people wishing to adopt a child who has primary carer responsibilities for that child.
21. Where the child is below the age of 18 adoption leave and pay will be in line with the maternity leave and pay provisions as set out in this agreement.
22. Eligibility for occupational adoption pay will be twelve months' continuous HPSS service ending with the week in which they are notified of being matched with the child for adoption. This will cover the circumstances where employees are newly matched with the child by an adoption agency.
23. If there is an established relationship with the child, such as fostering prior to the adoption, or when a step-parent is adopting a partner's children there is scope for local arrangements on the amount of leave and pay in addition to time off for official meetings.

24. If the same employer employs both parents the period of leave and pay may be shared. One parent should be identified as the primary carer and be entitled to the majority of the leave. The partner of the primary carer is entitled to occupational paternity leave and pay.
25. Reasonable time off to attend official meetings in the adoption process should also be given.
26. Employees who are not eligible for occupational adoption pay, may still be entitled to Statutory Adoption Pay (SAP) subject to the qualifying conditions. The rate of SAP is the same as for Statutory Maternity Pay.

Keeping in Touch

Work during the Adoption Leave Period

Keeping in Touch Days

27. Employees will be entitled to Keep in Touch Days (KIT) in line with the maternity leave and pay provisions as set out in Appendix VI.

Leave/Time Off for Domestic Reasons

28. This form of leave should cover a range of needs, from genuine domestic emergencies through to bereavement.
29. These provisions should cover all employees.
30. Payment may be made by local agreement, but the expectation is that relatively short periods of leave for emergencies will be paid.
31. If the need for time off continues, other options may be considered, such as a career break.
32. Applicants for the above forms of leave should be entitled to a written explanation if the application is declined.
33. Appeals against decisions to decline an application for leave should be made through the Grievance Procedure.

Monitoring and Review

34. All applications and outcomes should be recorded, and each leave provision should be annually reviewed by employers in partnership with local staff representatives.
35. Applications and outcomes should be monitored annually, in partnership with local staff representatives.
36. Monitoring information should be analysed and used to review and revise policies and procedures to ensure their continuing effectiveness.
37. Applications and outcomes, from both employer and employees should be recorded and kept for a minimum of one year.

APPENDIX XI
(Temporary Appendix)**REDUNDANCY PAY**

1. This section sets out the arrangements for redundancy pay for employees dismissed by reason of redundancy who, at the date of termination of their contract, have at least 104 weeks of continuous full-time or part-time service. These take effect from 1 October 2006. It also sets out the arrangements for early retirement on grounds of redundancy and in the interests of the service for those who are members of the HSC Superannuation Scheme and have at least two years continuous full-time or part-time service and two years qualifying membership in the Scheme. Pension changes take effect from 1 December 2006. It further sets out transitional arrangements from 1 December 2006 to 30 September 2011 for staff aged over 50 at the time of redundancy who are members of the HPSS Superannuation Scheme with at least five year's pensionable service.

Definition of Redundancy

2. The Employment Rights (Northern Ireland) Order 1996 Article 174 states that redundancy arises when employees are dismissed in the following circumstances:
 - “where the employer has ceased, or intends to cease, to carry on the business for the purposes of which the employee was employed; or where the employer has ceased, or intends to cease, to carry on the business in the place where the employee was so employed; or
 - where the requirements of the business for employees to carry out work of a particular kind, in place where they were so employed, have ceased or diminished or are expected to cease or diminish”.

Qualification for a Redundancy Payment

3. To qualify for a redundancy payment, the member of staff must be an employee, working under a contract of employment for a HSC employer. ‘HSC employer’ means HSS Boards, HSC Trusts, Special Agencies and employment in the NHS. Non executive directors of HSC organisations do not qualify. Contracts of employment may be written or verbal, and can be for a fixed period or be continuous. In law, employees have a contract as soon as they start work and in accepting and undertaking the work required they accept the terms and conditions offered by the employer. To qualify for a redundancy payment the employee must also have at least 104 weeks of continuous full-time or part-time service.

Definition of Continuous Service

4. “Continuous service” means full-time or part-time employment with the present or any previous HSC employer. If with more than one HSC employer, there must not have been a break of more than a week (measured Sunday to Saturday) between employments.

Definition of Reckonable Service

5. “Reckonable service” of the purposes of a HSC redundancy payment, which is calculated on the basis of the service up to the date of termination of the contract,

means continuous full-time or part-time employment with the present or any previous HSC employer but with the following additions:

- where there has been a break in service of 12 months or less the period of employment prior to the break will count as reckonable service;
- periods of employment as a trainee with a general medical practitioner in accordance with the provisions of the Trainee Practitioner Scheme will count as reckonable service;
- at employer discretion, any period or periods of employment with employers outside the HSC where these are judged to be relevant to HSC employment can be included in reckonable service.

6. The following employment will not count as reckonable service:

- employment that has been taken into account for the purposes of a previous redundancy, or loss of office payment by a HSC employer;
- where the employee has previously been given pension benefits, any employment that has been taken into account for the purposes of those pension benefits.

Definition of a Month's Pay

7. "Month's pay" means whichever is the more beneficial of the following calculations:

- 4.35 times a week's pay calculated in accordance with the provisions of Sections 17 to 25 of the Employment Rights (Northern Ireland) Order 1996;
- an amount equal to 1/12th of the annual salary in payment at the date of termination of employment.

Calculation of Redundancy Payment

8. The redundancy payment will take the form of a lump sum, dependent on the employee's reckonable service at the date of termination of employment. The lump sum will be calculated on the basis of one month's pay for each complete year of reckonable service subject to a minimum of two years (104 weeks) continuous service and a maximum of 24 year's reckonable service being counted.

9. Fractions of a year of reckonable service will not be taken into account.

Early Retirement on Grounds of Redundancy for Employees entitled top pension benefits

Qualification Criteria

10. Members of the HPSS Superannuation Scheme who are made redundant and meet the conditions set out above in paragraphs 3 to 6, may choose to retire early without reduction in the value of pension benefits as an alternative to receiving the full lump sum benefit set out in paragraph 8. To qualify for early retirement the member of staff must:

- be a member of the HPSS Superannuation Scheme;
- have at least two years' continuous service and two years' qualifying membership;
- have reached the minimum pension age. The Finance Act 2004 allows for protection of a minimum pension age of 50 for members who had the right to take reduced benefits at that age on 5 April 2006. This protection may continue as long as members retiring early after 6 April 2010 take all their benefits payable under scheme rules. In the HPSS Superannuation Scheme, for those without this protection, members who first joined and some who returned to the scheme after 6 April 2006, minimum pension age will change from 50 to 55 from 6 April 2010.[§]

Definition of Qualifying Membership

11. 'Qualifying membership' is membership that counts towards entitlement for benefits. Pensionable membership is membership that counts when benefits are calculated. This may be different from reckonable service for the purposes of a redundancy payment as it can include pensionable service from previous periods of employment with the HSC or another employer and periods of part-time working.

Use of Redundancy Payment to pay for Early Retirement

12. If the redundant member of staff chooses to take early retirement with an unreduced pension under these arrangements, they will receive immediately the full value of their qualifying pension benefits at the point of redundancy without the actuarial reduction that would occur with voluntary early retirement. Their employer will pay the relevant HPSS Superannuation Scheme a sum equivalent to the capitalised cost of paying the pension and lump sum early; either as one payment or in five instalments.**
13. This sum will be paid from the lump sum redundancy payment that otherwise would have been paid to the employee. If the cost to the employer of paying by single payment for early retirement is less than the value of the redundancy payment that the member would have received under paragraph 8 then the redundant employee will also receive from the employer a redundancy payment equivalent to the difference between the two sums. The cost to the employer would therefore normally be the same as if the employee had chosen to take a redundancy payment without unreduced early retirement. However, if the cost of early retirement is more than the redundancy payment due, the employer will pay the additional cost. If the employer chooses to pay in five instalments, the employer is responsible for the additional interest charge.

[§] Subject to consultation, for those who are in the new pension scheme (with a normal pension age of 65), minimum pension age will be 55 from when the scheme is set up.

** It is open to qualifying members to take early retirement under the normal scheme arrangements for voluntary early retirement or normal age retirement.

Treatment of Concurrent Pensionable Employment

14. Where there is concurrent pensionable employment, members may choose between:
- ceasing all pensionable employment and taking early retirement on the terms set out below in respect of each employment in which case they cannot be pensionable again in the current scheme (normal pension age of 60). (An employment may continue if it is not more than 16 hours a week, without affecting the payment of enhanced benefits, but it will not be pensionable in the scheme); and
 - taking benefits only in respect of the employment that is being terminated, in which case they can continue being pensionable in other employments. After 6 April 2010, this will not apply if taking benefits under the age of 55; and
 - members with concurrent practitioner and non-practitioner employments, who choose to cease all pensionable employments, will receive only their non-practitioner benefits on redundancy grounds. Where appropriate, benefits for practitioner membership may be taken on an early retirement basis with an actuarial reduction or preserved for payment at age 60.^{††}
15. The employer who authorises early retirement will be responsible for the pension costs accruing from other terminating employment. If a member returns to work after taking their pension, their pension will be abated, if the combined value of their pension and salary is greater than they earned prior to retirement. This will continue until they reach their normal pension age.

Exclusion from eligibility

16. Employees shall not be entitled to redundancy payments or early retirement on grounds of redundancy if:
- they are dismissed for reasons of misconduct, with or without notice; or
 - at the date of the termination of the contract have obtained without a break, or with a break not exceeding four weeks, suitable alternative employment with the same or another HSC employer; or
 - unreasonably refuse to accept or apply for suitable alternative employment with the same or another HSC employer; or
 - leave their employment before expiry of notice, except if they are being released early (see paragraphs 20 to 21 below); or
 - are offered a renewal of contract (with the substitution of the new employer for the previous HSC one);

^{††} Where practitioner membership ended 12 months or more before the date of non-practitioner retirement on redundancy, and all other posts have ceased, practitioner benefits will be paid at the same time as the redundancy benefits and associated pension costs will be met by the HSC employer authorising retirement.

[‡] Practitioners are general medical and general dental practitioners.

- where their employment is transferred to another public service employer who is not a HSC employer.

Suitable alternative employment

17. Employers have a responsibility before making a member of staff redundant or agreeing early retirement on grounds of redundancy to seek suitable alternative employment for that person, either in their own organisation or through arrangements with another HSC employer. Employers should avoid the loss of staff through redundancy wherever possible to retain valuable skills and experience where appropriate within the local health economy.
18. 'Suitable alternative employment', for the purposes of paragraph 17, should be determined by reference to Articles 173 and 176 of the Employment Rights (Northern Ireland) Order 1996. In considering whether a post is suitable alternative employment, regard should be had to the personal circumstances of the employee. Employees will, however, be expected to show some flexibility.
19. For the purposes of this scheme any suitable alternative employment must be brought to the employee's notice in writing or by electronic means agreed with the employee before the date of termination of contract and with reasonable time for the employee to consider it. The employment should be available not later than four weeks from that date. Where this is done, but the employee fails to make any necessary application, the employee shall be deemed to have refused suitable alternative employment. Where an employee accepts suitable alternative employment the 'trial period' provisions in Article 173(3) of the Employment Rights (Northern Ireland) Order 1996 will apply.

Early release of redundant employees

20. Employees who have been notified of the termination of their employment on grounds of redundancy, and for whom no suitable alternative employment in the HSC is available, may, during the period of notice, obtain other employment outside the HSC.
21. If they wish to take this up before the period of notice of redundancy expires the employer will, unless there are compelling reasons to the contrary, release such employees at their request on a mutually agreeable date. That date will become the revised date of redundancy for the purpose of calculating any entitlement to a redundancy payment under this agreement.

Claim for redundancy payment

22. Claims for redundancy payment or retirement on grounds of redundancy must be submitted within six months of date of termination of employment. Before payment is made the employee will certify that:
 - they had not obtained, been offered or unreasonably refused to apply for or accept suitable alternative Health Service employment within four weeks of the termination date;
 - they understand that payment is made only on this condition and undertake to refund it if this condition is not satisfied.

Retrospective Pay Awards

23. If a retrospective pay award is notified after the date of termination of employment then the redundancy payment and/or pension will be recalculated, and any arrears due paid.

Disputes

24. An employee who disagrees with the employer's calculation of the amount of redundancy payment or the rejection of a claim for redundancy payment should make representations to the employer via local grievance procedures. See also paragraph 22 about making a claim for a redundancy payment.

Early Retirement in the Interests of the Efficiency of the Service

25. Members of the HPSS Superannuation Scheme will receive payment of benefits without reduction if they retire early in the interests of the efficiency of the service, and they satisfy the qualifying conditions set out in paragraph 10. Retiring early in the interests of the service is a flexibility available at employer discretion. In these cases, no redundancy payment is due. In agreeing to retirement in the interests of the service, the employer undertakes to pay the costs of paying the pension and lump sum early. Employers will need to ensure that they exercise this discretion appropriately and will be conscious of the implications of any potential discrimination on grounds of age, sex, race, religion or disability.
26. These arrangements are aimed at employees who have given valuable HSC service in the past but are no longer capable of doing so. This might be because of new or expanded duties or a decline in the ability to perform existing duties efficiently but not so as to qualify them for ill health retirement. Employers would be expected to consider alternatives before agreeing to early retirement.
27. The relevant HPSS Superannuation Scheme certifies the grounds on which early retirement is taking place. The scheme does so on the basis of the information provided by the employer. In each case, therefore, an appropriate senior manager should authorise the early retirement, ensuring that the relevant criteria have been met.

Employer Responsibilities

28. Employer contributions to the HPSS Superannuation Scheme do not cover the costs of early retirement benefits. There is a requirement for HSC employers to pay these costs if they retire staff early on grounds of redundancy or in the interests of the service.

Transitional Arrangements: 1 October 2006 to 30 September 2011

29. There will be transitional arrangements in place from 1 December 2006 to 30 September 2011. These transitional arrangements apply to staff:
- whose continuous HSC service and/or pension scheme membership began before 1 October 2006;
 - who are aged over 50 on 30 September 2006 or who reach 50 during the transition period: 1 October until 30 September 2011; (after 6 April 2010 subject to the rules on minimum pension age set out in paragraph 10);

- who are members of the HPSS Superannuation Scheme and have at least five years qualifying membership in the scheme at the date of redundancy.
30. Employees who are made redundant and qualify for transitional protection can choose between a redundancy payment under the new arrangements and payment under transitional protection. The transitional arrangements for early retirement (but not the redundancy payment) will also apply to staff given early retirement in the interests of the service and who meet the qualifying conditions in paragraph 29.
 31. Transitional protection has two phases. The first phase applies from 1 December 2006 to 30 September 2009. During this phase, the maximum pension that an employee can receive on taking redundancy retirement is that to which they would have been entitled had they been made redundant under the old agreement on 30 September 2006.
 32. The second phase is from 1 October 2009 to 30 September 2011. During this phase, as well as freezing the maximum enhanced pension at that which would have been available on 30 September 2006, there will be a further reduction so that all enhancements are removed by 30 September 2011.
 33. The date used to calculate the level of both final pensionable pay and of salary for redundancy payment under the transition will be set by reference to the actual date of redundancy.

Calculation of Baseline Entitlement During Transition

34. For employees taking advantage of the transitional arrangements, and subject to a maximum of 20 years' reckonable service being counted, the lump sum redundancy payment will be calculated based on the arrangements in place before 1 October 2006 as follows. Based on service at 30 September 2006:
 - 1 ½ week's pay for each complete year of reckonable service at age 41 or over;
 - one week's pay for each complete year of reckonable service at age 22 or over but under 41;
 - ½ week's pay for each complete year of reckonable service at age 18 or over but under 22;
 - overall maximum 30 week's pay.
35. Fractions of a year of reckonable service will not be taken into account except that they may be aggregated under paragraph 34 above to make complete years. The lowest weeks' pay multiplier relevant to the employee's calculation will apply to the complete year aggregated.

Reduction to Baseline Entitlement

36. Redundant employees who are entitled to an enhancement of their pension benefits on ceasing to be employed will, if the enhancement of service if they had been made redundant on 30 September 2006 is less than 10 years, be entitled to receive a

redundancy payment. Where the enhancement of service does not exceed 6 2/3 years they will be paid in full; where the enhancement of service exceeds 6 2/3 years they will be reduced by 30 per cent in respect of each year of enhanced service over 6 2/3 years with pro-rata reduction for part years.

37. The redundancy payment made under these transitional arrangements will be based on the number of week's service applicable for a redundancy on 30 September 2006 along with the reduction for enhancement greater than 6 2/3 years that would have been made had the redundancy taken place on that date. If there has been a break in continuous service between 1 October 2006 and the date of redundancy, then the payment would be based on the number of years continuous service at the date of redundancy.
38. As a baseline calculation for transitional protection all employees eligible for premature payment of pension and compensation benefits under the terms of this agreement on transition shall have their reckonable years in the HPSS Superannuation Scheme at 30 September 2006 doubled subject to a maximum enhancement of ten added years. Total reckonable years (including enhancements) will in all cases be limited to the lesser of:
 - the total reckonable service that would have been attained by continuing in service to retirement age; or
 - 40 years; provided that:
 - the enhancement of reckonable service for employees with relevant optant service shall be based on the aggregate of their reckonable HSC service and their relevant optant service.

