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Chief Executives NHSScotland

Your ref:
Our ref:

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Dear Colleague,

NEW CONSULTANTS' CONTRACT

This is to let you know that the BMA and the UK Health Departments have reached agreement on the framework for a new contract for consultants. The framework agreement will be available on the Scottish Executive Health Department website this afternoon.

Final agreement on the framework document was reached late last night and an announcement was made at the BMA's annual conference of senior hospital medical staff earlier today.

The framework agreement includes some significant headlines including:

- A system of job planning which will give NHS Trusts the ability to manage consultants' time in ways that best meet local service needs and priorities;
- A more effective system for engaging consultants in joint action to improve NHS performance and modernise patient care;
- An increase in the amount of time consultants spent on direct clinical care;
- An extension of the working day by allowing work to be scheduled at plain time rates between the hours of 8.00am to 10.00pm Monday to Friday and between 9.00am and 1.00pm at weekends;
- An assumption that a consultant will remain on site throughout his or her programmed activities, unless he or she has reached agreement with their manager that this should not be the case;
- An end to consultants being paid twice for the same period of time, for example by undertaking work such as domicilary visits which attract a fee during their NHS sessions;
- A new pay structure which provides enhanced incentives for consultants to maintain commitment to the NHS up to normal retirement age;
- The ability to secure extra consultant activity more cost effectively, reducing the need for trusts to pay premium rates to secure additional work from consultants; and

- A rule book on private practice. Adhering to the rule book will be a contractual requirement, meaning that any consultant who breaches the rules will be liable to disciplinary action.

The new contract offers the potential for achieving considerable benefits for NHSScotland. It is clearly important that we reach an understanding quickly about how this can best be achieved, and I shall be in contact again shortly about this process.

I am copying this letter and attachments to Medical Directors and HR Directors.

Mark Butler
Director of Human Resources

cc: HR Directors
Medical Directors

CONSULTANT CONTRACT: FRAMEWORK

Under the Articles and Bye-laws of the British Medical Association the Central Consultants and Specialists Committee (CCSC), as a Standing Committee, has full delegated authority to act in relation to all matters within its terms of reference i.e. "matters affecting those engaged in consultant and hospital practice". The CCSC therefore has the exclusive right on behalf of the BMA to negotiate a new contract for consultants. The UK Health Departments, the BMA and the NHS Confederation have agreed the following framework for a new NHS consultants' contract.

The new contract is designed to provide a much more effective system of planning and timetabling consultants' duties and activities for the NHS. For NHS employers, this will mean the ability to manage consultants' time in ways that best meet local service needs and priorities. For consultants, it will mean greater transparency about the commitments expected of them by the NHS and greater clarity over the support that they need from employers to make the maximum effective contribution to improving patient services. The new system of **job planning** is described in Part 1 of this document.

In line with the same principles, the parties to the talks have agreed that a more effective approach to planning consultants' time can be achieved by moving towards a new system of programming activities in units of typically four hours each, with a full-time consultant's working week made up of ten such programmed activities. This framework will typically allow around seven of a consultant's programmed activities to be devoted to direct clinical care and around three to supporting professional activities. This new structure for the consultants' **working week** is set out in Part 2.

The parties to the talks have agreed that there should be an increase in average career earnings for consultants, linked to a new system to ensure that pay progression is based on consistently meeting job plan requirements, making best endeavours to achieve agreed individual objectives and demonstrating commitment to the NHS. The new system of **pay progression** described in Part 3 will introduce a new starting salary of £63,000 for consultants, followed by a stepped scale of 'pay thresholds' leading to a maximum salary of £85,250.

The current system does not consistently recognise the emergency work that consultants undertake for the NHS as a result of on-call duties. Nor does it recognise the different levels of disruption associated with different frequencies of on-call rota. Part 4 of this document describes new, more consistent systems for recognising **on-call duties**.

In line with the Government aim of facilitating extended service provision in evenings and at weekends, the new contract will recognise on an equal basis work undertaken during daytime and evenings (on weekdays) and on weekend mornings. There will be special arrangements, described in Part 5, for recognising flexible working patterns that include **out-of-hours work** outside these times.

The new contract is specifically designed to enable NHS employers to arrange extra consultant activity on a planned basis and at normal sessional rates, in preference to the ad hoc arrangements and premium payments made for some current initiatives. To support the aim of securing **extra programmed activities** in this way, the new contract will embody the principle that consultants should be expected to work at all times

towards the most efficient and effective use of NHS resources and that they should be prepared to make available to the NHS (in preference to any other organisations) the first portion of any spare capacity that they have. Part 6 sets out a new system to give effect to these principles.

Part 7 of this document sets out a new approach to managing the relationship between **private practice** and NHS commitments, based on the principle that an NHS consultant's commitment to the NHS must take priority over any work undertaken for other organisations. This approach will be embodied in a new set of binding contractual provisions, designed to ensure that there can be no real or perceived conflicts of interest between private and NHS work. In addition, consultants in the first seven years of their career will be asked to make available to the NHS (in preference to other organisations) the first two sessions' worth on average per week of any spare professional capacity that they have, so that the NHS can have exclusive access to up to 48 hours per week of a consultant's time where this capacity exists.

Part 8 describes in outline agreed plans for **implementation** of the new contract. In order to ensure a smooth transition to the new contract, to manage the build-up of investment costs, and to ensure that there is no unexpected impact on service capacity and continuity, there will be a phased approach to introducing some elements of the new contract. Guidance will be drawn up to support implementation, and this guidance will be able to address the different conditions which exist across the UK, particularly in the devolved administrations. These **transitional arrangements**, including the provisions for assimilation of existing consultants onto the new pay thresholds, are described in Part 9. In order to promote underlying stability in pay during this transitional period, the parties to the talks have also agreed to make joint recommendations to the Doctors' and Dentists' Pay Review Body on the general pay awards that should be made to consultants in the three years from April 2003.

The new consultant contract described in this document is designed to complement the new **clinical excellence award scheme** (see Part 10) that will replace discretionary points and distinction awards in England and Wales and a new system for **disciplinary arrangements** in England (see Part 11). Good progress has been made in discussions on these parallel reforms. The BMA and the Health Departments have agreed that these talks should be concluded as soon as possible, with a view to having arrangements agreed before the new contract is implemented.

The CCSC will now consult on the framework as set out in this document. In parallel, discussions will continue on the clinical excellence award scheme and disciplinary arrangements and on the detailed provisions, terms and conditions of service and guidance needed for implementation, all of which will need to be completed before implementation begins. The new contract will be implemented on 1 April 2003.

Benefits of the new contract

1. The UK Health Departments, the BMA and the NHS Confederation are committed to working with the NHS and the profession to ensure that the new contract is implemented in such a way as to maximise benefits for NHS patient services and for the quality of consultants' working lives in the NHS.

2. The parties to the talks will work together to secure improvements in the following areas, in particular. In preparing for implementation of the new contract, the parties will work up more detailed success criteria to monitor and evaluate progress in these areas when the contract is implemented.

Strand	Benefits for NHS patient care	Benefits for consultants
Job planning	Improved ability to manage consultants' time in ways that best meet local service needs and priorities. Greater clarity of objectives for consultants and more effective systems for engaging consultants in joint action to improve NHS performance and modernise patient care.	A stronger, unambiguous framework of contractual obligations. A more transparent framework for ensuring that consultants have the facilities, secretarial/administrative support and other support needed to carry out their responsibilities and duties and meet agreed objectives.
Working week and recognition of on-call duties	More efficient use of consultants' time and an increase in the time spent on direct clinical care, contributing to improvements in NHS productivity and quality of care. Greater opportunities and incentives to arrange consultant-delivered care in evenings and at weekends, leading to improvements in patient access (e.g. evening outpatient clinics) and in the quality of emergency care.	More consistent and equitable recognition for on-call duties. Agreed action to help reduce the number of consultants on the most frequent on-call rotas. More consistent and equitable recognition for work undertaken out-of-hours, including emergency work.
New pay structure	Improvements in recruitment and retention of consultants, contributing to the target increase of 15,000 consultants and GPs by 2008 (England). Sustained incentives for high-quality performance over the course of a consultant career Enhanced incentives for consultants to maintain commitments for the NHS up to normal retirement age	A significant increase in average career earnings, with earnings in the final phase of a consultant career 24% above their current level where requirements for pay thresholds are met. Greater opportunity for phased careers to recognise the changing focus of the consultant role over an individual's working life.

Extra programmed activities	Ability to secure extra consultant activity more cost-efficiently and thereby release efficiency savings that can be re-deployed in support of better NHS care.	Opportunities to undertake extra work on a more predictable and regular basis for the NHS.
Private practice	Preventing any conflicts of interest, or perceived conflicts of interest, between private practice and NHS commitments. Stronger guarantees that private practice will not disrupt provision of NHS services or detract from NHS performance	Preventing unfair perceptions of abuse in relation to NHS consultants with private practice commitments. Abolition of maximum part time contract. Type of NHS contract based solely on agreed time and service commitments.
Clinical excellence awards (England and Wales)	Greater scope to encourage and recognise outstanding performance. Improved quality of patient care through more transparent and consistent links between consultant rewards and quality of service.	More equitable system of rewarding commitment and quality across the consultant workforce. Access to an increased level of local award for outstanding contributions to improving health services. Consultants making the most outstanding contribution to the NHS will receive total earnings of £150,000.
New disciplinary arrangements (England)	Faster, fair and more effective disciplinary procedures.	Faster, fair and more effective disciplinary procedures.

This framework represents a common UK position, subject of course to the legitimate role of the Scottish Executive and the Welsh and Northern Irish Assemblies and recognising the need for suitable national implementation arrangements. The UK Health Departments will work with the BMA to ensure the new contract is implemented across the UK.

