Pay and Terms and Conditions of Service for Non-Consultant Career Grade Doctors and Doctors Working in Community Hospitals
Pay and Terms and Conditions of Service for Non-Consultant Career Grade Doctors and Doctors Working in Community Hospitals

Introduction

1. As requested by the Secretary of State for Health we have taken forward work to determine the needs of NHS employers in respect of a review of the pay and terms and conditions for doctors in non-consultant career grades, principally Staff Grade doctors and Associate specialists. We were also asked to consider the appropriateness of the current pay and contractual arrangements for clinical assistants and hospital practitioners and doctors working in community hospitals.

2. A range of different issues have emerged. For this reason we submit our findings as three separate papers on each of these topics.

   (i) Paper 1. Staff Grades and Associate Specialists
   (ii) Paper 2. Clinical Assistants and Hospital Practitioners
   (iii) Paper 3. Medical Staffing in Community Hospitals

Progress

3. We have informally engaged with the BMA’s Staff and Associate Specialists Committee (SASC) to discuss their objectives, the process for taking work forwards and to determine what scope there is for reaching a negotiated settlement about pay reform for staff grades and associate specialists with the BMA. The underlying principle of public sector pay reform is ‘investment in return for modernisation’ and we have engaged in discussions with SASC on this basis. We have not had separate formal discussions with the General Practices Committee of the BMA.

4. There are implications for some dentists from reform of the non-consultant career grades, although reform of the salaried community dental services is being taken forward separately. For these purposes we understand that the BMA, rather than the BDA will represent this group of staff.

Engagement with NHS employers

5. We have also sounded out the views of NHS employers about their needs in respect of any new contractual arrangements for non-consultant career grades. This was achieved through a limited programme of structured interviews followed by the targeted circulation of a questionnaire about options for reform to validate our initial findings. Through a stakeholder workshop we also brought together a
range of stakeholders from the NHS and we have developed a network of key NHS representatives who are interested in and well informed on these issues. Our recommendations are based on these sources of information.

The UK Dimension

6. Our remit was restricted to England, but there is a UK wide dimension to this work and we have engaged with colleagues from the Health Departments in Northern Ireland, Scotland and Wales. Our understanding is that colleagues in the other Health Departments are broadly content with the approach that we have taken so far, but that decisions about how any further work is taken forward in devolved administrations will rest with the Ministers concerned. We believe that they share our view that a UK wide framework for pay reform would be the preferred option.

General Practitioner Qualified Doctors Working in Hospitals

7. We initially considered clinical assistants and hospital practitioners who are also working in primary care and GPs who are providing a primary care service in a secondary care setting and GPs working in community hospitals alongside doctors in the SAS grades and the structured interview questionnaire was designed to sound out interviewees about issues relating to their pay and terms and conditions of service. We find that the issues in respect of this group are divergent from issues around the contractual arrangements for staff grades and associate specialists (or clinical assistants and hospital practitioners who are essentially doing similar work to staff grades and associate specialists). For this reason we have recommended a different process for taking this work forward.

Next steps

8. If Ministers wish the NHS Confederation, through NHS Employers, to take these issues forward it will be necessary to give us a mandate. Central to this will be clarity over the funding envelope, policy imperatives, implementation programme and timescale.

9. We are particularly anxious that there is clarity over funding. NHS organisations will be looking to us to ensure that any proposals which are agreed will be containable within the available funding envelope. There is an additional issue in that the distribution of doctors in this group is not even throughout the NHS and therefore care has to be taken to ensure that the allocation of funding is sensitive to the level of variation. This applies both to any national settlement for SAS group staff but also if solutions to staffing community hospitals are to be found through local commissioning.
10. We believe it is imperative that this work is carried out to a realistic and coherent timetable that allows sufficient time for all parts of the process including implementation. Experience has shown that simply setting a required end date can lead to the final stages being rushed and for the period for employers’ preparation and implementation to be squeezed. We would seek the commitment of the BMA to a jointly owned timetable which acknowledges the requirements and interrelations of the whole process.

Recommendations

11. For staff grade and associate specialist doctors we believe that there is a clear case for taking forward negotiated contractual reform and we have set out options for Ministers to consider, which would necessitate increased investment.

12. In terms of both the current arrangements for the employment of General Practitioners either working as clinical assistants and hospital practitioners providing a primary care service or working in community hospitals we feel that the current contracting arrangements are deficient and that change is needed. We do not feel that investing further in the existing arrangements such as ‘bed fund payments’ is justified, or that taking forward reform on a national basis is a viable option. We recommend that reform is taken forward on a local basis and we have identified a range of alternative contractual arrangements that are already available to NHS employers. Whilst it may not be possible to cost local solutions they will require resources.

13. If Ministers wish NHS Employers to proceed, a clear mandate is now agreed to cover the UK dimension, funding envelope, policy imperatives, implementation and timescale arrangements.
Paper 1. Staff Grades and Associate Specialists

Introduction

1. This paper describes the findings and recommendations of the NHS Confederation’s scoping work about arrangements for the employment of the staff grade and associate specialists (SAS) group of doctors. In addition to staff grades and associate specialists, we are also referring to a number of closed medical grades that are employed on a similar basis to staff grades and associate specialists. However, it is our assumption that any doctors remaining in those grades will have the opportunity to regrade into SAS grade(s) or the reformed structure that may replace them. We also suggest that those doctors currently employed on Clinical Assistant and Hospital Practitioner grades, who are not general practitioners working sessional commitments, should be assimilated into this structure. (See also paper 2).

Findings and Recommendations

Strategic Pay Considerations

2. Our first consideration must be the function of staff in these grades. What roles are trusts looking to be carried out by doctors who are not trained to consultant level but who have the skills and experience to practise outwith a training grade? This function must be matched by the skills offered by doctors employed in the grades and appropriately rewarded. Trust employment of SASC grade doctors varies from an average of 9% of the medical and dental workforce in teaching trusts to an average of 24% in mental health trusts with a mean of 16% across all Trusts in England.¹

3. All NHS employers recognised the value of the contribution to service delivery made by this group of doctors. As a group they are considered to be very productive. However the range of their skills and responsibilities varied widely and the regrading and PRP processes were seen as inconsistent. Some doctors are working at the level of quite junior doctors in training with limited responsibilities and practice; others have similar levels of clinical practice to consultants and are delivering high volumes of clinical care. The current contract provides no assistance with changing established working patterns for individuals or with incentivising out of hours working. Some employers saw these issues as a problem.

