ISTC programme phase 2

Human resources framework

To support independent sector elective and diagnostic schemes

August 2007 (updated)
1. Introduction
2. Background
3. Purpose of the HR framework
4. HR principles
   4.1 Partnership working and employee engagement
   4.2 Equality
   4.3 Fair and transparent process
5. The elective and diagnostic schemes
6. The additional activity policy
7. Employment model
   7.1 Retention of employment (RoE)
   7.2 The transfer of employment risk: “TUPE”
   7.3 Secondments
8. Utilisation of non contracted hours
9. Occupational health
10. Consultation process
11. Employee engagement and individual meetings
12. Employees on maternity leave, sick leave, fixed term contracts, secondments and career breaks
13. Training
14. Governance
Appendix A - Briefing on the additional activity policy on shortage specialties

Appendix B - Principles and protocol for use of NHS staff in non contracted hours
1. Introduction

1.1 This document has been developed to address the impact of phase 2 of the independent sector treatment centre programme (ISTC) which includes both elective and diagnostic schemes in England.

1.2 In particular this document addresses the potential workforce issues associated with the implementation of the policy, as they may apply to local NHS organisations. Similar issues may arise in the primary care sector however these will be dealt with separately.

1.3 Formulated in partnership, this HR framework is an updated and extended version of guidance that was produced for organisations involved in wave 1 of the ISTC programme. It is intended to provide guidance to NHS trusts, Staff Side representatives and independent sector (IS) providers on the processes that should be followed for the successful implementation of the elective and diagnostic programme within the local health economy. It draws upon the experience of wave 1 to maintain good practice.

1.4 This framework is intended to supplement existing organisational change management procedures, where they already exist, or current best practice in staff management and to provide answers to questions that have been raised during wave 1 roll-out.

1.5 The agreed aim is to ensure the retention of the valuable skills and experiences of NHS staff, within the NHS, through effective negotiations and consultation with staff to enable effective delivery outcomes for both staff and patients.

1.6 More resources are available through NHS Employers’ website (www.nhsemployers.org), which NHS organisations may find useful in managing their involvement in the elective and diagnostic programme.

1.7 This framework has been agreed by the Department of Health (DH), NHS Employers and the Staff Side representatives (including the BMA, RCN, Amicus, SoR and UNISON) who have worked collaboratively to this end. The document has also been received by the Executive of the NHS Staff Council. These bodies will work together to keep these arrangements under review.

1.8 It may be appropriate to update this document in light of developments arising during the roll out of the programme. Any such amendments will be jointly agreed.

2. Background

2.1 The Government is committed to creating a “patient led NHS” in which patients have a greater say in how, where, when and by whom they are treated. To realise this aim, the Government wishes to expand capacity and introduce more diversity, or plurality of provision. To facilitate this the Government is working to widen the range of service providers.
2.2 Creating extra capacity and a plurality of provision means bringing in new providers of healthcare (including from the independent sector) with the expectation that the extra capacity will produce a significant reduction in waiting times.

2.3 The process of creating plurality and patient choice is now well under way. The DH has arranged the procurement of agreed packages of elective surgery and diagnostic procedures from a wide range of IS providers.

2.4 Independent sector representation within the NHS is expected to remain on a small scale. The aim is to balance the goals of making choice meaningful and improving standards through additional capacity and competition with the need to preserve the integrity and values of the NHS. However, plurality will create new pressures and challenges for everyone involved in the NHS, including those involved in engagement, deployment and management of employees.

3. Purpose of the HR framework

3.1 The agreed aim of the framework is to ensure that fair and transparent processes are adopted and implemented that retain the valuable skills and experiences of NHS employees within the service. The framework aims to ensure that effective consultation takes place with employees and their representatives on how these processes will be applied, ensuring effective outcomes for employees, patients and IS providers.