1. Job planning

(a) There will be a new system of mandatory job planning, as described in Annex A. This will apply to all consultants, including clinical academics.

(b) Annual job plan reviews will be separate from but supported by the new appraisal system. Both appraisal and job plan review will be supported by improved information systems.

(c) Employers will draw up and agree job plans with the consultant, setting out a consultant's duties, responsibilities and objectives. The employer will, after full discussion with the consultant, decide how and when the duties and responsibilities in the job plan will be delivered, taking into account the consultant's views on resources and priorities and making every effort to reach agreement if possible.

(d) Job plans will set out a consultant's duties, responsibilities, time commitments and accountability arrangements, including all direct clinical care, supporting professional activities and other NHS responsibilities (including managerial responsibilities). It will be a contractual responsibility to fulfil these elements of the job plan.

(e) Job plans will set out appropriate, identified and agreed service and related personal objectives. Objectives will be expected to reflect different, developing phases in consultants' careers. The delivery of objectives will not be contractually binding, but consultants will be expected to participate in agreeing objectives and to meet or make every reasonable effort to achieve agreed objectives. Performance against objectives will inform decisions on pay progression (see below).

(f) Where consultants work for more than one NHS employer, a lead employer will normally be designated and an integrated single job plan agreed.

(g) Where a consultant disagrees with a job planning decision, there will be an initial referral to the Medical Director (or an appropriate other person if the Medical Director is one of the parties to the initial decision), with provision for a subsequent local appeal if required. The process for appeals will be governed by a national framework.

2. Working week

(a) The new system for organising a consultant's working week is described in Annex B.

(b) The working week for a full-time consultant will comprise ten programmed activities with a timetabled value of four hours each. The employer may programme these as blocks of four hours or in half-units of two hours each. Employers will schedule programmed activities after discussion with the consultant.

(c) There will be flexibility for the precise length of individual programmed activities to vary. Regular and significant differences between timetabled hours and hours worked should be addressed through the mechanism of the job plan review, either at annual review or interim reviews.

(d) Programmed activities will be separated into:

- 'direct clinical care'
- 'supporting professional activities'
- 'additional NHS responsibilities' that may be substituted for other work or remunerated separately
- 'other duties' – external work that can be included in the working week with the employer's agreement

(e) For newly appointed consultants in the first phase of their careers there will typically be a minimum of eight programmed activities for direct clinical care and a minimum of two for supporting professional activities. Beyond this, for full-time consultants, and for all existing consultants, there will typically be a minimum of seven programmed activities for direct clinical care and a minimum of three for supporting professional activities. There will be scope for local variation to take account of individual circumstances and service needs, for example management, research and development, and teaching duties.

(f) With the employer's and consultant's agreement, specified **additional NHS responsibilities**, for instance additional work undertaken by clinical governance leads, Caldicott Guardians or Clinical Audit leads, may be included in the working week. The employer and the consultant will work together to manage such additional NHS responsibilities. These responsibilities will be substituted for other activities or remunerated separately by agreement between the consultant and the employer.

(g) Certain **other external duties**, for example inspections for CHI or trade union duties, may also be included in the working week by explicit agreement between consultant and employer. The employer and the consultant will work together to manage such external duties. Where carrying out other duties might affect the performance of direct clinical care duties, a revised programme of activities should be agreed as far in advance as possible.

(h) **Fee-paying work for other organisations** may be undertaken during NHS programmed activities only with the agreement of the employer and (except in certain circumstances agreed by the employer) with any fee remitted to the Trust. There should be no separate fees given for NHS work (e.g. domiciliary visits) undertaken during NHS programmed activities.

(i) Consultants will generally be expected to be **on site** for all programmed activities, but with flexibility for employers to agree off-site working where appropriate.

(j) **Travelling time** between a consultant's main place of work and home or private practice premises will not be regarded as part of programmed activities. Travelling from main base to other NHS sites, travel to and from work for NHS emergencies,

and 'excess travel' will count as working time. 'Excess travel' is defined as time spent travelling between home and a working site other than the consultant's main place of work, after deducting the time normally spent travelling between home and main place of work. Employers and consultants may need to agree arrangements for dealing with more complex working days.

(k) The contract will allow for **additional programmed activities** to be contracted separately up to the maximum permitted under the Working Time Regulations (or over the maximum 48 hour weekly limit where a consultant has, by written agreement, disapplied the weekly working hours limits), where agreed between employer and consultant.

3. Pay progression

(a) The new arrangements for pay progression are described in Annex C.

(b) There will be a new starting salary of £63,000 for newly appointed consultants, followed by a stepped scale of pay thresholds leading to a maximum basic salary of £85,250. There will be four initial annual thresholds of £2,000 and three further thresholds of £4,750 at five year intervals. (All figures are at 2002/03 pay levels.)

(c) Progress through thresholds will not be automatic, although we expect the great majority of consultants will progress. Progression will depend on a consultant having in each of the years between thresholds:

- met the time and service commitments in their job plans
- participated satisfactorily in annual appraisal, job planning and objective setting
- met the personal objectives in their job plans, or – where this is not achieved for reasons beyond the individual consultant's control – having made every reasonable effort to do so
- worked towards any changes identified as being necessary to support achievement of the organisation's service objectives in the last job plan review
- allowed the NHS (in preference to any other organisations) to utilise the first portion of any additional capacity they have in line with procedures described in Part 6 below
- met required standards of conduct governing the relationship between private practice and NHS commitments (see Part 7 below).

(d) Where these conditions are not met in any year, pay progression will be deferred until the required number of years' satisfactory performance have been demonstrated. In other words, where a consultant does not meet the necessary requirements in a given year, pay progression may be deferred for that year only.

(e) If a consultant has not achieved satisfactory performance in all of the years between thresholds, the employer will have discretion to allow pay progression if they consider it appropriate, for example because of illness in a particular year.

(f) More detailed provisions will be agreed through which recognition for previous service in the NHS can be recognised, and to cover the circumstances in which employers may have discretion to recognise appropriate service outside the NHS

(g) Employers will have the flexibility to pay a recruitment premium to consultants, in addition to basic salary. Before awarding a premium of this kind, employers will have to:

- demonstrate clear evidence of recruitment difficulties
- demonstrate evidence that they have adequately considered and tried out non-pay solutions
- consult with other local employers and appropriate regional bodies (in England with the local Workforce Development Confederation).

There will be similar flexibility to pay retention premia.

(h) The value of any recruitment or retention premium will be determined locally by the employer, after consultation with other local employers, but will not typically exceed 30% of starting salary. The precise arrangements by which such a premium is determined, and the degree to which it might need to take account of the impact on other employers, may vary according to the circumstances in different parts of the UK. Premia may be paid as a one-off, or on a time-limited basis. Time-limited premia shall not typically be paid for more than four years. The employer may adjust the value of any time-limited premium each year, taking into account the extent of local recruitment or retention pressures.

4. On call duties

Work done whilst on-call

(a) All emergency work that takes place at regular and predictable times (e.g. post-take ward rounds) should be programmed into the working week on a prospective basis and count towards a consultant's programmed activities. Less predictable emergency work should be handled, as now, through on-call arrangements. The arrangements for recognising work arising from on-call duties are described below.

(b) Emergency work done whilst on-call and directly associated with a consultant's on-call duties (except in so far as it takes place during a time scheduled for a consultant's programmed activities) will be treated as counting towards the total number of programmed activities in a consultant's working week, up to a maximum of two programmed activities per week. Assessments of the number of programmed activities to be allocated to on-call work will be made on a prospective basis, based on periodic assessments of the average weekly amount of such work over a prior, agreed reference period. Programmed activities will be allocated over a one- to eight-week period. Where on-call work averages less than 30 minutes per week, compensatory time will be deducted from normal programmed activities on an ad hoc basis (see para 8.3 of Annex B for detail).

(c) Where consultants' on-call commitments give rise to different amounts of work than have been reflected in the prospective allocation of programmed activities, the employer and consultant should review the situation and, where appropriate, agree adjustments on a prospective basis (up to the same limit of two programmed activities on average per week). Where this results in a reduction in the number of programmed activities allocated, there will not be any protection arrangements in relation to previous entitlements.

(d) Where consultants' on-call commitments give rise to work significantly in excess of the equivalent of two programmed activities on average per week, this will typically need to be tackled through job planning. In exceptional circumstances, where employers and consultants agree additional work is necessary, employers should make arrangements locally to recognise this excess work.

On-call availability

(e) In cases where there is a very rare need for a consultant to be called outside the timetabled working week, employers and consultants should review the need for on-call arrangements.

(f) Consultants who need to be on an on-call rota will be paid a supplement on top of their basic salary, in addition to the arrangements described above for recognising emergency work arising from on-call duties.

(g) The parties to the talks will agree the precise arrangements for recognising on-call frequency after further data collection and testing. It is agreed, though, that these arrangements will be designed to provide initially for payments to consultants equivalent to 3.48% of the total consolidated pay bill for consultants . Supplements will be expressed as a percentage of basic salary, including pay thresholds but excluding discretionary points, distinction awards or clinical excellence awards. Part-time consultants qualifying for availability supplements will receive the appropriate percentage of the equivalent full-time salary provided their responsibilities when on-call are the same as a full-time consultant on the same rota.

(h) Within these funding parameters, the new arrangements will recognise two basic categories of on-call availability:

- the first category will cover consultants who typically need to return to the hospital or other site immediately when called, or need to undertake analogous interventions (e.g. telemedicine, complex telephone consultations)
- the second category will cover consultants who can more typically respond by giving advice by telephone and/or by returning to work later.

(i) Employers will decide on a prospective basis which of these categories should apply, based on a periodic assessment of the nature of the calls the consultant receives whilst on-call. Any change to this categorisation will also be made on a prospective basis. Where this results in a reduction in the level of supplement, there will not be any protection arrangements in relation to previous entitlements. The BMA, the Health Departments and the NHS Confederation will prepare guidance with indicative examples of which specialties are likely to fall into which category.

