



DEPARTMENT OF HEALTH AND SOCIAL SECURITY
EILEEN HOUSE
80-94 NEWINGTON CAUSEWAY LONDON SE1 6EF
TELEX 883669 TELEPHONE 01-703 6380 Ext.
G.T.N. 2916

Your reference

Our reference ETS/43/3

DA(86) 11

To:
Regional General Managers

General Managers of the SHAs for the
London Postgraduate Teaching Hospitals

9 April 1986

District General Managers- for information

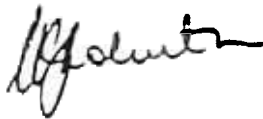
Dear General Manager

HOSPITAL MEDICAL AND DENTAL STAFF
APPOINTMENTS UNDER PARAGRAPH 94 AND PARAGRAPH 107 OF THE
TERMS OF SERVICE ("CLINICAL ASSISTANTS") FOR FIVE OR MORE SESSIONS

1. In the course of last year representatives of the medical and dental professions expressed concern at reports of increases in the numbers of doctors and dentists holding clinical assistant appointments involving five or more sessions. Comparison of hospital census figures for 1983 and 1984 confirmed that multi-session clinical assistant appointments (particularly those involving five or more sessions) had increased substantially.
2. These appointments are not subject to central control and it is not presently proposed to extend controls to them. However, earlier enquiries of Regional Medical Officers indicated that several regions already have informal arrangements for monitoring new clinical assistant appointments. A feature of these arrangements is the scrutiny of proposed appointments by the Regional Manpower Committee. In view of the evidence of increases in multi-session appointments it has been decided that similar arrangements should be established in all regions to enable RHAs to report periodically to the Department on trends in the use of these appointments.
3. I should therefore be most grateful if you would arrange for the advice of the Regional Manpower Committee to be sought on all proposed clinical assistant appointments involving five or more sessions (including instances where the number of sessions provided by a particular doctor is to be increased to five or more). The arrangements should also allow all appointments made since 1 April 1986 involving five or more sessions to be reviewed annually by the Regional manpower Committee.
4. RHAs are requested to monitor the use of such appointments and to report annually by 31 March for the previous 12 months on:-
 - 1) numbers of bids recommended by the Regional Manpower Committee by specialty
 - numbers of bids rejected by the Regional Manpower Committee by specialty
 - any instances in which appointments were made against the Regional Manpower Committee's advice.

5. The returns should be made to Mr B Greener Room 410 Eileen House at the above address (extension 3840) to whom any enquiries about this letter should be addressed. I am also copying this letter to Regional and District Medical Officers and Regional Specialists in Community Medicine (Medical Staffing).

Yours sincerely

A handwritten signature in dark ink, appearing to read 'W G Robertson', with a stylized, cursive script.

W G ROBERTSON
Medical Manpower and Education Division

CLINICAL ASSISTANTS: FACTUAL BRIEFA. PAY AND CONDITIONSDefinition

1. The term "clinical assistant" (CA) does not occur in the Terms and Conditions of Service of Hospital Medical and Dental Staff (TCS). It does not denote a defined grade; rather, a part-time medical officer appointment under TCS paragraph 94, or a part-time GDP appointment under TCS paragraph 107, at a rate of pay "where no other rate is appropriate". In 1948, it was envisaged that these appointments would be for GMPs employed on a limited range of duties (eg, in refraction and transfusion services, convalescent and mother-and-baby homes) under consultant oversight. No general guidance has been issued since then.

Pay

2. The annual rate is £1,615 per notional half day, or session. For an average weekly commitment of an hour or less it is £430, and £860 for up to 2 hours. The maximum salary is £14,535. There are no increments. This is equivalent to the minimum of the Hospital Practitioner (HP) scale and the third point for Associate Specialists (ASs). For CAs and HPs the notional, and for the ASs the actual, whole time maxima are, respectively: £17,765; £23,705; and £21,680. The HP maximum normally approximates the intended average net remuneration of GMPs, currently £23,440. The estimated gross pay bill for CAs in England and Wales is £48.3m, or some 4.6% of the total for hospital doctors and dentists.

