



# British Association for Sexual Health and HIV

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## JOB PLANNING GUIDANCE FOR CONSULTANTS IN GENITOURINARY MEDICINE (GUM)

**GUIDANCE PRODUCED BY BASHH WITH REPRESENTATIVES FROM BASHH, GUM  
JOINT SPECIALTY COMMITTEE (JSC) ROYAL COLLEGE OF PHYSICIANS AND  
DERMATOVENEREOLOGY COMMITTEE OF BRITISH MEDICAL ASSOCIATION (BMA)**

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### INTRODUCTION

This guidance has been produced to provide practical advice to assist GUM consultants in the United Kingdom with job planning, particularly with respect to the new consultant contract 2003. Advice specifically relating to England and Scotland has been included. Advice specifically relating to Wales and Northern Ireland will be issued as an addendum as soon as details are available.

Since 1991 it has been a requirement for all consultants to have a job plan, agreed with their general manager, which is reviewed annually. The need for a job plan remains whether or not the consultant elects to take up the new consultant contract 2003. However, job planning is particularly important for the successful implementation of the new consultant contract 2003.

Guidance on job planning has also been produced by the Central Consultants and Specialists Committee (CCSC) of the British Medical Association (BMA) and the NHS Modernisation Agency<sup>1,2</sup>. In addition, suggested workload recommendations are described in the document Consultant Physicians Working For Patients<sup>3</sup>. These have all been used to form the basis of the BASHH guidance and are valuable sources of information. Consultants are strongly advised to read them, in addition to this speciality advice, before completing their job plans.

Consultants may wish to discuss their position with their human resource department, or use the ready reckoner, to assess what their individual outcome would be, both in the short and long term, if they changed to the new consultant contract 2003<sup>4</sup>.

In order to receive full back-dating of pay under the new contract an individual consultant should have made a commitment to it by 31 October 2003 (31 December 2003 in Scotland)<sup>5</sup>. If a commitment is made later, but before 1 April 2004, pay will be back-dated for 3 months.

Eligibility for back-dated pay depends on agreeing a job plan within 3 months of making an individual commitment. However, if this is not possible for reasons beyond the individual consultant's control then the right to back-dated pay is retained.

### TERMINOLOGY

The old consultant contract was based on notional half days (NHDs), which were regarded as the equivalent of a period of 3 ½ hours. Under the new consultant contract 2003 there is a different definition of working time, known as a Programmed Activity (PA), which is typically 4

hours long in standard time. From 1 April 2004, premium time is differentiated from standard time. Standard time in England is between 7am to 7pm Monday to Friday, in Scotland it is between 8am to 8pm Monday to Friday. Outside of these times, including all day on Saturday, Sunday and public holidays, premium time applies and PAs are typically 3 hours long.

It is crucial that all workload and activity is captured, in order to allow an accurate job plan to be drawn up and agreed.

## **DESCRIPTION OF CONTRACTS**

Different types of contracts will be available including:-

1. Old style existing contract - whole-time.
2. Old style existing contract - maximum part-time.
3. Old style existing contract - nine NHDs or less.
4. New style contract – 10 PAs (1-2 PAs and/or additional remuneration may be added).
5. New style contract – part-time based on number of PAs worked.

## **AGREEING A JOB PLAN**

The new consultant contract 2003 and the Terms and Conditions of Service 2003 state that job planning should be a partnership approach with the job plan being drawn up and agreed between the consultant and their clinical manager<sup>6</sup>. It is inappropriate for the process to be undertaken by a non-medical manager. It is crucial that the first job plan under the new consultant contract 2003 accurately and fairly reflects the consultant's current activity.

Where a consultant works for more than one employer, one should be identified as the lead employer who will assume responsibility for agreeing the entire job plan.

A job plan is a detailed description of the duties and responsibilities of a consultant and of the facilities needed to carry them out. It incorporates a work programme showing the nature, location and timing of the consultant's commitments, which are agreed between the consultant and the employing Trust.

The first step in the process for the consultant is to keep a record of their current activity by collecting activity data in a diary. A standard diary has been produced by the Department of Health and can be downloaded<sup>2</sup>. It is important for individual consultants to check with their employing Trust to ensure that the data-collection diary they use is the one approved by the employing Trust.