¹ Broad definitions of Trust type have been used for this categorisation.
Entry to the Grade

4. Our work has been carried out in parallel with the development of the policy ‘Modernising Medical Careers’. That work will determine whether all doctors emerging from the foundation programme will be required to undertake further training before entering a career grade post. For the purposes of this paper we have assumed that this will be the case and that future entrants to the structure we describe below will be either:

- As experienced as current entrants to the staff grade; or
- That their experience will be defined in an alternative manner, perhaps in terms of educational programme, or part thereof, which has been successfully completed.

5. This parameter will require further discussion with education policy leaders in the Health Departments and with other stakeholders. However, the assessment below does not assume assimilation of trust doctors into the framework described.

The Range of Pay

6. The pay for SAS doctors currently ranges from £29,845 to £72,882 including discretionary points and there is considerable flexibility about setting starting salary, particularly in the staff grade. At the lower end this pay range is pitched above starting pay for Specialist Registrars and at the higher end it has now eclipsed the pre-2003 consultant basic pay scale. There remains a significant overlap with the post-2003 consultant pay scale. However, scale rates are only part of the equation and basic pay plus the range of payments and allowances in each contract need to be considered when comparing remuneration packages.

7. Based on the evidence we have received from NHS, we see no argument for increasing the overall pay range at the upper end. At the lower end, the rate of pay at the minimum of the scale is commensurate with the mid SHO/commencement of the SpR scale. We have also found that there is a significant group of SAS doctors operating at a level of clinical practice comparable to that of SHO grade doctors and although we consider that this is not the level at which it was assumed doctors in the grade would operate when the pay scale was originally determined, the pay scale is not inappropriate with this level of practice. For these reasons we believe that the pay range should not be altered significantly. Any significant alteration to the current scale would displace the current strategic fit of SAS grade pay between the rates of pay for doctors in training and consultants.
8. Rather we would wish to focus attention on assimilation within the pay ranges and the structure of the contract; these issues are discussed below.

9. We have received no dissent form NHS employers that the assumption of a two-tier structure, as recommended in 'Choice and Opportunity' and supported by SASC, is adopted.

10. There is currently an apparent discrepancy between the pay of some doctors in training and some SAS doctors when banding supplements are applied to the SHO and SpR salaries. However, this discrepancy seems less significant when hourly rates of pay are considered and the additional hours that doctors in training may be required to work is taken into account. This is demonstrated in the table attached at Annex A. However, this presupposes that staff grade doctors are paid for sessions contracted, as intended by their current contract. There is anecdotal evidence that his might not be universally the case.

Recruitment and Retention

11. We have not found that there are any general national recruitment and retention issues that are specific to SAS doctors. Furthermore, NHS employers already have considerable flexibility in setting starting salaries for staff grades, which can be used to facilitate recruitment by location or specialty group. It is difficult to see how further pay flexibilities would better address localised recruitment and retention problems without adding significantly to costs. In terms of associate specialist doctors any recruitment and retention problems are largely artificial because the existing personal regrading system means that posts are rarely advertised and vacant AS posts are normally filled by personal regrading.

The Pay Structure

12. Rather than continue with two separate salary scales we suggest assimilating the two existing scales into a pay spine covering the range outlined above with a break point at approximately £45,000. Progression beyond the break point would depend on the evaluation of role/competence and responsibility. As now, we would anticipate that discretionary points would be available for the lower tier beyond that point (see para. 26 below). As a working title only, and to avoid pre-empting discussions, we have called these Level 1 and level 2.

Structure of the Contract

13. We recommend that a new, more robust contractual mechanism should be introduced. Our view is that this should be developed along the lines of the new consultant contract with a separate model contract and terms and conditions in the form of schedules explicitly incorporated
into the model contract. We believe that much of the material can be adapted.

14. We would intend to strengthen the annual job plan review mechanism that would enable employers to review working patterns across clinical teams, thus supporting the most appropriate deployment of resources and design of services.

Introducing a Normal 40 Hours Working Week for Associate Specialists

15. Our findings suggest that the majority of NHS employers would find it helpful, from an administrative point of view, to assimilate associate specialists onto a full time contract of 40 hours per week, in line with other employed medical and dental staff. Rather than the current ‘notional half day’ of 3.5 hours, we suggest that a new contract structured around ten Programmed Activities of nominally 4 hours each should be explored for all staff and associate specialist doctors. This would be subject to appropriate consideration for doctors working less than full time who choose not to increase their time commitment.

16. We anticipate that this would increase the overall NHS pay bill for the AS grade by 3.9% or 1.3% of pay for the SASC group. It is likely that such a reform would more appropriately remunerate associate specialists for the hours of work that they actually undertake, and would facilitate administration by using a ‘common currency’ for all employed medical and dental staff. Although 1.3% of the NHS pay bill for SAS doctors is relatively modest, it should be noted that costs would not be incurred evenly across NHS organisations and the usual method of allocating funds through PCT budgets could result in greater costs being incurred in some organisations than in others.

17. Linked to this we suggest that additional hours worked by AS doctors, up to the EWTD limit of 48 should also be rewarded. There is already provision for staff grade doctors to work more than 40 hours and we anticipate that this would transfer to the new structure. However, we believe that Ministers should also be aware that there are risks of costs escalating if a more work-sensitive contract were introduced. Some associate specialists are working well in excess of 40 hours and it is likely that their employers would need to meet the costs of that additional activity in order to maintain current service levels and so funding is an issue. Nevertheless, a stronger focus on job planning would ensure that activities could be better planned and an annual review mechanism would facilitate addressing heavy workloads over the longer-term.

