Valuing consultants

The consultant charter for the NHS in England

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The Consultant Charter has been developed to provide an overview of the standards you should expect your employers to meet and to help identify where they are falling short. It will help both doctors and employers to recognise what good and bad employment practice for consultants looks like, covering areas such as job planning; safe working patterns; flexible working; workplace environment; facilities and more. The Charter also provides onward direction to additional detailed BMA guidance so that you understand exactly what provisions and protections are contained within the national consultant terms and conditions of service.

The aim of this Charter is:

– To facilitate and provide support for the work of Local Negotiating Committees (LNCs)

– To recognise the expertise that consultants bring as senior leaders who have responsibilities for services and their development; teaching, educating the next generation; advancing research and innovation to improve patient outcomes, as well as direct clinical responsibilities.

It is not intended to be exhaustive but aims to provide a framework to enable consultants to feel empowered in their professional life.

Our vision of the Consultant Charter is for Local Negotiating Committees to use it like an audit toolkit to drive local improvements in the workplace. LNCs should work through the various sections of this Charter on an ongoing basis and in the order that is of relevance locally - this could be because they tie into work that is already ongoing or because they are the areas that are in the most urgent need of addressing.

We are not seeking employers to 'sign up' to the Charter but instead to commit to working through the sections with LNC representatives on an ongoing basis. LNCs should seek to work with employers to assess the Trust's current adherence to the relevant Charter sections by using the appendix items within this Charter that correspond to these sections. Please note that it is recommended that LNCs see the 'Implementation guide for BMA representatives' for advice on wider factors that should be considered in addition to the appendix items that correspond to the Charter sections.

We will publicly acknowledge local employers who comply with the Charter standards by providing them with a Charter mark for the sections they meet. Charter marks will be accredited with the specific time they are acquired and can be reissued so long as the Trust continues to comply with the Charter standards. For an employer to be awarded with a Charter mark against a section of the Charter the LNC Chair and BMA regional member of staff must submit a completed copy of the relevant appendix item to info.cc@bma.org.uk and confirm that the 'Implementation guide for BMA representatives' has been considered against this Charter section and appendix item.

1 Good practice in consultant job planning

Job plans are part of your contract of employment. They are an annual agreement that sets out your duties, responsibilities and objectives for the coming year. The BMA has extensive resources and guidance to support your job planning.

The job planning process should be collaborative and must be mutually agreed, not imposed. You should never feel intimidated or bullied in the job planning meeting, and if there are any specific issues to be raised, a good employer will communicate this in advance so that you are prepared.

Key elements include but are not limited to:

- a timetable of activities
- a summary of all the Programmed Activities or sessions for all the type of work you do (including direct clinical care (DCC), supporting professional activities (SPAs), additional responsibilities, and external duties)
- on-call arrangements
- a list of SMART objectives or outcomes
- accountability arrangements
- any agreed flexible working arrangements, including for example, off site working

We know that being able to undertake wider professional roles helps with job satisfaction for consultants improving both recruitment and retention and extending consultant careers.[1] SPAs underpin clinical care and contribute to ongoing professional development as a clinician. They are the drivers of efficiency, service improvement and productivity; they are the professional glue and provide job sustainability.

Additional responsibilities are duties carried out on behalf of the employer or another relevant body and which are beyond the normal range of SPAs. External duties are not done directly for your NHS employer but are also vital to the functioning of the health systems across the UK. Additional responsibilities and external duties are categories of work within the terms and conditions and as such there should be no expectation that reasonable quantities of this work will be unpaid if the work is agreed to within the job plan. BMA Job Planning

The Academy of Medical Royal Colleges stated back in 2010 that it is unthinkable that a consultant could be employed with no involvement in management, to never be involved in teaching or training of any sort, therefore the original recommendation in the consultant contract of 2.5 SPAs as typical seems reasonable. AoMRC - Advice on Supporting Professional Activities in consultant job planning.

In 2012 the chief medical officers with the GMC wrote to all NHS employers GMC - CMO letter to NHS urging employers to look favourably on requests from doctors to undertake national work of benefit to healthcare systems across the UK. And this was reaffirmed in May 2022 by NHS Chief Executive, Chief Medical Officer, Chair of GMC and Chair of Academy of Medical Royal Colleges in a Letter to CCGs and NHS Trust CEOs regaring appropriate release of medical colleagues for the purpose of carrying out work for the health system.

If you are applying for your first post, the application pack should include a proposed job plan, although accepting the job after a successful interview doesn't mean that this advertised job plan is then the fixed outcome – there should still be a proper job planning discussion before you start.

A key part of job planning is making sure your job plan reflects the reality of your work. Ensuring you track your time accurately and evidencing your workload will help inform job planning meetings if you need to adjust the PAs allocated for each part of your work. The BMA's Dr Diary has been designed specifically to assist with this.

For consultant clinical academics, job planning should be a process undertaken jointly with the substantive university employer and honorary NHS employer in compliance with the Follett Review Principles.[2] Hence, where the employer is referred to in this guidance, for clinical academics it refers to both their NHS and university employers.

1 PDF - Academic factors in medical recruitment: evidence to support improvements in medical recruitment and retention by improving the academic content in medical posts on behalf of Medical Academic Staff Committee of the British Medical Association (researchgate.net)
2 A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties A report to the Secretary of State for Education and Skills, by Professor Sir Brian Follett and Michael Paulson-Ellis September 2001 Microsoft Word – folletreview.doc (bristol.ac.uk)

Terms and Conditions of Service (TCS) state the meeting should be between the Consultant and their Clinical Manager. The TCS are silent on the involvement of a third party, such as a HR Business Partner. The third-party involvement in the job planning meeting should only be with the agreement of the Consultant

It is possible to perform team service planning where there are a number of Consultants carrying out essentially the same number and type of duties, a good example is on-call duties, or to set out the strategic goals within the team. In such circumstances a team service planning meeting/discussion can take place as this allows any generic issues to be addressed. There is, however, no requirement within your TCS to undertake a team service plan, individuals should have an individual job planning meeting separate to any team service planning. Consultants should not agree team objectives in their individual job plans as the achievement of these will often not be within their individual control.

Job plans are not set in stone. There is an expectation that they will need to change over time to reflect your varying needs, the service needs, new treatments and new patient pathways. An interim review of your job plan can be requested either by you or your line manager at any point during the year if your circumstances change, that affect your work requirements and/or workload or if changes are being made to your job plan. You don't need to wait for the annual job plan review meeting.

You should not feel forced to agree any changes that you believe to be unfair. It is perfectly reasonable to say that you are not happy with the proposed changes that are being made and that you will need time to consider these. In doing so, you can reasonably request information pertaining to the justification for the changes. If you are still unable to reach mutual agreement on your job plan, you can use the mediation process and, if necessary, a job planning appeal.

Good practice

A good employer will recognise the need for a job plan that balances Direct Clinical Care (DCC) activity with the other essential aspects of a consultant role, such as medical education and training, medical research, personal education and professional development, clinical governance roles, and appraisal and revalidation. These are all categorised as Supporting Professional Activities (SPAs).

Your job plan will also need to accommodate other NHS responsibilities and external duties, which are also vital to the functioning of the health system. NHS Employers and the Department of Health & Social Care both endorse the importance to the wider NHS of work beyond local healthcare delivery.