(j) The value of a consultant's availability supplement will be determined by reference to these two categories and by reference to the frequency of the consultant's rota commitment, for instance:

Frequency of on-call rota	Value of supplement (as % of equivalent full-time basic salary)	
	Calls typically require immediate return to site	Calls typically dealt with other than by immediate return to site
High frequency (1 in 1 to 1 in 4)	8%	3%
Medium frequency (1 in 5 to 1 in 8)	5%	2%
Low frequency (1 in 9 or less frequent)	3%	1%

(k) Employers will be responsible for determining the size of the on-call rota, and a consultant's frequency banding will be related solely to the number of consultants on this rota. Consultants may agree alternative arrangements for covering emergency rotas, although such arrangements will not alter frequency bandings for the purposes of paying these supplements.

(l) Consultants in both categories will be required to be contactable throughout the on-call period. However, consultants in the second category may, by mutual agreement with the employer, arrange short intervals during an on-call period during which it will not be possible for them to be contacted straight away, provided that there are arrangements for any messages to be taken and for the consultant to be able to respond immediately after the interval in question.

Other emergency re-calls

(m) Consultants not on an on-call rota may be asked to return to site occasionally for emergencies but are not required to be available for such eventualities. Emergency work arising in this way should be compensated through a reduction in other programmed activities on an ad hoc basis. Where emergency recalls of this kind become frequent (e.g. more than 6 times per year), employers should review the need to introduce an on-call rota.

Reviewing frequent on-call rotas

(n) The BMA, the Health Departments and the NHS Confederation are committed to working with the medical profession and the NHS to help eliminate unnecessary on-call responsibilities and to minimise the number of consultants on the most frequent rotas (1 in 1 to 1 in 4).

(o) In conjunction with implementation of the new contract, NHS employers will be asked to identify the reasons for high-frequency rotas and produce action plans for reducing, where possible, the number of consultants on such rotas. The BMA, the Health Departments and the NHS Confederation will develop systems for reviewing local action, perhaps based on the model of the junior doctors' Regional Action Teams (New Deal Implementation Support Group in Scotland). However, it is recognised that special arrangements will be needed for consultants in isolated areas.

Intensity supplements

(p) Subject to the transitional arrangements described below, consultants working under the new contract will no longer be eligible for intensity supplements.

5. Out-of-hours work

(a) All programmed activities scheduled between 8am and 10pm on Monday to Friday and 9am to 1pm at weekends, and any emergency work arising from on-call commitments during these times (subject to the arrangements described above), will attract equal recognition under the new contract. As under the current contract, consultants will be given equivalent time off for all work on statutory and public holidays.

(b) From 1 April 2004, there will be new provisions to recognise the unsocial nature of work done outside these hours and the flexibility required of consultants who work at these times as part of a more varied overall working pattern.

(c) Subject to the transitional arrangements described below (in part 9), the effect of this additional recognition will be that either:

- in assessing the number of programmed activities needed to recognise emergency work done whilst on-call, three hours of emergency work during the times indicated above will be treated as equivalent to one programmed activity; and
- there will be a reduction in a consultant's timetabled weekly work, equivalent to one hour for each programmed activity scheduled in the times indicated above, up to a maximum of three hours per week;

or, by mutual agreement between employer and consultant –

- the consultant will receive a premium payment, worth 3.3% of basic salary (including pay thresholds but excluding discretionary points, distinction awards and clinical excellence awards) for an average of one programmed activity per week – and/or equivalent emergency work whilst on-call – expected to be carried out in the times indicated above; or 6.6% of basic salary for an average of two programmed activities or equivalent per week; or 10% for an average of three programmed activities or equivalent per week.

(d) Decisions on the allocation of programmed activities for out-of-hours work (including work arising from on-call) and the level of this recognition will be made on a prospective basis at job plan review. These decisions will be based on the number of programmed activities that a consultant is likely to have scheduled during the relevant times and expected patterns of emergency work whilst on-call. Where job plan reviews result in a reduction in the level of recognition for out-of-hours work, there will not be any protection arrangements in relation to previous recognition for out-of-hours work.

(e) Employers should ensure that where consultants work through the out-of-hours period adequate rest is provided before and after the period of duty.

(f) The Health Departments and the BMA do not expect that consultants will typically need to work, on average, more than the equivalent of three such programmed activities per week. Employers and consultants may agree appropriate arrangements locally in cases where out-of-hours work exceeds this level.

(g) Where a programmed activity spans the two relevant periods, the part of the programmed activity falling in the out-of-hours period will be treated accordingly.

6. Extra programmed activities

(a) The BMA, the Health Departments and the NHS Confederation have agreed that the new contract should support more rational planning of extra activity, for instance to help meet performance targets for waiting. The aim should be to allow, wherever possible, for extra consultant activity to be arranged on a planned basis and at normal sessional rates, in preference to the ad hoc arrangements and premium payments made for some current initiatives.

(b) As indicated above (Part 2), the new contract will allow additional programmed activities to be contracted, where agreed between employer and consultant.

(c) Under the new contract, consultants will be expected to work at all times towards the most efficient and effective use of NHS resources. In line with this principle, consultants will be expected to make available to the NHS (in preference to any other organisations) the first portion of any spare capacity that they have. To give effect to this principle:

- consultants (whether working full-time or part-time) who wish to undertake remunerated clinical work (as defined in Annex B, para 5.3, with the addition of clinical management in the private sector) outside their main NHS contract, e.g. work for the independent sector or other NHS work, should first consult their NHS employer
- the NHS employer may offer the consultant the opportunity to carry out additional programmed activities contracted for separately under the same terms and conditions of service as their main contract and at normal sessional rates, where possible at annual job plan review but, unless otherwise agreed between the employer and consultant, no fewer than three months in advance of the start of the proposed extra work, or six months in advance where the work would mean the consultant had to re-schedule external commitments
- a minimum notice period of three months should be given of termination of these additional activities
- the employer would be expected to give all those clinically appropriate consultants (i.e. not just those consultants wishing to undertake similar work outside their main NHS contract) the equal opportunity to express an interest in undertaking this additional work
- the additional programmed activities could be offered on a fixed basis, but where possible they should be offered on an agreed annualised basis
- where in a given year a consultant declines the opportunity to take on additional programmed activities that have been offered in the way described above including the minimum notice provisions, up to one additional activity per week on average, and subsequently undertakes remunerated clinical work (as defined above) outside their main NHS contract, pay progression would be deferred in respect of that year.

(d) Newly appointed consultants in the first seven years of their career will be expected to make available to the NHS (in preference to other organisations) a greater proportion of any spare capacity that they have, up to the Working Time Regulations limit of 48 hours per week. To give effect to this principle, the same provisions as set out in the previous paragraph would apply, with the exception that

- pay progression would be deferred where a consultant declines the opportunity to take on up to two additional programmed activities per week on average (subject to the procedures and minimum notice periods above) and subsequently undertakes remunerated clinical work outside their main NHS contract.
- more detailed provisions will be agreed to cover recognition for previous service in the NHS and the circumstances in which employers may have discretion to recognise appropriate service outside the NHS.

(e) At the employer's discretion, some categories of extra-contractual activities may be exempted from these arrangements.

(f) These provisions will apply to part-time consultants, subject to the following provisions:

- existing consultants who wish to transfer to the new contract and who undertake remunerated clinical work (as defined above) outside their main NHS contract will be subject to the provisions described above in sub-paragraph (c)
- where there is any significant increase in an existing part-time consultant's private practice following transfer to the new contract, the employer and consultant will review the appropriate number of programmed activities the consultant should undertake for the NHS
- consultants appointed after the date of implementation who wish to work part-time in order to undertake private practice may be offered part-time contracts, but such contracts will normally be for six programmed activities or fewer per week unless exceptionally agreed otherwise by the employer
- consultants appointed after the date of implementation wishing to undertake remunerated clinical work (as defined above) outside their main NHS contract will be subject to the provisions described above in sub-paragraphs (c) and (d)
- consultants appointed after the date of implementation who wish to work part-time and do not intend to undertake any private practice may be offered part-time contracts for up to nine programmed activities per week.

(g) These provisions will not create any obligation for consultants to undertake additional programmed activities. The provisions will apply only where consultants wish to do extra work, either for the NHS or for other organisations.

7. Private practice

(a) All consultants will have a standard contract, which may be either full-time or part-time depending on the weekly number of programmed activities carried out for the NHS. The type of contract will take no account of the extent of a consultant's earnings from private practice.

(b) There will be a new set of contractual provisions governing the relationship between consultants' NHS commitments and any private practice they undertake. This will include private practice in respect of both private patients and NHS patients. These rules will be designed to minimise the potential for conflicts of interest – or perceived conflicts of interest – to arise between private and NHS commitments.

(c) Employers will be required to satisfy themselves annually that a consultant is meeting the requirements set out in these rules in determining eligibility for pay progression. Compliance with these rules will (with some possible exceptions) also be a contractual requirement.

(d) The areas covered by the new rules will include (see Annex D):

- disclosure of information about private practice
- scheduling of private work
- transfer of patients between the NHS and private sector, and management of NHS waiting lists
- use of NHS facilities and staff for private and other fee-paying work
- engagement with measures to increase NHS capacity, including appointment of new consultants

8. Implementation

(a) The Health Departments, the BMA and the NHS Confederation will work together to prepare for implementation of the framework described in this document. This period of preparation will be designed:

- to provide additional assurances that the new contract will not have unintended consequences for costs or service capacity
- to assess the most effective ways of ensuring a smooth transition to the new contract
- to assess the most effective ways of supporting employers and consultants in working together to achieve the maximum benefits from the new contract.

