Final Summary Agreement

Specialty Doctor and Associate Specialist – Contractual Arrangements

The British Medical Association, British Dental Association and employers have reached agreement on a proposal for contractual arrangements for the new specialty doctor grade and new contractual arrangements for the associate specialist grade. It is therefore the intention of the parties to send this Summary Agreement to the four UK Health Departments. It will then be considered by the Public Sector Pay Committee and thereafter the BMA shall undertake to arrange for SAS doctors and dentists to vote on the proposed new contractual arrangements.

23rd November 2006
## Final Summary Agreement

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Proposals applicable to both the Specialty Doctor and Associate Specialist Grade (2006)

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SUMMARY AGREEMENT

NEW CONTRACT FOR SAS GRADE DOCTORS AND DENTISTS

SECTION 1: INTRODUCTION

1. NHS Employers, the BMA, the Scottish Executive, Welsh Assembly Government and Department of Health, Social Services and Public Safety – Northern Ireland are seeking to agree a new pay structure and associated terms and conditions of service for doctors in the Staff and Associate Specialist Group, to be implemented with effect from [effective date TBC]. Scotland, Wales and Northern Ireland have reserved the right to employ some flexibility to accommodate different local circumstances.

2. This document outlines the proposal for implementation in NHS organisations for:
   - Specialty Doctor
   - Associate Specialist grade

3. The proposal for the Specialty Doctor introduces the rationale behind the creation of a new grading structure and how progression occurs within the grade. The basic costing associated with the new contracts are included in this framework document and consist of salary scales and incentives for working nights, evenings and weekends. These, taken together with improved job planning, and emphasis on regular appraisal and portfolio development, form the fundamental basis of the contract proposal and aim to achieve the key objectives of the parties to the negotiations.

4. In respect of the Associate Specialist grade, the document recognises the role of this group of doctors and explains why the grade will no longer be open to new entrants. However, the proposal outlined is to revise the pay and other elements of the terms and conditions of service to a similar format to the Specialty Doctor to provide incentives for working flexibly.

5. The overall balance of the proposal is to construct an employment package which both improves basic pay by removing the provision of optional and discretionary points and gives an opportunity to enhance earnings through additional reward for flexible service delivery. Other components described here are the contract implementation process and good practice by employers in supporting training and career development.

1 The term ‘doctors’ is used throughout to mean doctors and dentists except where explicitly stated otherwise.
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6. The contract aims to provide benefits to service delivery by improving the clarity of role and responsibility of doctors, utilising doctors’ time in ways that best meet local service needs and priorities and continued professional development contributing to quality of patient care.

7. The paper is divided as follows:

Section 1    Introduction
Section 2    New Contract Arrangements
Part 1   New Grade
Part 2   Current Associate Specialist
Part 3   Proposals applicable to both
Section 3    Benefits of the New Contract and Associate Specialist package

8. A definition of terms is attached as appendix 4 to the framework

9. The aim of the new contract is to improve the existing arrangements for SAS doctors, and:

- value, recognise and reward the role of SAS doctors;
- support better opportunities for career progression;
- provide an attractive and fulfilling career;
- provide improved services to patients; and
- provide a clear definition for a new grade.

10. The contract is being negotiated on behalf of the following doctors:

- Staff Grades;
- Associate Specialists;
- Non GP Clinical Assistants and Hospital Practitioners;
- Senior Clinical Medical Officers;
- Clinical Medical Officers.

11. In developing a new contract we have considered the context of the modern NHS and service requirements for doctors who are fully competent for the roles they undertake. Additionally we considered the aspirations outlined by the BMA and the following recommendations laid out in ‘Choice and Opportunity’\(^2\):

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\(^2\) Choice and Opportunity – Modernising Medical Careers for Non Consultant Career Grade doctors (http://www.dh.gov.uk/assetRoot/04/08/52/64/04085264.pdf)
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- entry to Specialty Doctor post should only be available to those who have met clear educational standards and can demonstrate specialty specific competencies;
- the existing NCCG grades should be integrated into a single, simplified structure with no more than two recognised levels of practice;
- all NCCG’s should be appraised annually and have a personal development plan;
- the new structure should no longer be called the non consultant career grade;
- a new career structure will need new pay and terms and conditions of service which are appropriate for it.