Given the range of roles and responsibilities that consultants are usually expected to take on, as senior doctors and leaders of a service, an appropriate job plan will allow for a minimum of 2.5 PAs (10 hours) of SPA time per week, for a full-time consultant as per the model contract (paragraph 7.3).

Recognising that consultants need more than 1.5 PAs of SPA time to deal with other administrative tasks (emails, meetings, etc.).

SPA allocation should be sufficient to cover the full scope of practice such as service development and clinical leadership roles.

Ensuring that the job planning process enables discussion of, and gives equal weight to, supporting resources that are necessary for fulfilling elements of the job plan.

Job plans will be reviewed annually to ensure that the PAs allocated to specific activities match what is actually being worked (Schedule 3, paragraph 17).

A good employer will implement systems to facilitate interim reviews of job plans (which both parties can request, as per Schedule 3, paragraph 22). Where consultants demonstrate that their workload exceeds 15% above their PA allocation, a job planning meeting will automatically follow.

You should be able to access an interim review of your JP if requested by either you or your line manager at any point during the year – you do not need to wait for the annual JP review meeting if your circumstances or workload have changed.

A good employer will communicate in advance of the meeting who is attending and if there are any specific issues to be raised so that you are prepared. It should be confirmed that the purpose of the meeting is JP and not any other matter.

If issues are sprung upon you that you were not expecting it is reasonable to ask that the meeting is deferred/ rescheduled and have time to consider and take advice etc.

Providing time off in lieu (TOIL) for consultants when they attend training courses or conferences for their role on days they would not normally work.

Poor practice

The absolute minimum time required for SPAs in a job plan is 1.5 PAs (6 hours) per week, though this will only cover the time required for individuals to meet appraisal and revalidation requirements. Any employer that limits consultant SPA time to 1.5 PAs could not expect them to perform other critical elements of the consultant role, such as training, service development, audit and governance.

To limit SPA time to less than the minimum recommended 2.5 PAs for a full-time consultant is a very shortsighted approach and represents poor practice. If all employers took such an approach, work that is essential to training and governance would be critically affected, and the health system would cease to operate effectively.

The importance of consultants having time for educational and training roles is addressed in more detail later in this document.

Some employers have sought to further reduce SPA time available to consultants, have limiting or refusing to support their involvement in other NHS responsibilities (such as clinical governance or educational roles) and external duties (such as administering assessments and examinations for their specialty).

Additional time must be agreed for performing trade union duties and such activity should not be discouraged or subject to pressure or harassment by an employer.

2 Effective medical appraisal

A medical appraisal is a process of facilitated self-review supported by information gathered from the full scope of your work which culminates in an annual meeting between a doctor and their appraiser (or appraisers in the case of consultant clinical academics).

Medical appraisal can be used for several purposes. Crucially, the supporting evidence you gather is key to demonstrating your GMC fitness to practise. It can also help you to plan your professional development, identify learning needs and to demonstrate you are remaining up-to-date and fit-to-practice.

Whilst appraisal has bearing on job planning and vice-versa, these must remain as separate processes to mitigate potential conflicts of interest.

You can read more about the elements of the appraisal process from the AoMRC Medical Appraisal Guide 2022, AoMRC - Medical Appraisal Guide 2022 and also the BMA Medical Appraisal Guide.

If you are due an appraisal while on parental leave, please contact your appraisal office at your earliest convenience in the usual way to discuss how you can best be supported. Some doctors choose to pull their appraisal forward to plan for their parental leave; others delay their appraisal and wait to have it on their return to work.

Good practice	Poor practice
Providing systems and processes that allow for the effective gathering of evidence to support appraisal and revalidation.	Using the appraisal as a box ticking exercise, focused solely on organisational objectives, rather than considering broader professional career development.
Using the appraisal process to create a safe and supportive space for reflection and thinking about career development.	Creating a judgemental or combative environment which might limit the opportunity for critical self-reflection or examination.
Ensuring that the full scope of a consultant's practice is covered and is valued.	Failing to communicate with sufficient notice about appraisal timescales and detail about what needs to be covered.
Working collaboratively with consultants to identify individual learning needs and develop a plan for how those needs might be met.	Merging or dissolving the distinction between the appraisal and the job plan, rather than keeping these processes distinct.
Timely communication about when appraisals are due to take place and what evidence will and won't be expected.	Failing to maintain the confidentiality that is fundamental to a supportive and effective appraisal process (unless in exceptional circumstances e.g. where there is a safeguarding issue).
Assisting consultants in selecting an appraiser who is not their line manager and need not be in the same department.	Setting timescales for completion that fail to recognise working patterns of Appraiser or Appraisee, and / or place undue burden on one or the other if deadlines are not met through no fault of their own.
Providing consultant appraisers with adequate time and support to undertake their role.	For academics, failing to engage with the university/ other employers.
For academics, working jointly with the university and other employers as required.	

3 Managing safe patterns of working and avoiding burnout

Being a consultant typically requires any combination of treating the most complex patients in high intensity, time pressured working patterns, at all hours. These can lead to sleep deprivation and fatigue, affecting doctors' health, well-being and performance, their safety and that of their patients. The BMA Fatigue and sleep deprivation – the impact of different working patterns on doctors 2018 report highlights the factors that put doctors at risk and the impacts of this in both short and long term.

Compensatory rest refers to time taken to recover after undertaking work which otherwise interrupts the time that would ordinarily be spent resting. It is essential for patient safety and for doctors' wellbeing that they are able to rest appropriately.

The BMA has BMA compensatory rest guidance - Sept 2024 about appropriate arrangements and the amount of compensatory rest to which consultants are entitled. The key elements are:

- If you are unable to take 11 hours of continuous rest per day, you are entitled to compensatory rest.
- You should not have to "pay back" any activity missed during your period of compensatory rest
- Compensatory rest should be taken as soon as practicably possible after the rest period that has been disturbed
- If your rest period is interrupted, the clock should be "reset" so that you receive a full and uninterrupted 11 hours of rest
- We strongly advocate for free of charge sleep facilities, food preparation area and access to hot food 24 hours a day, 365 days a year
- Compensatory rest should not be calculated on a minute-for-minute basis, based on the duration of the interruption

Good practice	Poor practice
Putting in place simple local systems for consultants to inform their managers that they are too tired to work due to unpredictable activity while on-call and will instead be taking compensatory rest.	Taking a 'minute for minute' approach to compensatory rest, where, for example, a 10-minute call requires only 10 minutes of compensatory rest. This clearly ignores the true impact of a disturbance on an individual's sleep patterns.
Creating a culture in which it is recognised that it is not in anyone's interest for employers to compel doctors to continue working when tired, and not to pressure consultants to avoid or defer taking compensatory rest when it is necessary.	Making a consultant 'pay back' activity missed during their compensatory rest. This would mean undertaking rescheduled work for no additional pay, meaning that their compensatory rest time is effectively unpaid. This irresponsible approach only serves to discourage doctors from actually taking it, even if their tiredness means that it is entirely justified.
Accommodating potential on-call sleep disturbance by scheduling 'predictable on call' sessions on a supernumerary basis the following day. If the consultant is not disturbed, they will be able to attend and assist with the on-call duties. However, if they are disturbed, they will be able to take compensatory rest within the predictable on-call session without detriment to the service or the consultant.	Seeking to schedule 'zero hour' days, or similar, after individuals' on-call as this again means that compensatory rest is unpaid.
Taking into account commitments to other employers, including university employers.	Scheduling SPA time for the day following a night on-call, on the cynical basis that the employer is unconcerned whether such activity is undertaken then or is made up in an individual's free time.
	Failing to agree and implement an appropriate policy to address cover for absent trainees; there is no contractual obligation for consultants to provide such cover and therefore the onus is on the employer to agree arrangements to address this situation.
	Failing to recruit to address workforce shortages and instead relying on existing consultant staff to compensate and cover for vacant posts. It is not acceptable for employers to allow posts to go unfilled in order to generate savings; to do so has serious implications for patient safety and the wellbeing of those expected to pick up the slack. To address this in the short term, employers should be making agreed intensity payments to compensate.
	Failing to give appropriate consideration to academics undertaking research activities the following day, or assuming that it does not matter if they are tired to do so.