(b) The Health Departments will take the necessary steps to ensure that the new contract is applied to all newly appointed consultants and that NHS employers offer the new contract to all existing consultants. Existing consultants may choose whether to take up the new contract or remain on their current contract. NHS employers will not offer any other new contract either to existing or newly appointed consultants.

(c) The new contract will be introduced on 1 April 2003.

9. Transitional arrangements

(a) In order to ensure a smooth transition to the new contract, to manage the build-up of investment costs, and to ensure that there is no unexpected impact on service capacity and continuity, there will be a phased approach to introducing some elements of the new contract.

<u>Existing consultants</u>

(b) On transfer to the new contract, existing full-time consultants will move up to the fifth pay threshold (£71,000), with the exception of those with:

- one year's seniority (i.e. those on the first point of the current scale), who will move up to £63,000

- two years' seniority (i.e. those on the second point of the current scale), who will move up to £63,500
- three years' seniority, who will move up to £64,000
- four years' seniority, who will move up to £64,500
- five years' seniority, who will move up to £69,000
- six years' seniority, who will move up to £70,000
- thirty years' seniority, who will move up to £75,750

(c) Subsequent progression through pay thresholds for existing consultants will be based on meeting the requirements described in Part 3 above, but with accelerated eligibility for thresholds linked to a consultant's seniority as follows:

30 years' seniority	Intervals of one year before each of the two remaining thresholds
21-29 years' seniority	Intervals of one year before each of the three remaining thresholds
20 years' seniority	An interval of one year before the £75,750 threshold, two years before the £80,500 threshold and one year before the £85,250 threshold
19 years' seniority	An interval of one year before the £75,750 threshold, two years before the £80,500 threshold and two years before the £85,250 threshold
18 years' seniority	An interval of two years before the £75,750 threshold, one year before the £80,500 threshold and two years before the £85,250 threshold
17 years' seniority	An interval of two years before the £75,750 threshold, two years before the £80,500 threshold and two years before the £85,250 threshold
16 years' seniority	An interval of three years before the £75,750 threshold, one year before the £80,500 threshold and three years before the £85,250 threshold
15 years' seniority	An interval of three years before the £75,750 threshold, one year before the £80,500 threshold and four years before the £85,250 threshold
14 years' seniority	An interval of three years before the £75,750 threshold, two years before the £80,500 threshold and four years before the £85,250 threshold
13 years' seniority	An interval of three years before the £75,750 threshold, two years before the £80,500 threshold and five years before the £85,250 threshold
12 years' seniority	An interval of three years before the £75,750 threshold, three years before the £80,500 threshold and five years before the £85,250 threshold
11 years' seniority	An interval of four years before the £75,750 threshold, three years before the £80,500 threshold and five years before the £85,250 threshold
Ten years' seniority	An interval of four years before the £75,750 threshold, four years before the £80,500 threshold and five years before the £85,250 threshold
Nine years' seniority	An interval of four years before the £75,750 threshold, five years before the £80,500 threshold and five years before the £85,250 threshold
Seven or eight years' seniority	An interval of five years before the £75,750 threshold, five years before the £80,500 threshold and five years before the £85,250

	threshold
Six years' seniority	An interval of one year before the £71,000 threshold, four years before the £75,750 threshold, five years before the £80,500 threshold and five years before the £85,250 threshold
Five years' seniority	An interval of one year before a £70,000 threshold, one year before the £71,000 threshold, four years before the £75,750 threshold, five years before the £80,500 threshold and five years before the £85,250 threshold
Four years' seniority	An interval of one year before the £67,000 threshold, one year before the £69,000 threshold, one year before the £71,000 threshold, three years before the £75,750 threshold, five years before the £80,500 threshold and five years before the £85,250 threshold
Three years' seniority	An interval of one year before a threshold of £66,000, one year before the £69,000 threshold, one year before the £71,000 threshold, four years before the £75,750 threshold, five years before the £80,500 threshold and five years before the £85,250 threshold
Two years' seniority	An interval of one year before the £65,000 threshold, one year before the £69,000 threshold, one year before the £71,000 threshold, five years before the £75,750 threshold, five years before the £80,500 threshold and five years before the £85,250 threshold
One year's seniority	An interval of one year before a threshold of £64,000, one year before the £67,000 threshold, one year before the £69,000 threshold, one year before the £71,000 threshold, five years before the £75,750 threshold, five years before the £80,500 threshold and five years before the £85,250 threshold

(d) Existing part-time consultants will be offered the choice whether to take up a contract based on the number of programmed activities that are nearest in equivalence to their current notional hours, or – if they are able to demonstrate a commensurate increase in the amount of work done – a contract based on the same number of programmed activities as their current number of notional half days.

(e) Consultants who are currently on maximum part time contracts and who choose to take up the new contract on a full-time basis will receive higher rates of basic pay on a phased basis. In the first year of the new contract, these consultants will receive their current level of pay (including the annual pay increase) plus a third of the difference between this and their target pay, i.e. the pay that a full-time consultant with their level of seniority would ordinarily receive under the new contract. In the second year, they will receive their current level of pay (including the annual pay increase) plus two-thirds of the difference between this and their target pay.

(f) There will be a corresponding phasing of the number of additional programmed activities that a former maximum part time contract holder should be expected to be willing to offer the NHS under the provisions described in para 6(c) above.

(g) Existing consultants will be covered by the provisions governing extra programmed activities described in para (c) of Part 6 above. The additional provisions described in para (d) of Part 6 will apply only to consultants appointed after the date on which the new contract becomes effective, not to any existing consultants.

Phasing of other elements

(h) There will be a three-year transitional period, ending on 31 March 2006, for phasing in some other elements of the new contract.

(i) During this transitional period:

- for the first two years of the new contract, there will be a limit of one programmed activity on the level of recognition awarded for unpredictable emergency work arising from on-call duties
- there will be arrangements to ensure that the new system of recognising on-call work does not result in a reduction in the time available for consultants' other duties, if necessary by arranging for additional programmed activities to be contracted
- the arrangements described in Part 5 for recognising out-of-hours work will take effect from the start of the second year of the new contract
- where scheduled provision is made for out-of-hours work, the employer may decide whether to give recompense in the form of premia or a reduction in hours (see Part 5). After the transitional period, premia may be paid only by mutual agreement between the employer and the consultant
- there will be a phased approach to introducing the new provisions for securing extra activity described in para (d) of Part 6 above. For consultants appointed (defined for these purposes as when the consultant post is offered) before 1 April 2003, the provisions will not apply. For consultants appointed during 2003/04, the provisions will apply for the first year of the contract. For consultants appointed during 2004/05, the provisions will apply for the first three years of the contract. For consultants appointed in 2005/06, the provisions will apply for the first five years of the contract. After this transitional period, the provisions will apply for seven years to all newly appointed consultants.

General pay awards

(j) In order to promote underlying stability in pay during this transitional period, the parties to the talks have also agreed to make joint recommendations to the Doctors' and Dentists' Pay Review Body on the general pay awards that should be made to consultants in the three years from April 2003. The parties will recommend that:

- the annual general pay award for consultants should be 10% over the three years from 2003/04 to 2005/06, with equal increases of 3.225% in each of these years
- the Review Body should not recommend any other changes to the consultant pay system during this period.

(k) This agreement assumes that the underlying rate of inflation, as measured by RPI(X) will fall between 1.725% and4.725% per year. In the event that inflation falls outside these parameters, based on the average yearly increase in inflation in the twelve months to October of the year preceding an award, the parties to the talks will re-negotiate these arrangements and/or put fresh recommendations to the Review Body.

10. Pensions

(a) The Health Departments and the BMA have agreed that basic salary (including pay thresholds), clinical excellence awards and on-call availability supplements will be superannuable.

(b) As a result of higher salary and pay thresholds, the new contract will give consultants additional pensions benefits estimated at £100,000 (capital value).

(c) There will be further discussions on pensions arrangements.

The clinical excellence awards as set out below will cover England and Wales only. The disciplinary arrangements will cover England only.

11. Clinical Excellence Awards

(a) In England and Wales, a new clinical excellence award scheme will replace the existing discretionary points and distinction awards schemes. The new scheme will reward those consultants who show the greatest commitment to delivering, developing and managing a high quality service and/or the greatest levels of achievement in research and/or teaching. The maximum award under the scheme will be £65,000. The key elements of the new scheme are described in Annex E.

(b) The BMA and the Health Departments have agreed that talks on the new scheme should be concluded as soon as possible, with the aim of having arrangements agreed before the new contract is implemented

12. Disciplinary arrangements

(a) There will be a new national disciplinary framework to replace the existing local and national procedures (HC[90]9). This will include the removal of the paragraph 190 procedures. The Government's intention is that all appeals against disciplinary decisions will in future be handled locally.

(b) The BMA and the Health Department have agreed that talks on the new arrangements should be concluded as soon as possible, with a view to having agreed arrangements in place before the new contract is implemented.

ANNEX A

JOB PLANNING

1. PRINCIPLES

1.1. The principles are:

- mandatory job planning for consultants
- annual job plan review, supported by the agreed appraisal system and by improved information systems with appropriate benchmarks
- employer's responsibility to draw up and agree job plans with the consultant, setting out main duties, responsibilities and objectives in qualititative and quantitative terms
- job plans to cover all aspects of a consultant's practice in the NHS including research and teaching
- employers responsible for ensuring consultants have the facilities, training, development and support needed to deliver agreed commitments
- job plans should reflect current duties, responsibilities and objectives with an interim job plan review if these have changed or need to change significantly during the year
- equally explicit recognition of duties, responsibilities and objectives for clinical academics as for other consultants.

2. SUMMARY

2.1. There will be a new mandatory system of job planning and annual job plan reviews, supported by the agreed appraisal system.

2.2. The employer will draw up and agree job plans with the consultant setting out main duties, responsibilities and objectives.