Regrading and assimilation

18. Employers believe that progression should be linked to the acquisition of competence rather than simply time served. The current system whereby staff grades become associate specialists through what is
essentially a time based personal regrading system also militates against rapid career progression for doctors entering the grade. Currently a doctor is eligible to be considered for regrading only after acquiring a certain number of years experience. This system prevents doctors with high potential being appointed directly, or progressing more quickly, to the second level with increased responsibilities where both the clinical role and pay are more attractive.

19. We believe that in a fairer system eligibility would be described in terms of the skills and competencies needed to work at the higher level and more appointments would be made via open competition. Such a system would require a clearer definition of the different staff grades and associate specialist job roles. Adopting this approach would not prevent regrading where job roles developed over time to meet employers’ requirements. The range of practice at each level needs to be more explicitly described to enable job evaluation as well as assessment of an individual's skills. This means that a job evaluation framework would have to be the basis of setting the parameters for two levels of practice. A generic indication of these levels is included at annex B.

20. The costs of assimilating current staff and associate specialists would need to be carefully managed to avoid excessive immediate cost pressures. Introduction of a competence-based system is discussed at para 28 below.

Out of Hours Working

21. We understand that another key issue for SAS doctors is the flat rate of pay for out of hours working. NHS employers have indicated that the ability to further incentivise doctors to work out of hours would facilitate service modernisation and we believe that any new out of hours arrangements would be welcomed by both doctors and employers, provided that they were appropriately funded. As employers are increasingly moving towards the introduction of shift-working, we suggest that the time actually spent working out of hours should be incentivised and not time spent on-call.

22. We believe that better job planning should reduce total hours of work, to maintain compliance with the European Working Time Directive. However, we are aware of the risks of significantly high costs arising from out of hours work. In addition this group of doctors cover a wide variety of working patterns and suggest that further work is done to establish whether a supplement or differential rate would be more appropriate.

Productivity and Direct Clinical Care

23. We find that the majority of employers believe that SAS doctors, particularly staff grades, are very productive and many spend almost all
of their time in direct clinical care. In some cases the amount of time spent in direct clinical care may be an impediment to personal development. Rather than advocating systems to increase the productivity of this group of staff, we believe that it may be more appropriate to ensure that time is available for development activities. This will be particularly important if pay is to be linked to the acquisition of skills and knowledge.

Training and Development

24. Employers have indicated that it is essential for the maximum development of their potential that staff should have proper access to training and development. We know this is also important to SASC and would expect employers to want to make this investment.

25. If this group of doctors were to be given time in their job plan (e.g. one Programmed Activity every fortnight for developmental activities - which might be training, audit or management activity) there would be an impact on service delivery in some organisations. This is difficult to cost accurately as some organisations already have local arrangements in place providing time for development activities. If 50% of SAS doctors performed one fewer Programmed Activity per fortnight the cost to the NHS pay bill, to maintain the same service levels would be an increase in costs of around 2.5%. We would need to do more detailed work with a sample of employers to refine the likely costs.

26. We would not seek to extend the current recommended standards for professional and study leave, which are common to all senior doctors. Decisions about the approval and funding of study leave are a matter for employers and not for national decision.

Performance Related Pay

27. Employers are generally of the view that no additional pay mechanisms for rewarding performance are necessary. Employers are already required to have optional points and discretionary points schemes in place and, although there are marked differences from one organisation to another, there are some examples of good practice. There may be a need to reward quantity of work as well as quality and some employers felt the current balance was not right. We suggest that the criteria for meeting the award of discretionary points at each level are reviewed and distilled to a single set of criteria applicable for the pay spine. We may also need to consider the implications of any development of fee for service policy.

Implementing Competence-Based Pay

28. Employers are clearly supportive of the introduction of pay relative to competence. The key long-term benefit of introducing this will be to
encourage more targeted selection of staff and ensure that work is allocated to the most appropriately qualified member of staff. In other words, such a system would encourage NHS employers to think about the skills that they need and then recruit the worker most appropriately qualified to undertake the task. A clear link between level of pay and competencies will support the development of services.

29. We are quite clear that if a pay system linked to competence is to be manageable there are a number of principles that need to be applied:

i) The system must be simple and the links to pay should relate to levels of practice;

ii) Pay must be linked to the competencies required to perform a doctor’s duties and to the responsibilities of the post;

iii) There must be a system for recognising and documenting competencies as they are developed;

iv) Doctors must be supported in developing new competencies, but investment in development must be in line with the needs of the employing organisation; and

v) Personal regrading should be retained, but appointment by open competition should become the norm.

30. However, three concerns raised by the Staff and Associate Specialists Committee of the BMA (SASC) require further discussion. They are looking for a system where:

- Pay is linked solely to an individual’s abilities, rather than the duties and responsibilities of their job;

- Employers are required to fund individual doctors who wish to develop new skills and competencies of their own choice, irrespective of whether or not these meet the needs of the employing organisation; and

- Whenever an individual gains the necessary competencies they should automatically be appointed to a post in the next tier, irrespective of whether work of the higher level is required by the employer or not.

31. After careful consideration we think that these objectives are unrealistic and unjustifiable from the point of view both of provision and development of services as well as the affordability of the pay system. Negotiations will need to balance SASC aspirations with focusing resources on patient care priorities and the requirement of a publicly funded service to deliver better value in return for increased investment.
Taking Forward Reform

32. Based on the possibilities outlined above, we have considered three options for taking forward further work:

- **Option 1. Do nothing.**
  
  We do not believe that this is tenable given that Ministers have accepted the recommendation set out in ‘Choice and Opportunity’ to develop new pay and terms and conditions of service for reformed SAS grades. The Doctors and Dentists Review Body has also made it clear that reform is overdue and this is supported by feedback from NHS organisations, which believe that the pay reform is justified.

- **Option 2. Implement contract reform without investment.**
  
  This would involve negotiating with the BMA to implement the contractual changes implied by ‘Choice and Opportunity’ on a cost-neutral basis.
  
  The key reforms that we would have to implement in order to meet that commitment include changing the criteria for movement between the grades from time-served to competence based, making appraisal contractual and changing the name of the grade. Employers could impose a name change but changing the criteria for entry to the associate specialist grade would need to be negotiated as national terms and conditions currently define the criteria in terms of time-served.
  