4 Less than full time/flexible working and Shared parental leave

Less Than Full Time working (LTFT) or part-time and flexible working is an attractive option for many consultants and can improve recruitment and retention. The BMA has worked with the Department of Health and Social Care (DHSC) and the NHS Confederation in England to reach agreement on LTFT working under the NHS contract, and has produced detailed guidance.

Those whose training has been lengthened by virtue of being in a flexible training scheme (such as those who have trained on a LTFT basis) should have their starting salary on appointment to the consultant grade adjusted to ensure that they are not prevented from reaching the pay threshold they would have reached had they trained on a full-time basis (Schedule 14, paragraph 6).

Offering a form of Shared Parental Leave (SPL) is an important means of providing greater flexibility to parents and adopters. It allows both parents to share caring responsibilities rather than them falling to only one parent and can be a way of mitigating the gender pay gap.

With the consultant pay deal in 2024, Enhanced Shared Parental Leave was agreed as a contractual change. Consultants, like SAS doctors, resident doctors and other NHS staff have access to Enhanced Shared Parental Leave (ESPL) which is paid at the same levels as occupational maternity and adoption pay, meaning it reflects the pay doctors actually earn.

Apart from their timetabled activities, a part-time consultant should have no other commitments during the working week. Variations in the balance of activities will be a subject for agreement between the consultant and their employer.

Good practice	Poor practice
Creating a culture in which individuals feel able to express an interest in LTFT or flexible working patterns.	Asking about intentions around LTFT working prior to appointment. Basing appointment decisions around any such intentions is not legally permitted. You are not obliged to discuss this with your prospective employer before you are appointed.
Developing and communicating various flexible working options, including LTFT patterns; compressed hours patterns to allow work to be condensed into fewer days, or to accommodate caring responsibilities; job sharing arrangements; flexible retirement, etc.	Discouraging or shutting down reasonable enquiries about flexible working. Employers must give all requests for flexible working a fair hearing and must provide objectively justifiable reasons where they believe such arrangements are not practicable.
Embedding discussions of the range of flexible working options in annual job plan discussions; making open conversations about wellbeing a fundamental part of the job planning process.	Restricting opportunities available for development and leadership from LTFT consultants.
Where an LTFT contract is offered, recognising that these consultants have the same time and resource needs around appraisal and revalidation and allocating proportionately greater levels of SPA to accommodate this.	
Ensuring that LTFT consultants are not treated less favourably in respect of accessing professional leadership and development opportunities.	
Being mindful of adjustments to job plans of LTFT Consultants that may need to be made in order to assist them in meeting KPIs, targets and other performance indicators set by the Employer.	
Encouraging doctors to take more equal caring responsibilities by offering enhanced shared parental leave to consultants, promoting flexible working as an option for men and providing resources to help with the costs of childcare.	

5 Working in peri-retirement / adapted working patterns for a late consultant career

Consultants at a later stage of their career are immensely valuable to the NHS, both in terms of the provision of care and of leadership. This value is heightened in the current environment, where the has further stretched the capacity of the NHS to provide secondary care after decades of underinvestment in the workforce.

It follows that employers should make concerted effort to retain experienced consultants considering retirement and explore ways to re-engage those who already have retired. There are several employment pathways available to peri-retired consultants (including locum work), but employers can and should consider offering attractive working arrangements under a retire and return model. The BMA has extensive guidance on working in the peri-retirement period, which is summarised here.

The new partial retirement scheme was introduced in England, Wales and Scotland from 1 October 2023 for those with membership in the 1995 section of the NHS Pension Scheme. To qualify for partial retirement, active scheme members above the minimum pension age will need to reduce their pensionable pay by 10%, which would need to be done in discussion with their employer, including those who contribute to the NHS pension scheme but are not employed directly by the NHS. The new level of pensionable pay would need to apply for at least the following 12 months from the point partial retirement is taken.

There are plenty of ways to reduce pensionable pay and the most effective solution will depend on individual circumstances. Further guidance from England and Scotland

Good practice	Poor practice
Recognising the principle that the retention of consultant medical staff in the workforce is a beneficial goal and having them return under different working arrangements is vastly preferable to losing their experience and expertise altogether.	Refusing to discuss the possibility of retire and return arrangements with individuals. Doing so is unlikely to dissuade individuals from retiring and will only mean losing experience and knowledge from their organisation which could otherwise have been retained in some form.
Allowing consultant staff to go part-time or to relinquish parts of their role that they can no longer safely sustain (including but not limited to on-call or other onerous out-of-hours commitments).	Failing to create a clear and consistent retire and return policy or failing to communicate the existence of such a policy.
Considering how to make best use of the expertise at a later stage of their career consultant, including mentoring roles.	These arrangements should be available across the organisation rather than be used as a retention tool on an individual basis, and the contract and terms offered should not significantly vary.
Developing a clear offer around partial retirement or retire and return arrangements that is well communicated and applied consistently across an organisation.	Seeking to use those accessing partial retirement or retire & return solely to deliver clinical work. Consultants at an advanced stage of their career will have a great deal of experience, including in clinical leadership, and employers should seek to draw on the full range of their expertise.
With regard to partial retirement the optimum approach is for employers to allow flexibility for all, accommodating a changed working pattern or facilitating the structure of remuneration to create the required reduction in pensionable income without the need to change work commitments, thus ensuring service provision is maximised.	Refusing to offer recycling of employer pension contributions to those who are no longer part of the NHS Pension Scheme. There is nothing to prevent employers from paying contributions to the individual – this is a component of consultant pay and, as an offer, makes the prospect of returning after retirement more attractive.
Offering a contract to those accessing partial retirement or retire and return that is consistent with the 2003 consultant terms and conditions of service, allows them to resume their prior job plan, is set at a pay point appropriate to their service, maintains their continuity of service (for the purposes of employment benefits, such as leave entitlements), and that is substantive.	Refusing both changes in service delivery and also refusing to accommodate a change in pay structure to achieve the pensionable pay requirements for partial retirement provisions.
Managing those accessing partial retirement or retire and return reduced commitments carefully and being mindful of minimising detrimental impacts on others within a clinical team. Sensible discussion and broad agreement within a clinical team will be needed to ensure that such changes are effectively managed.	
Departments must also ensure that the additional burden created by someone returning on a reduced hours contract is not simply redistributed among others in the team; they must either seek to fill those gaps with recruitment or ensure that the additional work offered to others in the team is remunerated at appropriate rates.	
Developing a policy which allows for full employer pension contributions to be paid to the consultant's pension scheme or to them directly if this is their preference and better suited to their personal circumstances.	
Continuing to offer SPA time and CPD opportunities to those accessing partial retirement or retire & return.	
Developing a policy on managing menopause, including arrangements for menopause leave.	