2.3. The job plan will cover:

- Job content
- Time and service commitments
- Appropriate, identified and agreed personal objectives

2.4. There will be an annual job plan review to consider and review the job plan and to set out what the consultant should be seeking to achieve over the next 12 months incorporating the key development objectives set out in the agreed personal development plan.

3. LINKS WITH APPRAISAL

3.1. Job planning is linked closely with the agreed appraisal scheme for consultants, although in some cases the requirement for an appraiser to be medically registered will mean that they are carried out by different people. The attached figure

illustrates how the two processes interrelate. Both the appraisal and the job plan review are informed by information on the quality and quantity of the consultant's work over the previous year. Both processes will involve discussion of service objectives and linked personal objectives, including how far these objectives have been met (or what factors outside the control of the consultant have affected delivery) and how far the objectives were realistic.

3.2. Appraisal is a process to review a consultant's work and performance, to consolidate and improve on good performance and identify development needs which will be reflected in a personal development plan for the coming year. Job plan review will take into account the outcome of appraisal discussion on working practices, including the role of the individual consultant in the clinical team, and clinical governance responsibilities and continuing professional development as set out in the agreed personal development plan. The agreed personal development plan will be reflected and may be updated at the job plan review.

4. JOB CONTENT

4.1. The job plan will set out the main duties and responsibilities of the post and the service to be provided for which the consultant will be accountable.

4.2. This will include, as appropriate

- Direct clinical care duties
- Supporting professional activities
- Additional responsibilities
- Any other agreed external duties
- Any agreed additional programmed activities

as set out in the parallel working week paper.

5. MANAGERIAL RESPONSIBILTIES

5.1. The job content should include any management responsibilities, recognising that specific responsibilities and duties will vary between consultants. The job plan should allocate and timetable programmed activities within the total working week accordingly.

6. ACCOUNTABILITY ARRANGEMENTS

6.1. The job plan should also set out the consultant's accountability arrangements, both professional and managerial, within the NHS organisation. Accountability will usually be to the Clinical Director or Medical Director.

6.2. Consultants will also be expected to comply with the GMC's "Good Medical Practice"

7. OBJECTIVES

7.1. Objectives will be set in terms of protocols, policies and procedures to be followed, output and outcome measures, and work patterns to be followed. Objectives will set out a mutual understanding of what the consultant and employer will be seeking to achieve over the next 12 months – based on past experience and reasonable expectations of what might be achievable in future.

7.2. Objectives will vary according to specialty but the headings under which they could be listed include:

- activity and efficiency
- clinical outcomes
- clinical standards
- local service objectives
- management of resources, including efficient use of NHS resources

7.3. Objectives will need to be appropriate, identified and agreed. Numerical objectives are appropriate, provided that they are, like other objectives, appropriate, identified and agreed.

7.4. Objectives will need to reflect different, developing phases in consultants' careers.

7.5. Objectives will be agreed on the understanding that delivery against objectives may be affected by changes in circumstances or factors outside the control of the individual – all of which should properly be taken into account in the appraisal process and considered at the job plan review.

7.6. Objectives will be an integral part of the job plan, although not contractually binding in themselves. Consultants will be expected to endeavour to work towards the delivery of objectives set out in the job plan, recognising the impact of local circumstances and resources on delivery. Progress against objectives and factors affecting delivery will be considered at the annual job plan review.

7.7. Objectives should be kept under review, and the consultant or the employer will be expected to organise an interim job plan review if either believe that objectives might not be achieved. Employers and consultants will be expected to identify problems (affecting the likelihood of meeting objectives) as they emerge, rather than wait until the job plan review.

8. TIME AND SERVICE COMMITMENTS

8.1. The employer will decide how and when the duties and responsibilities in the job plan will be delivered after full discussion with the consultant, taking into account the consultant's views on resources and priorities, and making every effort to reach agreement if possible.

8.2. The employer will be responsible for ensuring consultants have the facilities, training, development and support needed to deliver the commitments in the job plan.

8.3. The employer, after discussion with the consultant, will draw up a timetable setting out when and how the job content and service objectives will be delivered and specifying the nature and location of the activity. This will cover all the activities to be included in the working week, including direct clinical care, supporting professional activities, additional responsibilities and any other agreed duties.

8.4. Consultants will normally be expected to be in the workplace for all programmed activities that form part of their agreed working week, except where agreed with the employer and specified in the job plan. Exceptions will include travelling between sites and attending agreed meetings away from the workplace [as defined in the working week paper]. Arrangements to work off-site or at home (e.g. telemedicine) at specified times could be agreed in relation to specified duties and set out in the job plan.

8.5. Timetables will usually cover a week, but alternative approaches, covering a number of weeks, or an annualised hours approach, could be adopted if agreed between consultant and employer.

8.6. The job plan will cover on-call and out-of-hours commitments. Regular, predictable commitments arising from on-call responsibilities will be scheduled, where possible, into programmed activities. Rota commitments will also be specified.

8.7. Consultants will be required to meet the time and service commitments set out in the job plan as part of their basic duties. Compliance with these aspects of the job plan will be a contractual responsibility and, except in emergencies or where otherwise agreed with managers, consultants will be expected to fulfil the duties and responsibilities set out in the job plan.

9. JOB PLAN REVIEW

9.1. The job plan will be agreed between the employer and the individual consultant on appointment to the post, and reviewed annually at the job plan review. The job plan review will be informed by the same information systems that feed into appraisal, and by the outcome of the appraisal discussion. Interim job planning reviews will be conducted where duties, responsibilities or objectives have changed or need to change significantly within the year.

9.2. The job plan review will be carried out by the consultant's manager, usually the same person who undertook the appraisal, in most cases the Clinical Director or Medical Director. The job plan review will review the job content and service objectives as well as the delivery of commitments.

9.3. Job plan review will be an opportunity for the employer and the consultant to discuss whether targets were at the right level, resources adequate, and whether the timetable of time and service commitments should be amended. For example, if a programmed activity is consistently overrunning its allotted time then consideration should be given to how to contain it within the time, or whether another programmed activity should be allocated.

9.4. Following the discussion at the job plan review the manager will inform the Chief Executive via the Medical Director whether the consultant has:

- met the time and service commitments in their job plans
- met the personal objectives in their job plan or - where this is not achieved for reasons beyond the individual consultant's control – has made every reasonable effort to do so
- participated satisfactorily in annual appraisal, job planning and objective setting
- worked towards any changes identified as being necessary to support achievement of the organisation's service objectives in the last job plan review

9.5. This will inform decisions on pay progression.

10. AGREEING THE JOB PLAN

10.1. If it is not possible to agree a job plan, either initially or at an annual review, there will be an initial referral to the Medical Director (or an appropriate other person if the Medical Director is one of the parties to the initial decision) and, if required, a subsequent local appeals panel in line with national guidance.

11. CONSULTANTS WORKING FOR MORE THAN ONE EMPLOYER

11.1. Where consultants work in more than one NHS organisation, the employing organisations will ordinarily agree a designated lead employer and design one integrated job plan. Exceptionally, there will be local flexibility to agree other arrangements with consultants across employers.

12. CLINICAL ACADEMICS

12.1. NHS organisations should work with universities to agree the commitments of those on honorary contracts and build a job plan accordingly.

ANNEX B

WORKING WEEK

1. PRINCIPLES

1.1. The structure of the working week should:

- set clear levels of accountability and contractual commitments, alongside reasonable expectations of professional flexibility
- recognise different patterns of work intensity, including emergency work
- allow for working patterns that will facilitate the provision of 24 hour a day seven day a week NHS services
- support the move to a consultant delivered service.

2. SUMMARY

2.1. There is agreement that:

- for full time consultants, there will be a total of 10 programmed activities with a timetabled value of four hours each. These may be programmed as blocks of four hours or in half-units of two hours each
- programmed activities will be separated into:
  - 'direct clinical care'
  - 'supporting professional activities'
  - 'additional responsibilities' that may be substituted for other work or remunerated separately
  - 'other duties' – external work that can be included in the working week with the employer's agreement
- for a full-time consultant there will typically be a minimum of 7 programmed activities for direct clinical care and a minimum of 3 for supporting professional activities. For full-time consultants in the first phase of their careers, there will typically be a minimum of 8 programmed activities for direct clinical care and a minimum of two for supporting professional activities.
- there will be recognition of on-call duties, with emergency work whilst on-call counted towards programmed activities to a maximum of two per week, subject to the transitional arrangements, and separate salary supplements of up to 8% to recognise on-call availability
- during the hours of 8am – 10pm Monday to Friday and 9am – 1pm Saturday and Sunday all programmed activities, including additional activities, will be paid at plain-time rates.
- from 1 April 2004, there will be additional recognition for work done out-of-hours, including emergency work
- there will be flexibility to vary the level of weekly programmed activities within an annual total, where agreed by consultant and employer

- there will be scope for extra programmed activities to be contracted for and remunerated separately, up to the maximum permitted under Working Time Regulations

3. THE WORKING WEEK

3.1. The working week will be expressed in terms of timetabled programmed activities. Each programmed activity could involve a combination of duties, for example a ward round and patient administration. For full-time consultants the working week will be 10 programmed activities, each with a notional value of 4 hours giving a timetabled working week of 40 hours. These may be programmed as blocks of four hours or in half-units of two hours each. Part-time consultants will agree with their employer the number of programmed activities which will make up their core working week.

3.2. During the hours of 8am to 10pm Monday to Friday and 9am to 1pm Saturday and Sunday and all programmed activities will be paid at plain-time rates.

3.3. The BMA and Health Departments agree that the contract should not involve any element of clocking on and off and overtime payments will not be available. Both sides also recognise that there should be scope for variation, up and down, in the length of individual programmed activities from week to week around the average assessment set out in the job plan.

