# Doctors returning to the **HSC** to assist with COVID-19: guidance

Includes pay, pensions and indemnity information for doctors returning to help with coronavirus.

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## Introduction

If you willing to help please email us at [Wpd.correspondence@health-ni.gov.uk](mailto:Wpd.correspondence@health-ni.gov.uk) to indicate whether this is something you’d be willing to consider.

Medical workforce augmentation is being planned in the event of a major COVID-19 outbreak. This involves asking professionals who have (either temporarily or permanently) left the HSC to consider returning to assist in several different ways.

In the event of an emergency, the GMC can grant temporary registration to certain groups. If this happens, doctors won’t need to go through the registration process themselves, as it will be done automatically for them. The first group to be registered would be fully qualified and experienced doctors of good standing who have recently relinquished their registration or licence to practise.

If you have any questions that are not answered here, please forward them to our mailbox:

[Wpd.correspondence@health-ni.gov.uk](mailto:Wpd.correspondence@health-ni.gov.uk)

## Will I be paid? If so, how much and how regularly?

You will be remunerated for any work you do, in a way that reflects the responsibilities you undertake.

## What are the implications on my pension and tax?

## What if I am post-pension?

If you are post-pension, this will not have an impact.

## What will be the pension payment arrangements for staff returning to the NHS to assist in the response to the COVID-19 outbreak?

* The government is bringing forward emergency legislation in response to the COVID-19 outbreak that contains important information on pension arrangements for extra HSC staff.
* The legislation provides for the suspension of the 16-hour rule which currently prevents staff who return to work after retirement from the 1995 NHS/HSC Pension Scheme from working more than 16 hours per week, in the first four weeks after retirement.
* The legislation also provides for the suspension of both the abatement for special class status holders in the 1995 Scheme and the requirement for staff in the 2008 Section and 2015 NHS/HSC Pension Scheme to reduce their pensionable pay by 10% if they elect to ‘draw down’ a portion of their benefits and continue working. Taken together, these measures will allow skilled and experienced staff who have recently retired from the HSC to return to work, and they will also allow retired staff who have already returned to work to increase their commitments if required, without having their pension benefits suspended.
* These measures are important in allowing individuals to return to work during a critical period for the HSC with clarity around their pension arrangements.

## When will these measures take effect?

* The legislation will give the Government the power to immediately bring these measures into effect, if required.

## What will happen when these measures are no longer needed?

* A 6-month notice period will be given to staff and employers before these measures will cease to apply, at which point the relevant sections of the scheme regulations will take effect again. Staff and employers will therefore have 6 months’ notice to readjust their working patterns.

## The impact of pension tax on high-earning clinicians is a big issue and a barrier to extra capacity amongst existing HSC staff. What are you doing about that?

* The manifesto pledged to address the taper problem in doctor’s pensions, which causes many to turn down extra shifts for fear of high tax bills. The Chancellor will do this via a tax solution, as follows:
  + The annual allowance taper thresholds are increased by £90 000 from 6 April 2020. The taxable pay threshold rises from £110 000 to £200 000, and adjusted income threshold from £150 000 to £240 000.
  + However, to ensure that the very highest earners pay their fair share of pension tax, the minimum level to which the annual allowance can taper down will reduce from £10 000 to £4 000. This will only affect those with total income (including pension accrual) over £300 000.

## Can I help without being in a directly patient-facing role?

Yes. There are also opportunities for non-patient facing roles.

## Where will I be placed/could I be sent to another part of the country?

Where possible, you will be sent to a HSC Trust where you have worked before or are linked with. There might be rare occasions where we would ask if you would consider moving to a different area to cover an acute workforce shortage, but this would be discussed with you beforehand.

## Are people employed by one HSC Trust or will they move around?

Initially we would expect staff to work in one organisation, although they may be asked to rota to different organisations based on clinical need, but always subject to an individual’s preferences.

## Will I have insurance and indemnity covered?

## Emergency indemnity

It is likely that ‘emergency indemnity’ to enable retired doctors to practise would be state backed, as it would be HSC contracted work, specifically to support the government’s plan to manage COVID-19. The Medical Protection Society (MPS) has stated that if those individuals who are former Medical Protection members wished to reactivate their membership to access supplementary non-claims benefits for a limited period, they would be welcomed.