  We feel it is unlikely that SASC would be willing to negotiate on a cost-neutral basis. They are expecting investment in line with that made in recent pay reform for other staff groups. In addition, we could make little change with immediate practical benefits to the NHS. For example, we would not be able to assimilate the associate specialist grade into a 40-hour contract, leaving them the only group on unreformed contracts.
  
  In the light of other contract reforms currently ongoing we have received a very clear message from employers that they support investment in this group of doctors but that a new contract must be accompanied by adequate, clearly identifiable resources.

- **Option 3. Press ahead with negotiating a national scheme.**
  
  This option depends on resources being secured from within Department of Health’s funding envelope for 2006 and beyond. Ministers should be aware that there is much ground to cover
with SAS doctors if we press ahead with implementing a competence-based system and, Ministers should be aware that implementing this system would involve agreeing transitional arrangements for existing SAS doctors. The existing SAS workforce would need to be integrated into appropriate points in the new structure according to the outcome of job evaluation. We estimate that this assimilation would be of a similar order of costs to Agenda for Change (6% of pay bill). However, there would be a risk of costs increasing if initial assumptions about the average level of competence of doctors in the grade were wrong, or if there was a lack of engagement, or ability to implement reform, on the part of local NHS organisations.

The other reforms outlined above would further increase between 5% and 10% of the pay bill (depending on the level of work contracted) and we suggest that further work is done to arrive at a package that could be agreed within a total cost envelope of 10 to 12% over two years. The interactions between elements of the package could influence costs and need to be clearly understood. This would require choices by the negotiators. Employers and the BMA would need to work in partnership to find the optimum affordable package.

33. We believe that, subject to satisfactory funding, Option 3 would be feasible and that we would hope that NHS Employers and the BMA would work in partnership to agree a contract. In the short term we would satisfy DDRB that this group of doctors was being appropriately rewarded.

Service Benefits

34. The key service benefit would be improved morale and motivation from a stable group of valued staff whose primary role is recognised as the delivery of high quality services. As indicated in ‘Choice and Opportunity’, pay is not the only element in achieving this outcome but it does play an important role.

35. In the longer term we would expect to deliver benefits in terms of improved development of doctors in the grade and create a pool of doctors from which a number could, with top up training be converted to become consultants relatively quickly, thereby supporting a more flexible workforce.

Timing

36. If national level negotiations are taken forward for existing SAS doctors, it is difficult to anticipate how long such a reform may take, but based on the experience of recent pay reform, we anticipate that at least 15 months could be required to complete negotiations, but this timeframe would depend on the stance that SASC take. Subject to the agreement
of the BMA members a further 8 to 12 months would be required to complete the process of assimilation into the new structure.

37. This would apply if the job evaluation system were largely based on that introduced for Agenda for Change. As it is the only system designed specifically to take account of clinical roles, it should require minimal adaptation for this purpose. The use of the AfC system would also provide objective evidence of skills and knowledge to protect against potential equal pay challenges. However, if a specialty specific competence-based system depended on Royal College competency frameworks being completed there would be a dependency over which negotiators would have no direct control and this could take years rather than months. However, we would recommend a more generic approach and would anticipate that outline agreement could be reached by December 2005 with a view to beginning implementation from April 2006.

38. As stated in our introduction we are clear that we have to have a realistic and coherent timetable. It has to be accepted that if there is slippage in the earlier part of the timetable there may need to slippage in terms of implementation. It is not reasonable to squeeze the preparation period and create undue pressure in implementation for employers.

Conclusion

39. The NHS Confederation has completed an initial assessment of the issues that are likely to emerge if pay reform for SAS doctors is implemented. There are risks associated with any course of action that Ministers may decide on. We have presented these risks as objectively as possible in order to enable Ministers to make an informed decision about the basis on which they intend to take further work forward.
Annex A – Pay Comparisons Between Doctors in Training and SAS Doctors

A comparison has been drawn, at Diagram 1, between the hourly rate of pay for staff grades and associate specialists and doctors in training in band 1A posts. In band 1A posts doctors in training receive a 50% salary supplement in addition to basic salary and they are expected to work up to an average of 48 hours per week. In addition, to qualify for a band 1A supplement a doctor must also be working:

(i) On an on call rota of 1 in 6 including prospective cover, or more frequently;

(ii) On an on call rota of 1 in 8 including prospective cover, or who work 1 in 4 weekends, and, for half of their out of hours commitment will be expected to work after 7pm and be residential on call;

(iii) On an on call rota of 1 in 8 including prospective cover, or who work 1 in 4 weekends, and, for half of their out of hours commitment will be non-residential, but expected to actually work for 4 hours or more after 7pm; or

(iv) On shifts where one third or more of their duty hours fall outside the 7am to 7pm period, Monday to Friday, or 1 in 4 or more weekends.

Diagram 1. Comparison of hourly rates of pay between the SAS grades and the training grades at Band 1A at April 2004
Diagram 1 shows that SpRs are earning slightly more than staff grades where all the conditions for a band 1A post have been met and considerably less than associate specialists. However, the rate of pay for staff grades does not vary depending on the intensity of out of hours commitments. The hourly rate of pay for staff grades is set between the hourly rate of pay for SpRs in Band 1A and Band 1B posts – it is an aggregate value. While the comparison with Band 1A posts is unfavourable, the comparison with Band 1B posts is generally favourable. This is illustrated in Diagram 2 below:

Diagram 2. Comparison of hourly rates of pay between the SAS grades and the training grades at Band 1B at April 2004

Staff Grades working similar conditions to Band 1A posts are relatively less well paid compared with SpRs, while Staff Grades working on less intense rotas not meeting criteria are relatively better rewarded. A similar result occurs if SAS grades are matched against band 2a or 2b. Comparisons with Doctors in Band 3 posts are inappropriate because band 3 payments for non contractually compliant posts may be made for technical reasons (e.g. failure to monitor hours) unrelated to the number of hours worked.
Annex B

Outline of levels of practice
Integrated NCCG Structure

Purpose

The purpose of generic job descriptions is to indicate the levels of practice for this group of doctors. The descriptions reflect the distinction that should exist between the upper and lower tier of practice. The descriptions here require development and are intended as a starting point for further discussion about job evaluation. We do not expect these to be taken or quoted as definitive proposals. In particular, the recognition of clinical experience will be a significant factor.