3.2 The framework is useful to potential providers of services and NHS employers, as one of the key objectives of developing this framework is to ensure consistency of the application of HR principles and best practice to new projects and those employees that may be affected. In addition there have been some valuable lessons learnt from the earlier sites in wave 1, which we aim to build upon.

3.3 There is a need for all organisations to ensure that staff are fully informed at all stages of the process and that sufficient information is made available to help inform any decisions that employees need to make.

4. HR principles

4.1 Partnership working and employee engagement

4.1.1 The complexity of the workforce issues arising from a plural workforce in general and the elective and diagnostic programme in particular, has been recognised by the DH, NHS Employers and Staff Side representatives nationally and across the service. In August 2004, Staff Side and NHS Employers agreed to work in partnership to identify, discuss and resolve these issues. Consultation has also taken place with IS representatives. This framework sets out the basis for partnership working and its priorities and outputs.

4.1.2 Effective change is best facilitated by effective partnership working and by fully involving employees and their representative organisations in
the proposed changes. Consultation with trade unions should be taken into account in managing the change process.

4.1.3 Trusts should support effective partnership working by providing protected time and other facilities for trade union representatives. Continuous dialogue with the trade unions must be maintained throughout the process.

4.1.4 Partnership working will also be maintained with trade unions at a national level.

4.1.5 All employees should be kept fully informed by their employer and supported during any change process.

4.1.6 Section 10 of this framework sets out the expected consultation process that should be adopted.

4.2 Equality

4.2.1 No employee should receive less favourable treatment on grounds of age, gender, marital status, race, religion, creed, sexual orientation, colour, disability, working patterns or on the grounds of trade union membership. The basis in law for these protections comes broadly from the provisions regarding, unlawful discrimination on the grounds of race, sex, disability and trade union membership contained in the Race Relations Act 1976 (as amended), the Sex Discrimination Act 1975 (as amended), the Disability Discrimination Act 1995 (as amended), the Trade Union and Labour Relations (Consolidation) Act 1992 (as amended), the Employment Equality (Age) Regulations 2006, the Part-time Worker (Prevention of Less Favourable Treatment) Regulations 2000, the Fixed-term Employee (Prevention of Less Favourable Treatment) Regulations 2002, the Employment Equality (Sexual Orientation) Regulations 2003 and the Employment Equality (Religion or Belief) Regulations 2003.

4.3 Fair and transparent process

4.3.1 An integrated HR process should be applied which will be fair and transparent and which will seek to match individual abilities with available posts. While this process should also be mindful of the need to move quickly and to continue to deliver a high quality service, this should not be at the expense of effective consultation with individuals and trade unions.

4.3.2 All appointment and selection procedures must be fair and transparent and meet the requirements both for equal opportunities legislation and best practice. For employees who are considering secondment opportunities, the process should allow sufficient time for employees to make informed decisions.

5. The elective and diagnostic scheme programme
5.1 Treatment centres are being developed as a way of increasing capacity for treating NHS patients. They will undertake elective and diagnostic work only and will be provided by either the NHS or the independent sector.

5.2 NHS treatment centres will be part of an NHS trust or foundation hospital. The service might be provided on the hospital site or in some cases on an external site. Employees working on these sites will be employed on NHS terms and conditions, which include all NHS benefits, pensions and improving working lives strategies and policies.

5.3 These centres will be staffed by either redeployed existing NHS employees or by recruiting additional employees from a variety of sources e.g. local area / overseas.

5.4 Independent elective surgery and diagnostic centres will be provided by the independent healthcare sector, which could be either a UK or overseas company. Some of these centres will be a single provision on a local site and others will be part of a chain or cluster i.e. a service provided on a number of different sites across the country but managed by one company.

5.5 The work undertaken in these centres will be either additional work or in some cases activity transferred from the NHS as part of the reconfiguration of local health services. The workforce for these centres will come from a variety of sources.

6. The additional activity policy

6.1 The Government’s objective is to ensure that IS involvement in the NHS creates genuine additional capacity. The additional activity policy establishes the basis for managing the deployment of skills in a plural system.