Transition Phase One: 1 October 2006 to 30 September 2009

39. For redundancies from 1 October 2006 until 1 December 2006, employees will receive enhanced pension based on the pre 1 October arrangements including the calculation of redundancy payment.
40. From 1 December 2006 to 30 September 2009, the enhancement that the employee will be eligible to receive will be the enhancement on which the pension would have been based had they been made redundant on 30 September 2006, less the number of days since 30 September 2006. For those who have any part-time membership, the reduction in enhancement will be scaled down according to the scaling factor applicable at 30 September 2006.

Transition Phase Two: 1 October 2009 to 30 September 2011

41. During this phase, maximum enhancement available to the employee made redundant will continue to be the enhancement available on 30 September 2006 less the number of days since 30 September 2006. There will be a further reduction in entitlement to enhancement. [The Department has yet to decide on the reduction factor during phase 2 in Northern Ireland]. However, the effect of the two transition elements together will be that no enhancement is available from 1 October 2011.
42. Paragraphs 29 to 42 will be removed from this agreement on 1 October 2011.

INDEX

ITEM	PARAGRAPH NUMBER
Acting-up Allowances	112
Allocation of Banding	18-23
ALLOWANCES	
Mileage	277-308
Sick Leave	225-244
Subsistence	311
Alternative Employment	191
ANNUAL LEAVE	205-217
Entitlement	205-206
Six weeks per year	205
Five weeks per year	206
Change of grade	217
General	215-216
House Officer	210
Leave years	209
Locum tenens	211-213
Part-time staff	208
Public holidays	214
Re-entry and entry into HS employment	342
(Residence) charges during annual leave	176
Voluntary service overseas	216
APPLICATION OF TERMS AND CONDITIONS OF SERVICE	117, 343 & 344
Locum practitioners	117
General provisions	343
Former trainees in General Practice	344
APPOINTMENTS TO AND TENURE OF POSTS	3-12
Appointment as Consultant	3
Appointment as Hospital Practitioner	6
Appointment as Associate Specialist	5
Appointment as Specialist Registrar	10
Appointment as House Officer/Foundation House Officer 1	12
Appointment as Senior House Officer/Foundation House Officer 2	11
Appointment as Staff Grade	7
Closed grades	4
Tenure of Posts	8
Appointment for a limited period	192
Appointments held only by part-time practitioners	94, 105

ITEM	PARAGRAPH NUMBER
ARRANGEMENTS FOR COVER DURING ABSENCES AND LOCUM TENENS	106-118
Acting-up Allowances	112
Consultant, SHMO, SHDO & AS	106
Hospital Practitioner	107
Locum Practitioners: basis of contract	111 & 113-118
Training grades	110
Staff Grade	108
Assessment of duties for part-time appointments	61-62
Assessment of Pay Supplements	22
ASSOCIATE SPECIALIST:	
Additional session	14
Annual Leave	205-206
Appointment as	5
Basis of contract	13-14
Increments on first appointment	127
Locum Remuneration	114
Minimum time off and Extra Duty Allowance	26-28
Remuneration of Part-timers	63
Attendance at Court as witness – special leave	260
BASIS OF CONTRACT:	
Consultant, SHMO, SHDO & AS	13
Temporary Additional Session	14
Staff Grade	15-17
Practitioners in the training grades	18-24
Locum practitioners: Training grades	111
BED FUND – SEE GENERAL PRACTITIONER HOSPITAL UNITS	
BLOOD TRANSFUSION SERVICE – OCCASIONAL WORK	104
CANDIDATES FOR APPOINTMENT, EXPENSES OF	313
CAR PURCHASE, LOANS FOR	302
CASUALTY WORK (STAFF FUND)	90-93
CARRIAGE OF PASSENGERS	308
CATEGORIES 1 & 2	30-39
CHANNEL ISLANDS – COUNTING OF PREVIOUS SERVICE	132, 136
CHARGES FOR PRIVATE USE (CROWN CARS)	306
CHARGES FOR MEALS	182

ITEM	PARAGRAPH NUMBER
CHARGES FOR RESIDENCE	173-178
Compulsorily resident practitioners	173
Voluntarily resident practitioners	174
Abatement of voluntary lodging charges	175
Charges during annual leave	176
Charges during sick leave	177
Charges during special leave or study leave	178
CHILD CARE	333
CLINICAL AND SENIOR MEDICAL OFFICERS: ADDITIONAL WORK	44
	4
CLOSED GRADE	
CONDITIONS OF USE (CROWN CARS)	305
CONSULTANTS:	
Additional session	14
Annual leave	205
Appointment to	3
Basis of contract	13
Domiciliary consultations	140-149
Exceptional consultations	155
Hard-to-fill posts	134
Increments on first appointment	126
Locum Remuneration	113
Part-timers Remuneration	63
Practitioners appointed before 1 Jan 1960; preserved rights	66
CONTINUITY OF SERVICE – HSC TRUSTS	341
CONTRACTUAL DUTIES OF PRACTITIONERS	30-39
COUNTING ON PREVIOUS SERVICE:	
Locum Appointments	123
Regular Appointments	122
Service outside HS hospitals	125, 132, 136
Counting of Service while on leave	124
CROWN CARS, ALLOCATION OF	304
DISCIPLINARY PROCEDURES	189
DISMISSAL: SEE TERMINATION OF EMPLOYMENT	
DISTINCTION AWARDS:	
General	1
Payment to maximum part-time practitioners	13
Counting for gross earnings for purposes of 10% limit on private practice earnings	42
10% limit on private practice earnings	42

ITEM	PARAGRAPH NUMBER
Proportional payment for part-time practitioners	63
Practitioners appointed before 1 January 1960	66
Calculation for staff holding more than one contract of employment in the HS	76
Joint appointments	86
Rates of awards	Appendix I
DOMICILIARY CONSULTATIONS:	140-149
Additional Fees	142
Series of Consultants - Anti-coagulant Therapy	143
Definition	140
Fees	141
Locum tenens	147
Long distance payments	146
Maximum number of visits	148
Ophthalmologists	145
Replacement of drugs	149
EMERGENCY VISITS: MILEAGE ALLOWANCE	279
EQUAL OPPORTUNITIES IN EMPLOYMENT	331
EXCEPTIONAL CONSULTATIONS:	155, 157
Consultants	155
General Practitioners	157
EXPENSES:	275-315
Candidates for appointments	313
General	275
Postage	312
Submission of claims	276
Travel and mileage	277-308
Removal	314-315
FEES:	
Domiciliary consultations	140-149
General	38
Lectures	165-166
Payable by employing authority	32
FORMER TRAINEES IN GENERAL PRACTICE	344
FULL PAY (Training grades)	23
GENERAL PRACTITIONERS	
Exceptional Consultations	157
Former Trainees	344
GENERAL PRACTITIONER HOSPITAL UNITS	87-93
Staff Fund	87
In-patients	88
Beds under the control of a consultant	89

ITEM	PARAGRAPH NUMBER
Casualty work	90
Basis of payment – casualty work	91
Limit on number of sessions	92
Very small casualty units	93
HARASSMENT AT WORK	332
HOME TO HOSPITAL MILEAGE: SEE “MILEAGE ALLOWANCES”	
HEALTH AWARENESS FOR HPSS STAFF	336
HONORARY CONTRACTS:	
Retired practitioners	201
HOSPITAL PRACTITIONER GRADE	
Annual leave	205
Appointments to	6
Increments on first appointment	131
Locum tenens	107
HOUSE OFFICER GRADE/FOUNDATION HOUSE OFFICER 1 GRADE :	
Annual leave	210
Appointment to	12
Basis of contract	18-24
Medical examination on appointment	188
Sick leave: HOs who have not passed a medical examination	226
INCREMENTAL DATES: See “Starting Salaries and Incremental dates”	
ISLE OF MAN – COUNTING OF PREVIOUS SERVICE	132, 136
JOB SHARING	70
JOINT APPOINTMENTS	86
JOURNEYS BEGINNING OR ENDING AT HOME: SEE “MILEAGE ALLOWANCES”	
JUNIOR DOCTORS: SEE “PRACTITIONERS IN TRAINING GRADES”	
JURY SERVICE – SPECIAL LEAVE	260
LEAVE	
Annual	205-217
Counting of service while on leave	124
Maternity Leave	261
Sick	225-244
Special	260-262
Study	250-254
LECTURE FEES	165-166
Lectures to Doctors or Dentists	166

ITEM	PARAGRAPH NUMBER
Lectures to non-medical or non-dental staff	165
LIMITATION OF PRIVATE PRACTICE	42
LIMITATION OF SICKNESS AND OTHER BENEFITS	229-230
LOCUM TENENS	
Annual leave	211-213
Application of Terms & Conditions of Service	117
Basis of Contract (Training grades)	111
Counting of previous service	123
Domiciliary Consultations	147
Hospital Practitioners	107
Maximum remuneration (part-time consultant, SHMO, SHDO, AS)	116
Mileage Allowances	289
Registration	118
Removal expenses	117
Remuneration of	113-116
Consultants	113
Associate Specialists	114
Other posts	115
Sick leave	243
Staff Grade	108
MATERNITY LEAVE	261
MEAL CHARGES	182
MEDICAL CERTIFICATION OF SICKNESS	235-236
MEDICAL EXAMINATION ON APPOINTMENT	186-188
Form of certificate	187
House Officers	188
MEDICAL SUPERINTENDENTS & DEPUTY MEDICAL SUPERINTENDENTS	49
MEMBERSHIP OF DISTRICT COUNCILS	339
MILEAGE ALLOWANCES AND TRAVEL EXPENSES	277-308
Allowances payable to all practitioners	278
Emergency visits	279
Home to Hospital Mileage – (Consultants, SHMO, SHDO, SCMO, AS)	280-283
Liability to make emergency visits	282
Official journeys beginning at home	280
Scattered hospitals	283
Subsequent official journeys	281
Journeys beginning or ending at home: other staff	284-287
Full-time staff	284
Part-time practitioners	286

ITEM	PARAGRAPH NUMBER
Part-time practitioners: all grades - reserved rights	287
Locum Tenens	289
Rates of mileage allowance	291-304
Cars out of use	296
Change in circumstances	292
Essential users (Consultants)	291
Garage expenses, toll and ferries	301
Loans for car purchase	302
Non-classification as regular user	293
Part months of service	295
Passenger allowances	300
Pedal Cycle Allowances	303
Payment of Lump sums	294
Protection of existing standard rates	297
Public transport mileage rate	299
Regular user allowances	290
Standard mileage rates	298, Appendix I
MINIMUM PERIOD OF NOTICE	195
MINIMUM TIME OFF-DUTY	
Practitioners in training grades	20-21
Practitioners in grade of AS	26
MISCELLANEOUS:	330-342
Annual leave and sick pay entitlement on re-entry into HPSS employment	342
Arrangements for redundancy payments	337
Child care	333
Disputes procedures	335
Employees who are elected to Parliament	338
Equal opportunities in employment	331
Harassment at work	332
Health awareness for HPSS staff	336
HSC Trusts – Continuity of Service	341
Membership of District Councils	339
Payment of annual salaries	340
Publications, lectures etc	330
Retainer schemes	334
MULTIPLE APPOINTMENTS	71-78, 81-86
Appointments in more than one grade	73
Appointments in one grade	72
Discounting of notional half-days in excess of limit	75
Medical and Dental Staff holding more than one contract of employment in the HPSS	76
Paragraph 66 appointments	74
Teaching and Research	78, 84-86
NON-HPSS EMPLOYMENT	77

ITEM	PARAGRAPH NUMBER
NOTICE	
Application of minimum periods	197
Contractual minimum periods	196
Pay during notice	198
Statutory minimum period	195
Great Britain, Isle of Man or Channel Islands – Counting of Previous Service	132, 136
Notifiable disease – contact with – special leave	260
Occasional work in the Blood Transfusion Service	104
Parliamentary can	338
PART-TIME APPOINTMENTS	
Annual leave	208
Assessment of duties	61-62
Maximum remuneration	69
Multiple appointments	71-75
Occasional work in the Blood Transfusion Service	104
Part-time General Dental Practitioners	105
Part-time Medical Officer	94
Practitioner appointed before 1.1.60 – reserved rights	66
Remuneration of Part-timers	63
Practitioners in training grades	65
Staff Grade	64, 69
Teaching and Research posts	84
Teaching duties undertaken by part-time consultants	85
PAY RATES	1, Appendix I
Pay during notice	198
Payment of annual salary	340
PRACTITIONERS IN TRAINING GRADES:	
Appointment as House Officer/Foundation House Officer 1	12
Appointment as Senior House Officer/Foundation House Officer 2	11
Appointment as Specialist Registrar/Specialty Registrar	10
Appointment as Specialty Registrar (Fixed-term)	10
Arrangements for cover during absences	106-112
Assessment of Remunerable Time	22-24
Basis of contract	13-24
“Full Pay”	23
Notice Period	195-198
Part-time appointments	61-69
Retention of existing contracts	24
PRE-REGISTRATION HOUSE OFFICERS (see also House Officers)/ FOUNDATION HOUSE OFFICER 1	
Medical examination on appointment	188
Sick leave	226
	40-42

ITEM	PARAGRAPH NUMBER
PRIVATE PRACTICE	
By clinical teachers	83
Definition	40
Entitlement to undertake private practice	41
Limitation of private practice	42
PROMOTION INCREASE	133
PROTECTION OF SALARY	132
PUBLIC HOLIDAYS	214
PUBLICATIONS, LECTURES, ETC	330
RATES OF MILEAGE ALLOWANCE	290-303 Appendix I
RATES OF PAY	1, Appendix I
REDUNDANCY PAYMENTS	337, 191
REIMBURSEMENT OF PETROL AND OTHER COSTS	307
REMOVAL EXPENSES:	
General	314
Rotational appointment	315
REMUNERATION OF PART-TIMERS	63
REMUNERATION OF LOCUM PRACTITIONERS	113-117
Consultants	113
Maximum Remuneration of Part-time Locum Consultants, AS and SHMO/SHDO	116
Application of Terms and Conditions of Service to Locum Practitioners	117
Registration of Locum Practitioners	118
Associate Specialists	114
Other Posts	115
REPRESENTATION AGAINST DISMISSAL	190
RETAINER SCHEMES	334
RETENTION OF EXISTING CONTRACTS(Training grades)	24
RETIRING AGE	
General provisions	200
Honorary or emeritus contracts	201
RESIDENCE CHARGES	173-178

ITEM	PARAGRAPH NUMBER
ROTATIONAL APPOINTMENTS	
Overseas appointments	216, 228
Removal expenses	315
SECTION 7 SERVICES	31
SENIOR HOUSE OFFICER GRADE/FOUNDATION HOUSE OFFICER 2	
Annual leave	206
Appointment to	11
Basis of contract	18-24
SENIOR HOSPITAL MEDICAL AND DENTAL OFFICER GRADE	4A
SERVICE OUTSIDE HS	125, 132, 136
SICK LEAVE:	
Accident due to sport or negligence	237
Calculation of allowances	227
Definition of "one month"	234
Forfeiture of rights	242
Injury on duty	238
Limitation on allowance when insurance or other benefits are payable	229-230
Locum tenens	243
Married women	233
Medical examinations	240
Practitioners admitted to hospital	236
Pre-registration house officers	226
Previous qualifying service	228
Recovering of damages from third party	239
Residence charges during sick leave	177
Scale of allowances	225
Staff Fund Appointments	244
Submission of doctor's statements	235-236
Termination of employment	241
Voluntary service overseas	228
SPECIAL LEAVE:	260-262
Attendance at Court as witness	260
Contact with Notifiable Diseases	260
Domestic, personal and family reasons	262
Jury service	260
Maternity leave	261
Residence charges during special leave	178
STAFF FUND	87-93
STAFF GRADE:	
Appointment to	7
Arrangements for cover during absence and locum tenens	108
Basis of Contract	15
Starting Salary	128
Remuneration of locum practitioners	115

ITEM	PARAGRAPH NUMBER
Remuneration of part-timers	64, 69
STARTING SALARIES AND INCREMENTAL DATES:	121
Counting of previous services:	122-125
Locum posts	123
Regular appointments	122
Service while on leave	124
Service outside HS hospitals	125
Increments on appointment to grade:	
Consultants	126
Hard-to-fill Consultant posts	134
Hospital Practitioner	131
Associate Specialist	127
Specialist Registrar/Specialty Registrar	130
Staff Grade	128
Interpretation	135-136
Promotion increase	133
Protection	132
STATUTORY MINIMUM PERIOD OF NOTICE	195
STUDY LEAVE:	250-254
Additional periods of leave (UK)	252
Conditions	254
Definition	250
Outside the UK	253
Recommended Standard (UK)	251
Residence charges during study leave	178
SUBSISTENCE ALLOWANCE	311
TEACHING AND RESEARCH:	78,82-85
Joint Appointments	78
Part-time posts	84
Private practice	83
Whole-time posts	82
Teaching duties undertaken by part-time consultants	85
TEMPORARY ADDITIONAL SESSION	14
TENURE OF POSTS	8-12
TERMINATION OF EMPLOYMENT	190-198
Alternative employment	191
Applications of minimum periods of notice	197
Appointment for a limited period	192
Contractual minimum period of notice	196
Pay during notice	198
Representations against dismissal	190
Statutory minimum period of notice	195

ITEM	PARAGRAPH NUMBER
Termination of employment – Sick leave	241
TRAINEES IN GENERAL PRACTICE, FORMER	344
TRAVELLING EXPENSES; (SEE ALSO MILEAGE ALLOWANCES)	277-308
USE OF HOSPITAL FACILITIES	34
VOLUNTARY SERVICE OVERSEAS	216, 228

**TERMS AND CONDITIONS OF SERVICE FOR HOSPITAL MEDICAL AND DENTAL
STAFF AND DOCTORS IN PUBLIC HEALTH MEDICINE AND THE COMMUNITY
HEALTH SERVICE**

Record of Amendments

Amendments to this handbook will normally be notified in the form of replacement pages attached to a Circular. Revised material will be indicated by a vertical marginal line. Please make amendments immediately they are received and keep the following record of amendments up to date.