Employers would be expected to use the job descriptions as a framework and to draw up more detailed, job specific criteria. This could be informed by guidelines drawn up by the Royal Colleges. However, it would need to be clear that responsibility for operating a fair and transparent system lies with the employer. Employing organisations would be expected to make public the criteria employed to make decisions about which tier jobs fell into.

Level 2 (senior posts)

Competencies

Displays a comprehensive range of general skills and knowledge specific to a chosen specialty and/or an in depth knowledge with associated clinical skills within in a narrow clinical field in a chosen specialty.

Is able to provide expert advice to other medical staff, patients and third parties about own field of clinical practice.

Has demonstrated ability to cope with clinical/medical complications and recognises when additional medical assistance is necessary.

Development needs

Will be working towards consolidating the breadth of knowledge and skills specific to his or her chosen specialty, or to develop depth of knowledge and expertise in a more focused clinical field.

Job Role

Responsible for delivering a range of specialty specific patient services within a clinical team and/or a limited range of complex patient services within a clinical field.
May have responsibilities (agreed with a consultant) to teach the theory and application of medicine and to instruct (train and educate) more junior medical staff.

May have some medical management responsibilities.

Is able to advise patients and other medical staff within the specialty-specific clinical field for which the practitioner is responsible. May be required to advise third parties from time to time.

Practises in a predominantly independent capacity within agreed boundaries and with formal accountability to a consultant.

May receive referrals directly within agreed boundaries.

**Level 1**

**Competencies**

Has completed basic medical education and displays some specialty-specific skills. Is able to demonstrate these skills in practice without the need for additional formal training.

Recognises when additional medical input is required.

**Development needs**

Working towards the development of both breadth and depth of knowledge and skills within chosen specialty.

**Job Role**

Provides clinical services within a clinical team that are specific to a chosen specialty primarily without the need for direct consultant supervision or formal training.

May be required to train or provide advice to clinical staff and students within an agreed, limited field of clinical practice.

Is accountable to a consultant or senior clinical practitioner and may practise in a largely autonomous capacity within a limited field agreed with a consultant.

Is able to advise patients on programmes of treatment, drug regimes and clinical procedures. May be required to advise other clinical staff on a range of routine clinical issues from time to time.

May receive emergency referrals in prior agreed circumstances.
Paper 2. Clinical Assistants and Hospital Practitioners

Introduction

1. This paper describes the findings and recommendations of the NHS Confederation’s scoping work about arrangements for the employment of clinical assistants and hospital practitioners in secondary care. There is a read-across to our findings both in paper 1 about staff grades and associate specialists and paper 3 in respect of medical staffing arrangements in community hospitals, as a number of GPs are employed as clinical assistants and hospital practitioners in community based organisations.

2. Clinical assistants and hospital practitioners employed in secondary care generally fall into one of three categories:
   i) doctors identified as clinical assistants or hospital practitioners without general practitioner qualifications;
   ii) doctors qualified as general practitioners employed to provide a general practitioner function in a secondary care setting; and
   iii) doctors qualified as general practitioners employed to provide an acute function, or for training and development purposes, under the supervision of a consultant;

Findings

(i) Doctors identified as clinical assistants or hospital practitioners without general practitioner qualifications

3. Clinical assistants are paid at a flat rate of pay equivalent to the lower end of the associate specialist range and doctors working in the hospital practitioner grade are paid according to a scale that is broadly comparable to the middle of the associate specialist pay range.

4. We find that, in some cases, clinical assistants working under the supervision of a consultant are undertaking a job role that may be less demanding and have fewer responsibilities than some staff grade jobs. In some settings justification for pay at a higher rate of pay than staff grades, is one of recruitment and retention rather than relative to job weight or clinical skill. That being so, we suggest that all non primary care qualified doctors in these grades are assimilated into medical specialist grades outlined in paper one. Consideration can be given to the potential requirement for recruitment and retention premia during negotiations.
(ii) Doctors qualified as general practitioners employed to provide a
general practitioner function in a secondary care setting

5. As noted above, Clinical assistants and hospital practitioners are paid
according to a scale that is broadly comparable to the lower half of the
associate specialist pay range. It is generally lower than the cost to a
GP practice of providing GP locum cover

6. Where clinical assistants and hospital practitioners are employed to
undertake a general practitioner function, within the trust, and where
they are making clinically autonomous decisions about patient care and
treatment, they are acting at a level of responsibility that exceeds the
level of responsibility normally associated with the SAS job role. In
these cases, although the clinical assistant or hospital practitioner may
be undertaking a less specialised role than the staff grade or associate
specialist, but they are being employed in order for NHS patients to
benefit from the breadth of skills and knowledge that they have
acquired in general practice.

7. Where doctors are fully qualified as general practitioners and where
they are employed in a general practitioner function, there is no
necessity for them to be clinically supervised by a consultant and the
clinical assistant/hospital practitioner pay scale may not be appropriate.
We do not suggest that they should not be accountable to a consultant
as members of a clinical team. However, the clinical assistant/hospital
practitioner pay scale is pitched at its current level on the assumption
that a consultant takes clinical responsibility for the work of the doctor.

8. This raises the question of the cost of employing GP locum cover. This
is most marked in relation to the earnings of clinical assistants. A
national survey suggested that GP locum earnings in 2004 varied from
£200 to £560\(^2\) per day. By comparison, clinical assistants earn £156.84
a day. In effect, this means that it could cost a GP considerably more
to hire a locum than he or she could earn as a clinical assistant. In
addition, PCT policy in respect of locum refunds vary from one part of
the country to another. Some GP practices may not be refunded the
costs of hiring a locum.

9. In some cases local agreements have been reached between
employers and local doctors to pay GP locum rates, but it has been
made clear to us that not all employers will be willing to retain clinical
assistant posts if costs increase significantly.

(iii) Doctors qualified as general practitioners employed to provide an
acute function, or for training and development purposes, under the
supervision of a consultant.