6.2 The guiding principle at the heart of the additional activity policy is that “scarce clinical skills may not be diverted to IS providers who have been appointed to provide the service with new capacity”. However this policy has to be balanced against the need to allow NHS employees maximum choice and mobility in their careers and to ensure that IS providers have a viable pool from which to recruit.

6.3 For phase 2 schemes the ‘additionality policy’ has been refocused and applies only to NHS clinical professionals in defined shortage specialisms (shortage specialisms are outlined in appendix A). However, it also enables all NHS employees (regardless of whether they are on the shortage list) to work non-contracted hours/extra hours above contracted hours for an IS provider, subject to some basic safeguards of patient and employee safety and with the agreement of their NHS employer.

6.4 IS providers may need to recruit additional staff. Each IS organisation, as part of its bid, will identify the proposed shape of its workforce including numbers, job titles and grades. This list will need to be agreed with host NHS organisations as part of the contract negotiations and posts may have
to be filled from non-NHS sources. IS providers may recruit NHS healthcare professionals who are not designated as being in a 'shortage profession'. For those who are in shortage professions, IS providers will be prevented from recruiting staff who have worked in the NHS in the previous six months. This will ensure that there is no inappropriate diversion of NHS healthcare professionals to the independent sector.

6.5 The long-term aim is that the professionals and support staff who work in the IS centres will be sourced and employed in the main by the IS provider. They will continue to be subject to the same high standards on equality.

6.6 It is recognised that the health sector labour market is dynamic and that the list of shortage specialties will need to be reviewed periodically by the DH/NHS Employers in consultation with Staff Side and the independent sector, and using the technical expertise of the workforce review team and other appropriate sources.

7. The employment model supporting transferred activity

7.1 The transfer of employment risk: ‘TUPE’

7.1.1 Any transfer of or overlap between current NHS trust activity and elective and diagnostic phase 2 activity leads to a concern that there may be an unintended transfer of staff under the Transfer of Undertakings (Protection of Employment) Regulations 1981 (or "TUPE" as it is commonly known).

7.1.2 The TUPE regulations are an employment protection measure. In broad terms, TUPE transfers employment and protects terms and conditions, when the business in which employees work, or the work that they do, is transferred to a new organisation.

7.1.3 Under the elective and diagnostic programme, TUPE might unintentionally (but automatically by law) transfer the employment of some NHS employees to the IS provider, notwithstanding the policy on recruitment of NHS staff in elective and diagnostic schemes.

7.1.4 NHS trusts, the Department of Health, NHS Employers and the Staff Side representatives intend that employees should remain in the NHS where this is their preference. There will be no compulsory transfers in the IS process. The objective where appropriate is to enable staff to make an informed decision, with the option of always remaining in the NHS.

7.2 Retention of employment model (RoE)

7.2.1 The retention of employment model (RoE) was developed jointly by the Department of Health and trade unions to avoid possible future deterioration of terms and conditions, which sometimes faced facilities management staff whose employment was transferred to the Private Finance Initiative contractors. RoE was designed to protect employee rights and also ensure that the service did not permanently lose their valuable contribution to patient care and service delivery.
7.2.2 Following consultation at national and local level, in circumstances where any elective and diagnostic contract results in transferred activity, it has been agreed that a strategy should be adopted to ensure that staff remain NHS employees whilst enjoying the opportunities that are likely to arise for secondments into IS providers.

7.2.3 The DH, NHS Employers and Staff Side representatives have agreed that the preferred model for retaining employees in the NHS and avoiding compulsory transfers under the TUPE regulations is the retention of employment (RoE) model in the context of the elective and diagnostic programme. It is recognised that this is the most effective model available for retaining employees.

7.2.4 Under RoE, employees who are seconded to an independent sector provider will remain NHS employees and they will retain all their current terms and conditions of service with continuity of service preserved for all purposes, including their NHS pension.