Amendment number	Circular number	Date inserted	Amendment number	Circular number	Date inserted
1			36		
2			37		
3			38		
4			39		
5			40		
6			41		
7			42		
8			43		
9			44		
10			45		
11			46		
12			47		
13			48		
14			49		
15			50		
16			51		
17			52		
18			53		
19			54		
20			55		
21			56		
22			57		
23			58		
24			59		
25			60		
26			61		
27			62		
28			63		
29			64		
30			65		
31			66		
32			67		
33			68		
34			69		
35			70		

THIS AGREEMENT is made the 22nd day of April 2020.

PARTIES

- (1) **NHS LITIGATION AUTHORITY** of 2nd Floor, 151 Buckingham Palace Road, London SW1W 9SZ ("**NHS Resolution**"); and
- (2) **Department of Health Northern Ireland (the Department)**, Castle Buildings, Stormont, Belfast BT4 3SQ

BACKGROUND

The Department and NHS Resolution wish to enter into an arrangement regarding maintaining high professional standards policy for handling concerns regarding Medical and Dental Staff employed in the Department whereby Practitioner Performance Advice, an operating division of NHS Resolution, will provide support to the Department and their nominated Health and Social Care Trusts. Details of the Health and Social Care Trusts shall be provided in writing by the Department to NHS Resolution during the Term.

Subject to and in accordance with the terms of this agreement:

The members and staff of NHS Resolution will perform the functions set out in Schedule 2 as services to the Department to deal with practitioners whose performance gives cause for concern.

NOW IT IS HEREBY AGREED as follows:

1. DEFINITIONS AND INTERPRETATIONS

- 1.1 In this Agreement (including the Background), the following terms shall, unless the context otherwise requires, have the following meanings:

"Practitioner Performance Advice" an NHS Resolution function that provides impartial advice, assessment and intervention services to health organisations to help the effective management and resolution of performance concerns about the performance of doctors, dentists and pharmacists;

"the Department" means the Department of Health Northern Ireland or their nominated Health and Social Care Trusts;

"In writing" means documented, signed and sent by post or by electronic mail;

"Practitioners" means Doctors, Dentists and Pharmacists;

- 1.2 References in this Agreement to numbered clauses are references to the clauses in the Agreement in which the reference bearing that number appears.

2. TERM

- 2.1 This Agreement shall come into force on the 1 April 2020 and remain in force for a period of 36 months unless terminated in accordance with clause 14 below.
- 2.2 This agreement will be reviewed at the end of each 12 month period during the term of this agreement for the period set out above at paragraph 2.1. or on an ad-hoc basis where deemed necessary by both parties.

3. FUNCTIONS OF PRACTITIONER PERFORMANCE ADVICE

- 3.1 The Department, with a view to accessing the advice and support system for Practitioners whose performance gives rise to concern, agrees that NHS Resolution will exercise the following Practitioner Performance Advice functions as more specifically set out in Schedule 2 to this Agreement including but not limited to:
- 3.1.1 provide an advisory service to the Department for advice cases arising and an assessment service on a case by case basis as agreed between the parties;
 - 3.1.2 provide an assessment and intervention service, including Professional Support and Remediation (PSR) services when required;
 - 3.1.3 provide support to local efforts to improve good practice in relation to the resolution of difficulties and concerns between the Practitioners and their employers and contractors, through policy support and website resources;
 - 3.1.4 provide support for reporting at a local level.
- 3.2 Practitioner Performance Advice shall also provide under this Agreement all ancillary administrative, professional or technical services necessary to enable Practitioner Performance Advice to carry out the functions in clauses 3.1 to 3.2 inclusive. Schedule 2 to this Service Level Agreement sets out the services to be provided.

4. STANDARD OF PERFORMANCE

- 4.1 NHS Resolution shall exercise all Practitioner Performance Advice functions and provide all services in accordance with NHS Resolution's standard policies or guidance and reflecting the resources and information provided by the Department.

5. ACTIVITY REPORTS

- 5.1 NCAS shall produce 2 activity reports each year. A mid-year report will be provided covering the period up to the end of September of the relevant year and a full annual report covering the full financial year in question. The former report will be received by the Department by end of October of the year in question and the annual report by end of June.

6. CONDUCT OF BUSINESS

- 6.1 NHS Resolution shall carry out its functions under this Agreement having regard to the matters specified in the Service Specification at Schedule 2 to this Agreement.

7. INDEMNITY AND INSURANCE

- 7.1 Each Party accepts unlimited liability to the other for:
- death or personal injury caused by the negligence of that Party; and
 - fraud or fraudulent misrepresentation committed by or on behalf of that Party.
- 7.2 Save as in Clause 7.1, NHS Resolution shall not be liable for (a) any indirect or consequential loss or (b) any loss of use or loss of profits, business, contracts, revenues or anticipated savings whether arising from tort (including, without limitation, negligence or breach of statutory duty), breach of contract or otherwise.
- 7.3 Except as otherwise provided in this Agreement, NHS Resolution limits its liability to the Department in contract, tort (including, without limitation, negligence or breach of statutory duty) or howsoever arising to a maximum limit of the contract price only.
- 7.4 (a). Save as set out in Clause 7.1 and subject to the limitation provision in 7.4 (b) the Department will indemnify NHS Resolution with any reasonable costs and compensation awarded as a result of civil action in connection with the exercise of its functions described in the Service Level Agreement, provided NHS Resolution and its employees have acted in good faith and with due care and diligence.
- (b). Except as otherwise provided in this Agreement the Department limits its liability to NHS Resolution in contract, tort (including, without limitation negligence or breach of statutory duty) or howsoever arising to a maximum limit of the annual contract price together with five (5) per cent interest on such contract price only.
- 7.5 Each Party hereby acknowledges and agrees that the provisions of this Clause 7 are fair and reasonable having regard to the circumstances as at the date hereof. The provisions of this clause 7 shall survive the termination of this agreement, however arising.

8. FREEDOM OF INFORMATION ACT and DATA PROTECTION ACT

- 8.1 NHS Resolution and the Department are subject to the Freedom of Information Act 2000. Both parties may be required to disclose information to ensure compliance with Freedom of Information legislation. Both parties note and acknowledge this legislation and the relevant Codes of Practice. The parties will act in accordance with their respective Freedom of Information legislation and Codes of Practice (and any other applicable codes of practice or guidance).
- 8.2 Any decision regarding the application of any exemption to the request for disclosure of recorded information is a decision solely for the body receiving and processing the request. Where a party is managing a request as referred to in this clause, the other party shall co-operate with them if they so request and shall respond within five (5) working days of any request by it for assistance in determining how to respond to a request for disclosure.
- 8.3 The parties must protect personal data in accordance with the provisions and principles of the UK Data Protection Act 2018. Both parties shall be registered under their respective legislation and both parties shall comply at all times with the Data Protection Legislation and shall not perform their obligations under the Agreement in such a way as to cause either party to breach any of their applicable obligations under the Data Protection Legislation. Both parties must promptly notify the other if they breach this clause.

9. INTELLECTUAL PROPERTY

- 9.1 In this clause 9, “Intellectual Property Rights” means all patents, rights to inventions, utility models, copyright and related rights, trademarks, service marks, trade, business and domain names, rights in trade dress or get-up, rights in goodwill or to sue for passing off, unfair competition rights, rights in designs, rights in computer software, database rights, topography rights, moral rights, rights in confidential information (including know-how and trade secrets) and any other intellectual property rights, in each case whether registered or unregistered and including all applications for and renewals or extensions of such rights, and all similar or equivalent rights or forms of protection in any part of the world.
- 9.2 All Intellectual Property Rights arising from or relating to the services, including without limitation any material prepared by or supplied by NHS Resolution in connection with Practitioner Performance Advice services shall remain the property of NHS Resolution.
- 9.3 To the extent that the Department or any individual employed or engaged by the Department, have been involved in the development of or provision of the services (“contribution”), the Department hereby assigns to NHS Resolution all Intellectual Property Rights in such Contribution by way of present and future assignment with full title guarantee.
- 9.4 The Department shall have no right or licence to use any Intellectual Property of NHS Resolution except that it shall be entitled to use any material, information or other documents provided by NHS Resolution as part of the delivery of the services and for the Department’s internal business processes pursuant to the services provided under this agreement only.

10. FINANCIAL ARRANGEMENTS

- 10.1 NHS Resolution shall charge the Department for the services described in this agreement, in the following manner:
- 10.1.1 A fixed cost for each 12 months period as set out in Schedule 1 and 2 to this agreement to cover;
- Provision of a case management service to Northern Ireland (with access to sufficient advisers and administration staff as required)
 - Policy support to DoH/HSC
 - Support for up to 25 advice and PSR cases each year
 - One Clinical Performance Assessment (for any specialty but excluding a surgery simulation, for which an additional charge will be made)
 - Advice case review meetings with employing/contracting organisations as required
 - 4 x ‘Managing concerns about performance of dentists, doctors and pharmacists’ workshops
 - 2 activity reports (one mid-year and one annual report)
 - Annual review meeting with the Practitioner Performance Advice Director and Senior Adviser to Northern Ireland
 - All direct and indirect costs, including travel, accommodation and further expenses incurred in providing the services listed above as part of the fixed cost.
- 10.1.2 The Department may also request Practitioner Performance Advice to provide additional services, at an additional cost as specified in Schedule 1.

10.2 Travel, accommodation and further expenses incurred by NHS Resolution staff providing services specified in clause 10.1.2. above will be claimed in accordance with the NHS Resolution expenses policy.

10.3 NHS Resolution shall invoice for the fixed cost at the commencement of this agreement and at the commencement of any subsequent term. Any additional charges for services specified in clauses 10.1.2 above shall be invoiced on agreement to the provision of the service.

11. AUDIT

11.1 In the exercise of its functions and provision of services under this agreement. NHS Resolution shall keep all case related documents for all referrals made by the Department.

12. DESIGNATED REPRESENTATIVES

12.1 NHS Resolution and the Department shall both nominate designated representatives for the day to day operation of the Agreement and senior officers with responsibility for resolving function and service issues of a more serious nature. These contacts shall be set out at Schedule 3 to this agreement.

13. DISPUTE RESOLUTION

13.1 In the first instance any dispute arising under the Agreement shall be discussed by the designated representatives of the parties, as described in clause 12.

13.2 In the event that the dispute is not resolved under clause 13.1, either party shall notify the other within 21 days of the dispute setting out reasonable details of the dispute. The dispute shall then be referred to the Senior Officer of the Department and the Director of Practitioner Performance Advice, who shall meet reasonably promptly to seek to resolve the matter.

13.3 If the dispute is not resolved in accordance with clause 13.2 above, then the Parties will attempt to settle it by mediation in accordance with the Centre for Effective Dispute Resolution ("CEDR") Model Mediation Procedure or any other model mediation procedure as agreed by the Parties. To initiate mediation the Parties may give notice in writing (a "Mediation Notice") to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Parties asking them to nominate a mediator.

14. TERMINATION

14.1 Either party may terminate this agreement forthwith by notice in writing if the other party is in breach of this agreement and fails to remedy the breach (if capable of remedy) within 30 days of written notice of the breach being given and has not or will not comply with the Dispute resolution procedure as set out above at Clause 13.

14.2 Termination or expiry of this Agreement for any reason shall be without prejudice to any right or remedy of either Party which may have accrued prior to such termination.

14.3 The Department shall return any NHS Resolution equipment or materials in its possession or control at its own cost to NHS Resolution no later than 30 days after the termination or expiry of this Agreement.

- 14.4 Upon expiry or earlier termination of this Agreement, NHS Resolution shall continue to be entitled to receive and the Department shall pay NHS Resolution the contract price for any services provided by NHS Resolution up to and including the date of termination or expiry.
- 14.5 The provisions of Clauses 7, 8, 9, 13 and 14 shall survive termination of this Agreement.
- 14.6 Either party may terminate this agreement on 3 months' notice in writing to the other party, unless a shorter timescale is agreed by both parties.

15 MISCELLANEOUS

- 15.1 No variation of this Agreement shall be effective unless it is in writing signed by each of the parties.
- 15.2 No waiver of any term, provision or condition of this Agreement shall be effective unless it is in writing and signed by the waiving party.

16 ASSIGNMENT AND NOVATION

- 16.1 Either party may assign, novate or otherwise dispose of its rights and obligations under the Contract or any part thereof to:
- (a) any other body established by the Crown or under statute in order substantially to perform any of the functions that had previously been performed by the transferring body;

provided that any such assignment, novation or other disposal shall not increase the burden of the other party's obligations under the Contract.

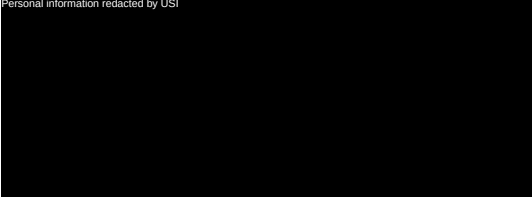
17 ENTIRE AGREEMENT CLAUSE

- 17.1 This SLA, together with the documents referred to in it/attached to it, constitutes the entire agreement and understanding between the parties in respect of the matters dealt with in it and supersedes, cancels and nullifies any previous agreement between the parties in relation to such matters notwithstanding the terms of any previous agreement or arrangement expressed to survive termination.
- 17.2 Each of the parties acknowledges and agrees that in entering into this SLA and the documents referred to in it/attached to it, it does not rely on, and shall have no remedy in respect of, any statement, representation, warranty or undertaking (whether negligently or innocently made) other than as expressly set out in this SLA. The only remedy available to either party in respect of any such statements, representation, warranty or understanding shall be for breach of contract under the terms of this Agreement.
- 17.3 Nothing in this clause shall operate to exclude any liability for fraud.

Signed for and on behalf of **Department of Health Northern Ireland**

By:

Personal information redacted by USI



Name: Brian Godfrey

Date: 22 April 2020

Signed for and on behalf of **NHS Resolution**

By:

Personal information redacted by USI



Name: Vicky Voller

Date: 22 April 2020

Schedule 1: Agreement Costs

Fee Structure

Annual fixed cost element	
Fixed cost (for each 12 month period of this agreement) This will include:	£216,000
• Provision of a case management service to Northern Ireland (with access to sufficient advisers and administration staff as required) • Policy support to DoH/HSC • Support for up to 25 advice and PSR cases each year • One Clinical Performance Assessment (for any specialty but excluding a surgery simulation, for which an additional charge will be made) • Advice case review meetings with contracting/employing organisations as required • 'Managing concerns about performance of dentists, doctors and pharmacists' workshops as required • Two activity reports (one mid-year and one annual report) • Annual review meeting with the Practitioner Performance Advice Director and Senior Adviser to Northern Ireland • All direct and indirect costs, including travel, accommodation and further expenses incurred in providing the services listed above as part of the fixed cost.	

Additional services available	Cost per case (excl.VAT if applicable)
Additional advice case	£ 2,885
Clinical performance assessment	£32,000
Behavioural assessment	£8,000
Professional Support and Remediation action plan	£ 2,465
Assisted mediation	£ 3,295
Team review	Guide: One day £6,517 and two days £10,064
Simulations as part of a clinical performance assessment	Cost per case
• Standard GP out of hours simulation • Standard GP simulation • Anaesthetics simulation	

Education and training events	Cost per event* (excl.VAT if applicable)
Understanding and using MHPS effectively	£1,520
Resolving performance concerns	£3,050
Case manager training (primary care)	£5,490
Case manager training (secondary care)	£3,500
Case investigator training	£5,500

* Costs indicated are the current costs per event and may be subject to change in the future. When requesting a training event, the charges applicable will be as stated on our website at that time. This information can be accessed at <https://resolution.nhs.uk/ppa-training/>

Schedule 2: Service Specification

1. Practitioners Covered

This Agreement covers all doctors, dentists and pharmacists for which the Department has responsibility, including GPs on the Department's GP Performers List.

2. Areas of Clinical Care Covered

- Primary care services
- Secondary care services
- Public Health
- Mental Health and Psychiatric Services

3. Contact/Request for advice

Contact/Request for advice and support to Practitioner Performance Advice for any activity/service covered by this Agreement will be made by the Department's Group Medical Director or by the named designated representative at Schedule 3.