3.4. Regular and significant differences between a consultant's timetabled hours and the hours actually worked will need to be discussed as part of job plan reviews either at the planned annual review or an interim job plan review.

4. FLEXIBILITY AND ANNUALISATION

4.1. The contract will allow, by agreement between consultants and employers, for flexible timetabling of commitments over a period. Flexible timetabling could help meet varying service needs by allowing adjustment to working patterns at different times of year. It could in some cases fit with the need for teaching and research requirements. Examples could include:

- offering the flexibility for a consultant to focus on an intensive research project for part of the year or to alternate clinical and teaching duties across the year;
- term time working;
- consultant of the week arrangements.

4.2. When arranging flexible timetables, the contract as a whole will be expressed in terms of the annual equivalent of the working week. By agreement between the consultant and employer, the job plan will specify variations in the level and distribution of programmed activities within the overall annual total. A consultant could thus work more or less than the standard number of programmed activities in particular weeks.

4.3. Any variations in the length of the working week will need to be consistent with the provisions of the Working Time Directive, which specifies a maximum 48 hour week averaged over a 26 week reference period, unless a waiver has been signed.

5. PROGRAMMED ACTIVITIES

5.1. Under the new system of mandatory job planning, each consultant will agree a job plan with their employer covering job content, duties and responsibilities and appropriate, identified and agreed objectives (as set out in the parallel paper on job planning). Time and service commitments will reflect the activities comprising the working week and employers will schedule programmed activities after discussion with the consultant.

5.2. This section sets out the framework within which time and service commitments will be agreed and timetabled.

Direct clinical care

5.3. Consultants will be expected to spend the majority of their time engaged in direct clinical care, that is:

- Emergency duties (including emergency work carried out during or arising from on-call)
- Operating sessions, including pre and post operative care
- Ward rounds
- Outpatient clinics
- Clinical diagnostic work
- Other patient treatment
- Public health duties
- Multi-disciplinary meetings about direct patient care
- Administration directly related to patient care (e.g. referrals, notes)

5.4. Typically, direct clinical care will be expected to account for a minimum of eight programmed activities within the working week for full time consultants in the first phase of their career (the first 7 years after appointment) and seven programmed activities for other full time consultants.

5.5. The proportion of time spent on direct clinical care might, however, be lower for consultants in the third phase of their career. There will also be scope for local variation to take account of individual circumstances and service needs, for example to recognise the diverse responsibilities of clinical and medical directors, or to recognise teaching or research duties.

Supporting professional activities

5.6. There are a number of activities which underpin direct clinical care and consultants will be expected to fulfil agreed commitments in respect of these activities, including as appropriate:

- Training
- Continuing professional development
- Formal teaching

- Audit
- Job planning
- Appraisal
- Research
- Clinical management
- Local clinical governance activities.

5.7. Typically supporting professional activities will be expected to account for a minimum of two programmed activities within the working week for full time consultants in the first phase of their career and a minimum of three programmed activities for other full time consultants.

Additional responsibilities

5.8. Some consultants have additional responsibilities agreed with their employer which cannot reasonably be absorbed within the time available for supporting activities. These will be substituted for other work or remunerated separately by agreement between the consultant and their employer. Such responsibilities could include those of:

- Caldicott guardians
- Clinical audit leads
- Clinical governance leads
- Undergraduate and postgraduate deans, clinical tutors, regional education adviser

5.9. Responsibilities of Medical Directors, Clinical Directors and lead clinicians will be reflected by substitution or additional remuneration agreed locally.

Other duties

5.10. Certain other external duties, including work for other NHS organisations, might be specified as within the working week by explicit agreement between consultant and employer based on a clear understanding of the programmed activities that will be fulfilled. Such duties, all of which must be explicitly agreed in advance, could include:

- Trade union duties
- Acting as an external member of an Advisory Appointments Committee
- Undertaking assessments for the NCAA
- Reasonable quantities of work for the Royal Colleges in the interests of the wider NHS
- Specified work for the General Medical Council
- Undertaking inspections for the Commission for Health Improvement

5.11. Where carrying out of these additional activities might affect the performance of direct clinical care duties, the consultant should agree with the employer the revised programme of activities within the working week at least a month is advance with an expectation that duties could either be substituted with the agreement of the employer, or otherwise undertaken with the approval of the employer. Where the additional duties extend over a period of time, the working week should be rearranged where possible.

5.12. Any other professional activities will not be covered in the job plan. Depending on the nature of the duties, paid professional leave or unpaid leave might be available.

5.13. Study and professional leave, with pay and expenses, could be granted by employers up to a maximum of thirty days (including off-duty days) in any period of three years. Employers may, at their discretion, grant professional or study leave above this limit, with or without pay. Otherwise, time taken out of the working week for such commitments will be treated as annual leave. More detailed provisions will be agreed to cover the circumstances in which employers may have discretion to allow periods of sabbatical leave, paid and unpaid.

5.14. Other special leave, for example compassionate leave and maternity leave, will be available as set out in the provisions of the General Council Conditions of Service.

5.15. All time taken out of the agreed working week (annual leave, professional or study leave) will have to be agreed with the employer, where possible at least a month in advance.

6. WORK FOR OTHER ORGANISATIONS

6.1. Fee-paying work, defined as category 2 work (including work for government departments) and additional work for NHS organisations, should be either:

- carried out in the consultant's own time or in annual or unpaid leave, with the fee retained; or
- carried out with the agreement of the consultant's employer within time for supporting activities and with the fee remitted to the employer.

6.2. Where work involves minimal disruption, there could be local agreement at the discretion of the employer for this work to be done in NHS time without the employer collecting the fee.

6.3. Employers have the discretion to charge consultants for the use of NHS facilities outside NHS time, although consultants should not be charged for the use of patient notes.

6.4. There should be no separate fees given for NHS work (e.g. domiciliary visits) undertaken during NHS programmed activities.

7. ON-CALL

<u>Work done whilst on-call</u>

7.1. All emergency work that takes place at regular and predictable times (e.g. post-take ward rounds) should be programmed, where possible, into the working week on a prospective basis and count towards a consultant's programmed activities. Less predictable emergency work should be handled, as now, through on-call arrangements.

7.2. Emergency work done whilst on-call and directly associated with a consultant's on-call duties (except in so far as it takes place during a time scheduled for a consultant's programmed activities) will be treated as counting towards the total

number of programmed activities in a consultant's working week, up to a maximum of two programmed activities per week (subject to the transitional arrangements).

7.3. Assessments of the number of programmed activities to be allocated to on-call work will be made on a prospective basis, based on periodic assessments of the average weekly amount of such work over a prior, agreed reference period. Programmed activities will be allocated over a one- to eight- week period.- Where on-call work averages less than 30 minutes per week, compensatory time will be deducted from normal programmed activities on an ad hoc basis:

Average emergency work per week directly associated with on-call duties	**Suggested allocation of programmed activities**
Half-an-hour	One programmed activity every eight weeks, or one half-activity every four weeks
One hour	One programmed activity every four weeks, or two half-activities per fortnight
One-and-a-half hours	One programmed activity every three weeks
Two hours	One programmed activity per fortnight, or half a programmed activity per week
Three hours	Three programmed activities every four weeks
Four hours	One programmed activity per week
Six hours	One and a half programmed activities per week, or three programmed activities every two weeks
Eight hours	Two programmed activities per week

7.4. A further table will be included in guidance to show the effect of recognising emergency work carried out in the out-of-hours period (as set out in section 8), e.g. an average of 3 hours emergency work out-of-hours would translate into one programmed activity per week.

7.5. Where consultants' on-call commitments give rise to different amounts of work than have been reflected in the prospective allocation, the employer and consultant should review the situation and, where appropriate, agree adjustments on a prospective basis (up to the same limit of two programmed activities). Where job plan reviews result in a reduction in the level of recognition for on-call, there will not be any protection arrangements in relation to previous recognition for on-call work.

7.6. Where consultants' on-call commitments give rise to work significantly in excess of the equivalent of two programmed activities on average per week, this will typically need to be tackled through job planning. In exceptional circumstances, where employers and consultants agree additional work is necessary, employers should make additional arrangements locally to recognise this excess work.

<u>On-call availability</u>

7.7. In cases where there is a very rare need for a consultant to be called outside the timetabled working week, employers and consultants should review the need for on-call arrangements.

7.8. Consultants who need to be on an on-call rota will be paid a supplement on top of their basic salary, in additional to the arrangements described above for recognising emergency work arising from on-call duties.

7.9. The parties to the talks will agree the precise arrangements for recognising on-call frequency after further data collection. It is agreed, though, that these arrangements will be designed to provide initially for payments to consultants equivalent to 3.48% of the total consolidated pay bill for consultants . Supplements will be expressed as a percentage of basic salary, including pay thresholds but excluding discretionary points, distinction awards or clinical excellence awards. Part-time consultants qualifying for availability supplements will receive the appropriate percentage of the equivalent full-time salary provided their responsibilities when on-call are the same as a full-time consultant on the same rota.

7.10. Within these funding parameters, the new arrangements will recognise two basic categories of on-call availability:

- The first category will cover consultants who typically need to return to the hospital or other site immediately when called, or need to undertake analogous interventions (e.g. telemedicine, complex telephone consultations)
- The second category will cover consultants who can more typically respond by giving advice by telephone and/or by returning to work later

7.11. Employers will decide on a prospective basis which of these categories should apply, based on a periodic assessment of the nature of the calls the consultant receives whilst on-call. Any change to this categorisation will be made on a prospective basis. Where this results in a reduction in the level of supplement, there will not be any protection arrangements in relation to previous entitlements. The BMA, the Health Departments and the NHS Confederation will prepare guidance with indicative examples of which specialities are likely to fall into which category.

7.12. The value of a consultant's availability supplement will be determined by reference to these two categories and by reference to the frequency of the consultant's rota commitment.