Proposal

12. The proposal will create a new grade which will provide a positive career choice for doctors, providing pay and terms and conditions which facilitate career development and the future delivery of quality service provision. We envisage doctors in the Staff Grade, non GP Clinical Assistants, Senior Clinical Medical Officers, CMOs and non GP Hospital Practitioners will be eligible to transfer into the new grade.

13. We value doctors in the current Associate Specialist grade and wish to recognise and reward the high levels of contribution and commitment they provide, whilst not wishing to recreate the situation in which those currently in the Associate Specialist grade find themselves not feeling adequately recognised for their level of skills and service contribution. For this reason we propose to close the Associate Specialist grade to new entrants. We propose for those doctors who wish to enter specialist training that the new contract provides terms and conditions that would support such a move. Those doctors who wish to avail themselves of the opportunities within the contract have the opportunity to progress towards gaining admittance to the Specialist Register via Article 14.

14. Within the defined specialty, the Specialty Doctor will, in the early stages of their career in the grade, be a competent doctor with experience in a defined specialty, rising up to become a highly competent doctor with areas of expertise. The level of delegated responsibility will be agreed between the clinical manager and the doctor in the agreed job plan, dependent upon experience and capability.

15. All doctors will be required to take part in annual appraisal and job plan discussions, which will provide the basis for a portfolio of evidence. The portfolio will be used by doctors to demonstrate their continuing professional development. The employer’s commitment to this is essential.
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Picture of Proposal

CCT or access to the Specialist Register via PMETB

Existing AS Grade

Training Grades

ST3+

ST1 & ST2

F1 + F2

Specialty Doctor

Fixed Term Specialist Training

(Not to any pay-related scale)
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SECTION 2: NEW CONTRACT ARRANGEMENTS

PART 1

New Grade

16. Within a team context and to support the continued development and acquisition of skills, the new career structure will be a single grade which will be called Specialty Doctor. Doctors will make a valuable contribution to the delivery of service within a defined specialty as a member of a multi-disciplinary team. Those doctors who choose to remain in this grade will have opportunity within the grade to progress. It is proposed that the new structure will provide a career option, which can lead to admittance to the Specialist Register through moving in and out of training, either by returning to a training post through competitive entry or successful application to PMETB via Article 14.

17. Doctors will develop a portfolio of evidence (see Appendix 6) as they progress through the grade. This will support their development and, if appropriate, desired application to return to training or help demonstrate that they meet the requirements for admittance to the Specialist Register via Article 14.

18. At the top of the grade doctors will have acquired a high level of specialist knowledge and expertise and have the capacity and opportunity to work independently within agreed lines of responsibility and may also take a broader role in the organisation through other activities such as teaching and audit.

Entry and Progression

19. The new grade will provide an attractive and meaningful career path where doctors can acquire skills and experience over a number of years.

Top of grade

Min
Entry Point

Threshold One

Threshold Two
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Entry into the grade

20. Entry into the new grade will commence at a level equivalent to full registration with the GMC/GDC, and a minimum of four years post-graduate training, two of which must be in a relevant specialty, or the equivalent. This must be compatible with any developments with Modernising Medical Careers/Modernising Dental Careers. This is to ensure the minimum entry requirements are set at an appropriate level to reflect the experience and skills needed by this group of doctors and their contribution to the service.

21. On appointment to the grade doctors will be paid at the minimum point of the scale. Where doctors are appointed to the grade from another NHS post, without a break in service, they will enter the grade on the next highest pay point, based on their previous NHS basic salary. Where a doctor is appointed to the grade after a break in service having given previous service in the AS, SG, SCM O, CMO, CA or HP grades, all such service shall be counted in determining their starting salary.

22. Doctors entering the grade who have never worked in the NHS will enter the grade at the minimum point of the scale. Employers may set basic salary at a higher incremental point to recognise any non-NHS equivalent experience in the specialty.

Progression/movement through the grade

23. There are three forms of progression within the grade. Incremental pay progression, for which the doctor will have satisfied the criteria set out in paragraph 25 below; progression through threshold one, for which the doctor will have satisfied the criteria set out in paragraph 28 below and progression through threshold two, for which the doctor will have satisfied the criteria set out in paragraph 32 below.