Telephone requests for advice and support directly from Practitioners concerned about their own performance are acceptable but Practitioner Performance Advice will make these callers aware that the relevant employing/contracting body will be informed of the conversation and that no more than telephone advice will be given without the formal involvement of their employing/contracting body.

4. Assessors

Practitioner Performance Advice assessments will be carried out by members of the Practitioner Performance Advice Assessor team. All assessors will work within the Practitioner Performance Advice assessment framework and guidelines for assessors devised by Practitioner Performance Advice.

5. Quality and performance indicators

Practitioner Performance Advice will aim to work to the highest standards of quality in all its activities, in particular all work undertaken by Practitioner Performance Advice under the terms of this agreement will be subject to Practitioner Performance Advice's programme of evaluation and quality assurance.

6. Timescales

Practitioner Performance Advice will undertake to respond to requests from the Department in accordance with standard operating procedures. Practitioner Performance Advice will complete all case assessments within a reasonable timeframe, taking account of the complexity of each individual case and the requirements outlined within this agreement.

7. Services

Case Management Service

All services provided by Practitioner Performance Advice, including our assessment services, are directed towards supporting the early identification, and fair and effective management and resolution of concerns in relation to the performance of Practitioners. In all cases, patient safety and public protection are our paramount concerns.

A contact or request for advice or support from the Department or nominated Health Trust will be passed to a member of the Adviser team who will then make contact with the Health Board at the agreed time. For the avoidance of doubt, the contact or request for advice will be formally logged as a Practitioner Performance Advice case if it requires telephone advice followed up in writing, and in some circumstances supported with a facilitated meeting, and requires review until the case reaches a conclusion.

A Practitioner Performance Advice Adviser will provide advice and support and will be responsible for directing the management of Practitioner Performance Advice's input to the case. The level of support will depend on the nature of the case. The progress of all active Practitioner Performance Advice cases are reviewed at monthly meetings between the Adviser and a senior colleague. Practitioner Performance Advice's lead and senior Advisers provide senior support and quality assurance for the work undertaken by the Adviser.

The method of support provided to the nominated Health Board will include telephone advice, case conferences and detailed work with the nominated Health Board to ensure that best use is made of local governance procedures. Where specialist interventions are required from Practitioner Performance Advice, the adviser will work with the nominated Health Board to ensure that these are tailored to the circumstances of the case.

It is not essential for the identity of a Practitioner to be shared with Practitioner Performance Advice as part of case management work, although Practitioner Performance Advice prefers that this is done. Whether or not the identity of the Practitioner is shared, local governance procedures will be required to be robustly able to assure patient safety and public protection, and this point will be addressed explicitly throughout the handling of the case.

The decision to close a case rests with the Adviser with the exception of exclusion cases, which must remain open until the exclusion has been brought to an end. It is normally appropriate to close a case in circumstances where:

- The Health Board has confirmed the case has been resolved.
- Local action is likely to resolve the case and the Health Board has a clear plan how to achieve this.
- There has been no active contact from the Health Board despite follow up requests for a period of 3 months (except where exclusion is involved or where there is felt to be particular risk in closing a case).
- The case is in the process of an intervention which does not require direct surveillance or a Professional Support and Remediation (PSR) plan which again does not require further Practitioner Performance Advice monitoring or input unless we wish to do so for evaluation purposes.
- The case is subject to external proceedings such as legal/GMC which is not likely to require further Practitioner Performance Advice support.

As a competent advisory body in this area of work, a key feature of Practitioner Performance Advice's involvement is to bring constructive challenge to the local management of concerns and support the resolution of disputes between Practitioners and the associated Health Board. Practitioner Performance Advice support may also include formal facilitation, assisted mediation or structured action planning. Practitioner Performance Advice retains staff who are accredited mediators to provide our Assisted Mediation service.

Practitioner Performance Advice Clinical Performance Assessments

In a small proportion of cases Practitioner Performance Advice will advise use of an assessment. In deciding whether to recommend an assessment, Practitioner Performance Advice will take into account the criteria set out in its Consideration of Assessment policy. In doing this, key considerations are:

- The nature of the reported concerns, the available evidence for those concerns and any steps that have been taken to resolve the concerns.
- Whether an assessment would appreciably add to what is already known from earlier investigation or other review.
- Whether there are likely to be significant constraints on the nature and scope of any assessment or the feasibility of undertaking assessment.
- The duration of the Practitioner's contract and/or their expectations or plans for future practice.
- The parties' submissions as to whether they wish for an assessment to be undertaken and the benefit they perceive it would bring in terms of managing the concerns.
- The nature and scope of our assessments including their ability to provide robust evidence to help identify any concerns and what might be causing them.

The purpose of a Clinical Performance assessment is to:

- Provide an independent view on the clinical performance of the Practitioner, identifying both satisfactory practice and any areas of poor practice.
- Provide information to assist the referring organisation in decisions about the next steps in their management of the case.

The assessment is carried out through a clinical assessment visit by a trained team of assessors, supported by an Assessment and Intervention Manager. It includes: clinical record review; direct observation of practice and case-based assessment.

Behavioural Assessments

Practitioner Performance Advice can also offer a behavioural assessment. The purpose of which is to:

- Provide an independent view on the behavioural characteristics of the Practitioner, including any areas which require consideration.

- Provide information to assist the referring organisation in decisions about the next steps in their management of the case.

The assessment includes the Practitioner completing two online psychometric questionnaires and then attending an all-day appointment with an occupational psychologist.

Professional Support and Remediation (PSR) action plan

The purpose of a PSR action plan is to:

- Provide the Practitioner with the opportunity to demonstrate (upon successful completion) that they are practising at the standard reasonably expected for the role they will be practicing.

The Practitioner Performance Advice PSR service develops action plans for Practitioners who have been identified as needing support in order to return to safe and effective clinical practice. The reasons for practitioners needing support are wide ranging, and usually involve:

- Remediation - following the identification of deficiencies in aspects of their clinical practice.
- Return to work / re-integration (following a period of absence from clinical practice).

Action plans are based and developed on the information provided to Practitioner Performance Advice by the Department and the Practitioner. The final action plan and programme represents an agreement between the Department and the Practitioner.

Assisted Mediation

Assisted mediation is an independent, voluntary and confidential process in which two Practitioner Performance Advice accredited mediators work with the parties concerned to create a mutual understanding of the issues and to find a way forward that enables a more effective professional working relationship.

The aim of the assisted mediation service is to enable a more professional working relationship between both parties which leads to a positive impact on the immediate team and, ultimately, better patient care.

Team Reviews

The purpose of a team review is to:

- Identify and better understand key issues that are perceived to be contributing to relationship difficulties within a team.
- Identify any barriers to resolving the issues which have been highlighted
- Assist the Department in formulating a plan for improving professional relationships within the team.

The team review does not focus on an individual's clinical performance or the general service provision but concentrates on the behaviours and relationships affecting the ability of the team to work effectively together. The outcome of the team review will, where possible, focus on providing the employing or contracting organisation with possible solutions to assist in the local management of the issues whilst ensuring any governance and safety issues are given priority. The benefit is likely to have a positive impact on the immediate team and patient or public safety.

Team reviews are delivered by trained facilitators who bring extensive experience of casework relating to performance, behaviours and team functioning. The team review discussion is confidential between Practitioner Performance Advice facilitators and the participants and is conducted on a 'without prejudice basis'. This means that what is discussed during the facilitated discussions cannot be used for other purposes, for example, formal HR or legal processes. The team review report is provided directly to the Department for sharing as they feel appropriate.

Education and training services

Practitioner Performance Advice's programme of workshops and conferences aims to share good practice and learning from casework and disseminate the information widely to NHS Medical Directors, Chief Executives, Clinical Directors, Responsible Officers, HR Directors and all those who deal first-hand with concerns about performance. Workshops are interactive, often using case studies. Practitioner Performance Advice provides events at national, regional and local level and for audiences defined by specialty and sector interests as well as for multidisciplinary groups.

Further information on all Practitioner Performance Advice services can be found on <https://resolution.nhs.uk/services/practitioner-performance-advice>

Schedule 3: Contacts

Practitioner Performance Advice

Name: Colin Fitzpatrick
Senior Adviser (NI)
Practitioner Performance Advice

Address: NHS Resolution
2nd Floor
151 Buckingham Palace Road
London
SW1W 9SZ

Email: colin.fitzpatrick@nhs.uk
Telephone: [Redacted]

Name: Karen Jeffrey
Department of Health Northern Ireland

Address: Castle Buildings, Stormont, Belfast BT4 3SQ

Email:
Telephone:

Roberts, Naomi

From: Colville, Victoria
Sent: 21 October 2010 11:04
To: Lindsay, Jane
Subject: RE: Maintaining High Professional Standards

Hi Jane

Thanks very much for this - it is helpful. I may have to contact you for an up-date before our next BMA Joint Forum meeting on 1 December if that's OK.

Best Wishes

Victoria

From: Lindsay, Jane
Sent: 21 October 2010 08:06
To: Colville, Victoria
Cc: Hutchison, Ruth; Cairns, Joyce; Woods, Paddy; Taylor, Diane
Subject: RE: Maintaining High Professional Standards

Victoria

We discussed this yesterday and agreed that, as the revision of this document has been in our Confidence in Care Programme plan, that it would be best that we proceed as planned in order to maintain consistency and avoid confusion among our stakeholders.

We will be progressing this work in January with the intention of gathering feedback on the current document more widely, developing a draft revision and consulting with our workstream members, as I mentioned in my previous email, this includes the BMA and HR and Medical Directors, as well as internal HR colleagues.

I hope this is helpful, I am more than happy to keep you updated on progress and please contact me if you have any other queries.

Best Wishes

Jane

Jane Lindsay
Project Manager-Confidence in Care
Annexe 2 Castle Buildings
Stormont Estate
Belfast BT4 3SQ

Personal Information redacted by the USI Mobile Personal Information redacted by the USI

From: Colville, Victoria
Sent: 19 October 2010 10:12
To: Lindsay, Jane
Cc: Best, David
Subject: RE: Maintaining High Professional Standards

Thanks for this Lindsay - its really helpful. Im wondering if the BMA are already involved in the current workstream would any additional work done on their behalf by us be a duplication of efforts? If there is to be a comprehensive range of comments collated by yourselves then it'll likely be fed back to BMA anyway.

You can let me know what Paddy and Joyce think anyway.

Thanks again

Victoria

From: Lindsay, Jane
Sent: 19 October 2010 09:32
To: Colville, Victoria
Cc: Woods, Paddy; Hutchison, Ruth; Cairns, Joyce; Taylor, Diane
Subject: RE: Maintaining High Professional Standards

Victoria

Within the Confidence in Care Programme we have begun looking at MHPS with a view to a revised document that will reflect the changes to medical regulation, namely the role of the Responsible Officer and the implementation of a system of Revalidation.

As part of this work, we have asked the relevant workstream (which includes membership from the BMA and Medical and Human Resources Directors) to provide us with comments and issues in relation to the current document and currently have quite a comprehensive range of comments on the document.

I am meeting with Paddy and Joyce tomorrow and will discuss your request and get back to you shortly.

Best Wishes

Jane

From: Colville, Victoria
Sent: 19 October 2010 09:22
To: Woods, Paddy; Lindsay, Jane
Subject: Maintaining High Professional Standards

Paddy/Jane

At the last BMA Joint Forum Meeting the BMA requested that we put a paper together highlighting any issues that employers have with MHPS and how it is operated. Diane Taylor agreed that I take this forward. She recommended I speak with you both.

Can you advise if there are any documented issues I can use - as well as contacting employers ourselves to ask for their comments? Are there any particular contacts within Trusts you would recommend I can go to?

I appreciate your help

Victoria

*Victoria Colville
DHSSPS Pay & Employment Unit
Room D1
Castle Buildings*

Personal Information redacted by the
USI

Confidence in Care

Programme Initiation Document

Confidence in Care Project Documentation

PROGRAMME INITIATION DOCUMENT

Project name **Confidence in Care Programme**

Release **Date: Version 1.1 September 2008**

PRINCE2

Author:	
Owner:	Programme Board
Document Number:	1

Confidence in Care Project Documentation

Document History

Revision date	Previous revision date	Summary of Changes
2/10/07	N/A	Discussions with Norman Morrow, Maura Briscoe, Martin Bradley and Andrew Hamilton
9/10/07	2/10/07	Discussions with Christine Jendoubi, Paul martin and David Bingham
15/10/07	9/10/07	Discussions with Michael McBride
5/11/07	15/10/07	Following circulation to Andrew Hamilton, Christine Jendoubi, David Bingham, Donnacha O Carolan, Martin Bradley, Maura Briscoe Michael McBride, Miriam McCarthy Norman Morrow, Paul Martin
21/01/08	5/11/07	Workstream structures amended. Approved by Andrew Hamilton, David Bingham and Michael McBride
2 April 08	21/01/08	Comments from Maura Briscoe and Norman Morrow - Representation on English working groups - addition of subgroups in tackling concerns locally - addition to PRLOG group - amendment to number of regulatory councils
6th June 2008	2 April 2008	Comments and changes from OSS directorate Comments and amendments from Maura Briscoe and Norman Morrow
16/09/08	6th June 08	Revisions to update document

Confidence in Care Project Documentation

Approvals This document requires the following approvals.

Name	Title	Date of Issue	Version
Programme Board	Confidence in Care Programme PID	9th June 2008 Written approval	0.8

Distribution This document has been distributed to:

Name	Title	Date of Issue	Version
Andrew Hamilton, Christine Jendoubi, David Bingham, Donnacha O Carolan, Martin Bradley, Maura Briscoe, Michael McBride, Miriam McCarthy, Norman Morrow, Paul Martin	Confidence in Care PID 0.4	19th October	0.4
Andrew Hamilton, Christine Jendoubi, David Bingham, Donnacha O Carolan, Martin Bradley, Maura Briscoe, Michael McBride, Miriam McCarthy, Norman Morrow, Paul Martin, Kathy Fodey, Joyce Cairns, John Farrell, John McCord	Confidence in Care PID 0.6	21st January 2008	0.6
Shipman Project Board	Confidence in Care PID V 0.6	13th March 08	0.6
Confidence in Care Programme Board	Confidence in Care PID V 0.7	24th April 08	0.7
Confidence in Care Programme Board	Confidence in Care PID V 0.7	12th May 08	0.7

Confidence in Care Project Documentation

Contents

Section	Topic	See Page
1	Strategic Context	6
2	Programme purpose and objectives	13
3	Programme Scope	14
4	Programme Deliverables	15
5	Constraints	17
6	Assumptions	18
7	Interdependencies	18
8	Benefits	18
9	Programme Infrastructure	19
10	Risk Assessment	26
11	Communication Plan	27
12	Project Plan	27
	Appendix 1	28
	Appendix 2	39
	Appendix 3	43
	Appendix 4	45
	Appendix 5	47

Confidence in Care Project Documentation

1. Strategic Context

The Department of Health 's (DH) White Paper "Trust, Assurance and Safety" published in February 2007 sets out a programme of reform to the United Kingdom's system for regulation of health professionals, based on consultations on the two reviews of professional regulation published in July 2006:

- *Good doctors, safer patients* by the Chief Medical officer for England, which was a comprehensive report examining medical regulation in its broadest sense and
- The Department of Health's "The regulation of the non-medical healthcare professions".

The primary purpose of professional regulation is to ensure patient safety. As such it is a vital component of the overall framework in the United Kingdom for ensuring the highest quality health care for the public. In Northern Ireland careful consideration must be given to the interface between health and social care within the integrated model.

The White paper is also complemented by the Government's response to the recommendations of the Fifth Report of the Shipman Inquiry, the recommendations of the Ayling, Neale and Kerr/ Haslam inquiries, as contained in 'Safeguarding Patients', which sets out a range of measures to improve and enhance clinical governance in the NHS.

In Northern Ireland the DHSSPS published their response and action plan to the Shipman Inquiry recommendations in the document "Improving Patient Safety: Building Public Confidence" in November 2006. A mapping exercise has been carried out to determine the outstanding recommendations of this report and the associated recommendations from HM Government publications "Safeguarding Patients" (Feb "2007) and "Learning from tragedy, keeping patients safe" (Feb

Confidence in Care Project Documentation

2007). The implementation of these recommendations will be addressed within this programme. It is envisaged that the work of the following established NI Shipman subgroups will be subsumed in the revised Confidence in Care work streams as outlined below

Existing Shipman Subgroups	Lead/ Contact	Proposed Confidence in Care Workstream
Accountable Officer Subgroup	Norman Morrow, John Farrell	Pharmacy Group
GP Data analysis subgroup	Kathryn Booth / Gillian Harkness (EHSSB)	Tackling Concerns Locally and Nationally
Enhancing prescribing in General Practice	Kathryn Turner - CSA	Tackling Concerns Locally and Nationally
Improving Governance in Single Handed GP practices	Discussions underway with Western Health and Social Services Board	Tackling Concerns Locally and Nationally
The Education Framework	Diane Taylor	Revalidation and Education
Whistle Blowing in General Practice	John Farrell	Tackling Concerns Locally and Nationally
Management of Underperformance in General Practice	Paddy Woods	Tackling Concerns Locally and Nationally
Improving Governance for sessional doctors	Discussions underway with Northern Health and Social Services Board	Tackling Concerns Locally and Nationally

The White Paper proposes a number of reforms for the modernisation of professional regulation. The aims of the reforms are to ensure that health professionals, throughout their careers, are able to assure themselves, their patients/ clients, colleagues and employers that their commitment to practise to

Confidence in Care Project Documentation

the highest standard is underpinned by objective confirmation of their competence to do so. It also recognises that there are a number of new roles emerging in health care that may require registration with a regulatory body in the near future.