6 Health and wellbeing support

Employers have a duty of care to their staff, and it has never been more important that they take steps to ensure that consultants' health and wellbeing are protected.

In a BMA survey in 2021, one in two doctors said they were suffering from depression, anxiety, stress, burnout, emotional distress or another mental health condition, with 38% reporting that this had become worse following the pandemic.[3] Employers need to place the health of consultants and other staff at the forefront of their considerations, rather than it being an afterthought. The BMA's recommendations on maintaining and improving doctors' health and wellbeing are set out in its 2018 report on this issue, and subsequently the BMA published a Mental Wellbeing Charter and accompanying BMA Mental Wellbeing checklist.

Consultants should have timely access to a specialist-led occupational health service that is free, comprehensive, consistent, and meets the individual needs and requirements of doctors working across all settings. Occupational Health (OH) therefore needs to be adequately funded in order to deliver high-quality services.

It is especially important to ensure that those involved in employment disputes or subject to complaints processes, which can take a significant psychological toll on doctors, are properly supported through OH and employee assistance programmes.

The BMA Report - Sexism in medicine highlighted the issue of sexism in medicine, with 91% of women doctors reporting they had experienced sexism at work in the previous two years. Following this the BMA developed the Joint Pledge on Ending Sexism in Medicine guide. The Workers Protection (Amendment of Equality Act 2010) Act 2023, placing a duty on employers to prevent sexual harassment of employees came into force on 26 October 2024. Building on the NHS Sexual Safety Charter, in October 2024 the NHS England Framework for anonymous reporting for NHS staff to report sexual misconduct at work was launched.

BMA also has Your wellbeing which contains additional information on what support is available.

Good practice	Poor practice
Implementing and utilising the BMA's mental wellbeing charter.	Providing limited or no support for staff subject to workplace disputes or complaints processes.
Developing mentoring schemes and support for new starters, and those experiencing difficulties or disputes.	Providing no or delayed access to occupational health and counselling services.
Where a dispute or complaints process is ongoing, providing a specific name for staff liaison in HR and establishing a clear timeline for the process.	Fostering a negative workplace culture where consultants are discouraged from taking time to process psychologically challenging work events or openly discussing them in a supportive forum.
Developing and supporting formal and informal support networks.	Failing to provide easily accessible, replaceable and sufficiently high-quality PPE.
Providing timely access to counselling and mediation services to resolve workplace disputes and support wellbeing. One positive example is of a psychologist appointed to provide mental health support to staff working in emergency departments.	Failing to embed and use the contractual *Maintaining High Professional Standards* processes as the principal means of addressing and remedying concerns about professionalism and performance; resorting to or threatening GMC referral in the first instance rather than making use of these contractual processes.
Ensuring appropriate ventilation and access to adequate personal protective equipment (PPE).	
Fostering a culture in which inappropriate or bullying behaviours are not tolerated; clearly signposting existing processes for dealing with bullying and harassment. A good employer will have developed policies that enable challenging of unacceptable behaviours.	
Having a clear policy for challenging bullying behaviours against those with protected characteristics, and additional wellbeing support and resources for the victims of such bullying, in line with good practice set out in the BMA's Racism in Medicine report.	
Ensuring that consultant clinical academics and other honorary consultants have access to the health and wellbeing support provided by the Trust, if necessary, in consultation with the substantive university employer.	
Takes a proactive approach to reducing sexism in medicine and the workplace.	
Has a zero-tolerance approach to sexual misconduct in the workplace, creates a culture at work where everybody feels safe and has appropriate reporting mechanisms available.	
Has a proactive approach to supporting menopause, developing a menopause policy and arrangements for menopause leave.	

3 https://www.bma.org.uk/bma-media-centre/thousands-of-overworked-doctors-plan-to-leave-the-nhs-bma-finds

7 Working with disability or long-term health conditions

Doctors with a disability or long-term health condition make vital contributions to the health service and should be provided with all support necessary to ensure the longevity of their career. This applies to all consultants, who may find that as they advance through their career that particular activities and working patterns are more onerous and take a greater physical toll.

There is a legal duty on employers to make reasonable adjustments – changes to their usual processes or facilities – to remove barriers individuals face because of disability or a long-term health condition. Reasonable adjustments can be made to support both physical and mental health conditions and for learning difficulties. Adjustments can include changes to processes, to physical spaces, and the provision of specialist equipment. It can also include changes to working patterns. These adjustments will be specific to the individual and context and can change over time.

If you have or develop a health condition, you should expect timely access to occupational health (OH) services. OH professionals should work with you to develop a plan for making adjustments to your duties or working environment which address your specific needs. For example, if an onerous on-call pattern begins to have a significant detrimental impact on your health, an OH professional may recommend to your manager that you be taken off that rota.

Recommendations made by an OH professional should be accepted by an employer in all, but exceptional circumstances and we would have serious concerns about decisions to diverge from these recommendations.

Remote and flexible working should be utilised and appropriately resourced to support disability and long-term health conditions.

Good practice	Poor practice
Demonstrating that colleagues with disabilities and ill- health requirements are valued as highly as any other member of staff. Providing timely access to OH services where an individual requests it or it is required. Making any reasonable adjustments recommended by OH professionals as soon as is practicable. Being mindful of disabilities that are not visible and recognising that these may also necessitate adjustments to regular ways of working. Fostering a culture where doctors are not reluctant to be open about their health. Ensuring that job planning conversations take account of disabilities and tailor work patterns accordingly. Conducting regular audits of disabled staff and support they are being offered. Promoting access and supporting disabled staff support networks; encouraging consultants to be part of them. Ensuring that consultants with disabilities are not disadvantaged in any recognition processes. Ensuring that consultants with disabilities receive equal access and encouragement to take on leadership and research opportunities.	Limiting or delaying access to OH services for those with or developing a disability or ill-health condition. Refusing to make adjustments recommended by OH professionals in a timely way – where such recommendations are made we would expect these to constitute 'reasonable adjustments' within the employer's capabilities and therefore they have a legal duty to make them. Failing to make regular audits of disabled staff and support they are being offered.

8 Career breaks and sabbaticals

A sabbatical is paid or unpaid time away from work to undertake training, other employment, or to pursue personal interests.

The NHS is facing an ongoing workforce crisis driven by doctors seeking early retirement due to exhaustion and burnout. In order to address this, employers will need to take drastic steps to make doctors' working lives more manageable and sustainable. One means of achieving that is pragmatic and widespread use of sabbaticals and career break options.

Doctors with disabilities or with childcare responsibilities may also seek to explore any career break options that are available to them.

Sabbaticals are allowed for by the consultant contract, noting that they may be applied for in line with an employer's sabbatical/employment break policy. Discussions about them should form part of the annual job planning process and are something that a good employer will be open to and supportive of.