\(^2\) Medieconomist locum earnings survey 2004
10. When the contribution of primary care practitioners is required in a specialty other than general practice to either maintain a service in an area where there are few clinicians in that specialty, or to enhance or maintain the specialty skills of the primary care practitioner, work will be carried out under the supervision of a consultant.

General Practitioners with a Special Interest

11. Where former clinical assistant and hospital practitioners have left secondary care to work as GPs with a Special Interest there may be a need to look at a more structured GP with a Special Interest career path in some localities and we believe that clinical assistant/hospital practitioner type posts could provide important training and continuing development opportunities for general practitioners wishing to develop competencies in hospital specialties.

12. In both of these cases, the level of practice may not be synonymous with a level of remuneration required to replace lost service in primary care. For this reason, a contract for services or service level agreement, at a rate agreed between the practice and the Trust, might be more appropriate than a contract of employment. The trust would have freedom to offer a tailored role according to its clinical service needs, or, according to the value of the package of training or experience it is providing.

Recruitment and retention

13. Numbers of clinical assistants and hospital practitioners nationally are falling and our evidence suggests that in many cases employers are not intending to refill posts once they become vacant, although this is not the case in every organisation. In contrast, there are some organisations; particularly those with acute recruitment and retention problems where there is an ongoing need for a clinical assistant/hospital practitioner function. There are also variations by specialty and in some organisations employers are keen to address recruitment and retention issues in specific specialties, but not in others.

14. The mixed situation nationally suggests that a single national rate or rates for this activity is not desirable and that there will need to be different arrangements according to local circumstances.

The Service Level Agreement Model

15. Under a service-level agreement model a NHS Trust would contract with a GP practice or a group of GP practices for services. The value of the contract would be determined through local negotiation and an honorary contract would be required for individual GPs providing the service for clinical governance purposes, but the NHS Trust would not employ the doctor directly. Under this model there would be no
nationally set fee for these services, but in agreeing arrangements account should be taken of;

- The cost to GP practices or PCTs of releasing a doctor from service in general practice;

- The particular skills and knowledge that a general practitioner can bring to a job and the most appropriate function for a doctor with these skills and knowledge; and

- The need to provide training posts and CPD for General Practitioners with a Special Interest;

Impact of the New GMS Contract

16. It is too early to judge the impact of the new GMS contract accurately. However, we believe that the new arrangements may impact on the recruitment and retention of clinical assistants. In particular, the enhanced service arrangements are likely to make it preferable for some GPs with specialty specific skills to provide services in their local practice, rather than in secondary care in order to attract more funding to the practice. It should be noted that this is not necessarily undesirable, as it may reflect service redesign and improved patient access.

17. A relatively small number of clinical assistants/hospital practitioners provide out of hours cover in secondary care. It is not yet clear what impact the new GMS arrangements may have on their willingness to continue providing these services but early indications are not favourable. Where GPs opt out of providing out of hours services, GP cooperatives will not necessarily be able to provide the necessary skills to replace the function of the existing clinical assistant/hospital practitioner function which may shift pressures to acute sector. Although this is likely to vary considerably from one locality to another.

Recommendations

18. After having considered the views of NHS Employers we make the following recommendations for Ministers to consider:

- The existing clinical assistant and hospital practitioner pay scales should be closed as separate national scales;

- Before employing a doctor to undertake clinical assistant/hospital practitioner function employers should identify whether the work that needs to be done is appropriate to the skills and competencies of a doctor;
Where it is appropriate to employ a doctor Trusts should have a range of options for contracting services. These should include:

i) Employing practitioners as whole or part time doctors any new contractual arrangements that replace the current SAS grades, according to their level of competence;

ii) Employing GP qualified doctors to provide a general practitioner function as salaried GPs in accordance with the recommended national pay range.

iii) Contracting practitioners to provide specific functions through a service level agreement with a GP practice or a group of GP practices. Doctors could be contracted in this manner to provide either a general practitioner or a specialist function and the value of the contract would be determined through local negotiation; and

• There should be no automatic obligation for GP qualified doctors, employed in an organisation providing secondary care services, to work under the immediate clinical supervision of a consultant. However, they should be fully integrated into the clinical team and be accountable to other staff, as normal, for management purposes.

• The appropriate contractual model for the employment of GPs in secondary care should be determined locally with due regard given to service developments across the health community. This should include taking into account the appropriate role of nurses and allied health professionals, the need to train and continually develop the GP with a Special Interest workforce and the local strategy for the development of intermediate care.

Costs and Benefits

19. The costs of moving to the suggested model will vary greatly from one organisation or locality to another and there needs to be further work on the resource implications. On the one hand, the downward trend in numbers of clinical assistants and hospital practitioners nationally suggests that some organisations will need to increase investment in these staff where they wish to retain them. In other cases, through creativity around the design and skill mix of clinical teams, savings may be made.

20. We found evidence that some clinical assistants and hospital practitioners are currently employed in inappropriate roles, given the skills and knowledge of a doctor. We anticipate that the benefit of moving to the suggested contracting arrangements will encourage employers to think more strategically about the skills of clinical teams and to develop roles that fully utilise the skills and knowledge of GPs working in secondary care. We also believe that the suggested models
will result in doctors providing clinical assistant and hospital practitioner functions being more appropriately remunerated in relation to the pay of other medical staff.

Next Steps

21. As a next step we believe that our recommendations would need to be discussed with the GPC and SASC, with a view to reaching agreement about the way forward. We also need to consider the type of support that NHS organisations would need, in order to empower them to develop appropriate medical staffing strategies and to use the skills of different clinical team-members more appropriately.

Conclusion

22. It is clear that the needs of NHS employers, in respect of the employment of current occupants of clinical assistants and hospital practitioners, vary greatly from one organisation to another. It is clear that more flexibility is needed in the way that these doctors are employed and remunerated in order to support service development. However, we do not believe that a single national solution could provide the necessary degree of flexibility to meet the needs of heterogeneous organisations.