Conditions

3. Sessions: pay depends on the number of sessions - equivalent to 3½ hours each - required. The employing authority must make a general assessment of the average time per week required by an average practitioner in the grade and specialty to perform the duties of the post, including an allowance of up to an hour's travelling time. The assessment is rounded up to the nearest session and for multiple employments aggregated before rounding. The maximum permissible number of sessions is 9, including multiple employments but excluding locum work. (1)

4. Entry requirements: none, other than full registration (registration for dentists). Appointments in England and Wales are not subject to manpower controls. From July 1985, proposed appointments of 6 or more sessions in Scotland require the approval of SHHD, on advice from the ACME.

5. Duties and tenure: for local determination. The duties of a practitioner should be agreed in his contract or its associated job description, but there are no model documents for CA appointments. A CA is entitled to 2 months' notice of termination, unless there is a mutually acceptable alternative or unless the provisions of the employment Protection (Consolidation) Act 1978 would, if they applied, be more favourable. Authorities are free to offer fixed-term or open-ended contracts. Contracts must be terminated when practitioners reach the age of 65, but may be renewed periodically up to age 70.(2)

6. Additional pay: there are no permissible additions to basic pay, other than London Weighting proportional to contracted hours. In particular, there is no provision for additional pay in respect of overtime or on-call liability. The Department has customarily advised that authorities should have regard to actual clinical workload in assessing the number of sessions required and should not normally attribute more than 2 sessions a week to periods of on-call liability.

7. Leave and expenses: CAs are entitled to the re-imbursement of expenses, other than removal expenses, necessarily incurred on official business. They have an annual leave allowance of 6 weeks. They are entitled to sick and maternity leave according to length of service, and are eligible for other forms of leave, except professional and study leave, on the same basis as other practitioners.

8. Other employment: outside their contracted hours, CAs are free to undertake private practice, NHS locum work, and, within the sessional maximum, other NHS employment. CAs who are principals in general practice may also hold staff fund appointments with the same or another employing authority.(3)

9. Other safeguards: CAs have no right of appeal to the Secretary of State against unfair termination.(4) They do, however, come within the scope of the arrangements for:

2. TCS, paragraphs 30, 195 to 197, and 200.

3. TCS, paragraphs 87 to 93; HC(PC)(79)5.

4. TCS, paragraph 190.

- 9.1 appeal against disciplinary action, including dismissal, under Section 40 of the General Whitley Council handbook (GWC);
- 9.2 the investigation of professional conduct and competence, under HM(61)112;
- the investigation of fitness to practise, under HC(82)13.
- 9.4 appeal on matters other than discipline and dismissal, under GWC Section 32;
- 9.5 redundancy pay, under GWC Section 45, subject to 2 years' NHS service of 16 or more hours (5 sessions) a week, or 5 years' service of 8 or more hours (3 sessions) a week. Such service need not be with the same employer and may be interrupted by up to a year;
- 9.6 the statutory right of appeal to an Industrial Tribunal against unfair dismissal, subject to unbroken employment with one employer of at least 2 years (5) of 16 or more hours a week or 5 years of 8 or more hours. The right of appeal is not affected by dismissal on the expiry of a fixed-term contract, unless the employee has previously signed a waiver, nor by the issue of a series of fixed-term renewable contracts.

It is, finally, envisaged that the revised GWC protection agreement (Section 74), on which discussions are now well advanced, will be applicable to all employees required to change posts as a result of organisational change. As drafted, it includes provision for short term protection of earnings (2 to 12 months, depending on length of service) where contracted minimum hours are reduced.

B. CAREER PROSPECTS

10. The Department does not regard CA appointments as training posts, and has advised authorities against representing them as such. There are, however, alternative avenues of advancement available to existing CAs.

5. From 1 June 1985; previously, 1 year.

Hospital Practitioner

11. A CA who:

is a principal in general practice; and

has been fully registered for 4 years (5 for dentists); and

11.3 has 2 years' whole time hospital experience in a relevant specialty, or its equivalent; OR

11.4 possesses an appropriate specialist diploma and has at least 5 years' experience as a CA in a relevant specialty, or its equivalent

may at any time apply for re-grading as an HP (or compete for an advertised post). Such an application is subject to approval by the district and region, with the advice of professional committees. Authorities may request dispensation with the need to advertise. Posts are limited to 5 sessions and are tenable, after a year, until retirement.⁽⁶⁾

Associate Specialist

12. Other CAs who:

12.1 have at least 3 years' (4 for dentists) hospital experience since full registration, including 2 as a Registrar in an appropriate specialty, or its equivalent

may apply on a personal basis for re-grading as an AS. Unlike HPs, ASs are not regarded as established posts filled by competition, and lapse when vacated. Such an application is subject to approval by the district and region, with the advice of the regional manpower committee, and then of the Department, with the advice of the Central Manpower Committee. Exceptionally, posts may be advertised if authorised in the same way as a personal application. This facility covers a very limited field, eg, refraction, audiology, blood transfusion and dental services for long-stay patients. Posts may be, and

usually are, whole-time and are tenable, after a year, until retirement.⁽⁷⁾ ASs share certain consultant privileges, notably the maximum part-time option, the 10% rule, and the possibility of temporary additional sessions.