## Will returning doctors be provided with clinical indemnity cover?

* Any professional working in a HSC organisation or GP practice will be covered.
* If engaged by an HSC organisation to provide HSC services, individuals will be covered by the normal HSC Clinical Negligence arrangements.
* Any professional returning to work in a HSC organisation or GP practice and who does not have existing clinical negligence indemnity cover, will have clinical negligence indemnity covered.

## What about professional indemnity products provided by Medical Defence Organisations? Won’t existing staff have greater cover through these schemes than staff joining in response to COVID-19?

* The Government recognises that, in addition to clinical negligence indemnity cover, professional indemnity (including medico-legal cover) is required for those individuals who are providing HSC services during the Coronavirus pandemic.
* Therefore, for those returning to the workforce who do not already have professional indemnity policies in place, we are exploring options to ensure that adequate professional indemnity is available for those that need it, in order to assist with the provision of HSC services as part of the Government’s response to the Coronavirus pandemic.

## Will I have to pay to go back onto the GMC register?

No, you will not have to pay to temporarily return to the GMC register.

## Will I be expected to re-do an appraisal or re-validation process?

No, this will not be necessary.

## Will I receive an induction process?

A Trust departmental induction will be required. A further update on this will be provided in due course.

## My Access NI is out of date – does it matter?

An Access NI will be required. This will be a remote, fast-tracked, process in collaboration with the Department of Justice.

## I have a co-morbidity or am a primary carer, can I also work?

Given the increased risk of COVID-19 in those with co-morbidity and in the elderly population, we would advise this group against returning to patient facing clinical work. However, there may be a non-patient facing role that you are interested in exploring.

## I’ve accepted temporary registration. What will happen next? How will I find out where I’ll be working?

With your permission, your contact details will be passed on to the relevant Trust Medical HR Team so that you can be linked with local HSC Trust.

## Will I be sent to multiple different clinics and hospitals or stay in one role?

Ideally you would be placed in one role, but this cannot be guaranteed.

## Will I need to learn new skills?

Fast-track induction processes are being developed locally. This will include refreshing on old skills, such as death certification and prescribing, as well as new skills such as training in the appropriate use of Personal Protective Equipment (PPE).

## What if I become ill when I am working?

If you become ill while working, you should immediately inform your line manager and withdraw from work. If you think you may be ill due to COVID-19 you should follow national guidance in place at the time.

## What if I change my mind and don’t want to work anymore – who do I tell?

If you change your mind and don't want to work anymore you should tell your line manager. Mutually agreed notice periods should apply. A professional approach would be expected - for example not leaving in the middle of a shift.

## Could I be asked to work in a clinical area I am not familiar with?

As far as possible, we aim to match doctors to suitable service areas in line with their specialist expertise. In some situations, you may need to be placed in a different service area according to service requirements. Where this is necessary, you will be supported adequately to take on these roles. Arrangements will involve discussion between the relevant HSC organisation and affected staff. The GMC’s Good Medial Practice should be followed and you would be expected to recognise and work within the limits of your competency.

## I am working in an educational or research role, what are the next steps for me?

If you have a joint contract between clinical and educational/research roles, your provider health board / trust will contact you to discuss whether you are prepared to give up these activities in the short term (unless working on education or research in relation to COVID-19) to provide more clinical support in the workplace. Those with teaching expertise may be able to help provide induction for others including those returning doctors – for example, in the use of Personal Protective Equipment (PPE), managing high flow oxygen or ventilated patients (if appropriately trained to do so).

## In addition to my clinical role, I undertake a regional/national role. What are the next steps for me?

Discuss with your employers under what circumstances you should temporarily suspend your external commitments in order to provide more clinical support in your employing health board / trust. The balance between supporting front-line HSC services directly and delivering the business as usual work of the national bodies should be carefully balanced in each case.

## What sort of work might I be expected to do? Will I have a choice?

There are multiple possible roles that you might be expected to take on including (but not limited to): , death certification, backfill for clinicians dealing with acute respiratory patients, helping with outpatient clinics (this could be via telephone), seeing Emergency Department patients with acute non-respiratory presentations, providing elective treatment, training other clinicians.