24. The principles for progression/movement through the grade are that:

- The process should be fair and clear, as straightforward as possible to implement and neither the process nor the gathering and demonstrating of evidence should be onerous.
- The evidence required must be as objective as possible
- There should be ‘no surprises’ at any review; good employment practice is to provide employees with feedback on a continuing basis.

Incremental progression

25. Incremental progression will depend upon a doctor having:

- made every reasonable effort to meet the time and service commitments in their job plan and participated in the annual job plan review;
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- participated satisfactorily in the appraisal process in accordance with the GMC’s requirements set out in ‘Good Medical Practice’;
- met the personal objectives in the job plan, or where this is not achieved for reasons beyond the doctors control, made every reasonable effort to do so;
- worked towards any changes identified in the last job plan review as being necessary to support achievement of joint objectives; and,
- taken up any offer to undertake extra Programmed Activities in accordance with Schedule 7 of the TCS and met the standards governing the relationship between private practice and NHS commitments set out in Schedule 10 of the TCS.

26. Clear contractual provisions will be in place to ensure that the increments are awarded in circumstances where, for any reason, the appraisal or job plan is not carried out due to any action or lack of action by the doctor’s employer. Therefore, if the doctor can demonstrate that they have made reasonable endeavours to ensure an appraisal and job plan review take place but either of these have not been carried out, or have not been finalised, the doctor will nevertheless receive the incremental increase. Employers and doctors will be expected to identify problems affecting the likelihood of meeting objectives as they emerge, rather than wait until the job plan review, and in the event of spotting an issue which may affect the doctors progression then an interim job plan review should be arranged as soon as practicable.

27. Similarly, if the doctor has been prevented by any action or inaction on the part of the employer from undertaking any of the threshold one or threshold two criteria they will not be prevented from moving through the relevant threshold.

Passing through Threshold One

28. All doctors will pass through this threshold unless they have demonstrably failed to comply with any of the following criteria:

- made every reasonable effort to meet the time and service commitments in their job plan and participated in the annual job plan review;
- participated satisfactorily in the appraisal process in accordance with the GMC’s requirements set out in ‘Good Medical Practice’;
- met the personal objectives in the job plan, or where this is not achieved for reasons beyond the doctors control, made every reasonable effort to do so;
- worked towards any changes identified in the last job plan review as being necessary to support achievement of joint objectives;
- taken up any offer to undertake extra Programmed Activities in accordance with Schedule 7 of the TCS and met the standards governing the relationship between private practice and NHS commitments set out in Schedule 10 of the TCS; and,
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- undertaken 360 degree appraisal/feedback (in the year preceding threshold one).

Threshold one – process

29. All doctors who have complied with the threshold one criteria will automatically pass through threshold one. The clinical director/medical director will have the responsibility for ensuring processes are in place to sign off the threshold assessment. It is expected that employers will have administrative processes in place for payments to be made automatically unless payroll are informed otherwise.

Progression between Threshold One and Threshold Two

30. The aim should be that doctors who have passed through threshold one will acquire the skills and experience to allow them to meet the criteria for entry through threshold two, with appropriate support and development through job plan review, appraisal and CPD.

31. Doctors will continue to undertake annual appraisal and job plan review between threshold one and threshold two, and continue to develop a portfolio of evidence in order to meet the criteria for threshold two. The normal requirements for incremental progression set out in paragraph 25 will need to be satisfied annually between threshold one and threshold two.

Passing through Threshold two

32. The criteria for passing through threshold two recognises the higher level of skills, experience and responsibility of those doctors working at that level. Doctors will pass through threshold two if they have met the criteria at a), b) and c) as set out below:

  a) Doctors will be expected to continue to meet the threshold one criteria:

- made every reasonable effort to meet the time and service commitments in their job plan and participated in the annual job plan review;
- participated satisfactorily in the appraisal process in accordance with the GMC’s requirements set out in ‘Good Medical Practice’;
- met the personal objectives in the job plan, or where this is not achieved for reasons beyond the doctors control, made every reasonable effort to do so;
- worked towards any changes identified in the last job plan review as being necessary to support achievement of joint objectives;
- taken up any offer to undertake extra Programmed Activities in accordance with Schedule 7 of the TCS and met the standards governing the relationship between private practice and NHS commitments set out in Schedule 10 of the TCS; and,
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- undertaken 360 degree appraisal/feedback (this time in the year preceding threshold two).

b) Doctors should be able to demonstrate an increasing ability to take decisions and carry responsibility without direct supervision;

c) Doctors should also provide evidence to demonstrate contributions to a wider role, for example, participation in or contribution to relevant:

- Management or leadership
- Service development and modernisation
- Teaching and training (of others)
- Committee work
- Representative work
- Innovation
- Audit

33. This list is not exhaustive but is intended to give an indication of the types of evidence of contributing in a wider role that a doctor could provide.