For the purpose of awarding incremental credit, CA service is treated as equivalent to Registrar service.

Re-training

13. CAs may move back into a training grade and qualify for protection of their maximum salary, provided that they have been CAs for at least a year.

C MANPOWER

General

14. In 1984, 7716 medical and dental CAs provided a whole-time equivalent (WTE) of 1917.8. Since 1979, numbers have fallen by 2.2%, but WTEs have risen by 3.4%. the proportion of CAs to hospital medical and dental staff decreased from 17.8% to 16.2%, and from 5.3% to 5% by WTEs. The attached Tables give a detailed analysis.

Medical CAs:

Gmps and non-gmps

15. Most medical CAs are gmps, but non-gmps work the majority of CA hours. From 1979 to 1984 gmp numbers and the WTEs of hospital doctors, excluding CAs, both increased by about 10½%, but gmps participated less in CA work, and non-gmps participated more. The number and WTEs of gmp CAs fell by 0.5% and 5.8%, respectively. Non-gmp CAs also fell 7½% by number, but rose 12.2% by WTEs (Table 6). The proportion of the gmp population⁽⁸⁾ doing CA work is now about 17½%, compared to 19½% in 1979. The offsetting increase in non-gmp participation is attributable first to overseas-born doctors and secondly to women.

7. PM(81)16; TCS paragraphs 5 and 7; Hospital Staffing Structure:
Third Progress Report (1972).

8. Unrestricted principals (GB).

Place of birth

16. Overseas-born doctors constitute 26.7% of CAs and provide 36.5% WTEs. Their average sessional commitment is considerably higher than that of UK and Irish-born doctors (Table 1). Since 1979, there has been a substantial increase of 37.5% in their WTEs (Table 5). It is non-gmps who account for most of this rise. The role of overseas-born doctors, of both sexes, among gmp CAs seems unremarkable: 21% of all gmps are overseas-born, and their number has increased by 20.4% since 1979; they are slightly over-represented among gmp CAs (23% by number) and work slightly longer hours. By contrast, overseas-born doctors account for a third of non-gmp CAs by number and 45.7% by WTE (Table 11), compared to 28.8% and 29.4%, respectively, among other hospital grades. They have the highest average hours, and the men do more than the women. Among other hospital grades there has been an 18.1% increase since 1979 in the proportion (WTEs) of UK and Irish-born doctors and a 4.7% drop in those born elsewhere. Among CAs, the proportion of UK and Irish-born doctors fell by 10.1%. So the prominence of overseas-born CAs seems explicable, at least in part, in terms of the diminution of outlets in regular hospital posts, combined with the availability of employment in specialties and/or kinds of activity where regular posts are judged inappropriate or, in other cases, prove hard to fill.

Sex and age

17. The age profile of CAs has not changed greatly since 1979, with the bulk of practitioners in the 40-60 range (it is estimated that about two-thirds of the current CA work force have been in post longer than this (Table 13)). Nor is there a marked difference between the age distribution of the sexes (Table 4A). But women have entered the younger age bands up to 35 faster than men, and the number of women has increased overall and in every age band, save over 65. The number of men has fallen overall and in every age band, save 35-39 (possibly new entrants from general practice, for whom this is also the fastest growing age band). Women now account for 27.8% of CAs, provide 33.7% WTEs, and do more sessions on average than men. Since 1979, there has been an increase of 16% in their WTEs (Table 4B). As with overseas-born doctors, it is non-gmps who account for most of this.