## How long will I be needed for?

At this stage, the exact length is unpredictable. You are free to stop working at any point subject to appropriate notice. Contracts are likely to be drawn up for 6 months with the possibility for extension.

## Will I have a contract?

Yes. You will have a contract that reflects all the working hour protections, pay arrangements, annual leave entitlement and hospital inductions that are provided to new doctors.

## What documentation do I need to have checked before I start work? Can this be done remotely?

Identify checks will be required but this will be a fast-track process with your local HR department.

## Will I have a rota/need to work a specific number of hours?

You may be placed on a rota but this will be discussed with the department you will be placed in locally. Working hours will be in line with European Working Time Regulations (NI).

## Will you check that I don’t have coronavirus?

If you develop symptoms, national guidance for testing will be followed.

## Will I be provided with personal protective equipment?

Yes, if required.

## What happens if I treat patients while having coronavirus?

As soon as coronavirus is identified in staff, they will be withdrawn from work.

## I haven’t been fit tested for the correct masks (FFP3)? Could I be asked to go into a room with a patient with suspected or confirmed covid-19?

Clinicians preparing to assess a patient with suspected COVID-19 must wear Personal Protective Equipment (PPE)

## I’m pregnant or immunosuppressed. What rights do I have to protect myself from infection at work?

Pregnant women and immunosuppressed people may well be at increased risk, depending on the reason for the immunosuppression, drug type and dosage, and so on. A risk assessment will be conducted locally and you are advised to avoid COVID-19 exposure, which could mean redeployment to a non-frontline role.

## Is there specific advice for other high risk chronic diseases?

People with chronic heart and lung disease have a higher risk of complications and higher mortality than the general population. We would not advise this group to return to directly patient facing roles.

## I’m concerned that I may have to work in unsafe conditions. How can I protect myself?

The GMC acknowledges that doctors may be anxious about context not being taken into account when concerns are raised about their actions in very challenging circumstances. Where a concern is raised about a registered professional, it will always be considered on the specific facts of the case, taking into account the factors relevant to the environment in which the professional is working. The GMC would also take account of any relevant information about resources, guidelines, or protocols in place at the time.

## Can I decline if I am asked to work beyond my clinical competence?

Yes you can. If the epidemic worsens it is likely that doctors will have to work outside their normal field of practice. When deciding the safest and best course of action in the circumstances, doctors should consider factors including what is within their knowledge and skills; the protection and needs of all patients they have a responsibility towards; and minimising the risk of transmission and protecting their own health.

Defence organisations advise that any doctor faced with clinical duties outside their clinical competence should explain their concerns clearly to someone with responsibility for providing the service to determine the safest way to proceed who should respond supportively. If they have done so and still feel uncomfortable, their medical defence organisations can advise them further. The GMC’s Good Medial Practice should be followed.

## How would I handle patients’ requests for extra medication?

While there are currently no reported medicine shortages as a result of COVID-19, doctors may face requests from patients for extra medication to stockpile. We advise doctors to resist pressure to overprescribe and to stick to existing policy on repeat prescribing unless they receive official advice stating otherwise.

## If I opt to see patients remotely, does this affect my indemnity?

In making the decision to consult and advise patients remotely, doctors must balance the risks and benefits and be satisfied that they can adequately clinically assess the patient remotely. Defence organisations advise doctors to make a record of the reasoning behind any decisions made and the information they give to patients in case they need to explain the approach they’ve taken later on.

## I’m about to graduate from medical school and would really like to help. Can I start work before August?

The Department is in discussion with the GMC and medical schools to see how medical students could safely help if needed.

## Who verifies a person is registered and how do people find out?

Organisations will need to this by checking the regulator’s website which most regulators use but we are checking the HCPC.

## How are Terms and Conditions agreed? With individual Trusts?

Individual Trusts will decide the appropriate terms and conditions in line with the role being undertaken.

## Will travel be paid?

We would not be expecting to pay for home to work travel.

## What are line management arrangements?

Line management would be the normal lines of accountability and supervision.

## How will any issues be escalated?

Individual should in the first instance contact their line manager, local HR department / Medical Director.  We would expect normal governance rules / policies to apply as well.

## What is the role of agencies?

Our preference would be to employ staff direct or utilise staff banks, as this is the most cost effective way to employ people. Agencies should be used as a last resort.