23. We believe that our proposals should be discussed with the representatives of clinical assistants and hospital practitioners with a view to disassociating discussions about GP qualified staff from staff working only full or part time in delivering specialty specific care.
Paper 3. Medical Staffing in Community Hospitals

Background

1. This paper describes the findings and recommendations of the NHS Confederation’s scoping work about arrangements for the employment of medical staff in community hospitals. There is a read-across between our findings in respect of community hospitals and those in respect of the clinical assistant and hospital practitioner grades and this paper should be read in conjunction with Papers 1 and 2.

2. Both the Doctors and Dentists Review Body (DDRB) and the General Practices Committee of the BMA (GPC) believe that a review of the current medical staffing arrangements in community hospitals is necessary in view of the new arrangements for the pay and employment of general medical practitioners that were introduced in the new GMS contract. The GPC believes that as a result of the new out of hours arrangements a number of GPs will no longer be prepared to work in community hospitals, especially out of hours.

3. It is clear that community hospitals are neither clearly defined, nor homogenous organisations. For these purposes we have defined community hospitals as NHS organisations providing a range of mainly intermediate care services in close proximity to the users of those services. It should be stressed though that the nature of intermediate care is evolving and increasingly community hospitals are providing a range of patient services that would traditionally have been provided in a primary, or secondary, care setting.

Findings

4. In most cases Primary Care Trusts (PCTs) are responsible for maintaining facilities, employing staff and commissioning services in community hospitals. However, some community hospitals are managed by NHS Trusts and a small number of larger community organisations are NHS Trusts in their own right.

5. Community hospitals provide a range of important patient services locally. They improve access to NHS services for patients, in both rural and urban settings. In rural areas community hospitals often provide local services in the absence of an acute service provider. Such services frequently include rehabilitation, care of the elderly, some outpatient services (sometimes as outreach from a larger acute trust) and minor injuries units. In inner-city areas community hospitals often provide local services such as rehabilitation, care of the elderly, learning disability, mental health and drug and alcohol misuse services. In some areas dental services are also provided by community based organisations.
6. Many community hospitals also provide an important function in the care of the elderly and people with long-term conditions. Community hospitals provide a step-up facility for patients whose conditions would normally be managed in primary care, but need more intensive care over the short-term. They also provide a step-down facility for patients leaving the acute sector but requiring a higher level of care until they are fully recovered; in this way community hospitals support the integrated management of patients and facilitate increased independence.

7. In delivering these services community hospitals provide an integrated patient experience between primary and secondary care and in particular, provide services to vulnerable groups of people.

**Medical Staffing**

8. Community hospitals range in size from small units with a number of local GPs involved in providing medical services through staff-fund arrangements to larger organisations providing a range of different services and directly employing significant numbers of medical staff. Community hospitals are increasingly nurse-led with GPs providing medical interventions on an on-call basis and a number of them are piloting the Kaiser-Permanente model of care. However, in addition to providing 24-hour medical cover, medical staff are also frequently employed to provide a number of fixed commitments such as outpatients sessions, or minor injuries services.

9. Medical staff providing fixed commitments are not exclusively GPs. In some cases consultants, staff grades and associate specialists are also providing services. Non-consultant career grades provide a significant proportion of services in mental health and learning disability services. However general practitioners are often contracted to provide services as clinical assistants or hospital practitioners in a range of medical and dental specialties.

10. In a number of cases medical staff are not directly employed by community organisations. These staff are usually GPs remunerated solely through staff fund and casualty payment arrangements.

**Remuneration**

11. We have separately reviewed pay and contractual arrangements for non-consultant career grade doctors, including clinical assistants and hospital practitioners where they are working in hospitals under the supervision of a consultant. Similarly, the pay and terms and conditions of service for dentists in the community dental services are subject to a separate review led by the Department of Health. For these purposes

---

3 See NATPACT briefing paper [http://tinyurl.co.uk/jk08](http://tinyurl.co.uk/jk08)
only doctors remunerated through staff fund or casualty payment arrangements and clinical assistants and hospital practitioners working in community hospitals without the supervision of a consultant are considered here.

12. Staff fund arrangements are inconsistent with the principles that have been applied to recent pay reform for other groups of NHS staff. The staff fund is based on payments for the number of beds falling under the supervision of a GP (beds to which a doctor may admit and discharge patients) and takes no account of the time commitment necessary. This means that the remuneration of the doctors involved may be inconsistent. Doctors involved a 40-bed rehabilitation unit would be paid four times as much as those involved in a 10-bed elderly care or palliative care unit. The payment would not be sensitive to the intensity of medical involvement, or the time commitment given.

13. Casualty payments appear to be equally anachronistic. Casualty payments are normally based on the national rate of pay for clinical assistant sessions. In these cases a set number of new patient attendances (e.g. 700) will attract a payment equivalent to one clinical assistant session per week. The payment is fixed, irrespective of whether or not the doctor actually sees the patient. In some cases, a patient may never see the doctor and be treated throughout by a nurse or another non-medical member of staff. However, the doctor must be available if needed. This model is likely to be increasingly inappropriate as the roles of nurse and other healthcare professionals expand.

14. A number of clinical assistants and hospital practitioners are also employed by NHS Organisations to provide sessional commitments (e.g. outpatient services or minor injuries clinics) in community hospitals. The pay for clinical assistants and hospital practitioners is determined on the assumption that these doctors are working under the supervision of a consultant and reflect that level of responsibility. The rate of pay for clinical assistants and hospital practitioners is not intended to reflect an appropriate level of remuneration where a doctor is making clinically autonomous decisions.

15. The use of the clinical assistant/hospital practitioner contract to employ GPs in community hospitals, where they are employed to undertake a GP function, is not necessarily an appropriate use of these types of contract. There are already a range of alternative contractual/commissioning models available to PCTs and other NHS employers.

Out of Hours Work

16. Although the GPC has portrayed this issue as being primarily about out of hours work, this premise does not bear up on investigation. There is a general issue about the pay and contractual arrangements for doctors working in community hospitals. As a result of the new enhanced service arrangements there may be more of an incentive for
GPs with the competencies to work in community hospitals to provide services at their GP practices instead of at the community hospital in order to attract a higher rate of funding. However, it does not follow that the ability for GPs to opt out of providing out of hours services should automatically impact on their willingness to work in community hospitals.