34. In making a judgement about whether a doctor has met the requirements for threshold two, there will not be an expectation that the doctor will be able to provide evidence in all wider areas of contribution listed in addition to those required for threshold one. An overall picture will be considered.

Threshold two – process

35. As with threshold one, when a doctor has successfully demonstrated that they have complied with the criteria for threshold two, this should be signed off by a clinical manager. The clinical director/medical director will have the responsibility of ensuring processes are in place to sign off the threshold assessment. It is expected that employers will have administrative processes in place for payments to be made automatically unless payroll are informed otherwise.

Moving to a new employer

36. If, when an annual increment or progression through a threshold is due, the doctor is scheduled to change NHS employing organisation then the current employer is expected to carry out the review required. If such a review is not undertaken, the new employer should conduct one no later than three months following the transfer of employment. A decision should then be made on incremental progression or progression through the relevant threshold and, if granted, pay backdated to the date that progression was originally due.

Mediation and Appeals
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37. The doctor and clinical manager will make every effort to agree the job plan and personal objectives. If it is not possible to reach agreement, the doctor may refer the disputed job plan and/or personal objectives to mediation, and if mediation does not result in agreement then appeal, as set out in Part 3 paragraph 64. The doctor also has the right of appeal, as set out in Part 3 paragraph 64 against a decision that he or she has not met the criteria for annual incremental progression or the criteria for progression through threshold one and two. In the event of an appeal, it will be the responsibility of the employer to show why this decision was taken.

Salary package

38. The grade will comprise eleven pay points. There will be annual progression to point six of the scale. Threshold one must be passed to reach point six. Progression beyond point six is at two yearly intervals. To progress to point nine, threshold two must be passed and progression beyond point nine is at three yearly intervals.

Closure of the associate specialist grade

39. Once the new contract is introduced there will be a window of opportunity, until 1 October 2007, for eligible doctors to apply for re-grading to the Associate Specialist grade based on the existing criteria.

40. Thereafter there will be no facility for entry to this grade which will become a closed grade to new entrants. This proposal is outlined in Appendix 2.

PART 2

Current Associate Specialists

41. The quality of service provision and degree of expertise of this group of doctors will continue to be recognised and rewarded using a similar process to that used for the new career grade, but recognising the higher level of expertise of Associate Specialists in their current field of practice. The proposal to close the grade recognises that historically the creation of the Associate Specialist grade has not provided a rewarding career pathway; the proposals for the new career grade provide the opportunity for doctors in the future to choose to continue to make a valued contribution.

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3 In England these are set out in full in Annex 2 to EL(97)25.
4 To be eligible for appointment to the associate specialist grade, doctors and dentists shall have completed 10 years medical or dental work since obtaining a primary medical or dental qualification which is (or would at the time have been) acceptable by the GMC/GDC for full, limited or temporary (but not provisional) registration. The doctor or dentist shall have served for a minimum of four years in the Registrar or SpR grade, or in the Staff Grade. Two of these years shall have been served in the appropriate specialty. Equivalent service is also acceptable.
contribution to service delivery or to seek to re-enter the training grades. We recognise that there will be a number of Associate Specialists and Staff Grades who will wish to progress, via Article 14 and PMETB towards inclusion on the Specialist Register.

Pay progression and thresholds

42. It will be the norm for Associate Specialists to achieve pay progression. The purpose of the thresholds is to enable a doctor to demonstrate the provision of continued high quality service with an increasing range of contribution. Progression will depend upon a doctor having in each year:

- made every reasonable effort to meet the time and service commitments in their job plan and participated in the annual job plan review;
- participated satisfactorily in the appraisal process in accordance with the GMC’s requirements set out in ‘Good Medical Practice’;
- met the personal objectives in the job plan, or where this is not achieved for reasons beyond the doctors control, made every reasonable effort to do so;
- worked towards any changes identified in the last job plan review as being necessary to support achievement of joint objectives; and,
- taken up any offer to undertake extra Programmed Activities in accordance with Schedule 7 of the TCS and met the standards governing the relationship between private practice and NHS commitments set out in Schedule 10 of the TCS.

