

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	<p>Improved ability to manage consultants' time in ways that best meet local service needs and priorities.</p> <p>Greater clarity of objectives for consultants and more effective systems for engaging consultants in joint action to improve NHS performance and modernise patient care.</p>	<p>A stronger, unambiguous framework of contractual obligations.</p> <p>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.</p>
Working week and recognition of on-call duties	<p>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.</p> <p>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.</p>	<p>More consistent and equitable recognition for on-call duties.</p> <p>Agreed action to help reduce the number of consultants on the most frequent on-call rotas.</p> <p>More consistent and equitable recognition for work undertaken out-of-hours, including emergency work.</p>
New pay structure	<p>Improvements in recruitment and retention of consultants, contributing to the target increase of 15,000 consultants and GPs by 2008 (England).</p> <p>Sustained incentives for high-quality performance over the course of a consultant career</p> <p>Enhanced incentives for consultants to maintain commitments for the NHS up to normal retirement age</p>	<p>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.</p> <p>Greater opportunity for phased careers to recognise the changing focus of the consultant role over an individual's working life.</p>

Strand	Benefits for NHS patient care	Benefits for consultants
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.

Existing consultants

- (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% and 4.725% 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.