7.13. Employers will be responsible for determining the size of the on-call rota, and a consultant's frequency banding will be related solely to the number of consultants on this rota. Consultants may agree alternative arrangements for covering emergency rotas, although such arrangements will not alter frequency bandings for the purposes of paying these supplements.

7.14. Consultants in both categories will be required to be contactable throughout the on-call period. However, consultants in the second category may, by mutual agreement with the employer, arrange short intervals during an on-call period during which it will not be possible for them to be contacted straight away, provided that there are arrangements for any messages to be taken and for the consultant to be able to respond immediately after the interval in question.

7.15. Consultants not on an on-call rota may be asked to return to site occasionally for emergencies but are not required to return or be available to return. Emergency

work arising in this way should be compensated through a reduction in other programmed activities on an ad hoc basis. Where emergency recalls of this kind become frequent (e.g. more than 6 times per year), employers should review the need to introduce an on-call rota.

Reviewing frequent on-call rotas

7.16. The BMA, the Health Departments and the NHS Confederation are committed to working with the medical profession and the NHS to help eliminate unnecessary on-call responsibilities and to minimise the number of consultants on the most frequent rotas (1 in 1 to 1 in 4).

7.17. In conjunction with implementation of the new contract, NHS employers will be asked to identify the reasons for high-frequency rotas and produce action plans for reducing, where possible, the number of consultants on such rotas. The BMA, the Health Departments and the NHS Confederation will develop systems for reviewing local action, perhaps based on the model of the junior doctors' Regional Action Teams (New Deal Implementation Group in Scotland). However, it is recognised that special arrangements will be needed for consultants in isolated areas.

7.18. Consultants working under the new contract will no longer be eligible for intensity supplements

8. OUT-OF-HOURS WORK

8.1. All programmed activities (including additional activities) between 8am – 10pm Monday to Friday and 9am – 1pm Saturday and Sunday, and any emergency work arising from on-call commitments during these times, will attract equal recognition under the new contract. Consultants will be given equivalent time-off for all work on statutory and public holidays.

8.2. From 1 April 2004 there will be special provisions to recognise the unsocial nature of work done outside these hours and the flexibility required of consultants who work at these times as part of a more varied overall working pattern.

8.3. Subject to the transitional arrangements, the effect of this additional recognition will be that either:

- in assessing the number of programmed activities needed to recognise emergency work done whilst on-call, three hours of emergency work out-of-hours will be treated as equivalent to one programmed activity; and
- there will be a reduction in a consultant's timetabled weekly work, equivalent to one hour for each programmed activity scheduled out-of-hours, up to a maximum of three hours per week;

or, by mutual agreement between employer and consultant –

- the consultant will receive a premium payment – worth 3.3% of basic salary (including pay thresholds but excluding discretionary points, distinction awards and clinical excellence awards) for an average of one programmed activity per week – and/or equivalent emergency work whilst on-call –

expected to be carried out out-of-hours; or 6.6% of basic salary for an average of two programmed activities or equivalent per week; or 10% for an average of three programmed activities or equivalent per week

8.4. For a transitional period of two years, ending 31 March 2006, the employer may decide whether to give recompense in the form of premia or sessional allocation. Thereafter, premia could be paid only by mutual agreement between the employer and the consultant.

8.5. Decisions on the allocation of programmed activities for out-of-hours work (including work arising from on-call) and the level of this recognition will be made on a prospective basis at job plan review. These decisions will be based on the number of programmed activities that a consultant is likely to have scheduled during the relevant times and expected patterns of emergency work whilst on-call. Where job plan reviews result in a reduction in the level of recognition for out-of-hours work, there will not be any protection arrangements in relation to previous recognition for out-of-hours work.

8.6. Employers should ensure that where consultants work through the out-of-hours period adequate rest is provided before and after the out-of-hours period.

8.7. There will be a maximum of 10% salary supplement or reduction of three hours per week, to recognise out-of-hours work equivalent to an average of three programmed activities per week. The Health Departments and the BMA do not expect that consultants will typically work, on average, more than the equivalent of three such programmed activities per week. Employers and consultants will need to agree appropriate arrangements locally in cases where out-of-hours work exceeds this level.

8.8. Where a programmed activity spans the two relevant time periods, the part of the programmed activity falling in the out-of-hours period will be treated accordingly.

8.9. As with other programmed activities, consultants will be expected to be on site, with flexibility for employers to agree off-site working where appropriate. Out-of hours recognition will be based on the agreed job plan, and recognition may be increased, decreased or withdrawn at job plan review with any changes made on a prospective basis.

9. TRAVELLING

9.1. Where consultants are expected to spend time on more than one site during the course of a day, travelling time to and from their main base to other sites will be included as working time.

9.2. Travel to and from work for NHS emergencies, and 'excess travel' will count as working time. 'Excess travel' is defined as time spent travelling between home and a working site other than the consultant's main place of work, after deducting the time normally spent travelling between home and main place of work. Employers and consultants may need to agree arrangements for dealing with more complex working days.

9.3. Travelling time between a consultant's main place of work and home or private practice premises will not be regarded as part of working time.

10. LOCATION OF DUTIES

10.1. Consultants will normally be expected to be in the workplace for all their programmed activities during the timetabled working week, except where agreed in the job plan. Exceptions will include travelling between sites and attending official meetings away from the workplace. Arrangements to work off-site or at home at specified times could be agreed in the job plan in relation to specified duties.

10.2. Consultants may be required to work at any site within a Trust or other NHS organisation, including new sites. Travelling between sites will count as working time.

ANNEX C

STARTING SALARY AND PAY PROGRESSION

1. PRINCIPLES

1.1. The system of pay progression for consultants should:

- reward sustained good performance
- reward long-term commitment to the NHS
- facilitate better career development for consultants
- ensure minimum duplication and bureaucracy for employers and consultants.

2. SUMMARY

2.1. Under the new contract:

- there will be a higher starting salary of £63,000
- there will be a stepped scale of "pay thresholds" on top of starting salary, subject to satisfactory performance. There will be four steps of £2,000 at one-year intervals followed by three further steps of £4,750 at five-year intervals, making a threshold scale of:
  £63,000
  £65,000
  £67,000
  £69,000
  £71,000
  £75,750
  £80,500
  £85,250
- progression through pay thresholds will be linked demonstration of fulfilment of job plan, including objectives
- existing consultants will progress through pay thresholds on the same basis as new consultants, but with quicker progression (subject to fulfilment of job plans, including objectives) for more senior consultants (as set out in the section on transitional arrangements).

3. CRITERIA FOR PAY PROGRESSION

3.1. Progress through the thresholds will not be automatic, although we expect the great majority of consultants will progress. Progression will depend on a consultant having in each of the relevant years between thresholds:

- Met the time and service commitments in their job plans
- Met the personal objectives in their job plan or – where this is not achieved for reasons beyond the individual consultant's control – having made every reasonable effort to do so

- Participated satisfactorily in annual appraisal, job planning and objective setting
- Worked towards any changes identified as being necessary to support achievement of the organisation's service objectives in the last job plan review
- Allowed the NHS (in preference to any other organisation) to utilise the first portion of any additional capacity they have
- Met required standards of conduct governing the relationship between private practice and NHS commitments (see Annex D)

3.2. Objectives will be expected to reflect different, developing phases in consultants' careers.

4. MOVEMENT THROUGH THRESHOLDS

4.1. Pay progression will be linked to performance against job plans**.**

4.2. Under this system, one of the outcomes of the annual job plan review will be a recommendation via the Medical Director to the Chief Executive of the employing organisation as to whether a consultant has met the requirements described in paragraph 3.1 above.

4.3. In order for a consultant to receive a pay threshold, the Chief Executive, informed by the Medical Director's recommendation, will have to be satisfied that the consultant has met these requirements in each of the relevant years (i.e. one year for each of the first four thresholds, five years for subsequent thresholds). Where a consultant has not met the requirements in any of these years, the threshold will be deferred until the required number of years' satisfactory performance has been demonstrated. Failure to meet requirements in any one year will delay pay progression for one year only.

4.4. Where a consultant has not met the relevant requirements in one or more of the years between thresholds, the employer will have discretion to allow pay progression if they consider it appropriate, for example where illness has prevented some requirements being met.

4.5. More detailed provisions will be agreed through which recognition for previous service in the NHS can be recognised, and to cover the circumstances in which employers may have discretion to recognise appropriate service outside the NHS.

4.6. Progression through thresholds, where agreed, will be on the anniversary of appointment for consultants appointed to their first consultant post after the introduction of this contract, and on the anniversary of transfer to this contract for other consultants.

5. OBJECTIVES AND PAY PROGRESSION

5.1. A consultant's personal and service related objectives should be appropriate, identified and agreed. Numerical objectives are appropriate, provided that they are, like other objectives, appropriate, identified and agreed.

5.2. Consultants should not be penalised if objectives have not been met for reasons beyond their control. Employers and consultants will be expected to identify problems (affecting the likelihood of meeting objectives) as they emerge, rather than wait until the job plan review.

6. EXISTING CONSULTANTS

6.1. Transitional arrangements for existing consultants are set out in part 9 of the main framework document.

7. APPEALS

7.1. Consultants will have the right of appeal against a decision not to allow pay progression, with the onus on the employer to show why progression has been withheld.

7.2. The process for appeals will be governed by a national framework. Appeals against pay progression will be referred directly to a local appeals panel. Guidance will follow on the process for appeals.

8. RECRUITMENT AND RETENTION FLEXIBILITIES

8.1. Employers will have the flexibility to pay recruitment or retention premia to consultants, in addition to basic salary. Before awarding a premium of this kind, employers will have to:

- demonstrate clear evidence of recruitment difficulties
- demonstrate evidence that they have adequately considered and tried out non-pay solutions
- consultant with other local employers and with appropriate regional bodies (in England with the local Workforce Development Confederation)

There will be similar flexibility to pay retention premia.