43. In addition to meeting the above criteria progression through the grade will be through the application of skills and expertise as demonstrated in a portfolio of evidence.

Progression/movement through the grade

44. There are three forms of progression within the grade. Incremental pay progression, for which the doctor will have satisfied the criteria set out in paragraph 46 below; progression through threshold one, for which the doctor will have satisfied the criteria set out in paragraph 49 below and progression through threshold two, for which the doctor will have satisfied the criteria set out in paragraph 53 below.

45. The principles for progression/movement through the grade are that:

- The process should be fair and clear, as straightforward as possible to implement and neither the process nor the gathering and demonstrating of evidence should be onerous;
- The evidence required must be as objective as possible; and,
- There should be ‘no surprises’ at any review; good employment practice is to provide employees with feedback on a continuing basis.
Incremental progression

46. Incremental progression will depend upon a doctor having:

- made every reasonable effort to meet the time and service commitments in their job plan and participated in the annual job plan review;
- participated satisfactorily in the appraisal process in accordance with the GMC’s requirements set out in ‘Good Medical Practice’;
- met the personal objectives in the job plan, or where this is not achieved for reasons beyond the doctors control, made every reasonable effort to do so;
- worked towards any changes identified in the last job plan review as being necessary to support achievement of joint objectives; and,
- taken up any offer to undertake extra Programmed Activities in accordance with Schedule 7 of the TCS and met the standards governing the relationship between private practice and NHS commitments set out in Schedule 10 of the TCS.

47. Clear contractual provisions will be in place to ensure that the increments are awarded in circumstances where, for any reason, the appraisal or job plan is not carried out due to any action or lack of action by the doctor’s employer. Therefore, if the doctor can demonstrate that they have made reasonable endeavours to ensure an appraisal and job plan review take place but either of these have not been carried out, or have not been finalised, the doctor will nevertheless receive the incremental increase. Employers and doctors will be expected to identify problems affecting the likelihood of meeting objectives as they emerge, rather than wait until the job plan review.

48. Similarly, if the doctor has been prevented by any action or inaction on the part of the employer from undertaking any of the threshold one or threshold two criteria they will not be prevented from moving through the relevant threshold.

Passing through threshold one

49. All doctors will pass through this threshold unless they have demonstrably failed to comply with any of the following criteria:

- made every reasonable effort to meet the time and service commitments in their job plan and participated in the annual job plan review;
- participated satisfactorily in the appraisal process in accordance with the GMC’s requirements set out in ‘Good Medical Practice’;
- met the personal objectives in the job plan, or where this is not achieved for reasons beyond the doctors control, made every reasonable effort to do so;
- worked towards any changes identified in the last job plan review as being necessary to support achievement of joint objectives;
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- taken up any offer to undertake extra Programmed Activities in accordance with Schedule 7 of the TCS and met the standards governing the relationship between private practice and NHS commitments set out in Schedule 10 of the TCS; and,
- undertaken 360 degree appraisal/feedback (in the year preceding threshold one).

Threshold one – process

50. All doctors who have complied with the threshold one criteria will automatically pass through threshold one. The clinical director/medical director will have the responsibility for ensuring processes are in place to sign off the threshold assessment. It is expected that employers will have administrative processes in place for payments to be made automatically unless payroll are informed otherwise.

Progression between threshold one and threshold two

51. The aim should be that doctors who have passed through threshold one will acquire the skills and experience to allow them to meet the criteria for entry through threshold two, with appropriate support and development through job plan review, appraisal and CPD.

52. Doctors will continue to undertake annual appraisal and job plan reviews between threshold one and threshold two, and continue to develop a portfolio of evidence in order to meet the criteria for threshold two. The normal requirements for incremental progression set out in paragraph 46 will need to be satisfied annually between threshold one and threshold two.