The White Paper notes that the Devolved Administrations are committed to regulation across the UK, including in the professions new to regulation. It is however recognised that in terms of operational practicalities some of the proposals will need to be considered by the Northern Ireland Assembly. These local arrangements will need to enable health professionals to move easily around the UK during their careers. It is likely that pilot exercises will be used to test and evaluate some of the proposed approaches to implementation.

Equally the White Paper recognises that public trust in the professionals needs to be sustained by ensuring that the nine regulators of healthcare professionals in the UK, i.e.

- The General Medical Council,
- The Nursing and Midwifery Council ,
- The Health Professional Council,
- The General Dental Council,
- The Optical Council
- Pharmaceutical Society of Northern Ireland,
- Pharmaceutical Society of Great Britain
- General Chiropractic Council
- General Osteopathic Council

provide objective scrutiny of the practitioners from the perspective of reasonable patient/ client expectation and free from any doubt that the regulators are overly sympathetic to lapses in conduct or competence through a sense of professional loyalty. The White Paper's key proposals for reform are outlined in **Appendix 1**.

Confidence in Care Project Documentation

In summary the White Paper is based on five key principles

1. The overriding interest of professional regulation must be the safety and quality of the care that patients/clients receive from health professionals.
2. Professional regulation needs to sustain the confidence of both the public and the professions through demonstrable impartiality. Regulators need to be independent of Government, the professions themselves, employers, educators and all other interest groups that impact on healthcare.
3. Professional regulation should be as much about sustaining, improving and assuring the professional standards of the overwhelming majority of health professional as it is about identifying and addressing poor practise or bad behaviour.
4. Professional regulation should not create unnecessary burdens, but should be proportionate to the risk it addresses and the benefit it brings.
5. There is a need for a system that ensures the strength and integrity of the health professions within the United Kingdom, but is sufficiently flexible to work effectively for the different health needs and healthcare approaches within NHS England, Scotland, Wales and Northern Ireland and to adapt to future changes.

To take forward the requirements of the White Paper the Department of Health in England has established a range of working groups. While interim arrangements have been made for suitable representation from Northern Ireland on these groups this will need to be revisited in the longer-term.

Current proposed groups are:

- **Medical Education and Revalidation;**
 - ❖ Current NI representative – Carolyn Harper (Deputy Chief medical Officer, DHSSPS)
- **Non-Medical Education and Revalidation;**

Confidence in Care Project Documentation

- ❖ Current NI representative – Joyce Cairns (Deputy Director HR, DHSSPS)
- **Tackling Concerns Locally** – which would include consideration, for example, of the proposal for GMC Affiliates, the role of the Medical Director, Death Certification, Performers List, Alert Letters and the local management of information;
 - ❖ Current NI representative – Paddy Woods (SMO)

Nationally a number of groups have been established under the Tackling concerns locally banner. These are:

- I. GMC Affiliates group – Lead - Paddy Woods
- II. Responsible Officer group –Lead – Paddy Woods
- III. Clinical Governance group – Lead (to be agreed)
- IV. Information Management group - Lead (to be agreed)
- V. Death Certification group – Lead Heather Neagle
- VI. Performers List group – Lead John Farrell

The ongoing work and outcomes of these subgroups will be picked up and included in the Tackling concerns nationally and locally subgroup.

- **Tackling Concerns Nationally** – which includes consideration of an independent adjudicator;
 - ❖ Current NI representative – John Farrell (Principal Officer general medical services, DHSSPS)
- **Enhancing Confidence in Healthcare Professional Regulators** – covering governance arrangements for the regulatory bodies;
 - ❖ Current NI representative – Joyce Cairns (Deputy Director HR, DHSSPS)
- **Health of Health Professionals**
 - ❖ Current NI representative – Kathryn Fodey (Nursing Officer, DHSSPS)

Confidence in Care Project Documentation

- **Extending Professional Regulation.**

- ❖ Current NI representative – Joyce Cairns (Deputy Director HR, DHSSPS)

In addition there is a **Pharmacy Regulation and Leadership Oversight Group** (PRLOG), chaired by Ken Jarrold, allied to the establishment of a General Pharmaceutical Council. Representation from Northern Ireland is provided by Norman Morrow, Chief Pharmaceutical Officer (DHSSPS), the President of the NI Pharmaceutical Society and Ms Tracey Boyce, Director of Pharmacy, SHSCT.

Pharmacy Regulation in Northern Ireland

The Minister has yet to make a final decision on the future of the Pharmaceutical Society of Northern Ireland (PSNI). However, he has indicated that he is going to wait until the General Pharmaceutical Council (GPC) is established in Great Britain; Current timescales would propose this new body would operate in shadow form in 2009 and become fully operational by January 2010.

The Minister has also indicated that in developing new arrangements for the future the Department will continue to work with the PSNI and other relevant bodies to ensure that patients/clients and the public are fully protected. The Department is therefore committed to changes in the current legislative provisions underpinning the PSNI and will be further informed by the Council of Healthcare Regulatory Excellence allied to its current performance review of the PSNI, published in August 2008.

In either event i.e. the incorporation of PSNI into a UK wide GPhC or the continued existence of PSNI as a separate regulator this is likely to have legislative resource implications for the programme. To this end a Pharmacy group will be established within the Confidence in Care programme to take forward these areas of work.

Confidence in Care Project Documentation

1a Interface with Social Care

The Northern Ireland Social Care Council (NICSS) is the regulatory body for the social care workforce in Northern Ireland. Its aim is to increase the protection of those using social care services, their carers and the public. NISCC was legally established on October 1 2001 by the Health and Personal Social Services Act (Northern Ireland) 2001. It is a non-departmental public body, sponsored by the Department of Health, Social Services and Public Safety (NI).

An exercise has been undertaken by the DHSSPS to compare the White Paper recommendations against current NICSS activity.(attached as **Appendix 2**) The actions from this exercise are currently being addressed by the Office of Social Services of the DHSSPS, however issues regarding the future regulation of the wider health care support and social care workforce as per section 2 paragraph (3) of the _Health and Personal Social Services Act (Northern Ireland) 2001 (attached as **Appendix 3**) will require further dialogue and action.

In addition consideration should be given to linkages with the new Independent Safeguarding Authority (ISA) whose aim is to prevent unsuitable people from working with children and vulnerable adults. The scheme is scheduled to go live on 12 October 2009.

1b Legislative implications

9. The Health and Social Care Bill, which includes elements of the White Paper proposals, was introduced at Westminster on 15th November 2007. The Assembly demonstrated support to the full content of the Bill by agreeing a legislative consent motion on 14 January 2008. The Bill received Royal Assent in July 2008.

Confidence in Care Project Documentation

The areas within the Bill which will extend to Northern Ireland are attached as **Appendix 4**

2. Programme purpose and Objectives

The purpose of this programme is to contribute effectively to policy formulation nationally associated with the requirements outlined in the White Paper “Trust, Assurance and Safety” and ensure that the proposals of the established working groups are successfully implemented in Northern Ireland. The programme will also address the work of the PRLOG Group and ensure the implementation of the outstanding recommendations of the DHSSPS report “Improving Patient Safety: Building Public Confidence” and the associated recommendations from HM Government publications “Safeguarding Patients” (Feb “2007) and “Learning from tragedy, keeping patients safe” (Feb 2007)

2a Overarching Objectives

The overarching objectives of the programme are:

- To ensure effective engagement as appropriate with the Minister.
- To ensure, through robust programme management, that the recommendations of the working groups are successfully co-ordinated, implemented, monitored and evaluated in Northern Ireland.
- To identify and action any short term measures required pending the outworking of the working groups including outstanding work associated with the outputs of the DHSSPS report “Improving Patient Safety: Building Public Confidence” and the associated recommendations from the HM Government publications “Safeguarding Patients” and “Learning from tragedy , keeping patients safe”

Confidence in Care Project Documentation

- To ensure effective representation, and quality of input, from Northern Ireland into the working groups and harmonisation of the regulatory framework in Northern Ireland.
- To ensure there is effective communication with key stakeholders throughout Northern Ireland, taking account of the diversity of professional roles and locations and the integrated structure of health and social care.
- To quantify the resources necessary to support the running of the programme and ensure that they are allocated appropriately
- To develop a business case for any resources to support the effective implementation of the programme.

Each of the working groups will also have a clear set of measurable objectives to deliver against. (Initial thinking attached as **Appendix 5**)

3. Programme Scope

The programme will address all actions arising from the White paper based on outcomes from the DoH working groups. While this does not include the implementation of the associated legislative framework nationally, action in respect of the role of the Assembly and Executive in this regard will form part of the work of the programme. The assurance of independence of professional regulators will be undertaken nationally by the Department of Health, England. The programme will also encompass the implementation of any of the outstanding recommendations from the DHSSPS report “Improving Patient Safety: Building Public Confidence” and the associated recommendations from the HM Government publications “Safeguarding Patients” (Feb “2007) and Learning from tragedy, keeping patients safe” (Feb 2007)

The programme will not directly address social care which remains the responsibility of the NISCC. The DoH is planning to publish a report later this year on the regulation of Health Care Support Workers in addition to a pilot scheme in NHS Scotland. Issues regarding extended workforce regulation will require continued co ordination and dialogue and this will be addressed by the group charged with ‘Extending Professional Regulation’. There will also be senior

Confidence in Care Project Documentation

representation from the Office of Social Services on the Programme Board who will be accountable for the identification and translation of recommendations as appropriate from the working groups into the work of the NISCC.

4. Programme Deliverables

This section is based on the key deliverables currently identified in the individual White Paper working groups and the outputs of the DHSSPS report “Improving Patient Safety: Building Public Confidence” and the associated recommendations from the HM Government publications “Safeguarding Patients” and “Learning from tragedy , keeping patients safe” The advice of the working groups will enable more detailed characterisation of the key deliverables to be developed for each workstream and these will be refined over time as implementation plans proceed.

4a Medical Revalidation and Education

- A comprehensive system of appraisal in Northern Ireland using multi source feedback which will be sufficiently robust and consistent to inform reliably a UK wide system of revalidation
- In undertaking this work the groups should take due regard of the regulatory arrangements for medical staff within the Irish Republic.

In addition this working group will need to advise on the implementation of the delivery of the White Papers proposals for medical education.

4b Non –Medical Revalidation

- Formative and summative appraisal arrangements for the non – medical professions in Northern Ireland which are sufficiently wide-ranging, robust and consistent to inform reliably a UK wide system of revalidation.
- Generic and profession specific identification of areas where risk necessitates further assessment approaches over and above appraisal and development of appropriate standards and assessment methodologies.

Confidence in Care Project Documentation

- In undertaking this work the groups should take due regard of the regulatory arrangements for non-medical staff within the Irish Republic.

4c Tackling Concerns Nationally

- Proposals and protocols for sharing information about registrants with the public, patients, employers and other interested parties and an extension of the range of actions available to regulators when they have identified concerns, so that , where appropriate, the options of rehabilitation, remediation and retaining are more readily available.
- Clarification and agreement of the role of the Council for Healthcare Regulatory Excellence in ensuring fair, effective and consistent fitness to practise arrangements and a move to a common standard of proof across professionals

4d Tackling Concerns Locally

- The development and implementation of new arrangements for the roles and responsibilities of a UK network of GMC Affiliates and Responsible Officers
- The review and, if necessary, redesign of the Performers' List system;
- The review and development of systems for collecting and using information on health professionals for complaints, investigations and disciplinary measures
- The design and implementation of a new system of Death Certification for the United Kingdom.

4e Enhancing Confidence in Healthcare Professional Regulators

- Measures to provide assurance to the public, patients, the professionals and the Assembly that Councils are operating fairly and effectively in the exercise of their duties

4f Extending Professional Regulation

Confidence in Care Project Documentation

- The development of criteria against which all roles in the United Kingdom will be judged to determine which should be statutorily regulated and the priorities for doing so.
- Future regulation of the wider health and social care workforce
- In undertaking this work the groups should take due regard of the growth in integrated health and social care working patterns throughout the UK and of the integrated health and social care structures in Northern Ireland, alongside plans for registration and regulation of the social care workforce in each of the four countries

4g Health for Health Professionals

- The development of an integrated national strategy for the health of all health professionals including the piloting and evaluation of referral services for doctors which will inform the remedial and rehabilitative aspects of fitness to practise and revalidation outputs

Outstanding Recommendations

The recommendations of the DHSSPS report “Improving Patient Safety: Building Public Confidence” and the associated recommendations from the HM Government publications “Safeguarding Patients” and “Learning from tragedy , keeping patients safe” have been mapped against the proposed working groups and will be included in their objectives and terms of reference

5. Constraints

- Resource requirements have not been determined at this stage, but from the DoH, Partial Regulatory Impact Assessment of the White Paper, benchmarking from other regions and discussion with key stakeholders, appears to be significant
- Availability of adequate resources for programme and project management
- Availability of Departmental and HSC staff to lead and populate project teams

Confidence in Care Project Documentation

- Timescales for this programme will be primarily driven by the National framework

6. Assumptions

- The national element of the legislative framework will be managed by the Department of Health, England.
- Appropriate local representation on working groups

7. Interdependencies

Most of the working groups will have interdependencies and connections with the other groups. This will be addressed by ensuring

- Appropriate representation on programme board
- appropriate cross-membership between working groups,
- regular formal meetings of the project managers ,
- circulation of Programme Board minutes and updated Programme plan.

8. Benefits

- Compliance with the recommendations of the DHSSPS report “Improving Patient Safety: Building Public Confidence” and the associated recommendations from the HM Government publications “Safeguarding Patients” and “Learning from tragedy , keeping patients safe”
- The timely, effective and affordable introduction of a revalidation system comprising relicensure and recertification of doctors.
- Each regulator will develop the standards that a registrant will need to meet to periodically maintain their registration.
- The education function of the GMC would be brought into line with the operating methods of Post Graduate Medical Education and Training Board (PMETB). (The PMETB through its founding order has a wide range of interests on its Board including lay members, patients and the NHS).
- All professional staff will be recorded on a live register.

Confidence in Care Project Documentation

- Greater emphasis on remediation, rehabilitation and support for those health professionals who are experiencing difficulties.
- A legal practical way in which all health professionals could reach an appropriate standard of English language proficiency.
- The improved safety of patients, with lower risk of potential exposure to abuse, incompetence or unacceptable behaviour.
- A strengthening of the process through which health care organisations learn from mistakes and strive for continuous improvement in the quality of services they deliver.
- The development of criteria against which all professional roles in the UK will be judged to determine which should be regulated.

9. Programme infrastructure

The programme will use a structured programme management approach in line with Prince 2 methodology and 'Managing Successful Projects'.

9a Resource Requirements and Benchmark Data

Programme support will need to be kept under review as the Programme develops, however experience would suggest that this will be significant. Evidence from Scotland indicates that there is a clear requirement for a dedicated management team to take forward the programme i.e.

Professional Regulation Programme Team - Scottish Executive

Grade of Staff	Current Establishment	Additional Requirements
Head of regulatory unit – C1	1.0 WTE	No Change
Policy Officer B2	1.0 WTE	1.0 WTE
Personal Assistant	Nil	1.0 WTE

Confidence in Care Project Documentation

Administrator	0,5 WTE	Nil
Professional Advisor – NHSS secondee	1.0 WTE	1.0 WTE

The Welsh implementation team, who are also at the set up stage, have recently gained approval for a secondee at Executive Officer level to assist with their project for the next number of years.

The Department already has resources allocated to related activity including regulation, safety, quality and standards and will have to consider the extent to which the programme can also be supported through re-prioritising and/or deferring current activity.

However, discussion with key stakeholders during the preparation of this PID has also highlighted the additional requirement for a supplementary dedicated resource over the next 2/3 years at programme support level, and for professional staff within some of the Departmental directorates, to ensure the delivery of agreed objectives and to support the work of the Programme Board and working groups. This could potentially be provided through fixed-term secondments. It is therefore proposed that a business case for this resource is completed as soon as possible.

The Director of HRD (who currently has the lead role in regulation of professional staff) has indicated that the Directorate would be willing to host this project provided additional resources were forthcoming.

.

9b Programme Board

A Northern Ireland Confidence in Care Programme Board has been established to oversee the whole Programme. The Board are accountable for the success of the programme and are responsible for approval of all major plans and authorisation of any deviation from those plans.

The Programme Board are responsible for confirming the completion of the Programme and will report progress to the Departmental Board, as depicted

Confidence in Care Project Documentation

below ensuring that the Departmental Board is made aware of any issues of concern.