Good practice	Poor practice
Using a clear and accessible policy which has been agreed with the BMA.	Taking a short-termist approach to workforce issues and seeking to shut down conversations about sabbaticals/ career breaks.
Fostering a job planning culture that is open and supportive when discussing career breaks – career breaks should be referenced in job planning discussions to remind consultants of the possibility of accessing this opportunity.	Prioritising business/service needs over the needs of the consultant when reviewing requests for career breaks.
Developing roles with a built-in sabbatical component, allowing for relevant experience to be secured abroad or in other working contexts and brought back to enhance the service being delivered.	Authority for granting career breaks being overly bureaucratic.
Allowing reasonable paid work to be undertaken as the default position (where it does not create a conflict for the individual/organisation).	
Recognizing and supporting the value that volunteering and humanitarian work can bring to individuals, and the benefits that new skills and approaches which can be applied to their work in the health service and improving quality of care' added to the 'Good practice' section.	

9 Consultants as clinical leaders

Consultants are leaders of their profession and take ultimate responsibility for their patients, often over many years and with great continuity. They lead the teams in which they work, train the future medical workforce, drive forward the medical research and innovation strategy for the NHS, and work collaboratively with Trusts and other employers to achieve the best for their teams, patients and departments.

Good employers recognise the value that consultants bring to the health service, as an indispensable source of expertise and experience as a senior decision maker, with vital insights into healthcare delivery and service design. Employers should seek to harness these skills and knowledge and facilitate greater engagement of consultants in the planning and development of services.

Employers should recognise and engage with staff representatives, such as LNC Chairs and BMA officers, who will often be consultants, when considering service redesign. Rather than superficially consulting with them, they should seek their input at the earliest opportunity to ensure that consultants are able to shape and improve the care being delivered.

Good practice	Poor practice
Valuing consultants as innovators and leaders; consultants should be integral to service development and key decision makers and should be empowered to drive change.	Failing to recognise the importance of, and appropriately promoting, clinical leadership.
Valuing the clinical expertise that consultants can bring and how this can support and enhance the contributions of non-clinical management.	Only informing or engaging with consultants at a late stage of service design, rather than at a point where their expertise can help shape it.
Ensuring that all consultants involved in a service are involved in developing plans for change.	Expecting or imposing additional leadership responsibilities outside of the consultant's role profile without properly accommodating it within the job plan.
Job planning clinical leadership and medical management roles appropriately; ensuring that time is properly recognised and remunerated, whether as SPA activity, additional PAs, or a separately contracted leadership role. Identifying the mentoring and leadership that is regularly delivered by consultants and ensuring that it is recognised within the job plan.	Failing to recognise the opportunities of staff mentoring, or failing to recognise when it is already being undertaken and the value this brings to a service.
Taking a broad and positive view of what constitutes quality improvement, recognising leaders as bringing improvement in quality.	Taking a narrow view of quality improvement and restricting it to audits and quantitatively measured performance outcomes.
Being flexible in the opportunities and pathways available for leadership.	Setting a rigid and defined career path for leadership rather than utilising all available talent.
Developing a support network for clinical leadership.	Discouraging consultants from speaking out about issues or concerns they have identified and creating a culture that is intolerant of criticism or perceived dissent.
Supporting consultants in roles for external organisations, in line with the letter about appropriate release for work of benefit to the wider health system, produced by the Chief Medical Officer, the NHS, AoMRC and GMC.	Disregarding or diminishing the contributions of elected medical leaders and viewing them less favourably than those in Trust-appointed roles.
Fostering an environment in which consultants, as clinical leaders, feel free to speak up about clinical and professional concerns without fear of negative consequences.	
Acknowledging the benefit of active engagement with elected medical leaders, such as Local Negotiation Committee (LNC) and Regional BMA committee chairs.	

10 Consultants as educators, trainers and life-long learners

Consultants play a vital role in the education and supervision of medical students and the training and supervision of resident doctors and other healthcare trainees. Without this commitment to sharing their knowledge and expertise the NHS would not have the doctors and other healthcare professionals it needs for the future. Consultant clinical academics play a particular role in developing the curricula and quality assurance procedures in medical education and in developing academic trainees – the consultant clinical academics of the future.

To underpin these roles and help ensure the continued provision of high-quality care, employers should value the continuing education and training of its professional staff.

Professional or study leave is granted for consultants for postgraduate purposes approved by the employing authority. It covers study (usually but not always on a course), research, teaching, examining or taking examinations, visiting clinics and attending professional conferences.

For all consultants, there is a contractual entitlement of 30 days of study and professional leave with pay and expenses within each three-year period (Schedule 18, paragraph 13). This should not be interpreted as 10 days per year.

While no clear distinction is made in the contract between professional and study leave, the two are not the same there will be courses or conferences intended specifically for professional development, separate from study, which will equally require leave allocation. Employers should not seek to set a cap on the amount spent on study leave. Appropriate CPD should be fully funded. The Department of Health & Social Care has also said that it is unreasonable for employers to pre- determine the level of expenses which they are prepared to approve – BMA guidance on study and professional leave.

Good practice	Poor practice
Ensuring that consultants that take on teaching and training responsibilities have the time, skills and resources to undertake it effectively and are appraised and valued for this work. Developing a clear local policy on how study leave should be applied for and approved, and what the arrangements for claiming expenses are. Where a study leave application is accepted, paying all reasonable expenses associated with that period of leave. Recognising that some valuable learning opportunities only arise irregularly and will not fall within the three-yearly cycle and allocation. Employers will therefore need to be flexible to ensure that those opportunities can be taken up, to the mutual benefit of the employer and consultant. Using employer discretion to grant professional or study leave in addition to the 30 days with pay and expenses where this is appropriate. Encouraging the inclusion of regular professional leave, such as examiner responsibilities, into job plans rather than requiring the use of study and professional leave allocation.	Seeking to limit study leave budgets by setting a notional cap. Turning down reasonable study leave applications on non-educational grounds, such as financial constraints. Seeking to classify work that should be categorised as additional NHS responsibilities or external duties (such as sitting on advisory appointments committees) as a professional leave activity and requiring consultants to use their leave allocation to attend.

11 Consultants as researchers

Many consultants undertake or support medical research, often continuing to do it in their own time. The Keogh report of his Review into the quality of care and treatment provided by 14 hospital trusts in England published in July 2013 demonstrated that Trusts that lacked a commitment to and support for research activity provided lower quality care.

Hence, it is in the interests of Trusts and patients to foster the spirit of inquiry amongst consultants and to facilitate and support research activity.[4]

Good practice	Poor practice
Encouraging consultants to become involved in research including collaborating with colleagues external to their teams and their trust where appropriate. Ensuring that time is allocated in job plans for all aspects of research – e.g. preparing funding bids, managing projects and research staff and dissemination of results. Providing time and facilities for the sharing and discussion of research results with colleagues in teams in order to contribute to service improvement and improved patient care.	Allowing research to be undertaken only in non-working time.

4 Keogh Report (2013): keogh-review-final-report.pdf (improvementacademy.org)

12 Workplace and facilities

The consultant contract recognises the importance of doctors having access to necessary resources and facilities in order to work effectively. As part of the job planning process, specific discussions should be had about 'agreed supporting resources, which may include facilities, administrative, clerical or secretarial support, office accommodation, IT resources and other forms of support', as well as how any obstacles to these can be removed (Schedule 3, paragraph 14-16). These should be specifically written into the job plan.