Passing through threshold two

53. The criteria for passing through threshold two recognises the higher level of skills, experience and responsibility of those doctors working at that level. Doctors will pass through threshold two if they have met the criteria at a), b) and c) as set out below:

a) Doctors will be expected to continue to meet the threshold 1 criteria:

- made every reasonable effort to meet the time and service commitments in their job plan and participated in the annual job plan review;
- participated satisfactorily in the appraisal process in accordance with the GMC’s requirements set out in ‘Good Medical Practice’;
- met the personal objectives in the job plan, or where this is not achieved for reasons beyond the doctors control, made every reasonable effort to do so;
- worked towards any changes identified in the last job plan review as being necessary to support achievement of joint objectives;
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• taken up any offer to undertake extra Programmed Activities in accordance with Schedule 7 of the TCS and met the standards governing the relationship between private practice and NHS commitments set out in Schedule 10 of the TCS; and,
• undertaken 360 degree appraisal/feedback (this time in the year preceding threshold two).

b) Doctors should be able to demonstrate an ability to make independent decisions about diagnosis, management follow up and definitive treatment within the defined field of expertise.

c) Doctors should also provide evidence to demonstrate:

- A proven ability to lead a team;
- Regular completion of audits to demonstrate high quality work;
- An ability to innovate within their area of specialisation;
- Evidence of involvement in the wider management role;
- Significant involvement in research; or,
- A leading role in teaching.

54. This list is not exhaustive but is intended to give an indication of the types of evidence of contributing in a wider role that a doctor could provide.

55. In making a judgement about whether a doctor has met the requirements for threshold two, there will not be an expectation that the doctor will be able to provide evidence in all wider areas of contribution listed in addition to those required for threshold one. An overall picture will be considered.

Threshold two – process

56. As with threshold one, when a doctor has successfully demonstrated that they have complied with the criteria for threshold two, this should be signed off by a clinical manager. The clinical director/medical director will have the responsibility of ensuring processes are in place to sign off the threshold assessment. It is expected that employers will have administrative processes in place for payments to be made automatically unless payroll are informed otherwise.

Moving to a new employer

57. If, when an annual increment or progression through a threshold is due, the doctor is scheduled to change NHS employing organisation then the current employer is expected to carry out the review required. If such a review is not undertaken, the new employer should conduct one no later than three months following the transfer of employment. A decision should then be made on incremental progression or progression through the relevant threshold and, if granted, pay backdated to the date that progression was originally due.
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Mediation and Appeals

58. The doctor and clinical manager will make every effort to agree the job plan and personal objectives. If it is not possible to reach agreement, the doctor may refer to mediation, and if mediation does not result in agreement then appeal, as set out in Part 3 paragraph 65.

59. The doctor also has the right of appeal, as set out in Part 3 paragraph 65 against a decision that he or she has not met the criteria for annual incremental progression or the criteria for progression through threshold one and threshold two. In the event of an appeal, it will be the responsibility of the employer to show why this decision was taken.

Salary package

60. The salary package will reflect both the experience and wider contribution made by the doctor, and, if appropriate, reward out of hours and additional work. The pay scale will replace the current Associate Specialist pay scale and the discretionary points scheme. The proposed Associate Specialist pay structure provides a more equitable pay scale, as it creates the opportunity for progression for all doctors in the grade. The pay scale available for the proposed Associate Specialist grade is from £47,087 to £78,164.

61. The grade will comprise of eleven pay points. There will be annual progression to point six of the scale. Threshold one must be passed to reach point six of the scale. Progression beyond point six is at two yearly intervals. To progress to point nine, threshold two must be passed and progression beyond point nine is at three yearly intervals.

62. These arrangements will remove the arbitrary and unsatisfactory discretionary points scheme.

63. There is no compulsion to accept the new contract. Doctors may remain on their existing contract of employment.
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PART 3

Proposals applicable to both the new career grade and current Associate Specialists

Job Planning

64. Job planning will be based on a partnership approach and will be a mandatory part of the contract. The clinical manager will normally prepare a draft job plan, which will then be discussed and agreement sought. The discussion should focus on the prospective timetable and list all the duties of the doctor, the number of programmed activities for which the doctor is contracted and paid, a schedule for carrying out programmed activities, the doctor’s objectives and agreed supporting resources. The doctor must fulfil their agreed duties and make best endeavours to meet their objectives.