18. Over this period, the recruitment of women to general practice has been strong: an increase of 32%; and they now constitute 18.4% of the gmp population. They are in fact under-represented among gmp CAs, at 12.3% (12.8%

WTE). By contrast, 57% (52.2% WTE) of non-gmp CAs are women (Table 10); and of those born in the UK and Ireland, twice as many are women as men, and they work slightly longer hours. The recruitment of women to hospital grades other than CA has been almost as strong as to general practice (+ 29.3% WTE since 1979), and women now constitute 22.3% WTEs of those grades. Even so, women remain heavily over-represented among non-gmp CAs. Given the expansion of career opportunities for women, personal choice seems likely to be a stronger factor in influencing them to become and remain CAs than it is for overseas doctors; but it is far from clear that the increased participation of women in the CA workforce is wholly explicable in those terms.

Hours of work

19. Most CAs still work short hours, and most are contracted to one authority (Table 12). Only 14.1% have over 5 Sessions and 41.7% have one or less. The average commitment was 2.7 sessions in 1979 and is now 2.8. These averages mask considerable variations. By specialty, the proportions working over 5 sessions range from under 3% for assistants in dermatology to nearly a third for those in mental illness (Table 7). Table 1 summaries variations by groups of practitioners. Only 4.1% of gmps have over 5 sessions, compared to 27% of female non-gmps, a third of non-gmps generally, and 57% of those born overseas.

20. The number of CAs with 9 sessions is 522. Half the sessions are in mental illness, anaesthetics and A & E, and 65% are held by overseas-born non-gmps. The number of doctors concerned increased by 39% in 1984 over 1983, but from a relatively small base, and the total represents only 7.5% of all CAs and 1.1% of hospital medical WTEs. It cannot be assumed that these sessions would be readily convertible to whole-time posts: 10% are aggregates of multiple employments, (Table 12) and 8% are gmp appointments, presumably involving concurrent hospital and practice cover.

Specialties

21. The top 5 specialties, accounting for over half of CA manpower, are, in descending order: mental illness; geriatric medicine; A & E, anaesthetics; and general medicine. For gmps, the leading specialty is geriatrics; and, for non-gmps, ophthalmology, obstetrics and gynaecology and - notably for overseas-born doctors - mental handicap are also important fields. (Tables 8 and 9).

Relative to hospital medical service, CAs provide a significant, and rising, contribution in mental illness, mental handicap, ophthalmology and blood transfusion. It is still significant, but falling, in A & E, geriatrics and dermatology (Table 2).

Regions

22. In most regions ⁽⁹⁾, CAs provide 4-5% of hospital medical WTEs, although the heaviest users of CAs (in South Western, Wessex, SW Thames) are about twice as reliant on them as the lightest (in Trent, Northern, Mersey). Changes since 1979 reveal no clear pattern; in half, CA WTEs have been increased, by up to 40%, and in half they have been reduced, by up to 17% (Table 3). The regional distribution by specialty ⁽¹⁰⁾ approximates the national one, with the possible exception of South Western, where CAs provide 21% of mental illness services, compared to 8.2% nationally.

Hospital Practitioners and Associate Specialists

23. Some of the gmps who were CAs in 1979 will have been re-graded as HPs and some of the non-gmps as ASs, but recruitment to these grades does not appear to account for any substantial or sustained movement. The current WTE for HPs is 235 and for ASs 824. Neither figure has altered significantly in the last 4 years.

24. The specialties in which HPs are concentrated match those in which gmp CAs predominate (Table 8). The following account for 65% of HP time, in descending order: geriatrics; general medicine; anaesthetics; mental illness; o & g; a & e; and dermatology. A similar relationship holds for ASs and non-gmp CAs (Table 9): 67% of AS time is devoted, in descending order, to: mental illness; anaesthetics; a & e; geriatrics; traumatic and orthopaedic surgery; blood transfusion; o & g; and mental handicap.

25. Of about 1,000 practitioners in each grade, HPs are by definition part-time, and the majority - 62% - of ASs are whole-time. Only 22% of ASs have 5 or fewer sessions each. The use of the grade does not appear to reflect the intention of providing career posts for practitioners unable or unwilling to work full-time.

(9) together with Wales and the London SHAs

(10) not tabulated

26. | It appears (on the basis of an analysis of applications referred to the Department from June 1982 to September 1984) that the majority of doctors seeking re-grading as AS are women UK graduates and overseas-born men. Of the applications determined by September 1984, half had been from CAs, of whom two-thirds were unsuccessful. The analysis suggested that both the number of applications and the likelihood of success were declining.

DHSS/FPS1

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