8.2. The value of any recruitment or retention premium will be determined locally by the employer, after consultation with other local employers, but will not typically exceed 30% of starting salary. The precise arrangements by which such a premium is determined, and the degree to which it might need to take account of the impact on other employers, may vary according to the circumstances in different parts of the UK. Premia may be paid as a one-off, or on a time-limited basis. Time-limited premia shall not typically be paid for more than four years.

8.3. The employer may adjust the value of any time-limited premium each year, taking into account the extent of local recruitment or retention pressures.

9. LINKS WITH APPRAISAL

9.1. The process for determining pay progression should not be directly linked to the appraisal process. Appraisal is a distinct process for reviewing and developing performance, conducted annually and feeding into revalidation. There will almost

certainly, however, be some commonality in the evidence and information base to support the two processes. In addition, it will be one of the factors determining eligibility for pay thresholds that consultants have fulfilled their contractual obligations in relation to appraisal.

ANNEX D

CONSULTANT CONTRACT: PRIVATE PRACTICE

1. PRINCIPLES

1.1. The key principles are:

- There should be no real or perceived conflict of interest between independent work and NHS work
- The provision of services for private patients should not prejudice the interest of non-paying patients.
- Consultants should not allow private practice to disrupt the provision of NHS services or have any adverse impact on NHS performance or delivery of NHS commitments
- Work outside NHS employment should not adversely affect NHS employment, nor in any way hinder or conflict with the interests of the NHS employer, other NHS employers or NHS employees
- Agreed NHS commitments should take precedence over private work
- NHS facilities, staff and services are provided for the benefit of NHS patients and may only be used for private practice with the agreement of the NHS employer

2. CONTRACT

2.1. All consultants will have a standard contract, which may be either full-time or part-time depending on the average weekly number of programmed activities carried out for the NHS. For consultants wishing to undertake private practice the part-time contract will normally be for six programmed activities or fewer per week (unless agreed otherwise by employer in exceptional circumstances). The type of contract will take no account of the extent of a consultant's earnings from private practice. The concept of a maximum part-time contract will be abolished for consultants on the new contract, subject to the transitional arrangements described in Part 9 of the main framework.

3. STANDARDS

3.1. There will be a new set of contractual provisions governing the relationship between consultants' NHS commitments and any private practice they undertake. This will include private practice in respect of both private patients and NHS patients.

3.2. These standards are designed to minimise the potential for conflicts of interest – or perceived conflicts of interest – to arise between private and NHS commitments.

3.3. Employers will be required to satisfy themselves annually that a consultant is meeting the standards before awarding progression through the new pay

thresholds. Compliance with these provisions will (with some possible exceptions) also be a contractual requirement.

3.4. The areas covered by the new provisions will include:

- Disclosure of information about private practice
- Scheduling of private work
- Transfer of patients between the NHS and private sector, and management of NHS waiting lists
- Use of NHS facilities and staff for private and other fee-paying work
- Engagement with measures to increase NHS capacity, including appointment of new consultants

3.5. Some of the more detailed areas to be covered are set out below. The BMA, Health Departments and NHS Confederation will work together to agree more detailed provisions alongside preparation for implementation ofthe new contract . There will be some areas in which the provisions will need to be adapted to cover private work in NHS private patient facilities.

Disclosure of information about private practice

3.6. Consultants should inform employers of their private practice commitments, including work for the private sector that has been contracted by another NHS employer.

3.7. Information should be disclosed at least annually as part of the job planning and/or appraisal process. Consultants should inform their employer in advance of any significant changes to this information.

Scheduling of work

3.8. Consultants should not undertake private practice when on-call for the NHS, nor undertake on-call for the private sector when working for the NHS. However, there may be circumstances where, with the prior approval of the NHS employer, a consultant on a higher frequency NHS on-call rota with a low likelihood of recall may undertake some private practice. There will be circumstances in which consultants may reasonably provide emergency or essential continuing treatment for an existing private patient during NHS time. Consultants should make alternative arrangements to provide cover where work of this kind regularly impacts on NHS commitments.

3.9. There should be clear arrangements to ensure that there can be no significant risk of private commitments disrupting NHS commitments, e.g. by causing NHS activities to begin late, or to be cancelled.

3.10. If NHS sessions are disrupted by private work, the consultant should make up the missed time. If NHS sessions are disrupted regularly the consultant should rearrange the private sessions. NHS commitments should take precedence over private work and NHS employers will, after discussion with consultants, determine when particular activities (e.g. operating lists, outpatient clinics) are to be scheduled. Where there is a proposed change to the scheduling of NHS work, the employer should be required to allow a reasonable period for consultants to

rearrange any existing private sessions, taking into account any binding commitments entered into (e.g. leases.

Management of waiting lists and the transfer of patients between the NHS and private sector

3.11. Subject to clinical considerations, consultants should be expected to contribute as fully as possible to reducing waiting times for NHS patients. This should include ensuring that patients are given the opportunity to be treated by other NHS colleagues or NHS Trusts where this will reduce their waiting time and facilitating the transfer of such patients.

3.12. More detailed provisions will be agreed to ensure that consultants are not put in a position where it could appear that they are asking patients to consider private treatment.

3.13. Consultants should follow their employer's guidelines on the management of waiting lists and on the scheduling or cancellation of appointments.

Use of NHS facilities and staff

3.14. Consultants may not use NHS facilities for the provision of private services without the agreement of their NHS employer.

3.15. Consultants may use NHS facilities for the provision of fee paying services (category 2 services) only with the agreement of their NHS employer, either in their own time, in annual or unpaid leave, or in NHS time and with the fee remitted to the NHS organisation. Where work involves minimal disruption, the employer and consultants may arrange by mutual agreement for this work to be done in NHS time without the employer collecting the fee.

3.16. Where the employer has agreed that a consultant may use hospital facilities for the provision of fee paying or private services, the employer may determine and make such charges for the use of its services, accommodation or facilities as it considers reasonable. Any charge will be collected by the employer, either from the patient or third party commissioning the work, or from the consultant. A charge will not be made if a consultant is remitting a fee to the NHS organisation.

3.17. Consultants may not use NHS staff for private practice without the agreement of their NHS employer.

3.18. Where arrangements are made to use NHS staff for private practice it must be made clear that treatment of NHS patients and provision of NHS services is a priority. Any work for the private sector should be done outside NHS time.

Increasing NHS capacity

3.19. Consultants should make all reasonable efforts to support initiatives to increase NHS capacity, including appointment of new consultants and changes to ways of working.

ANNEX E

CLINICAL EXCELLENCE AWARD SCHEME (England and Wales)

1. PRINCIPLES

1.1. The new Clinical Excellence Award scheme will:

- be transparent, fair and based on clear evidence;
- be open and accessible to all consultants (within two years of appointment);
- better reward those consultants who contribute most to the NHS;
- better reward those consultants who contribute most to service delivery and patient care;
- support the practical application of skills and knowledge for the benefit of patients;
- be dependent on a satisfactory level of performance as judged in the annual appraisal process;
- allow early intervention to review an award where there are concerns about a doctor's performance;
- ensure fair distribution between academic and non-academic award holders;
- give the public direct access to the performance grounds for an individual doctor's award, and categories of holders and reasons.

2. SUMMARY

2.1. The Clinical Excellence Award scheme will replace the existing discretionary points and distinction awards schemes with a single, more graduated consultant reward scheme. The new scheme will reward those consultants who show the greatest commitment to delivering, developing and managing a high quality service and/or the greatest levels of achievement in research and/or teaching.

2.2. The majority of new awards will go to those who make the biggest contribution to delivery and to improving local health services. At the same time, the importance of research in contributing to the knowledge base of the NHS and to promoting evidence-based practice will continue to be recognised.

3. STRUCTURE OF THE NEW SCHEME

3.1. The scheme will include a local, a regional and a national element. All awards will be governed by a common rationale and objectives with the criteria and eligibility for awards set nationally. There will be a standard nomination form for all levels of award, which will contain details of the current level of award and the level of award for which the consultant is being considered.

3.2. Local (individual employer) committees will make awards up to a maximum of £30,000. The new Clinical Excellence Awards Committee (CEAC) and its regional

sub-committees will make awards of £30,000 and above. The regional committees will monitor the operation of the local scheme. The CEAC will publish an annual report which will include information on the distribution of both local and higher awards.

3.3. Consultants will become eligible for regional/national awards only after having achieved at least four local awards. Criteria will be developed to ensure that consultants whose duties are not primarily concentrated on front line care, e.g. clinical academics and public health doctors, are able to receive local awards based on their overall contribution to the NHS. Consultants who have achieved the maximum level of local awards will after a defined period be automatically put forward for a higher award on the basis of their local contribution, subject to sustained levels of excellence locally. Consultants delivering a wholly local contribution will be eligible to progress to the top level of higher awards.

4. LEVELS OF AWARD

4.1. There will be thirteen levels of award, nine of which will be awarded by local committees and four awarded by regional committees and the national CEAC. The first six awards will rise in steps of around £2,500, from £2,500 to £15,000, and the remaining local awards in steps of around £5,000, from £20,000 to £30,000. The two regional awards will be around £30,000 and £40,000 and the national awards around £50,000 and £65,000.

4.2. Employers will, subject to strict guidelines, be permitted to make multiple awards to a consultant for the first few levels of local awards.

4.3. As with the current schemes:

- All levels of award will be paid in addition to consultants' basic salaries
- Higher awards will subsume the value of any award held previously.
- Awards will be paid on a pro rata basis
- Awards will be uprated, subject to the recommendations of the Doctors and Dentists Pay Review Body.

4.4. Consultants with existing discretionary points or distinction awards will retain these awards and will be eligible to apply for awards under the new scheme in the normal way.