Doctors need suitable office space to ensure confidentiality of patient information, conduct sensitive meetings and phone calls in private, have a quiet environment in which to read and undertake work, and have a place to store materials and equipment necessary for their work. Other appropriate office facilities and resources (such as internet access and secretarial support) will also be needed. Without these, a consultant will be hindered in their ability to properly perform their role.

Equally important are appropriate rest and refreshment facilities, particularly given the increase in work undertaken in unsocial hours. There is ample evidence to demonstrate that ensuring staff have access to such facilities and are able to remain rested and refreshed while working, is beneficial for patient care and is likely to prevent adverse incidents.

Good practice	Poor practice
Prioritising supporting resources in job planning conversations, ensuring consultants feel confident in making appropriate requests for relevant support.	Providing no or limited private office space, such as only using hot-desking arrangements, in which materials and equipment cannot be safely stored or sensitive patient data or conversations cannot be appropriately handled.
Providing access to an appropriate space in which materials, books and specialty specific equipment can be stored, accessed and used.	Providing no or poor-quality rest facilities; allowing these to fall into a poor state of hygiene or repair.
Providing access to a secure private office space in which sensitive conversations or activities, such as handling patient data, can be undertaken when required.	Failing to maintain access to high quality, nutritious food and drink during unsocial hours.
Ensuring that suitable internet/phone connections and secure networked storage are available, as well as office equipment such as filing cabinets.	Allowing other facilities, such as changing or shower areas, to fall into disrepair or failing to have them cleaned regularly.
Making arrangements for appropriate secretarial support to ensure that consultants are freed up to deliver their clinical and administrative work; ensuring that any absences are covered.	
Providing rest facilities which are clean and in a good state of repair, and where individuals can have adequate undisturbed rest.	
Providing access to high quality, nutritious food at whatever time of day or night the consultant is expected to be working.	
Making available properly equipped changing and shower facilities, appropriately located, with secure access.	
Providing appropriate and dedicated spaces for education and training, such as seminar rooms near to the relevant department, including standard teaching and electronic equipment.	
Providing high quality breastfeeding facilities for those who are nursing.	

13 Armed forces / consultant reservists

This section of the charter is to support consultants who are working as reservists for the Ministry of Defence. To support this valuable contribution Trusts should have a policy which supports those that are and for those wanting to join the Armed Forces as reservists.

Trusts need to understand that a Reservist's employment cannot be terminated on the grounds of their military duties or their requirement to be mobilised. To do so would be a criminal offence under s.17 of The Reserve Forces (Safeguarding of Employment) Act 1985. Instead, Trusts need to provide the support and time that Reservists require to develop skills and abilities to fulfil their role.

You can find out more about the BMA's armed forces committee by clicking here: BMA Armed Forces Committee Overview.

Good practice	Poor practice
To have an agreed reservist/armed forces policy which details the Trust's obligations towards all who are members of the armed forces.	Deterring doctors from applying to be Reservists in the first place by making unreasonable objections citing service or other operational needs of the NHS Employer.
Operate a meaningful culture of support for Reservists.	Creating a judgmental environment where Reservists are made to feel uncomfortable and unvalued in discharging their responsibilities to the Armed Forces.
Discussions should take place at annual job planning to ensure support and arrangements are in place for annual camps, mobilisation and post mobilisation.	Failing to make timely, practical provision for the support that Reservists and their department may require.
Clinical leads/directors should hold meetings as needed on notification of mobilisation to discuss draw down of new patient clinical activity in the months before a consultant is mobilised to prevent build up of waiting lists.	
Clinical leads/directors should hold meetings as needed with reservist consultants to agree arrangements regarding clinical care when they are attending annual training camps.	
On call consideration when planning rotas needs to take place so that Consultants are not expected to be solely responsible for swapping out of on call cover whilst away.	
Clinical lead/director should arrange meetings post mobilisation to discuss phased return to work, occupational health requirements, support and general integration back to work.	

Appendices – Introduction

The following are a series of checklists to work alongside the narrative chapters of the Consultant Charter. These are to support LNCs on specific areas of policy or provisions in the Trust that relate to the relevant section of the charter. Those items that are starred in the checklist are compulsory to achieve the Charter accreditation for that section.

Appendix 1

Good Practice in Consultant Job Planning	
Is there an agreed Job Planning Policy in place which is predicated on mutual agreement and not imposition?	☆
Does the Policy Provide for:	
– communication in advance of job planning meeting of who is attending and if there are any specific issues that are being raised?	☆
– the job planning meeting to take place with no more than one clinical manager in attendance?	☆
– a minimum allocation of 1.5 SPAs for the purposes of revalidation and appraisal only, including for LTFT consultants?	☆
– minimum 2.5 SPA allocation to cover the typical full scope of practice?	☆
– flexibility to allow a job plan to support the full scope of the doctor's non-clinical role beyond the typical SPA of 2.5 eg trade union duties, additional responsibilities and external NHS duties.	☆
– job plans that are designed such that compensatory rest should not impact on the doctor's ability to carry out their role in full e.g. does not disrupt planned SPA activity?	☆
– a job planning process which enables discussion of, and gives equal weight to, supporting resources that are necessary for fulfilling elements of the job plan?	☆
– provide time off in lieu (TOIL) for consultants when they attend training courses or conferences on non-working days for their role?	☆
– a single level of sign off, which confirms the employer's contractual agreement to the job plan without reference to secondary sign off or referral to the employer's job planning consistency committee?	☆
– agreed timescales for mediation and appeal processes, which do not place a doctor at any disadvantage or detriment when compared to the national terms and conditions?	☆
– a system to facilitate interim reviews of job plans (which both parties can request, as per Schedule 3, paragraph 22)?	☆
Requirements to achieve Charter Standards = 12/12	

Appendix 2

Effective Medical Appraisal	
Is there an agreed Medical Appraisal Policy in place?	☆
Does the policy provide for:	
– a timescale for communication about when appraisals are due to take place and what evidence will and won't be expected?	☆
– timely communication confirming when appraisals are due to take place and what evidence will and, as importantly, won't be expected?	☆
– timescales that ensure that appraisees and appraisers who are unable to meet them through no fault of their own e.g. sickness, LTFT working patterns, are not unfairly penalised?	☆
– the full scope of a consultant's practice to be covered and valued?	☆
– the inclusion of local appraisal processes in the induction programme of all new consultant starters?	☆
– allocation of appropriate time and support for appraisers to fulfil their role, with the additional PA allocation reflecting the number of appraisees and workload involved?	☆
– a maximum number of appraisees per doctor?	☆
– the exclusion of mandatory training from appraisal requirements in line with GMC Guidance?	☆
– the exclusion of the consultant's line manager as their appraiser?	☆
– does the Trust provide training update sessions for appraisers annually?	☆
– joint appraisal with the university for medical academics?	☆
– joint appraisal with the university for medical academics?	☆
– commitment to recording and learning from systematic feedback about the quality of appraisal as reported by appraisers and appraisees?	☆
Requirements to achieve Charter Standards: 14/14	