17. In some cases the range of duties undertaken by doctors working in community hospitals may be more complex, than the range of duties that would normally be provided in general medical service. The willingness and ability of staff in GP cooperatives to undertake work in community hospitals may vary from one locality to another. The NHS may need increased pay flexibility to adapt to a range of differing local circumstances.

Comparison with Earnings Potential in Independent Practice

18. It is incorrect to draw a direct comparison between the GMS pay arrangements and arrangements for doctors working in community hospitals through staff funds or as clinical assistants. The GMS arrangements reflect the nature of work in independent practice and, in addition to appropriately remunerating clinical work, they reflect the need for GPs to purchase equipment, rent premises, hire staff etc. Where a GP undertakes work in a community hospital none of these factors applies as the hospital and equipment are maintained by a NHS organisation.

Recommendations

19. After careful consideration of the issue we believe that the current arrangements for remunerating doctors with general practitioner qualifications working in community hospitals should be reformed. We make the following recommendations:

- There should be an option to commission GP services in community hospitals through a locally enhanced service option or alternatively through a service level agreement with individual GP practices. These arrangements should replace existing staff fund and casually payments;

- Although the direct employment of GPs working in community hospitals by NHS organisations or groups of GP practices will not be necessary in many cases, NHS Organisations and groups of GP practices already have the option of directly employing GPs as salaried GPs. We suggest that this arrangement will be appropriate where employed GPs are not directly working under the clinical supervision of a consultant. This option could also be used to employ salaried GPs with a Special Interest.
• In future there may be a role for non-consultant career grade doctors with appropriate, accredited competencies to work without immediate consultant supervision in community hospitals.

20. It is our view, and that of our members, that there needs to be greater flexibility in the way doctors employed to work in community hospitals are remunerated. This will support the increasingly important role of intermediate care. In particular, the development of enhanced levels of practice for nurses and allied health professionals is likely to change the role of doctors in community hospitals. Furthermore, the introduction of GP practice budgets may also impact on the types of contractual models that are needed.

21. We believe that the salaried GP scale is more appropriate than the clinical assistant/hospital practitioner pay scales where doctors are working in a primarily clinically autonomous capacity. Local factors affecting pay will vary from one locality to another and we do not believe that a prescriptive, centralised formulae for calculating the value of payments would be responsive to local needs.

22. Where GPs are employed directly by NHS organisations or groups of GP practices rates of pay should be determined locally in accordance with local practice. Where GP services are commissioned via service level agreements or through the provision of locally enhanced services, the price of such services should be determined through local negotiation and influenced by the practicalities of the local situation. However, the following factors should be taken into account in determining the value of contracts:

- The appropriateness of work being undertaken by a general practitioner rather than another member of staff.
- The time commitment required from GPs involved in providing services;
- The complexity of work involved and the skills necessary to perform it;

23. Where GPs work via a service level agreement they will not be employees of a NHS organisation and employers will wish to ensure, by the terms of the agreement that appropriate clinical governance arrangements are in place and that GPs working in community hospitals are committed to observing the procedures and standards required by the organisation. GPs working in community hospitals on this basis must be on a Performers List, held by a PCT Where a GP is also working under a contract to provide PCTMS, an NHS organisation would have the option of employing them directly.
24. In line with the recommendations of ‘Choice and Opportunity’, further consideration should be given to the involvement of non-consultant career grade doctors without general practice qualifications where, in future, they have been accredited as having the necessary competencies to work in community hospitals.

Cost Implications

25. The use of GPs in community hospitals is not consistent throughout the NHS and cost implications will vary from one locality to another. Although we are not recommending pay reform but more appropriate and more flexible use of existing contracting options there are still likely cost implications. Agreeing appropriate service level agreements with a range of GP practices could be a difficult and costly exercise for PCTs/trusts. In some cases GPs are already threatening to leave work in community hospitals unless pay arrangements improve. In these cases, there may be significant cost implications, as it may be necessary to increase remuneration in order to retain existing staff and services. However, in other cases more appropriate contracting may result in savings as well as improved remuneration for doctors continuing to work in community hospitals. Further work will need to be undertaken on the cost implications of this new approach. It can not acceptable to have considerably greater expectations of NHS organisations without resourcing them appropriately.

Benefits

26. The key benefit for patients and NHS services will result from encouraging NHS employers to focus on the skills available within healthcare teams and the most appropriate way of contracting for skills that are needed. For example, we believe that there could be cost savings from more appropriate contractual arrangements for some medical staff. In addition, the increased flexibility in contracting that we are proposing should support the redesign and development of intermediate care services. Without reform we anticipate that some local organisations could experience difficulties in recruiting and retaining medical staff to undertake this work. It should be recognised that negotiating local arrangements could be a difficult exercise in some areas.

27. For doctors the benefits will include the use of contractual arrangements that more appropriately reflect their workload and working pattern. The increased flexibility that we are recommending should encourage GPs to continue working in community hospitals where they would otherwise have withdrawn their services.

Next Steps

28. We recommend that as a next step the proposals outlined above should be discussed with the GPC. In the meantime, to inform these
discussions, it is recommended that organisations employing GPs in community hospitals are encouraged to monitor the frequency and length of medical interventions to provide themselves with information to support the possibility of local negotiations in future and assess any potential increased costs for inclusion in local delivery plans. This should be done in conjunction with an assessment of the skills required to deliver patient services and consideration of the type of healthcare professional that can most appropriately provide those skills/services.

29. Subject to discussion with the GPC we recommend that the introduction of any new arrangements should be voluntary on the part of all parties and where agreement cannot be reached existing commitments would need to be honoured. We suggest that it should be made clear that there will be no obligation on NHS organisations or groups of GP practices to backdate payments where new arrangements are introduced.

30. NHS organisations may wish to co-ordinate arrangements across health communities and Strategic Health Authorities could take on this role.

31. NHS organisations may require support in identifying and spreading good practice in terms both of service redesign in intermediate care and specific commissioning/contracting models for GP services in community hospitals. Any work should be taken forward in a way that reflects the wider health agenda and, in particular, the developments of intermediate care services and new care pathways for patients with long-term conditions and chronic disease management. Consideration needs to be given as how best to provide such support.