7.2.5 Essentially RoE provides a way of enabling employees to remain in NHS employment for legal and (as deployed on the IS programme) HR management purposes while enabling them to experience working in an IS environment through secondment. Very importantly, RoE also allows each individual employee a choice about who his/her employer might be.

7.2.6 RoE is being used for wave 1 schemes and will be used for phase 2 elective and diagnostic schemes to the extent that they involve transferred activity. In this process the employees may object to the possibility of transfer. This objection technically ends their employment. However, they are then immediately re-employed by the trust on exactly the same terms and conditions of service with continuity of service preserved for all purposes, including pension rights. These re-employed staff may then be seconded to the IS provider. However the NHS remains their employer and maintains responsibility for issues arising out of their employment.

7.3 Secondment

7.3.1 In the context of transferred activity employees who may wish to consider secondment will need to make an informed decision about their opportunities. To facilitate this, during the contractual discussions the independent sector will need to notify the trust of the number of posts which will be available to potential secondees within their organisation.

7.3.2 The IS organisation will need to detail the numbers of jobs, their roles, location and grade. All of these posts will have job descriptions and person specifications attached to aid the decision making process. There is an expectation that where an activity is transferred these posts would be restricted to those staff that are associated with the transfer in the first instance. Thereafter, it would be expected that posts would be advertised. If only one person expressed an interest in a particular job, the objective
would be to slot that person in, as long as they met the person specification and the job description was appropriate for them.

7.3.3 Some IS providers may wish to observe this process and local discussion will need to take place to facilitate this on the understanding that there is an expectation that employees who meet the job description, and work on transferred activity would be seconded to the IS provider. If an employee felt that they had not been allowed the opportunity of secondment there would be an opportunity for them first to raise this informally and then, if they felt it necessary, formally through their employers grievance procedures.

8. Working non contracted hours/ working extra hours above contracted hours

8.1 All NHS employees may be permitted to work non-contracted hours for IS providers providing that this is agreed with the employing trust via job planning or appraisal processes and providing that both organisations are satisfied, having reviewed the situation, that the deployment creates no risks around patient or employee safety. An agreed set of principles and protocol on this process is in appendix B.

8.2 Consultant medical staff will be able to work for IS providers after they have offered their first four hours of additional time to the NHS, and the NHS employer and the IS provider have satisfied themselves that this additional work will not compromise patient or employee safety. This work will be described as programmed activities in an integrated job plan and be reviewed in the new ‘whole career appraisal’ process.

8.3 IS providers will need to satisfy themselves that all employees they employ or engage are safe and competent to work in their facility. They will also need to ensure that any proposed working arrangements do not conflict with NHS staff responsibilities or commitments. As part of the process of ensuring good governance, IS providers will need to satisfy themselves that the proposed arrangement is safe, having regard to the employee’s planned/contractual NHS commitments. They will confirm they are satisfied in writing to the employee. The employing NHS trust will receive a copy. If IS providers engage employees without issuing such a letter, they will be in breach of their contract with the service commissioner. Legal action may follow, leading to an injunction to restrain the recruitment or payment of compensation.

8.4 When asked to approve a change of job plan or otherwise to support employee deployment of non-contracted hours, NHS trusts are expected to take into account the potential impact of the proposed IS work on patient safety, employee health and safety and the employee’s NHS duties. It will be for the NHS trust employer and the IS provider, in consultation with the prospective employee, and where requested their representative to agree the specific arrangements about how the individual will work and how the accountability for the integrated job plan or job description will look. Particular consideration will have to be given to monitoring actual hours of
work and to developing a mechanism to share information on hours worked to ensure patient and staff safety and compliance with working time regulations.

8.5 For nurses and allied health professionals, discussions around any potential IS work should take place via the NHS trust’s ongoing appraisal process. For all consultant medical staff, discussion around any IS work should normally occur as part of the existing job planning process.