Appendix 3

Managing Safe Patterns of Working and Avoiding Burnout	
Does the Trust provide TOIL for bank holiday on non-working day for compressed weeks on 10 PAs or more?	☆
Are bank holidays subject to pro-rata for LTFT consultants?	☆
Does the Trust's Job Planning Policy expressly ensure that SPA is not routinely scheduled following a night on-call or night shift?	
Does the Trust accommodate potential on-call sleep disturbance by scheduling 'predictable on call' sessions on a supernumerary basis the following day?	☆
Does the Trust adhere to the BMA's Compensatory Rest Guide - March 2022?	☆
Does the Trust ensure that if a consultant is unable to take 11 hours continuous rest per day, that they are entitled to compensatory rest as soon as practicably possible?	☆
Does the Trust make sure that consultants are not required to 'pay back' activity missed during their compensatory rest?	☆
Does the Trust's Covering Absent Colleagues Policy appropriately assume the consultant would be too tired to work following an unscheduled unsocial hours period of work?	
Does the Trust allow for enhanced TOIL to be taken as an alternative to monetary payment for extracontractual work or covering absent colleagues?	☆
Does the Trust have appropriate policy for consultants covering absent resident doctors agreed and ratified with the LNC, recognizing that there is no contractual obligation for consultants to provide such cover?	☆
Does the Trust actively seek to recruit to address workforce shortages rather than relying on existing staff to compensate and cover for vacant posts?	
Does the Trust provide free of charge, easily accessible sleep facilities for consultants too tired to drive home during out of hours or following a busy night shift?	☆
Does the Trust take into account commitments to other employers with scheduling patterns of work?	☆
Does the Trust have an option to 'buy back' additional annual leave?	☆
Does the Trust consider academics undertaking research activities in scheduling out of hours/on call rotas?	☆
Requirements to achieve Charter Standards = 11/15	

Appendix 4

Less than Full time / Flexible Working & Shared Parental Leave (SPL)	
Does the Trust have a culture where individuals feel they can express an interest to be LTFT or request flexible working patterns?	☆
Has the Trust got various flexible working options that a consultant could request?	
Do discussions around flexible working take place at annual job planning meetings?	
Do LTFT consultants have proportionately greater levels of SPA to accommodate that they still have the same appraisal and revalidation requirements?	☆
Do LTFT consultants have access to the same professional leadership and development opportunity as full-time consultants?	
Are adjustments made to the job plans of LTFT Consultants to assist them in meeting KPIs, targets and other performance indicators set by the Trust?	☆
Is enhanced shared parental leave offered to consultants?	☆
Is flexible working request information easily available? Is the process clear?	
Requirements to achieve Charter Standards: 4/8	

Appendix 5

Working in peri-retirement / Adapted working patterns for a late Consultant Career	
Does the Trust offer retire and return and/ or partial retirement arrangements under an established policy to retain/re-engage consultants on retirement?	☆
Retire and Return:	
Is the retire and return policy well publicised and applied consistently in all departments?	☆
Are those returning offered a contract consistent with 2003 consultant terms and conditions of service, (or previous national contract/TCS if applicable pre-retirement) allowing them to resume their prior job plan, maintaining continuity of service (for the purpose of employment benefits and not having an imposed dis-qualifying break in service)?	☆
Are returners offered a contract that is substantive?	
Are returners employed on the same pay threshold, appropriate to their service?	☆
Are returners given the same SPA and CPD provisions as pre-retirement colleagues?	☆
Partial Retirement:	
Does the Trust have a partial retirement policy that is well publicised and applied consistently in all departments?	☆
Does the Trust allow flexibility and to give employees the choice of a changed working pattern or change of pay structure to achieve the required reduction in pensionable income to access partial retirement?	☆
Supportive practice for working peri-retirement:	
Does the Trust facilitate flexible working options for those working peri-retirement, e.g. relinquishing onerous aspects of their role they cannot safely sustain such as (but not limited to) reducing out of hours commitments or other onerous clinical activities?	☆
If so, is this well managed to ensure that changes do not negatively impact on other team members?	
Does the Trust demonstrate that they value the experience of consultants at a later stage of their career, e.g. actively encouraging experienced consultants to take on mentoring roles?	☆
Has the Trust developed policies to support different age groups, e.g. menopause policy with arrangements for menopause leave?	☆
Does the Trust allow the recycling of pension contributions, i.e. allowing the employer's contribution to be paid directly to the consultant in circumstances where it is appropriate for the consultant to have left the pension scheme?	
Requirements to achieve Charter Standards = 10/13	

Appendix 6

Health and Wellbeing Support	
Has the Trust formally adopted the BMA Mental Wellbeing Charter?	☆
Does the Trust have a wellbeing strategy and named wellbeing lead?	
Has the Trust formally signed up to the BMA Joint Pledge on Ending Sexism in Medicine?	☆
Does the Trust have a Sexual Misconduct Policy that follows the framework of the NHS England Sexual Misconduct Policy	☆
Does the Trust have a proactive approach to the menopause including having a menopause policy?	
Has the Trust implemented the NHS England policy framework on baby loss?	
Does the Trust induction for new consultants include information on the policies in place to support wellbeing?	☆
Does the Trust have a consultant led mentoring scheme for new starters and is this supported by management?	
Does the Trust demonstrate inclusion of doctors of different faiths and having the flexibility to enable doctors to observe different religious holidays and practices	
Does the Trust mirror all health and wellbeing initiatives for consultant clinical academics and other honorary consultants? Do policies appropriately extend to this group?	☆
Does the Trust have protocols in place to ensure that staff self-harm or suicide is treated as an organisational SUI (or equivalent) and thoroughly investigated with an evaluation of working conditions and their role in the incident?	☆
Support during ongoing dispute or complaints:	
Where a dispute or complaint is ongoing does the Trust provide a named point of contact who is available for advice, guidance and support throughout the process? (For both those who raise concerns as well as those subject to investigation)	☆
Does the policy provide a timeline for the completion of the process?	☆
Does the Trust use a Just Culture approach when initially addressing concerns?	☆
Does the Trust have a conduct policy that has been expressly ratified by the JLNC?	
Bullying and Harassment:	
Does the Trust have a Bullying and Harassment/Dignity at Work Policy ratified by the JLNC?	☆
Does the Trust foster a culture in which inappropriate or bullying behaviours are not tolerated?	☆
Are there clearly signposted existing processes for dealing with bullying and harassment?	☆
Does the Trust have a clear policy for challenging bullying behaviours against those with protected characteristics?	☆
Does this provide wellbeing support for victims in line with BMA's Racism in Medicine report?	☆
Occupational Health Access:	
Does the Trust have a policy which allows for personalised occupational risk assessments?	☆
Does the Policy ensure the recommendations are fully implemented and reviewed appropriately, including the involvement of occupational health as required?	☆
Is there timely access to a specialist-led occupational health service that is free and meets the individual needs of doctors?	☆
Requirements to achieve Charter Standards = 17/20	