The normal working week for a full time consultant will be 10 PAs, of which 7.5 PAs will typically be for direct clinical care and 2.5 PAs will be for supporting professional activities (SPAs). However, whilst this is a typical figure, modification may be needed for individual consultants, particularly where the consultant has heavy commitments in non-clinical areas.

It is particularly important to note how much work is performed in premium time, as after 1 April 2004, any work performed outside 7am to 7pm Monday to Friday in England and outside 8am to 8pm Monday to Friday in Scotland, will count as premium time. If this is applicable, it is recommended that an agreement is reached with the employing Trust, at the first job planning meeting, on how this will be dealt with.

If the individual consultant's job requires more SPAs, or includes additional NHS responsibilities or external duties, this needs to be reflected in the job plan. There are a range of ways this may be done, either by reducing direct clinical care, paying extra PAs, or both.

The job plan should also include specific objectives, which are agreed between the consultant and the employing Trust and the resources, which are needed to support the agreed job plan.

## **COLLECTING ACTIVITY DATA FOR THE DIARY**

All of the work done, from arriving at work in the morning until leaving at night, should be recorded. Travelling time should be included between sites and where extra time is taken getting to a site, which is not the consultant's usual place of work. All of the work done on-call should be included, such as telephone advice, travelling to and from work and waiting time to begin work. Flexible breaks for food can be included as part of a PA, if the consultant is available for contact during the period.

The following three general categories are available:-

### **1. Direct clinical care**

**This should equate to 7.5 PAs ie. 30 hours, based on 1PA = to 4 hours.**

**It will be less after 1 April 2004 if the PAs are in premium time and equal to 3 hours.**

**It may be modified depending on the individual consultant's other commitments.**

This includes work directly relating to the prevention, diagnosis or treatment of illness, both planned and emergency duties. It also includes administration relating to direct patient care, and travelling time relating to on-call emergency care or between hospital sites. The administrative load will vary between consultants and the BMA advice is that it is inappropriate for Trusts to set a 'tariff' for the proportion of administration to the overall amount of direct clinical care.

The exact composition of direct clinical care will vary between consultants but the hours spent on the following should be included, where applicable:-

- Out-patient or other clinic, whether performing or providing cover for the clinic. If cover is being provided the consultant should be available for direct clinical care. Out-patient clinics relating to GUM consultants may include general GUM, HIV and/or mother and baby, colposcopy, psychosexual, erectile dysfunction, genital dermatology, young/older person, sex worker, or family planning/contraception clinics. This is not an exhaustive list and will vary between individual consultants. It should also be noted whether there are other factors influencing the complexity of the clinic, such as the case-mix, numbers and skill-mix of supporting staff, concurrent nurse practitioner, clinical assistant or doctors in training clinics, or teaching commitments, both undergraduate and postgraduate.
- Clinical supervision of doctors in training, non-consultant career grade doctors and nursing staff. This is complementary, but separate to educational supervision or teaching, and focuses on enhancing the delivery of clinical care. It may include a wide variety of activities but typically includes, direct supervision in the clinic, discussion of individual cases, and reviewing the clinical management of patients.
- Patients seen in the clinic but outside the usual clinic times.
- Patient or relative consultation.
- Ward round.
- Operating session, including minor procedures eg. diagnostic skin biopsy.
- Patient treatment or procedure eg. lumbar puncture.

- Investigative, diagnostic or laboratory work.
- Telephone advice to other hospitals or colleagues, both in secondary and primary care.
- Visits to other hospitals, hospice centres and community facilities to see patients.
- Meetings about direct patient care, these may be between doctors or multidisciplinary with other healthcare professionals.
- Public health duties eg. work with public health colleagues, during outbreaks of infection or to implement the sexual health strategy, liaising about notifiable conditions, clinical coding for KC60 (ISD(D)5 in Scotland) and case note review.
- Travelling time between sites, not to usual place of work.
- Patient administration, which includes dealing with referrals, letters, following up results and reviewing case notes. This should also include the time spent on dealing with reports eg. for social services, disability living allowance, child protection, medico-legal and in association with asylum seekers who are HIV positive, specifically with respect to the Home Office, solicitors and for social support.
- Work on developing guidelines for patient care or clinical pathways.
- All clinical work relating to on-call emergency duties, including all travelling time and waiting time relating to on-call work. If cover is provided for colleagues during their annual and study leave then, based on 6 weeks annual leave and approximately 2 weeks study leave plus statutory days, up to 10 weeks cover per year could be required. Additional cover is also required for colleagues during approved special or discretionary leave. This means the consultant's average out-of-hours workload is likely to be 25% greater, than that measured when no one is on leave.