9. Occupational health

9.1 The NHS, as an employer of seconded staff, will need to ensure an individual’s fitness or otherwise for the role within an IS provider. In these circumstances there is no need for the IS provider to have detail of occupational health records. However, they may need to be informed of any arrangements that they need to put in place to ensure a seconded employee is able to work safely. Employees may be requested to provide details of immunisations as part of the pre-employment process, which will be in accordance with Healthcare Commission and NHS recruitment standards.

9.2 The normal relationship between the employee and the trust occupational health provider will remain the same as it was prior to the secondment because they remain a trust employee.

9.3 It is important for trust occupational health providers, who are responsible for staff on secondment, to ensure that they have familiarised themselves with the job specifications and the working conditions of those staff in order to be able to provide effective advice and support.

9.4 The process described reflects the DH and NHS Employers’ view on the minimum that is required to ensure safety and consistency with the phase 2 elective and diagnostic schemes. Employing organisations and IS providers are required to collaborate in partnership on staffing issues, such as workforce planning, training and recruitment.

10. Consultation process

10.1 Section 4.1 of this document establishes partnership working and employee engagement as a key principle for underpinning the management of change through the IS programme.

10.2 Outlined below are the different levels of consultation that are expected to take place as best practise. Consultation involves being open and forthcoming with information. It is important that this is transparent and involves listening, responding and taking on board employee and trade union concerns and suggestions. The nature of the elective and diagnostic programme – with long lead in times from expressions of interest to service commencement – gives everyone plenty of time to discuss and agree how best to retain and protect NHS employment. In cases where the lead time is
shorter, the consultation plan will need careful design and NHS Employers can assist with this.

10.3 **Nationally** - relevant Staff Side organisations are being constantly involved in relation to the service impact of the national procurement programme and the impact on employees. The full spectrum of employee interests, concerns and points of view have been taken into account and will continue to be so. Regular meetings have been maintained to jointly monitor the process. These discussions will be maintained and both sides will openly and honestly share their opinions and concerns to ensure patient and public safety. Members of the working group will, wherever possible, give advice or points of clarification resulting from the local negotiations with a view to facilitating agreement and resolution of the concern.

10.4 **Regionally** - strategic health authorities must consult with all major stakeholders within their geographical area, such as NHS employers (including foundation trusts), local government and patient groups, staff representatives and the public regarding any possible proposals to implement elective and diagnostic phase 2 schemes. They should also consider any concerns that are expressed surrounding possible implications, current or future, for the health economy. They should have an important role in overseeing and managing the service and workforce risks including the IS compliance with the rules on recruitment and use of non contracted hours in conjunction with the central contract management unit at the Department of Health. To assist with efficiency and consistency, Staff Side organisations will, where possible, designate a local official to take a special interest in IS related issues at a regional level. The consultation should be meaningful, and sufficient time should be allowed, to ensure that all stakeholders have the opportunity to make informed decisions surrounding any proposals.

10.5 **Locally** – local trusts and joint partnership forums, should establish joint working groups to discuss and oversee the development of the elective and diagnostic schemes. This should include contractual issues, employee secondments, training and access to information that prospective providers may require. Consideration should be given to any impact or risk that may be posed to the organisation as a result of it. Time also needs to be taken to ensure that the IS provider has sufficient governance and training arrangements in place to ensure patient safety and employee development.

10.6 The consultation will provide the:

a) identification of employee groups and services affected by the programme, if any

b) available options for employees under RoE where there is a transfer of employment risk

c) identification of how the programme may affect existing employee roles and responsibilities
d) information on the way in which the service is expected to function  
e) details of the nature and scope of any transferred services  
f) an assessment of how transferred services will impact on services remaining in the NHS trust  
g) how the IS provider is expected to interact with the NHS more generally  
h) satisfactory governance arrangements  
i) details of the selection process for the IS provider including the interview process.