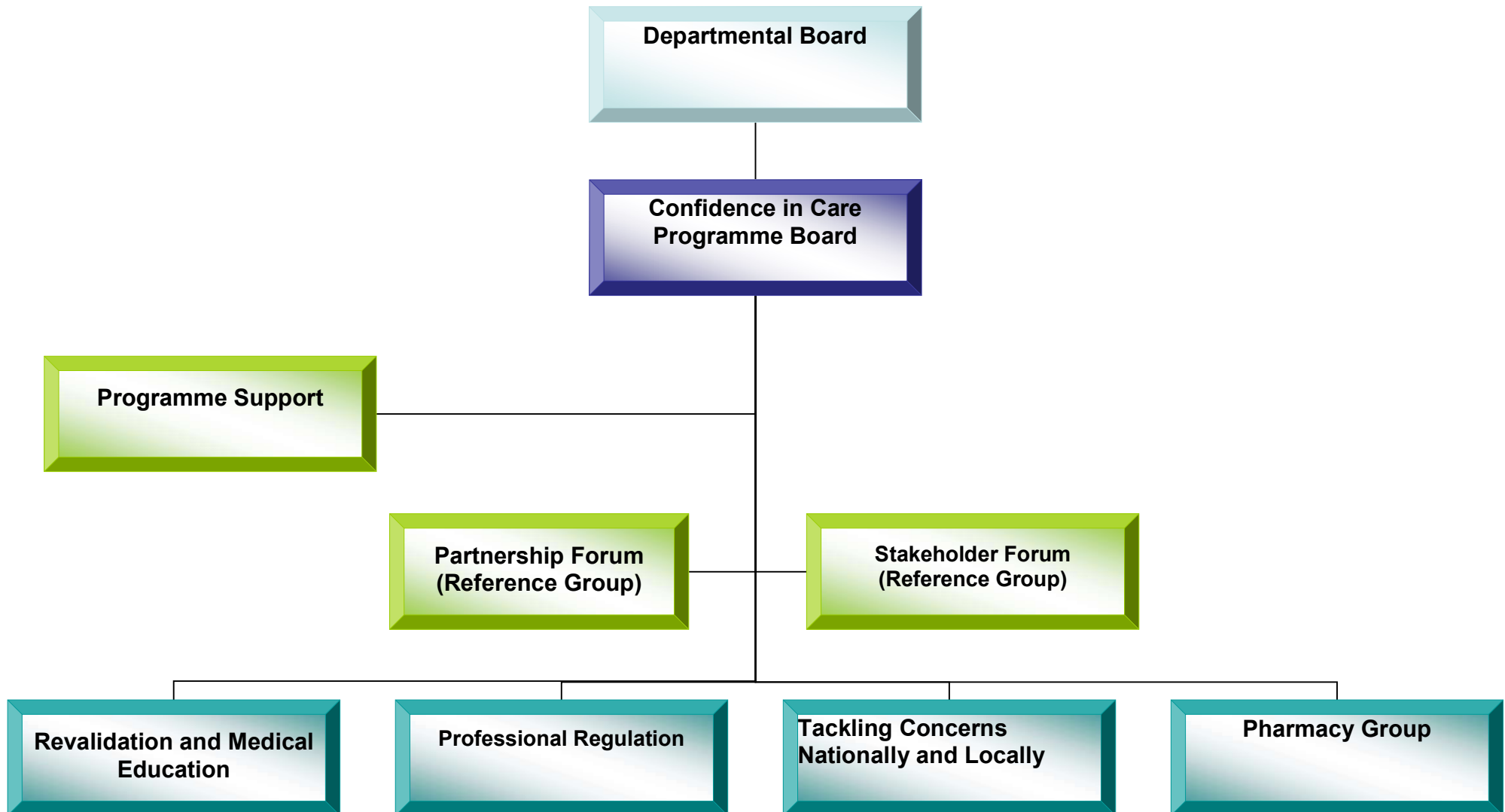
While it is normally preferable to have a single programme SRO in this instance this will be shared between the Chief Medical Officer and the Chief Nursing Officer, both of whom are also members of the Departmental Board

A Programme Director/manager, of suitable seniority, will be appointed for the day to day running of the programme and will have appropriate programme management support with access to legislative expertise. The role of the legislative advisor is to ensure that all the references to NI legislation quoted in the GB legislation are accurate and complete and are in accordance with the local NI policy requirements. The advisor is also required to provide associated advice throughout the process.

The Programme Board meet on a 6 weekly basis. Deputies are only acceptable with the agreement of the Programme SROs. At each meeting, the Programme Board among other things consider;

- An updated Programme Plan
- A highlight report from each of the working groups detailing progress against agreed milestones in Project Plans, next steps and potential problems
- An updated Programme Risk Register
- Matters requiring approval and/or issues referred under escalation procedures

The Programme Board will report to the Departmental Board via quarterly highlight reports

9c “Confidence in care” Programme Structure

Confidence in Care Project Documentation

9d Stakeholder Forum

It is proposed that a forum will be established to facilitate key stakeholders, including representatives from professional bodies and academia to meet to discuss updates on progress and provide independent advice and input.

Forum Chair – Martin Bradley – Chief Nursing Officer, DHSSPS

9e Partnership Forum

Communication with staff side would be provided largely through the exiting partnership forum. The framework document on Partnership Arrangements for HSC states that the remit is:

- providing advice to the DHSSPS and the HPSS regarding partnership and employment issues
- supporting research and development in employment issues
- supporting and advising the project groups established to develop key themes of the HR Strategy and
- providing advice and support in the development of employment issues from the Workforce Planning Initiatives.

9g Working Groups

The Programme Board will be supported by four workstreams, each of which will have a lead person identified who will:

- report directly to or be a member of the Programme Board,
- ensure the appropriate project /administrative support is available for their team.
- be responsible for meeting agreed objectives and reporting to the Programme Board

Confidence in Care Project Documentation

Workstream and Chairs

Tackling Concerns Nationally and Locally – Paddy Woods

Medical / Non Medical Revalidation and Medical Education – David Bingham

Professional Regulation – Martin Bradley

Pharmacy Group – Norman Morrow

In order to co-ordinate the outputs of the workstreams it is proposed that the leads will meet on a monthly basis with the Programme Director, approximately 10 days before the Programme Board meeting, to discuss progress and highlight any issues to be addressed.

The complexity of the programme is reflected in the overall approach. The methodology describes a series of interlinked Projects. The Programme Board will consequently oversee and quality assures the contribution of the various work streams to the overall requirements.

9h Programme Board Membership

Name	Role	Organisation
Michael McBride	Chief Medical Officer Co chair (SRO)	DHSSPS
Martin Bradley	Chief Nursing Officer Co chair (SRO)	DHSSPS
Miriam McCarthy	Deputy Secretary	DHSSPS
Paddy Woods	Senior Medical Officer	DHSSPS
David Bingham	Director HR	DHSSPS
Donncha O'Carolan	Acting Chief Dental Officer	DHSSPS
Norman Morrow	Chief Pharmaceutical Officer	DHSSPS
Nuala McArdle	Principle Officer Allied	DHSSPS

Confidence in Care Project Documentation

	Health Professionals	
Maggie Reilly	Chief Officer	WHSSC
Joan Pedan	Co-Director Governance, Equality and Improving Working Lives, Belfast HSC Trust	Belfast Trust
Bernard Mitchell/ Levette Lamb	Programme Director	DHSSPS
Christine Jendoubi	Director Primary and Community Care	DHSSPS
David Galloway	Director of Secondary Care	
Paul Martin	Social Services Chief Inspector	DHSSPS
Carolyn Harper	Deputy Chief Medical Officer	DHSSPS
Jim Livingstone	Director of Safety , Quality and Standards	DHSSPS

9e Roles and responsibilities**Co Chairs (SROs)**

The co-chairs are responsible for ensuring that the Programme meets its objectives and delivers its stated benefits. The co-chairs are ultimately accountable for the success of the programme and are responsible for enabling the organisation to exploit the new environment resulting from the programme, meeting the new business needs and delivering new capabilities.

Programme Manager/ Director

The Programme Manager/ Director has the authority to run the programme on a day – to day basis on behalf of the steering group within stipulated constraints with appropriate project management support. The Programme Director's main

Confidence in Care Project Documentation

responsibility is to ensure that the programme produces the required products to the required standard of quality within the specified constraints of time and cost.

9f Governance Arrangements

To promote effective governance of the Programme:

- The SRO / Project managers of each of the working groups will be tasked with ensuring that 6 weekly reports are prepared for the Programme Board.
- The Programme Board will implement a Communication Plan which ensures that there is effective communication with key stakeholders and between the component parts of the Programme. This will include a regular meeting of the Northern Ireland representatives on each of the working groups which will be chaired by the Programme Director.
- A template for Highlight Reports has been developed and issued to each of the project SRO/ project managers to ensure that they are consistent and fit for purpose
- The Programme Board will ensure escalation arrangements are in place so that mission-critical problems are drawn to the attention of the Departmental Board in good time.

10. Risk Assessment

The list below sets out the risks associated with the Programme. The actions taken and/or position with regard to each risk are detailed in **risk register**.

- Lack of robust programme management
- Risk of ineffective communication due to the complexity of the programme
- Lack of representative input into the DoH working groups
- Regional voice will not be heard
- Inappropriately resourced Programme Team
- Lack of control, with the pace of progress generated by DOH in England

Confidence in Care Project Documentation

11. Communication Plan

Effective Communication is a crucial component of this programme and a considerable challenge due to the dispersed nature of the staff affected including those in the independent, voluntary and community sector, the large number of stakeholders and the complexity of the Programme both nationally and locally. There will also need to be consideration given to the specific issues associated with locum and agency employees. Good communication will enable regular reporting of developments on implementation of the programme and enable stakeholders to feed their views, comments and concerns easily. **See Communication Strategy**

12. Programme Plan

TBC

Appendix 1**TRUST, ASSURANCE AND SAFETY –THE REGULATION OF HEALTH PROFESSIONALS IN THE 21ST CENTURY****1. Assuring independence: the governance and accountability of the professional regulators**

This section sets out a series of measures to ensure the independence of the national professional regulators. In order to exercise their functions effectively and command the confidence of patients, the public and the professions, they need to be seen to be independent and impartial in their actions. To ensure that this is the case, the White Paper proposes that:

- the councils that regulate health professionals have, as a minimum, parity of membership between lay and professional members, to ensure that purely professional concerns are not thought to dominate their work;
- the Government will agree arrangements to ensure that all councils become more accountable to Parliament, presenting annual reports to the UK Parliament and, for those councils that regulate professionals whose regulation is a devolved matter, to the Devolved Assembly legislatures;
- to dispel the perception that councils are overly sympathetic to the professionals they regulate, council members will be independently appointed;
- to enable councils to focus more effectively on strategy and the oversight of their executives, they will become smaller and more-board like, with greater consistency of size and role across the professional regulatory bodies;
- Similar changes will be made to the Council for Healthcare Regulatory Excellence (CHRE), enabling it to take on a stronger and more independent role in providing expert advice on professional regulation;

Confidence in Care Project Documentation

- there will be no mergers, for the time being, of the professional regulatory bodies and the Government will review these arrangements in 2011; and the Government will work with the pharmacy profession to establish a General Pharmaceutical Council responsible for the regulation of pharmacists and pharmacy technicians, and the registration of pharmacy premises. The profession will need a strong and clear voice to assume the critical responsibility of undertaking a role akin to that played by a Royal College, supporting clinical excellence in the profession. A working party will be established to take forward detailed proposals. Its work will help inform future decisions about the regulation and leadership of pharmacy in Northern Ireland.

2. Revalidation: ensuring continuous fitness to practise

This section sets out new proposals to ensure that all the statutorily regulated health professions have in place arrangements for the revalidation of their professional registration through which they can periodically demonstrate their continued fitness to practise.

For doctors, the Government endorses the revalidation proposals set out in the Chief Medical Officer's report, *Good doctors, safer patients*. Medical revalidation will have two core components: relicensure and specialist recertification.

For relicensure, all doctors will have a licence to practise that enables them to remain on the medical register. This licence to practise will have to be renewed every five years. In order to bring objective assurance of continuing fitness to practise, the appraisal process will include 'summative' elements which confirm that a doctor has objectively met the standards expected. Specialist recertification will apply to all specialist doctors, including general practitioners, requiring them to demonstrate that they meet the standards that apply to their particular medical specialty. These standards will be set and assessed by the medical Royal Colleges and their specialist societies, and approved by the

Confidence in Care Project Documentation

General Medical Council (GMC). The Department will discuss with stakeholders ways of ensuring that revalidation can be applied appropriately to all practising 71doctors, not just those who work in the NHS.

For the other health professionals, this White Paper sets out new arrangements to ensure that they also have the opportunity to demonstrate their continuing fitness to practise through appropriate revalidation arrangements. The Department will discuss with each profession and its regulator the most appropriate arrangements.

Professionals in England will fall broadly into one of three groups for revalidation:

- For employees of an approved body, for example nurses, dieticians or paramedics working in an NHS organisation or a licensed private or independent sector provider, evidence to support revalidation will be provided as part of the normal staff management and clinical governance systems, with employers providing recommendations to the professional regulators.
- For those, including self-employed contractors, performing services commissioned by NHS primary care organisations (such as dentists or optometrists), the revalidation processes will be carried out under the supervision of either the NHS commissioning organisation or, particularly where it is necessary to take an overview of both NHS and private work, the regulatory body, but in either case with appropriate collaboration between the two bodies.
- For all others, for example osteopaths, the relevant regulatory bodies will develop direct revalidation arrangements.

The responsibility for revalidation arrangements for staff directly employed by primary care contractors, for example practice nurses or dental hygienists, will be discussed with the relevant professions and regulators.

Confidence in Care Project Documentation

The appraisal process, which will be a central component of revalidation, should be both formative and summative, to ensure objectively that required standards are met. Within the English NHS, information gathered under the Knowledge and Skills Framework should be used as far as possible as the basis of revalidation, with any additional requirements justified by risk analysis. Scotland, Wales and Northern Ireland will consider how they wish to take this forward within their particular contexts.

3. Tackling concerns: the local role

For doctors and other relevant health professionals working in primary care, the Government will review the current Performers List arrangements to consider whether or not they are being used effectively. In particular, following the GMC's introduction of the GP register in April 2006, the Government will consider the regulatory burden of separate lists being held by each primary care trust (PCT).

For all doctors working in the UK, the Government will seek parliamentary approval to establish a UK network of GMC Affiliates at a regional level in England and at a national level in Scotland, Wales and Northern Ireland. In some larger regions with a large number of doctors, sub-regional arrangements may provide more effective engagement with local services. The Government will pilot these approaches at different levels of engagement in England prior to full-scale rollout. The Devolved Administrations will consider implementation of the Affiliates measures in the light of learning from these pilots.

Appointed by, and accountable to, the GMC, the Affiliates would lead and establish devolved GMC offices in England and work within existing structures in Scotland, Wales and Northern Ireland. In England, they would lead regional medical regulation support teams, including the strategic health authority (SHA) the director of public health, the SHA clinical governance lead, the National

Confidence in Care Project Documentation

Clinical Assessment Service (NCAS), the Healthcare Commission (or its successor), the postgraduate dean and four lay GMC Affiliates.

Advised and assisted by the regional medical regulation support teams, the GMC Affiliates would provide support, advice and guidance to employers in managing concerns about doctors and would quality assure the processes for revalidation of doctors.

These changes mean that medical directors, and others in similar roles, will take on the organisational roles originally envisaged for GMC Affiliates in Good doctors, safer patients. In England, all practising doctors on the medical register will need to relate to a responsible officer approved by the GMC Affiliate. Where medical directors are in place, they will generally take on this role.

The Department will lead a project to establish more explicit competencies for the role of medical directors as well as measures to enhance their direct accountability to boards for actions relating to their new responsibilities and powers for regulation and revalidation. In England, all PCTs will be expected to have in place, at board level, a responsible officer.

Good doctors, safer patients also proposed a new measure, Recorded Concerns, for the local regulation of concerns about doctors' conduct or practice that will facilitate proportionate local responses to problems and allow patterns of misconduct or behaviour to be tracked over time and place. The Department will discuss with key stakeholders from across the UK how to frame detailed proposals on the practical implementation of the new system of GMC Affiliates and Recorded Concerns through a piloted approach in England, with the Devolved Administrations considering local arrangements in the light of learning from these pilots. The Department will invite stakeholders covering appropriate UK interests to participate.

Confidence in Care Project Documentation

In order to provide assurance of the quality of all health professionals who work as locums, the Department will consider, with stakeholders, the regulatory and other impacts of developing a more effective system of registration and inspection for agencies supplying health professionals.

4. Tackling concerns: the national role

This section sets out proposals to ensure public and professional confidence in the handling of cases in which a health professional's fitness to practise is called into question. To ensure greater fairness and openness in the handling of such cases, the White Paper includes the following proposals:

- in the adjudication of fitness to practise cases for all health professionals, panels should use the civil standard of proof, with its sliding scale, rather than the criminal standard;
- CHRE should have enhanced powers to scrutinise the regulators' handling of fitness to practise cases;
- CHRE should develop common protocols for local investigations across all the regulators, with guidance to employers on when such cases should be referred to the national regulator;
- the Department should work with the NCAS, the GMC and the General Dental Council to agree protocols to ensure that, in England, full use is made of the NCAS in its investigations; and
- the Department should work with the NCAS and with stakeholders to review the cost-effectiveness of extending its scope to other health professionals, as suggested by the Public Accounts Committee.