## **2. Supporting professional activities (SPAs)**

**This should equate to not less than 2.5 SPAs ie. 10 hours, based on 1PA = to 4 hours. It may be higher depending on the individual consultant's commitments.**

These are activities which underpin direct clinical care and all consultants need at least 2.5 SPAs. If more are required than this must be negotiated with the employing Trust, as described in 'Agreeing a job plan'. Activities in this category include:-

- Participation in training, which includes medical students; doctors in training, both in GUM and other specialities; community doctors and nurses, including those in primary care and family planning; health advisors; nurses and midwives; and other community groups, such as schools or the voluntary sector. It is particularly important for educational supervisors to include the time spent teaching doctors in training in GUM, arranging their required training, performing assessments and appraisals, and in completing any necessary supporting documentation.
- Undergraduate examining for medical school.
- Continuing professional development, including medical education and keeping up to date with relevant medical journals and literature. This should also include the time spent in recording this activity with the Royal Colleges, either using the paper or electronic system.
- Teaching, which includes formal teaching responsibilities to medical students; doctors in training, both in GUM and other specialities; community doctors and nurses, including those in primary care and family planning; health advisors; nurses and midwives; and other community groups, such as schools or the voluntary sector.
- Audit.
- Clinical governance.
- Job planning.
- Appraisal. This should also include the time needed to collect data and keep the appraisal folder up to date for personal appraisal as well as the time spent in appraising others.

- Research.
- Clinical management. This includes work needed for service delivery within the GUM clinic, outreach facilities, community services or within the Trust, but which is not related to direct patient care.

### **3. Additional responsibilities**

Additional responsibilities are undertaken by some consultants. These duties may be scheduled into the job plan or an agreement may be reached for flexible working. The time allowed for these duties, the action to be taken by the consultant should any further time be required, and the notice which the consultant will give for any absence in relation to the duties should be agreed with the employing Trust.

The duties fall into two categories:-

#### **a. Additional NHS responsibilities**

These are special responsibilities, which are agreed between a consultant and the employing Trust, which cannot be absorbed within the time set aside for SPAs. These are specific to individual consultants and usually support the work of the NHS by special responsibilities, usually within the Trust or in relation to education.

The list is not exhaustive but the type of responsibilities include:-

- Medical director.
- Director of public health.
- Clinical director, lead clinician, head of service.
- Caldicott guardian.
- Clinical audit lead.
- Clinical governance lead.
- Undergraduate or postgraduate dean.
- Director of postgraduate education.
- Clinical tutor or regional education advisor.
- Trust committees.

#### **b. External duties**

These are duties which are not included in any of the other categories and which do not fall within the categories of fee paying services or private professional services. They are undertaken as part of the job plan by agreement between the consultant and the employing Trust. It may be difficult to work out the amount of time spent on these duties as the work may be irregular and unpredictable. Where it is predictable it should be set out and scheduled in. Where it is unpredictable an agreement should be sought about the amount of time required for these duties. External duties are specific to individual consultants and usually support the wider work of the NHS by special responsibilities, usually external to the employing Trust, on a National basis.

Consultants performing these duties should highlight with their employing Trust that external work is crucial to the function of the wider NHS and that many of the external duties include clinical governance and education components. These duties are not only essential to the wider NHS but also will ultimately benefit the employing Trust, as individuals get specialist expertise and knowledge.

The list is not exhaustive but the type of responsibilities include:-

- Trade union duties.
- Membership of Advisory Appointments Committees.
- Undertaking inspections for the Commission for Health Improvement (or its successor body).
- Undertaking inspections for the National Clinical Assessment Authority.
- Participating in Peer review visits.
- Reasonable quantities of work for the Royal Colleges in the interests of the wider NHS, including examining duties.
- Reasonable quantities of work for specialist societies in the interests of the wider NHS. This would include work for BASHH and the Special Interest Groups.
- Reasonable quantities of work for a government department.
- Specified work for the General Medical Council.