Appendix 7

Working with Disability or Long -term Health Conditions	
Are colleagues with disabilities and ill health requirements valued as highly as other members of staff?	☆
Are there processes in place to ensure this happens?	☆
Are disability-related absences recorded separately to sickness absences?	
Are Occupational Health services accessible in a timely way for those that request or require them?	☆
Is the Trust able to make recommended reasonable adjustments as soon as practicable?	☆
Is training provided to staff regarding local processes/practices to help disabled colleagues?	☆
Is training provided to clinical managers regarding local processes/ practices to help disabled colleagues?	☆
Is training provided to remind staff to be mindful of disabilities that may not be visible?	
Is there an open culture where doctors feel able to speak up about their health?	
Is this culture of being able to speak up about one's health promoted in the workplace via staff communications, training and/or events?	
Do job planning conversations take into account any disabilities or any health restrictions?	☆
Is there training for clinical managers/ CDs for having job planning conversations that take into account disabilities or health restrictions?	☆
Is the Trust conducting annual audits of disabled staff or staff with long term health conditions and the support they are being offered?	☆
Does the Trust have any staff networks to support disabled staff?	☆
Are these networks promoted and easily accessible?	
Are consultants with disabilities or long term health conditions encouraged to take on leadership and research opportunities?	☆
Requirements to achieve Charter Standards = 11/15	

Appendix 8

Career Breaks and Sabbaticals	
Is there a policy in place to manage career breaks/sabbaticals?	☆
Is that policy approved by the BMA/LNC?	
Does the policy provide:	
– the opportunity for a consultant to undertake reasonable paid work without seeking permission?	☆
– an acknowledgement that experience gained by a consultant undertaking work or other activities away from their substantive employer during a career break can be of value to the NHS upon their return?	☆
– for the consultant's line manager to have the authority to approve a career break request without requiring multiple sign offs?	☆
– a clear and transparent process for feedback to be given to the consultant in the event that their request is denied?	☆
If there is not a policy containing all of the above, is this information referenced elsewhere in an alternative source?	☆
Does the Trust develop roles with a built-in sabbatical component?	
Does the Trust job planning policy reference the opportunity to discuss career breaks at the (annual) job plan review?	☆
Does the Trust enable consultants to apply for leave to participate in humanitarian work?	
Requirements to achieve Charter Standards = 7/10	

Appendix 9

Consultants as Clinical Leaders	
Are consultants involved in a service included in and consulted with regularly and meaningfully through the multiple stages of a service's development?	☆
Are consultants given sufficient time in job plans to undertake leadership and management roles?	☆
Are consultants given time in their job plan to provide mentoring to other staff?	
Does the Trust have organised networks for clinical leaders to share experience and knowledge?	
Does the Trust advertise all leadership roles to the whole consultant body?	☆
Does the Trust provide training to consultants to develop their leadership skills?	
Does the Trust encourage consultants to take up roles outside the Trust and agree to provide adequate time in job plans for such roles in the interests of the wider NHS (e.g. within Royal Colleges, within the wider NHS, GMC or other relevant organisations)?	☆
Does the Trust encourage consultants to speak up about professional concerns?	☆
Do all consultant representatives on the LNC have the trade union facilities time required for this leadership role recognised in their job plan?	☆
Requirements to achieve Charter Standards = 6/9	

Appendix 10

Consultants as Educators, Trainers and Life-long Learners	
Are consultants given appropriate time in their job plans to supervise trainees, locally employed doctors, students and other clinical staff?	☆
Does the Trust provide consultants with appropriate resources and training to undertake supervision?	☆
Does the Trust allocate the recommended SPA time for educational supervisor role of 0.25 PAs per trainee, or as recommended by the Royal Colleges?	☆
Does the Trust have a study leave policy agreed with the LNC?	
Does the Trust pay full course costs and expenses associated with approved study leave?	☆
Does the Trust allow flexibility in number of days per year of study leave and professional leave within the 30 days over 3 years?	☆
Does the Trust allow flexibility to access learning opportunities which may fall outside the study leave policy (e.g. by allowing additional time or funding to access specific opportunities that may occur irregularly)?	
Does the Trust support the attendance of international learning opportunities where this is appropriate?	
Does the Trust support (with time and expenses) attendance in specialty specific mandatory training outside the study leave policy?	☆
Does the Trust include time allocation for Royal College examiner and educational roles agreed in job plans rather than requiring study and professional leave allocation?	☆
Requirements to achieve Charter Standards = 7/10	

Appendix 11

Consultants as Researchers	
Does the Trust encourage consultants to undertake research?	☆
Does the Trust provide consultants with appropriate time and resources to undertake research?	☆
Does the Trust provide time in job plans for the development of research proposals?	☆
Does the Trust encourage consultants to collaborate with colleagues in other organisations to undertake research e.g. Universities, other trusts, commercial organisations?	☆
Does the Trust encourage the dissemination and discussion of research among the consultant body through formal meetings?	☆
Requirements to achieve Charter Standards = 5/5	

Appendix 12

Workplace and Facilities	
Resources:	
Do consultants have access to a secure, private, readily accessible office space for participating in confidential activities?	☆
Is adequate secretarial support provided to ensure consultants are not burdened with unnecessary administrative tasks?	☆
Is appropriate, secure storage available for consultants' essential materials and equipment?	☆
Is the infrastructure sufficient e.g. working internet and phone lines that are repaired/replaced as needed?	☆
Does the job planning policy emphasise the importance of supporting resources, and prioritising these in job planning discussions?	☆
If job planning training is conducted in the Trust, are supporting resources highlighted as a vital component of the job plan?	
Facilities	
Are there well-maintained, secure changing/shower facilities in reasonable proximity of all relevant clinical areas?	☆
Is high quality food available 24/7 for consultants who are present on site?	
Are there adequate rest facilities which are clean, and enable a consultant to rest uninterrupted where appropriate?	☆
Are there dedicated rooms or spaces for teaching and education activities containing appropriate equipment for participating in training?	
Are well-maintained, hygienic and private facilities available for those who are nursing?	☆
Requirements to achieve Charter Standards: 8/11	

Appendix 13

Armed Forces / Consultant Reservists Checklist	
Has a Reservist Policy been written and agreed to with the JLNC where there are consultants who are reservists?	☆
Are proactive annual meetings taking place with a Clinical lead/director to identify what is happening and how patients will be covered for the duration and what the locum/backfill arrangements will be whilst training (annual camp)?	
On mobilisation are meetings taking place with Clinical lead/director and immediate draw down of new patient clinical activity in the months before being mobilised to prevent large patient waiting list build up.	
Are there a nominated clinical and a nominated HR point of contact given at the start of mobilisation?	
Is there early identification of on-call cover to prevent consultants having to swap out of on-calls when they are away to when they come back or being subject to unfair rota practices?	
Do job plans reflect and support Reservists obligations to the Armed Forces e.g. avoiding on call commitments on drill nights?	
Is there proactive extensions of the appraisal/revalidation cycles if deployment crosses the appraisal/ revalidation window?	
Post Mobilisation	
Does the Trust implement a 3-month phased return into NHS work post return from mobilisation, without out of hours on call activity to allow integration back into home and work?	
Is a meeting arranged with Clinical lead/director prior to return to work to identify areas of concern for consultant?	
For long deployments, is there consideration of dual consultant refresher training?	
Is there identification of consultant buddy for six months for peer support?	
Does the Trust arrange an early meeting with medical HR on deployment and on return to ensure pay and allowances restart quickly?	
Is it standard practice to receive a comprehensive occupational health assessment on return from mobilisation?	
Requirements to achieve Charter Standards: 1/13	

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