To ensure an integrated, affordable and cost-effective approach to the health of all health professionals, the Department will establish a wide-ranging and inclusive national advisory group to inform the development of a national strategy. Including UK stakeholders, the group will advise on measures to ensure appropriate prevention and early intervention for health professionals; the role of

Confidence in Care Project Documentation

health in revalidation arrangements; enabling easier and confidential uptake of services; the roles and responsibilities of employers, regulators, professionals themselves and others in ensuring the health of professionals; and more effective arrangements for the rehabilitation of health professionals whose actions have led to regulatory involvement.

For doctors, the Government agrees with Dame Janet Smith and with the CMO that the separation of investigation and prosecution from adjudication is essential to ensure complete public and professional confidence in the independence of the decisions made by the adjudicator. Working closely with the GMC, the Government will seek legislative agreement to establish an independent body to adjudicate on fitness to practise cases involving the medical profession. Doctors and the GMC will have a right of appeal against the decision of the independent body to the High Court or the Court of Session.

For all the other regulators, the Government will charge the new independent body with establishing a central list of people, vetted and approved for all adjudication panels, chosen by the Appointments Commission for their expertise and specifically trained to undertake these duties in a fair and impartial manner. Regulatory bodies will be able to draw on this list in order to conduct independent adjudication panels within their own organisations. Over time, and in the light of the experiences of fully independent adjudication for the medical profession, other regulators may wish to adopt the independent body to provide further assurance of independence to the public.

5. Education: the role of the regulatory bodies

The Government agrees that the non-medical professional regulatory bodies should continue to be responsible for the educational standards of the professionals they regulate.

Confidence in Care Project Documentation

The Government recognises the gains to be secured from single oversight of medical education, but believes that change should be introduced in such a way as to preserve the expertise and experience of the present organisations that undertake this role. The Government agrees with the proposal, set out in the GMC's response to consultation, for a three-board model covering undergraduate education, postgraduate education and continuing professional development. The Department will work with the GMC to establish an undergraduate board and a continuing professional development board in the GMC. The Postgraduate Medical Education and Training Board will continue as a separate legal entity, fulfilling the role of the postgraduate board within this three-board approach. Both organisations will continue to have a duty of cooperation.

The Department will ask UK professional regulatory bodies to work with NHS employers to develop arrangements for selective language testing for applicants to posts, where appropriate.

6. Information about health professional

This section sets out further proposals for the professional registers and the extension of the information held on them for patients, the public, employers and the professions.

Entry to the professional register depends ultimately on demonstrating fitness to practise by securing the educational qualifications and, in some cases, levels of competence, recognised by the relevant regulatory body. As 'The regulation of the non-medical healthcare professions' noted, however, the different regulatory bodies have similar, though not identical, requirements of people seeking new registration. The Government will ask CHRE to recommend a single standard definition of good character, working with the regulatory bodies, and encompassing wider work within Europe to promote information sharing on the good character of professionals who cross national borders.

Confidence in Care Project Documentation

The Government will also take forward the recommendation to ensure closer co-operation and co-ordination between regulators and employers when a health professional enters employment for the first time. The Department will ask CHRE to lead a programme of work with regulators and employers from across the UK to investigate the feasibility and practicability of these proposals, reporting to ministers by April 2008.

Good doctors, safer patients and 'The regulation of the non-medical healthcare professions' raised the issue of whether students and trainees should have closer relationships with their future regulators prior to qualification. The Government believes that each regulator should consider this issue on the basis of the risk presented to patients by trainees and students in particular professions. The Department will ask the regulators to report back with proposals by January 2008.

The Government agrees with the CMO's key proposals for changes to the medical register. The medical register should be the key national list of doctors entitled to practise in the UK. The Department will discuss with the GMC how the register can be further developed to become the single authoritative source of information on doctors, including disciplinary action by employers and alert notices. In reviewing such arrangements, the Department will ask the regulators what other changes could be made to provide better access to information for patients, the public and employers.

7. New roles and emerging professions

Some existing professionals who are not statutorily regulated have been in practice with patients for many years; practice that carries at least the same potential risk to members of the public who use their services as that of the statutorily regulated professions. The Government believes that these professionals should also be subject to a system of regulation that is proportionate to the risks and benefits entailed.

Confidence in Care Project Documentation

The Government is planning to introduce statutory regulation for applied psychologists, several groups of healthcare scientists, psychotherapists and counsellors and other psychological therapists. These are the priorities for the introduction of statutory regulation.

For emerging professions, the Department will establish a UK working party to develop criteria to determine which roles should eventually be statutorily regulated. The regulation of emerging and existing unregulated professions will be managed by the existing statutory regulatory bodies and the proposed new General Pharmaceutical Council. This will help to foster consistency where appropriate and the application of best regulatory practice across all regulated professions. With the exception of the new arrangements for the regulation of pharmacy, the Government will not establish any new statutory regulators.

The Government will consider areas in which regulatory practice and legislative provisions should be harmonised across the regulators so that they all have the most up-to-date and comprehensive duties and powers.

Where a health professional joins a new regulated profession from within an existing regulated profession, it might be possible for them to remain registered with their existing regulator, in a system of distributed regulation, to avoid costly dual regulation.

8. Implementation

The Government will consult with the Devolved Administrations, the regulators, the professions, employers and other key stakeholders on the development of a detailed implementation programme that encompasses both this White Paper and the Government's response to the recommendations of the Fifth Report of the Shipman Inquiry and the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, Safeguarding Patients.

Confidence in Care Project Documentation

Many of the reforms set out in this White Paper will require primary legislation. Other measures need to be enabled by seeking parliamentary approval for secondary legislation. On specific matters where there is clear public, professional and parliamentary agreement on the need for change, the Department will consider with stakeholders whether it would be appropriate to seek Parliament's agreement in primary legislation to enable these issues to be addressed through secondary legislation. These legislative proposals will be developed in close consultation with the Devolved Administrations to ensure that they are appropriate to the whole of the UK.

The White Paper sets out the key principles for a lasting settlement for professional regulation, but putting those principles into practice will require the advice and participation of a wide range of stakeholders to ensure effective delivery. The Government will establish an inclusive national advisory group on professional regulation to advise the Department and the Devolved Administrations on the detailed implementation of the White Paper and the response to the Shipman Inquiry, and related inquiries.

Confidence in Care Project Documentation

Appendix 2

Comparison of White Paper recommendations against NISCC activity.

White Paper Trust, Assurance & Safety <u>Recommendations</u>	NISCC
1. <u>Assuring Independence</u> - Parity of membership between lay and professional - Accountability to Parliament - Independent appointments - Smaller councils - Expert advice (CHRE)	Membership = 1/3 lay, 1/3 registrants, 1/3 stakeholders Current membership = 5 social workers/7 'other' - NISCC accountable to NI Assembly through DHSSPS (Permanent Secretary = accountable officer) - members are publicly appointed - Council downsized from a possible 24 members + Chair to 12 members + Chair following a review in 2005. Remuneration for members introduced in October 2007. - no equivalent
2. <u>Revalidation – fitness to practise</u> - Revalidation of professional registration - Re-licensure + specialist recertification	- re-registration every 3 years - registrants expected to undertake 5 days post-registration training and leaving per year (15 days every 3 years) to be eligible for re-registration. Employers endorse registrants' application for re-registration PSS Development and Training Strategy 2006 – 2016 – strategic target of a phased introduction of linking re-registrations with accredited training/qualifications by 2016. Opportunity to review employer involvement in re-registration

Confidence in Care Project Documentation

3. <u>Tackling concerns – the local role</u> - Sub-regional arrangements for more effective engagement with local services - GMC affiliates - role of Medical Directors - Record concerns to track patterns of concern - More effective registration and inspection and inspection for agencies supplying health professionals	- devolved Social Care Councils in 4 jurisdictions - professional accountability arrangements for social work clearly set out in new arrangements under RPA with Director of Social Work/Services in new Trusts - all reported concerns are recorded and retained by NISCC even where individual is not yet registered - RQIA → extension of regulation of social care services
4. <u>Tackling concerns – the national role</u> - Civil standard of proof - External scrutiny - CHRE - National advisory group – health of health professionals - Separation of investigation and prosecution from adjudication - Regulatory bodies work with NHS employers to develop arrangements for selective language testing for applicants to	- civil standard of proof - registrant can challenge process (Judicial Review) or outcome (Care Tribunal) - Same requirement re health. Enshrined in registration and where it is root cause of misconduct. Would be interested in national strategy – early intervention. (NB: current challenge reported by Disability Rights Commission) - Conduct committees are independent from Council members and staff. They are trained and supported by NISCC staff. - EU Directive 2005/36 prevents NISCC from administering or taking into account language proficiency of visiting EEA professionals for

Confidence in Care Project Documentation

posts	registration purposes. Same standards applied to overseas nationals. Workers from outside UK are an increasing reality in the social care workforce in NI and language proficiency can be an issue. NISCC could work with employers to develop arrangements for selective language testing with employers but cannot administer or take this into account for registration purposes
5. <u>Education – the role of the regulatory bodies</u> - Regulatory bodies responsible for educational standards of the professionals they regulate	- regulatory body for social work training (qualifying and post-qualifying) - contribute to development of national occupational standards which underpin NVQs → recognised qualification for social care workers
6. <u>Information about health professionals</u> - Single standard definition of good character - Information-sharing on good character of professionals who cross national borders - Closer co-operation and co ordination between regulation and employers when a health professional enters employment for the first time - Closer relationship of students and trainees with future regulator	- Interested in consistent approaches across health and social care given integrated structures in NI. - EU Directive 2005/36 will establish a database of regulatory bodies in other EU countries which will facilitate information-sharing. No similar arrangements for countries outside EU. - Assessed Year in Employment (AYE) – newly qualified social workers are registered for one year in first instance and employer must confirm successful completion of AYE which is based on consolidation of graduate training. - requirement for social work students to be registered with NISCC as a condition of enrolment on an approved social work Degree course

Confidence in Care Project Documentation

7. <u>New Roles and emerging professions</u> - Regulation of emerging and existing unregulated professions will be managed by existing statutory regulatory bodies - Avoid dual duplication	- Foster Report – identified NISCC as the potential ‘default’ regulator for health care support workers. Legislation allows NISCC to register staff in nursing homes and any person providing personal care as a ‘social care worker’ irrespective of their job title or work setting. Issue of regulation of largely unqualified part of the health and social care workforce within an integrated structure. Potential to create inequities/anomalies between social care workers and health care support workers who may be carrying out broadly similar tasks (e.g. in nursing homes and adult residential care homes) and therefore differentials in standards of protection for people who use the services. - NISCC regulations do not require registration of any person who is registered with another specified regulatory body.

Confidence in Care Project Documentation

Appendix 3

PART I SOCIAL CARE WORKERS

Preliminary

The Northern Ireland Social Care Council

1.—(1) There shall be a body corporate to be known as the Northern Ireland Social Care Council (referred to in this Part as “the Council”) which shall have the functions conferred on it by or under this Part or any other statutory provision.

(2) It shall be the duty of the Council to promote—

(a) high standards of conduct and practice among social care workers; and

(b) high standards in their training.

(3) The Council shall, in the exercise of its functions, act—

(a) in accordance with any directions given to it by the Department; and

(b) under the general guidance of the Department.

(4) Schedule 1 shall have effect with respect to the Council.

“Social care worker”, etc.

2.—(1) This section has effect for the purposes of this Part.

(2) “Social care worker” means a person (other than a person excepted by regulations) who—

(a) engages in relevant social work (referred to in this Part as a “social worker”);

(b) is employed at—

(i) a children’s home;

(ii) a residential care home;

(iii) a nursing home;

(iv) a day care setting;

(v) a residential family centre;

Confidence in Care Project Documentation

(c) manages an establishment of a description mentioned in paragraph (b); or

(d) is supplied by a domiciliary care agency to provide personal care in their own homes for persons who by reason of illness, infirmity or disability are unable to provide it for themselves without assistance.

(3) Regulations may provide that persons of any of the following descriptions shall be treated as social care workers—

(a) a person engaged in work for the purposes of the personal social services functions of a Health and Social Services Board or HSS trust;

(b) a person engaged in the provision of personal care for any person;

(c) a person who manages, or is employed in, an undertaking which consists of or includes supplying, or providing services for the purpose of supplying, persons to provide personal care;

(d) a person engaged in the provision of services which are similar to services which may or must be provided by Health and Social Services Boards or HSS trusts in the exercise of their personal social services functions;

(e) a person employed in connection with the discharge of functions of the Department under Article 149 of the Children (Northern Ireland) Order 1995 (NI 2) (inspection of children's homes etc.);

(f) a person participating in a course approved by the Council under section 10 for persons wishing to become social workers.

(4) "Relevant social work" means social work which is required in connection with any health, education, probation or personal social services provided by any person.

Appendix 4**Regulation of Healthcare Professional – Implications for Northern Ireland**

Independent adjudication: It is intended to provide for an independent adjudicator who will hear fitness to practise cases of professionals within the scope of the healthcare regulatory bodies.

Lay majorities: It is proposed to amend the Health Act 1999 to permit subordinate legislation to provide for a Council of a healthcare regulatory body to have a majority of lay members.

Standard of Proof: It is proposed to ensure that healthcare regulatory bodies adopt a civil standard of proof in determining allegations of lack of fitness to practise.

Responsible Officers: The introduction of provisions that will require healthcare organisations to appoint an officer known as a “Responsible Officer. The Responsible Officer would have duties to safeguard patients by identifying and handling issues of poor performance by doctors, liaising with the General Medical Council on possible fitness to practise cases and making recommendations on the re licensing of doctors.

Council for Healthcare Regulatory Excellence (CHRE): It is proposed to amend the constitution and functions of CHRE, in particular it is proposed that the appointment of non-executive members of the Council will be made by the Privy Council with the provision that they must ensure that at least one member is appointed from each of England, Wales, Scotland and Northern Ireland and lives or works wholly or mainly in the country concerned. Currently the appointment of a Northern Ireland representative is made by DHSSPS.

Pharmacy: The Pharmaceutical profession is enjoined in the wider regulatory reform of the health professions. At the same time there are matters specific to the profession which have a unique bearing on the Northern Ireland context. In Great Britain the pharmaceutical profession is regulated by the Royal Pharmaceutical Society of Great Britain (RPSGB) while here it is by the Pharmaceutical Society of Northern Ireland (PSNI). Both bodies have both

Confidence in Care Project Documentation

regulatory and professional leadership functions. The decision has been made in Great Britain to separate these functions in favour of a General Pharmaceutical Council for regulation and a College-like body for professional leadership.

The Minister for Health Social Services and Public Safety in Northern Ireland has indicated his support for this principle and to the establishment of a General Pharmaceutical Council covering the profession throughout the UK. This would harmonise arrangements not only across the profession itself but with other health professions who are already regulated on a UK-wide basis.

Confidence in Care Project Documentation

Appendix 5

GROUP 1: MEDICAL EDUCATION AND REVALIDATION: A DISCUSSION PAPER

The White Paper, Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century (February 2007) set out the following recommendations:

- Medical revalidation will have two components: relicensure and specialist recertification. All doctors wishing to practise in the UK will require a licence.
- The Department of Health England will consult with the GMC, the profession, the medical royal colleges, patient groups, NCAS and the Devolved Administrations, and develop proposals to commission and pilot appropriate national tools for multi-source (360 degree) feedback to support this process.
- The Department will discuss with stakeholders the most effective means for the introduction of an appraisal process with summative components. The quality of the process will be regularly assured by the GMC. The appraisal arrangements will need to take account of the large number of doctors who work outside the NHS/HSC as well as in the NHS/ HSC.
- There are some non-medical professional staff, such as clinical scientists, who undertake higher specialist training and practise for most of their careers at a specialist's autonomous level. DH will work with the Devolved Administrations to establish a short term working party to consider how regulation and revalidation should reflect this.
- The Government agrees with the proposal for a three-board model covering undergraduate education, postgraduate education and continuing professional development.

Confidence in Care Project Documentation

The working group established to address this area will be asked to consider these proposals and to make recommendations on the timely, effective and affordable introduction of a revalidation system comprising relicensure and re-certification of doctors. The group will also be asked to consider the impact of the introduction of such a system on medical education, training and continuing professional development.

GROUP 2: NON-MEDICAL REVALIDATION: A DISCUSSION PAPER

The White Paper – Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century - set out proposals to ensure that all the statutorily regulated health professionals have in place arrangements for the revalidation of their professional registration through which they can periodically demonstrate their continued fitness to practise.

The White Paper endorsed the recommendations of the Foster Review that the regulatory body for each non-medical profession should develop the standards that the registrant will need to meet periodically to maintain their registration. It is noted that it will be important that those standards and arrangements for assessment are proportionate to the risk that each profession may pose to the public.