## **SPECIFIC SITUATIONS**

### **1. On-call work**

All emergency work on-call is counted as part of direct clinical care as described in 'Direct clinical care', including travelling and waiting time as part of emergency duties, and any time spent on telephone calls as part of emergency duties. It does not include the time spent on-call but not actually working, this is recognised by the availability supplement as described in 'Availability supplement'.

Some on-call work will be predictable eg. ward rounds after an on-call period, and should be programmed into the job plan.

Other work will be unpredictable eg. recall for an emergency admission or a telephone consultation. Unpredictable on-call work is more difficult to assess but can be measured over a typical rota period and averaged to obtain a weekly amount. This can then be allocated into the weekly job plan. Until 31 March 2005, a maximum of 1 PA can be allocated per week for unpredictable work. From 1 April 2005, the maximum is 2 PAs but if more than 2 PAs are being worked after this time, then the employing Trust can recognise this by pay or time off.

Until April 2006, in England, the employing Trust can require the consultant to perform extra paid PAs, if recognising the on-call work would reduce the consultant's daytime clinical activity.

### **2. Availability supplement**

In addition to the actual clinical work done on-call, which is recognised as indicated in 'Direct clinical care', there is an additional supplement paid for being available on-call. The amount of the supplement varies from 1% to 8% of the basic consultant salary and depends on a number of factors such as, the number of consultants on the rota and whether the consultant is expected to return immediately to site.

If the consultant is typically required to return immediately to site when called, or has to undertake complex interventions eg. telemedicine or complex telephone consultations, this is Category A in England and Level 1 in Scotland. If the consultant can typically respond by giving telephone advice and/or returning to site later, this is Category B in England and Level 2 in Scotland. A higher supplement is paid for Category A (Level 1) compared to Category B

(Level 2) and it is important to agree with the employing Trust which category or level is applicable.

If the employing Trust assesses the consultant's duties as falling within Category B (Level 2) the consultant may arrange with the employing Trust for short intervals during the on-call period when they may not be contactable immediately. In these circumstances the consultant must agree the intervals with the employing Trust in advance, make arrangements for messages to be taken during any agreed intervals and respond immediately after the interval.

On-call rotas of 1 in 4, or more frequent, are considered high frequency. The employing Trust should review these rotas annually and take any practical steps to reduce the on-call frequency.

This is an area where a collective agreement for all consultants operating within the same rota might be agreed with the employing Trust.

### **3. Extra programmed activities**

The basic working week for a full time consultant is 10 PAs ie. 40 hours until 1 April 2004. It may be less after 1 April 2004, as PAs, including work done on-call, outside 7am to 7pm Monday to Friday in England and outside 8am to 8pm Monday to Friday in Scotland, will be reduced to 3 hours duration, with the onset of premium time.

There is no obligation to work beyond this, except as described in 'On-call work'.

It is important for consultants to demonstrate to the employing Trust the number of hours being worked, so that additional payments can be agreed for this work. The best way to do this is by carefully and accurately filling in the diary sheet as described in 'Agreeing a job plan' and 'Collecting activity data for the diary'. This should be done at the first job plan meeting.

An additional 2 PAs or SPAs can be agreed with the employing Trust. These may be paid under a separate contract and this should be clarified with the employing Trust.

According to the European Working Time Directive consultants should not work more than 48 hours for the employing Trust, unless an individual opt out is signed.

### **4. Private professional services**

Consultants wishing to undertake private professional services, also known as private practice, are advised to inform their employing Trust in writing of this. Under the new consultant contract 2003 there is no requirement for consultants undertaking private practice to work more than 10 PAs. However, one of the criteria for pay progression is that the consultant accepts an extra paid PA, if offered, before doing private work. This may be obviated if the consultant is already doing 11 PAs, or if the employing Trust does not wish to offer an additional paid PA. There must also be equity in the system, which means that additional PAs must be offered to all consultants in the speciality employed by the Trust. If the additional PAs are taken up by colleagues there is no impact on the consultant's pay progression. The requirement for former maximum part-time consultants to offer the additional PA will be phased in during a transitional period.