11. **Employee engagement and individual employee meetings**

11.1 Effective partnership working at national level has successfully developed this framework to date. It is expected that the principles contained within the framework will be applied locally as best practice to ensure smooth and consistent implementation of the procurement programmes.

11.2 The key principle of employee engagement in this process is that all employees must be kept fully informed during the change process through communication from their trust.

11.3 Every affected member of staff will have at least two one-to-one meetings with their line manager or a member of the HR team. Where issues of concern to employees arise, further meetings should be arranged to address them. Staff representatives or another colleague may also attend if the employee wishes. These meetings should be agreed sufficiently in advance to allow time to arrange for a trade union representative to be present.

11.4 The purpose of these meetings is for the employee to discuss their own personal circumstances and any other issues around the programme. Trusts must ensure that employees understand all the options available to them and enable them to make an informed decision.

11.5 Before employees are asked to consider a secondment, they must be given sufficient information to enable them to express an interest, which does not commit them to a preference, particularly on the question of whether they wish to be seconded under ROE or transferred to an IS provider. This will help identify any concerns and help both the NHS and IS provider in staff planning, particularly where employee numbers are large.

11.6 Employee meetings do not preclude ongoing one-to-one dialogue with employees. Because of the nature of the programme, it is expected that there will be continued discussions at all levels throughout the process.

12 **Employees on maternity leave, sick leave, fixed-term contracts, secondments and career breaks**
12.1 Employees on maternity leave, sick leave, fixed-term contracts, other secondments and career breaks must be included on the staffing lists and receive all communications, including those published electronically. The trust must understand the potential complexity for some employees to attend meetings e.g. because of childcare arrangements and be flexible to meet the needs of the individual.

12.2 Employees absent from work must be similarly offered an individual employee meeting. Where appropriate and at their request or agreement, home visits should be arranged and any relevant paperwork should be forwarded to the absent employee at home.

12.3 The importance of these meetings must be stressed to staff that are not at work and may be a little more out of touch with the programme. Unless it is absolutely impossible to arrange (for example, a member of staff is too ill to discuss their future), trusts must discuss employment options with all staff who are not at work. Where appropriate for the individual, and with their agreement, the manager and trade union representative could conduct the meeting at the individual’s home.

13. Training¹

13.1 All IS providers must demonstrate a clear commitment for the continuation of NHS employee development through the knowledge and skills framework. This will include access to additional skills and training either via a workplace or NVQ route, or through diploma and graduate courses. In addition to this, the IS provider must demonstrate compliance with mandatory training and must maintain their own records, which should be periodically audited in partnership with the trust, to ensure that they comply with employer obligations. An IS provider must show a commitment to release employees from work for training and financial commitment.

13.2 Nationally, consideration will need to be given to the funding of courses and what access, if any, the independent sector will have to national funding. However, there is an expectation that as a good employer, they will also contribute financially. Many IS providers currently invest significantly in training and developing their staff.

13.3 Locally, negotiations should take place to aid joint training wherever possible. Small IS providers may not have the capacity to provide their own infrastructure. Where this is the case, it may be possible for them to purchase training from the NHS. Where this occurs the training provider will be expected to provide the IS provider with training records.

13.4 The NHS is keen to ensure that the introduction of IS schemes into the health economy supports, rather than disrupts, the provision of pre and post-qualification training and placements for doctors, nurses and AHPs.

¹ More information will be inserted here after key points of policy and implementation are agreed. Further discussions regarding this matter are scheduled to take place at the end of November 2006.
The need to ensure continuity and integration of training is particularly acute where NHS activity is being transferred.

13.5 On wave 1 schemes, steps have been taken to oblige IS providers to cooperate with trusts to accommodate training. A pilot scheme has also been set up to gather information on the educational and financial effects of elective and diagnostic schemes on current training.

13.6 Going forward, in line with the enhanced roles of deaneries and PMETB and the introduction of modernising medical careers, it is expected that deaneries and/or SHAs will contract directly with IS providers, to provide training services where that is desirable. It is also expected that contracts will address the provision of training services for doctors, nurses and AHPs.