The working group addressing this area will be asked to consider and make recommendation on:

- A clear definition of revalidation across medical and non-medical working groups to ensure commonality of understanding and language;
- The scope, structure and processes for revalidation for all statutorily regulated non-medical health professionals, paying particular attention to how these interact with existing clinical governance/risk systems;
- What revalidation will mean in terms of post-registration (advanced or higher level practice);
- A process for establishing common standards across the regulators and clarifying where this is not appropriate;

Confidence in Care Project Documentation

- The use of information systems to collect data that might be used for appraisal and revalidation, and how to overcome problems around confidentiality and data protection issues;
- Effective appraisal processes (both formative and summative) and clarifying the role of the Knowledge and Skills Framework in revalidation;
- Revalidation and appraisal processes for health professionals working in non-NHS/HSC sectors, e.g. research, teaching and private sector health providers;
- Models for Continuing Professional Development and demonstrating how they fit in with formative and summative processes for appraisal;
- Models for piloting recommendations made by the group and early discussion of evaluation in order to get robust baseline data prior to piloting any new systems;
- The consequences of failed revalidation in terms of systems and support and how this would work with fitness to practise procedures;
- The timetable for the introduction of new processes within the five-year window.

It is proposed that, by the end of 2008, this group, working jointly with the medical revalidation working group, will develop:

- Generic standards to support summative appraisal;

Confidence in Care Project Documentation

- Standards for specialist/advanced practice;
- Methods of testing against the agreed standards;
- Pilot studies to inform development of a system of revalidation (reflecting differing standards of risk);
- An effective appraisal and revalidation system for all non-medical health professionals, which meets the requirements and standards set out in the White Paper, is acceptable to stakeholders, ad practical and affordable to the NHS/HSC and others;
- A remediation strategy for those not meeting the relevant standards; and
- Guidance on the role of the employer and individual in the revalidation process.

GROUP 3: TACKLING CONCERNS LOCALLY: A DISCUSSION PAPER

A series of high-profile cases in the late 1990s drew attention to the need for better systems to identify and address concerns about individual professional conduct and competence. Subsequently, the Donaldson and Foster Reviews highlighted the need for clarity about the respective responsibilities of local employers, local commissioners and regulators and for close co-operation between them.

The key proposals for addressing this area, as set out in the White Paper are:

- Better signposting of the means for lodging complaints and concerns and better handling in healthcare organisations;
- Improving skills and capacity to investigate complaints and concerns, including guidance on the thresholds at which issues should be referred on to the professional regulator
- The better use of quality indicators to help identify potential poor performance, including (for GPs) “practice profiling” and the use of information from death certification;
- The development of guidance on managing and where appropriate sharing information held by individual employers or PCTs
- The development of GMC register as a central authoritative source of information on doctors, including disciplinary action by employers and alert notices, and the potential equivalent arrangements for other professions;

Confidence in Care Project Documentation

- A review of the Performers List arrangements in England; and
- The introduction of a network of “GMC Affiliates” linked to “responsible officers” in individual healthcare organisations, to improve the liaison between local management and the national GMC.

The group established to address this area will be asked to consider:

- Potential development and piloting of a UK network of GMC Affiliates initially at a regional level in England and subsequently at a national level in Scotland, Wales and N Ireland;
- To consider the development of the “Responsible Officer” concept and establish more explicit competencies and accountability for the role of medical directors in England;
- To inform the review of the Performers List in England;
- To inform the review and development of systems for collecting and using information on health professionals for complaints, investigations and disciplinary measures;
- To review and up-date current guidance on clinical governance;
- To inform the development of improved arrangements for death certification;
- To ensure equality and diversity issues are fully considered in all work streams; and

Confidence in Care Project Documentation

- To ensure that recommendations are sensitive to the relevant differences in the healthcare systems of England, Scotland, Wales and Northern Ireland.
- This group will be required to liaise with other working groups.

GROUP 4: TACKLING CONCERNS NATIONALLY: A DISCUSSION PAPER

The Donaldson and Foster Reviews highlighted the need to develop greater confidence in the way professional bodies deal with concerns about individual professional conduct or competence. The way in which professions and their regulators respond is often subject to scrutiny from patients, the public in general, and the media. Confidence in the handling of fitness to practise cases is therefore fundamental to sustaining confidence in the system of professional regulation as a whole.

To address this, the White Paper recommended:

- The civil standard of proof, with its sliding scale, should be the common standard of proof for all the regulatory bodies in fitness to practise proceedings;
- Consideration of whether a common memorandum of understanding between the healthcare professional regulators and the Healthcare Commission and ombudsmen would be desirable and whether this should apply across the UK;
- For doctors, the separation of investigation and presentation of cases from adjudication by establishing an independent body to adjudicate on fitness to practise cases involving the medical profession;
- For all other regulators, the new independent body should establish a central list of vetted and approved potential panellists for all adjudication panels, chosen by the Appointments Commission for regulatory bodies to draw on in order to conduct independent adjudication panels within their own organisations;

Confidence in Care Project Documentation

- The development by the Council for Healthcare Regulatory Excellence (CHRE) of a single standard definition of good character;
- The medical register should be the key national list of doctors entitled to practise in the UK; and
- The Register should be further developed to become the single authoritative source of information on doctors, including disciplinary action by employers and alert notices.

It is proposed that the group established to address this will be required to:

- Oversee the creation of the new Independent Adjudication Body, to adjudicate fitness to practise cases referred to it and to maintain a central list of trained panellists for all fitness to practise cases;
- Develop advice and options on achieving harmonisation of Fitness to Practise systems, including reviewing of closed cases at investigation stage and decisions not to proceed to adjudication; this will include a locus on the CHRE project for a single definition on good character;
- Develop advice and options on what information might be best to record on a regulator's register and the tiers of disclosure appropriate for employers and the public;
- Review the existing Memoranda of Understanding between regulators and other organisations with a view to effective protection of the public; and

Confidence in Care Project Documentation

- Ensure equity and diversity issues are fully considered in all work streams.

GROUP 5: HEALTH FOR HEALTH PROFESSIONALS: A DISCUSSION PAPER

The increasing complexity of modern clinical practice has placed greater pressure on health professionals. In recognition of this, there needs to be a greater emphasis on remediation, rehabilitation and support for those health professionals who struggle to cope.

The group established to address this will be required to:

- Inform the development of an integrated national health strategy covering all health professionals;
- Oversee the development of a service specification of a pilot service for practitioners with mental health or addiction problems;
- Ensure recommendations from the BMA's "Doctors for Doctors" pilot are considered;
- Ensure the recommendations from the forthcoming report "Mental Health and Illness in Doctors" by Louis Appleby are considered as part of the work programme;
- Ensure this work interfaces with the fitness to practise procedure work stream; and
- Ensure work on relevant policy areas is reflected in the overall strategy.

Confidence in Care Project Documentation

The work of this group will reflect all professional working contexts, including the independent sector, students and trainees and will support a risk-based approach that seeks to provide support and rehabilitation where possible and appropriate.

GROUP 6: EXTENDING PROFESSIONAL REGULATION: A DISCUSSION PAPER

Although a large number of professionals are already regulated it is important that the scope of statutory regulation is kept under review. Some existing professionals who are not statutorily regulated have been in practice with patients for many years, carrying at least the same potential risk to people who use their services as that of the professions currently regulated.

The group established to take this forward will be required to:

Develop criteria against which all roles in the UK will be judged to determine which should be regulated. The criteria should take account of:

- The wide variety of existing and emerging professions that are either seeking statutory regulation or, on the basis of risk, may require regulation;
- The work carried out by the National Governance Group that now oversees the development of new roles in England and any similar groups in the Devolved Administrations;
- Existing evidence supporting the demand for emerging roles within the health services across the UK;
- The available options of stand-alone statutory regulation; post-registration specialists qualifications recorded on the register that are to agreed common standards regardless of original primary qualifications; no statutory regulation, but with the option for voluntary registration.

Confidence in Care Project Documentation

The group will also be required to make recommendations, based on these criteria, on which groups should be considered for statutory regulation.

GROUP 7: ENHANCING CONFIDENCE IN PROFESSIONAL REGULATION: A DISCUSSION PAPER

Patients, the public and health professions need to be able to take it for granted that the Councils overseeing the administration of the policies and procedures of the regulatory bodies carry out their functions without due regard to any one particular interest, pressure or influence. Doubts based on perceived partiality have threatened to undermine this trust in a number of the regulators over the years.

To regain confidence, all stakeholders need to be assured of the independence of Councils. To achieve this it is recommended that professionals do not form a majority in the membership of the Councils, and that all members, both lay and professional, are appointed rather than elected.

The White Paper set out a number of recommendations to achieve these aims:

- The reconstitution of councils with parity of membership as a minimum;
- For the regulators that adopt parity rather than lay majorities, the putting in place of alternative packages of measures to demonstrate their impartiality;
- The appointment of all members of all Councils independently by the Appointments Commission against clearly specified criteria and competencies; and
- Councils moving to a more consistent and smaller size that enables them to function more effectively as Boards for their organisations, with a

Confidence in Care Project Documentation

statutory duty to ensure that the interests of all its stakeholders are considered in its deliberations.

The group established to take this forward will be required to make recommendations on:

- The strategic role of councils;
- Measures to demonstrate to the public, patients and parliament the councils' commitment to conducting their responsibilities in a manner that commands public confidence;
- How to ensure that the interests of all stakeholders are considered in council deliberations;
- The size and composition of the councils;
- The role of the council committees;
- Job and person specifications for council members; and
- Ensuring equity and diversity issues are fully considered in all work stream

From: Dawson, Andrew
Sent: 28 June 2022 15:21
To: 'Jane Kennedy' [Personal Information redacted by the USI]
Subject: RE: Schedule 50 of S21 Notice - Urology Inquiry - Response due 6 June

Hi Jane

Many thanks for the reply. [Irrelevant Information Redacted by the USI]

Thanks also for the information below – much appreciated.

Many thanks.

Andrew

From: Jane Kennedy [Personal Information redacted by the USI]
Sent: 28 June 2022 15:18
To: Dawson, Andrew [Personal Information redacted by the USI]
Subject: RE: Schedule 50 of S21 Notice - Urology Inquiry - Response due 6 June

Caution – This email has been received from outside the NICS network.
Please ensure you can verify the sender's name and email address.
Treat all attachments and links with caution.
FOR INTERNAL NICS STAFF ONLY - If you have any concerns regarding the email
please forward to [Irrelevant Information Redacted by the USI]

Hi Andrew

I'm good thanks, [Irrelevant Information Redacted by the USI]

See a few points below in red, hope these are helpful. If you're in contact with Paddy he may have more information.

Best Wishes

Jane

From: Dawson, Andrew [Personal Information redacted by the USI]
Sent: 27 June 2022 13:43
To: Jane Kennedy [Personal Information redacted by the USI]
Subject: RE: Schedule 50 of S21 Notice - Urology Inquiry - Response due 6 June

Hi Jane

Hope all's well with you.

I have included the amendments in the draft statement.

I was just wondering on two points which I would like to cover in the statement if possible:

- do you recall if there were any major concerns with MHPS highlighted in the review, or was this a tidying-up exercise?- I think there were two reasons- the GB version had been updated and ours had not. Also medical directors were feeding back that the process was 'clunky' and took too long as it allowed legal representation for doctors at an early stage of the process which caused significant delays in addressing the concern.

- do you recall why the revised MHPS was not taken forward as a result of the review? I think it was a capacity issue in DoH and the system- the new version would have required extensive negotiation with the BMA and we were already working with them to agree updated appraisal documentation to support the implementation of revalidation which was more urgent. It also would have required input from the Medical Directors and HR teams in Trusts – they were also working on preparedness for revalidation beginning

Very grateful for any assistance.

Many thanks.

A

From: Jane Kennedy [Personal Information redacted by the USI]
Sent: 16 June 2022 09:08
To: Dawson, Andrew [Personal Information redacted by the USI]
Subject: RE: Schedule 50 of S21 Notice - Urology Inquiry - Response due 6 June

Caution – This email has been received from outside the NICS network.
Please ensure you can verify the sender's name and email address.
Treat all attachments and links with caution.

FOR INTERNAL NICS STAFF ONLY - If you have any concerns regarding the email please forward to [Irrelevant Information Redacted by the USI].

Hi Andrew

A few suggested changes below, hope these are helpful.

Jane

From: Dawson, Andrew [Personal Information redacted by the USI]
Sent: 15 June 2022 20:57
To: Jane Kennedy [Personal Information redacted by the USI]
Subject: RE: Schedule 50 of S21 Notice - Urology Inquiry - Response due 6 June

Hi Jane

I have cobbled the below text together. Very grateful for your views or any amendments which I will be happy to make.

Many thanks.

Andrew

[To be new paragraph 16]

I will digress slightly at this point to advise that Jane Lindsay is now known by her married name of Jane Kennedy. Ms Kennedy has requested that this statement includes the detail that she is currently the National Head of the General Medical Council- Northern Ireland ~~Head of the Northern Ireland office of the General Medical Council~~. As at October 2010, Ms Kennedy was on secondment to the Department from the South Eastern Health and Social Care Trust, **to the Confidence in Care Programme** [can we include details of function?]. This secondment lasted from **2009** [year] to 2014.

Roberts, Naomi

From: Lindsay, Jane
Sent: 12 April 2011 16:16
To: Colville, Victoria
Subject: RE: Maintaining High Professional Standards

Hi Victoria

No update as yet, I am finalising our Workplan for 2011-12 and am estimating we commence work on this in June this year.

Best Wishes

Jane

From: Colville, Victoria
Sent: 12 April 2011 16:15
To: Lindsay, Jane
Subject: FW: Maintaining High Professional Standards

Hi Jane

Can you please provide me with an up-date on the progress with MHPS?

Thanks

Vic

From: Colville, Victoria
Sent: 21 October 2010 11:04
To: Lindsay, Jane
Subject: RE: Maintaining High Professional Standards

Hi Jane

Thanks very much for this - it is helpful. I may have to contact you for an up-date before our next BMA Joint Forum meeting on 1 December if that's OK.

Best Wishes

Victoria

From: Lindsay, Jane
Sent: 21 October 2010 08:06
To: Colville, Victoria
Cc: Hutchison, Ruth; Cairns, Joyce; Woods, Paddy; Taylor, Diane
Subject: RE: Maintaining High Professional Standards

Victoria

We discussed this yesterday and agreed that, as the revision of this document has been in our Confidence in Care Programme plan, that it would be best that we proceed as planned in order to maintain consistency and avoid confusion among our stakeholders.

We will be progressing this work in January with the intention of gathering feedback on the current document more widely, developing a draft revision and consulting with our workstream members, as I mentioned in my previous email, this includes the BMA and HR and Medical Directors, as well as internal HR colleagues.

I hope this is helpful, I am more than happy to keep you updated on progress and please contact me if you have any other queries.

Best Wishes

Jane

Jane Lindsay
Project Manager-Confidence in Care
Annexe 2 Castle Buildings
Stormont Estate
Belfast BT4 3SQ

Personal Information redacted by the USI Mobile Personal Information redacted by the USI

From: Colville, Victoria
Sent: 19 October 2010 10:12
To: Lindsay, Jane
Cc: Best, David
Subject: RE: Maintaining High Professional Standards

Thanks for this Lindsay - its really helpful. Im wondering if the BMA are already involved in the current workstream would any additional work done on their behalf by us be a duplication of efforts? If there is to be a comprehensive range of comments collated by yourselves then it'll likely be fed back to BMA anyway.

You can let me know what Paddy and Joyce think anyway.

Thanks again

Victoria

From: Lindsay, Jane
Sent: 19 October 2010 09:32
To: Colville, Victoria
Cc: Woods, Paddy; Hutchison, Ruth; Cairns, Joyce; Taylor, Diane
Subject: RE: Maintaining High Professional Standards

Victoria

Within the Confidence in Care Programme we have begun looking at MHPS with a view to a revised document that will reflect the changes to medical regulation, namely the role of the Responsible Officer and the implementation of a system of Revalidation.

As part of this work, we have asked the relevant workstream (which includes membership from the BMA and Medical and Human Resources Directors) to provide us with comments and issues in relation to the current document and currently have quite a comprehensive range of comments on the document.

I am meeting with Paddy and Joyce tomorrow and will discuss your request and get back to you shortly.

Best Wishes

Jane

From: Colville, Victoria
Sent: 19 October 2010 09:22
To: Woods, Paddy; Lindsay, Jane
Subject: Maintaining High Professional Standards

Paddy/Jane

At the last BMA Joint Forum Meeting the BMA requested that we put a paper together highlighting any issues that employers have with MHPS and how it is operated. Diane Taylor agreed that I take this forward. She recommended I speak with you both.

Can you advise if there are any documented issues I can use - as well as contacting employers ourselves to ask for their comments? Are there any particular contacts within Trusts you would recommend I can go to?

I appreciate your help

Victoria

*Victoria Colville
DHSSPS Pay & Employment Unit
Room D1
Castle Buildings*

Personal information redacted by the
USI

Maintaining High Professional Standards
in the 21st Century Health and Social Care
Organisations

Formatted: Superscript

*A framework for managing concerns about
doctors and dentists in the HSC.*

Department of Health, Social Services & Public Safety

July 2011