It is essential to clarify with the employing Trust how the system will be operated with respect to GUM and collective negotiation with colleagues, or via the local negotiating committee, may be appropriate.

## **5. Fee paying work**

This includes Category 2 work, domiciliary consultations and Section 12 Mental Health Act assessments but with respect to GUM it predominantly applies to Category 2 work.

Consultants may receive additional fees for work done in their own time but they should not receive fees for work conducted during NHS PAs. It is important to recognise that some work eg. lectures, which may be conducted in NHS PA time, may include substantial preparation work conducted outside the NHS PA time, and this will need to be included in discussions with the employing Trust regarding fee-paying work.

There is flexibility for the employing Trust to allow the consultant to retain the fee if there is 'minimal disruption to NHS work' or to agree to 'time-shifting' to allow the NHS time to be made up at another time. Alternatively, it may be agreed that the work is adopted as an agreed PA with the fees going to the employing Trust. It is important to clarify with the employing Trust how the system will be operated with respect to this work and collective negotiation via the local negotiating committee may be appropriate.

## **6. Premium time**

From 1 April 2004, premium time is differentiated from standard time, as described in 'Terminology'. Reimbursement of premium time is typically achieved by shortening the PA to 3 hours. However, it can also be achieved by reducing another PA by 1 hour, or agreeing an enhanced payment for the activity. Where a PA falls only partly in premium time the reduction in the hourly value will be on a pro-rata basis.

The employing Trust cannot schedule non-emergency work in premium time without the agreement of the consultant, except in Scotland where work can be imposed on Saturday between 9am and 1pm and public holidays, after a job plan appeal.

## **7. Compensatory rest**

The European Working Time Directive recognises that it may not be practical for consultants to take the minimum continuous rest break provisions of 20 minutes every 6 hours, 11 hours in every 24 hours and 24 hours off per week. Therefore, consultants do not have an entitlement to take them at these times. However, if they are unable to take them at these times then compensatory rest can be claimed at another time. The compensatory rest, which is due, should be scheduled into the job plan using a weekly estimate. The BMA have produced guidance on this topic<sup>7</sup>.

## **8. Part-time workers**

Part-time workers who elect to move to the new consultant contract 2003 may wish to transfer over on the number of hours currently paid for, or on the number of hours actually worked, depending on their personal situation, and the job plan would need to be agreed to reflect this.

Proportionately more time is required for supporting activities and the ratio of direct clinical care to supporting professional activities should be on a 2 to 1 basis.

Additional PAs with respect to private work should be on a pro-rata basis.

## **9. Location of duties**

The contract will state the consultant's principal place of work and they will generally be expected to undertake the programmed activities at their principal place of work. However, off-site working can be agreed for administration or SPA work by negotiation with the employing Trust, subject to agreement on the amount of time involved and flexible working of the time on the part of the consultant.

## **10. Travelling time**

Travelling time should be included when on-call, incorporating the time taken travelling to and from work in response to a call out. Travelling time should also be included when not on-call, where extra time is needed to travel between sites, or to a site which is not the consultant's usual place of work.

## **11. Sabbatical leave**

In England, a consultant may apply for sabbatical leave in accordance with the employing Trust's current arrangements. In Scotland, a consultant is eligible to apply for one period of paid sabbatical leave of up to 6 weeks after 7 years of service, or 3 months after 10 years of service.

## **AGREEING SPECIFIC OBJECTIVES**

Specific personal objective should be included in the job plan. These need to be appropriate and agreed between the consultant and clinical manager. The consultant will need to make every reasonable effort to meet these objectives in order to achieve pay progression.

Objectives could relate to quality, clinical outcomes, standards, service objectives or development, resource management, team objectives, educational activities, network roles, audit and evaluation, research and development. This list is not exhaustive and the specific objectives identified depend on the individual consultant and the specific service situation. However, the objectives must be reasonable and specifically agreed by the consultant. There is no obligation to agree to any objectives which the consultant thinks are unreasonable, specifically where there are factors outside the control of the consultant eg. waiting times.

It is crucial that the consultant considers their own objectives and is able to explain and justify them when discussing the job plan. If objectives cannot be agreed, then the mediation and appeals procedure may be employed.