14. Governance

14.1 All IS providers will be expected to put their own governance arrangements and effective clinical policies into place. Copies of all policies should be made available in every ward and department. In addition IS providers will need to demonstrate how employees are involved in the development of the protocols and kept updated of changes. These may also need to be made available for inspection by a regulator.

14.2 IS providers will need to establish a multi disciplinary governance committee. This committee should examine all untoward incidents and amend protocols and procedures based on their findings or national recommendations from other organisations and regulators.
Appendix A - Briefing on the additional activity policy on shortage specialties

The list of shortage professions has been drawn up based on the results of qualitative and quantitative analysis by the workforce review team – a body attached to Hampshire and Isle of Wight SHA, responsible for analysing NHS workforce data. This work has been reviewed with effect from 1 September 2007.

The list will be the basis of the additionality clause in the relevant elective and diagnostic services agreement. This clause is a form of restrictive covenant. As such, the clause and the list must go no further than is demonstrably necessary to protect the interests of the NHS.

However, there are other sections of the NHS workforce – not covered by the list – which may raise risks to NHS capacity. In relation to them, proper caution and risk management is also required. For example, Agenda for Change band 6 covers a wide range of clinical staff and skills, some of which are very specialist and are key to delivering service in both the NHS and the IS. Because band 6 is very broad, it is not appropriate to include people within it in the list of shortage specialisms or the restrictive covenant. However, bidders are specifically reminded of their contractual obligation to participate in good faith in NHS workforce planning. This will include the obligation to liaise closely with the relevant strategic health authority and to co-operate in ensuring fair access to these key elements of the workforce, avoiding predatory recruitment practices and cooperating with NHS employers in ensuring adequate resourcing and succession planning across the local health economy.

The shortage professions covered by the phase 2 elective and diagnostic additionality policy are:

The position in Phase 2 ISTCs is that from 1 September 2007:

(i) Any profession or specialty not on the Shortage Professions List is eligible to apply in a Phase 2 ISTC without a waiting period.

(ii) All professions or specialties are eligible to work in a Phase 2 ISTC during their non contracted hours, including those professions and specialties which remain on the shortage professions list.
The revised additionality shortage professions list is as follows:

<table>
<thead>
<tr>
<th>Additionality Shortage Professions list</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical cytogenetics and molecular genetics (consultants)</td>
</tr>
<tr>
<td>Immunology (consultants)</td>
</tr>
<tr>
<td>Cardiac physiology including echo-cardiology (HCS)</td>
</tr>
<tr>
<td>Bands 7 and 8 - therapeutic and diagnostic radiography</td>
</tr>
<tr>
<td>Nuclear medicine (consultants)</td>
</tr>
<tr>
<td>Allergy (consultants)</td>
</tr>
<tr>
<td>Highly specialised physiotherapists bands 7 &amp; 8</td>
</tr>
<tr>
<td>Medical ophthalmology (consultants)</td>
</tr>
<tr>
<td>Clinical neurophysiology (consultants)</td>
</tr>
<tr>
<td>Anaesthetic nurses</td>
</tr>
<tr>
<td>Critical care nurses</td>
</tr>
<tr>
<td>Band 7 and 8 nurses</td>
</tr>
<tr>
<td>Audiological medicine (consultants)</td>
</tr>
<tr>
<td>Sleep physiology (HCS)</td>
</tr>
<tr>
<td>Clinical vascular scientists/technologists</td>
</tr>
<tr>
<td>Neurophysiology (HCS)</td>
</tr>
<tr>
<td>Health care scientists (HCS) bands 7 and 8</td>
</tr>
</tbody>
</table>

The following specialties and professions remain on the additionality list whilst further negotiation and discussion is undertaken:

<table>
<thead>
<tr>
<th>The following specialties and professions remain on the additionality list whilst further negotiation and discussion is undertaken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemical pathology (consultants)</td>
</tr>
<tr>
<td>Medical microbiology and virology (consultants)</td>
</tr>
<tr>
<td>Histopathology (consultants)</td>
</tr>
<tr>
<td>Haematology (consultants)</td>
</tr>
<tr>
<td>Pharmacists</td>
</tr>
<tr>
<td>Audiologists (hearing therapists, audiological scientists or audiological technicians)</td>
</tr>
<tr>
<td>Respiratory physiology (HCS)</td>
</tr>
<tr>
<td>Operating department practitioners</td>
</tr>
</tbody>
</table>
Appendix B - Principles and protocol for use of NHS staff in non contracted hours

Deployment of non contracted hours by NHS staff on phase 2 schemes

The additionality policy adopted by the DH for phase 2 elective and diagnostic schemes represents a refocusing of the wave 1 position.

1 The contractual restriction by which IS providers may not substantively engage healthcare professionals, who have been engaged (as employees or otherwise) in the NHS during the previous six months, is now restricted to staff who are in defined shortage specialisms. These are defined in the invitation to negotiate (ITN). The list will be reviewed periodically using the expertise of the workforce review team. This is a specialist function hosted within the Hampshire and Isle of Wight SHA. The list of shortage specialisms in the ITN is based on qualitative and quantitative data compiled and analysed by them. Bidders are likely to be asked to contribute information from time to time, as part of the local health economy workforce planning process and as part of working with employers and SHAs to manage the workforce risks.

2 In contrast to wave 1 schemes, all NHS staff (doctors, nurses and allied health professionals) may be permitted to deploy non-contracted hours in the IS. This will be so whether or not the relevant member of staff is in a shortage profession, as defined and reviewed from time to time. However, this will be subject to certain safeguards designed to assure patient and employee safety, particularly with regard to working hours and potentially subject to agreement with their substantive NHS employer.

3 DH, NHS Employers and national Staff Side representatives are in the process of devising a set of principles and protocol indicating how these basic safeguards can be realised. In doing so, all parties recognise that there is a balance between transparency, risk, safety and flexible use of staff.

4 While the details remain under discussion, the core process will be as follows:

(a) the IS provider will let it be known that it has work to be done (e.g. it will advertise)

(b) if employed substantively in the NHS, the member of staff will commence dialogue with their employer about the request to work in the IS provider

(c) the member of staff will tell the IS provider of his/her interest and find out more

(d) the IS provider will run its own standard employment checks on the relevant member of staff, as required by its agreement with the NHS, and its own policies, and commence discussion with the NHS trust
about how the arrangements for the member of staff will be put in place. This should ideally be the director of human resources or the chief executive

(e) the member of staff will inform his/her NHS employer (ideally their line manager and HR department) of the proposed engagement

(f) the trust decides whether and on what basis to support the deployment of non contracted hours, having regard to the member of staff’s actual and anticipated workload for the trust, their working pattern and any contractual duty the employee may have to make more time available to the trust. These discussions may also take place as part of a job plan review (in the case of doctors) or in the context of the appraisal process or related conversation with line manager in the case of nurses and allied health professionals

(g) this will be at the trust’s discretion, using reasonable regard to the issues of patient safety and the health and safety of both the relevant member of staff and immediate colleagues and the impact on services provided

(h) if the trust declines to support the arrangement, staff may have access to any trust appeal/review processes. If it supports the arrangement, an integrated job plan/description and appraisal papers will be put in place. Trusts and IS providers will be required to liaise on these issues.

(i) ultimately, it will be for the IS provider and the NHS employer to decide whether to proceed. If it does proceed, a letter will be issued to the member of staff, copied to all parties confirming the arrangement that all necessary patient and employee safety issues have been examined to satisfaction

(j) The NHS employer and the IS provider will be required to keep robust and auditable records of hours worked and arrangements agreed for joint monitoring to ensure patient and staff safety and compliance with working time regulations.