## **SUPPORTING RESOURCES**

The resources needed to do the agreed job plan should be identified. It is important that these are included in the job plan as they may be integral to the consultant being able to achieve the agreed objectives. If the objectives have not been met for reasons beyond the consultant's control then pay progression should still be achieved.

The resources needed will depend on the individual consultant and the specific service situation. Particular attention should be given to ensuring that a quality service, which is safe and in the best interests of patients can be provided. The following resources should be considered and included where applicable:-

- The clinic premises should not be less than the standards outlined in Health Building Note 12, Supplement 1, GUM Clinics.

- The numbers of supporting medical, nursing, health advising, pharmacy, administration and clerical staff should allow adequate time for each consultation for both pre-booked and unbooked walk-in patients.
- Specific support for specialised GUM work, including HIV management, genital dermatology, colposcopy, therapeutic procedures, and psychosexual services should be available, where applicable. These may include specially trained nurses, pharmacists, physiotherapists, dieticians, psychologists, psychosexual counsellors or social workers.
- The clinic staffing and facilities should be sufficient to allow all individuals presenting with a new clinical problem suggestive of a sexually transmitted infection (STI), or who consider themselves at risk of such an infection, to be seen on the day of presentation, or failing that on the next occasion the clinic is open.
- High quality clinical diagnostic support should be available. This includes having adequate facilities for near-patient microscopy, appropriate modern, sensitive testing methods eg. nucleic acid amplification tests (NAAT), and laboratory support. For HIV-infected patients facilities for undertaking CD4 lymphocyte sub-sets, viral load assay and resistance testing are essential.
- There should be adequate provision for in-patients, particularly with respect to sufficient and appropriate beds, supporting medical, nursing and other allied staff.
- Any outreach facilities offering GUM services should have satisfactory staffing, premises, and laboratory support and be under consultant supervision.
- A range of antimicrobial drugs, antifungal drugs, antiviral drugs and any other therapies or equipment required for the treatment of common STIs or genital conditions should be available in the clinic so that immediate, appropriate therapy can be given.
- A range of antiretroviral drugs should be available, to enable highly active antiretroviral therapy to be provided for HIV-infected patients, when needed, as well as any other medication required for other intercurrent illnesses or complications.
- Medical secretarial support must be available within the clinic, throughout the time it is open for patient care. The support should also be sufficient for the consultant to perform their direct clinical care, including administrative tasks, teaching, audit and administration.
- There should be designated office space for the consultant with a direct telephone line and appropriate, current information technology including PC and printer, fax, internet and email access. If mobile telephone contact is required facilities should be provided.
- Information systems should maintain the specific GUM confidentiality requirements and be of a sufficient calibre and functionality to deal with the data-requests made of them.
- Appropriate departmental library and seminar facilities should be available.
- Equipment to support teaching should be available, such as audio-visual aids, portable computer and projector, CD-ROM writer, slide projector, slide and text scanner.
- Adequate time and car parking is essential if travel between sites is undertaken and this should be included.

## **DISPUTE PROCESS**

If there is a dispute with respect to the diary data, or on agreeing a job plan, then the consultant may seek informal mediation. This is usually led by the medical director, provided they have not been involved in the job plan under dispute. If this does not achieve resolution then the consultant may initiate a formal appeal process, as described in Schedule 4 of the Terms and Conditions of Service 2003 (England) and Section 3.4 of the Terms and Conditions of Service (Scotland)<sup>5,6</sup>. The consultant has the right to nominate a representative for the formal appeal panel, in Scotland this must be an NHS employee. It would be advisable to contact the BMA, or other appropriate organisation, in this event.

## **JOB PLAN REVIEW**

The job plan should be reviewed on an annual basis although there is the facility for an interim review if the consultant requests this. An interim review is usually proposed because the consultant's duties and responsibilities have changed during the year.

The annual job plan review provides an opportunity for the consultant to discuss any additional work undertaken, any proposed changes to the job plan, and is essential in determining pay progression.

The key points which should be considered at the review include:-

- Factors affecting the achievement of objectives.
- Adequacy of resources.
- Potential changes to duties and responsibilities. This may include changes, which have already taken place.
- Ways to improve workload management.
- Career planning.

## **REFERENCES**

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