Mediation and Appeals

65. Wherever possible, disagreements over job planning or pay progression should be resolved by referral to the medical director for mediation to be arranged between the doctor and the clinical manager. If matters are not resolved in this way there will be access to a fair and balanced appeal process.

The working week

66. The working week for a full-time doctor will comprise ten programmed activities with a timetabled value of four hours each. The employer may programme these as blocks of four hours or half units of two hours each. The precise length of Programmed Activities may vary from week to week around the average assessment set out in the job plan.

67. Programmed activities will be separated into:

- ‘direct clinical care’;
- ‘supporting professional activities’;
- ‘additional NHS responsibilities’;
- ‘external duties’.

that may be substituted for other work or remunerated separately.

68. For full time doctors, most programmed activities will be devoted to direct clinical care and a minimum of one will be allocated for supporting professional activities.

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5 On assimilation to the new contract current doctors will be expected to present a timetable of their current activities to inform the discussion of a prospective job plan. Using this initial timetable the doctor and the employer will work in partnership to agree the job plan.
69. As a doctor becomes more experienced and takes on a broader role the employer will need to keep all elements of the job plan under review. Employers should ensure that doctors have the support needed to enable them to meet the requirements of the second threshold and can progress in their career. Threshold two requires evidence of demonstrating a contribution to a wider role which may require reassessment of the balance between SPA and DCC duties and allocations.

70. With the agreement of both the employer and doctor, specified additional duties may also be included in the working week by explicit agreement. The employer and the doctor will work together to manage such additional NHS responsibilities.

**Additional programmed activities**

71. The contract will allow for additional programmed activities for additional hours worked to be contracted separately up to the maximum permitted under the Working Time Regulations to help meet performance targets. These must be agreed between employer and doctor and reviewed at least annually as part of the job planning process.

**Work outside the normal working week**

72. As part of the job planning process, doctors in the new grade and Associate Specialists may be required to take part in shifts or on call rotas.

**Recognition for evening and weekend work**

73. There will be extra recognition for work outside the hours of 7am to 7pm (weekdays) and work at weekends and on public holidays. In addition, a doctor who in the course of his or her duty is required to be present in hospital or other place of work between the hours of midnight and 9am on statutory or public holidays should receive a day off in lieu.

74. The basic principle will be that at nights, evenings and weekends and public holidays, an enhanced rate of pay of time and a third will be paid for work undertaken out of hours. In practice, this would generally mean that a programmed activity worked during these hours would last for three hours rather than for four. Where this work is carried out as part of the basic 10 PA working week this will be pensionable. Additional programmed activities, and out of hours work undertaken in excess of the 10 PA commitment will not be pensionable.

**On Call duties**

75. All emergency work that takes place at regular and predictable times should be programmed into the working week on a prospective basis and count towards programmed activities. Less predictable emergency work
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should be handled, as now, through on-call arrangements. Doctors who need to be on an on-call rota will be paid an on-call supplement which is calculated as a percentage of basic pay (excluding any additional PAs, London Weighting allowance and any other fees, allowances or supplements). The supplement is payable depending on the frequency of on call duties:

more frequent than or equal to 1 in 4 6%
less frequent than 1 in 4 or equal to 1 in 8 4%
less frequent than 1 in 8 2%

On Call Rotas

76. Where the doctor is working on an on call rota, the job plan will set out the frequency of participation in the rota.

Private Practice

77. Contractual provisions governing the relationship between Associate Specialists' NHS commitments and any private practice they undertake are set out in the Code of Conduct for Private Practice – guidance for NHS medical staff (DH, May 2003). This includes private practice in respect of both private patients and NHS patients. These rules are designed to minimise the potential for conflicts of interest – or perceived conflicts of interest – to arise between private and NHS commitments.

78. The areas covered by the Code of Conduct 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; and,
- Engagement with measures to increase NHS capacity.

Training Provision

79. Opportunities for career progression may arise either through:

- development in the new career grade (potentially leading to progression via an application to PMETB to go on the specialist register); or,
- return to formal training (by application for a numbered training post).

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6 http://www.dh.gov.uk/assetRoot/04/10/07/02/04100702.pdf
Final Summary Agreement

80. Criteria for further career progression are a matter for PMETB and are outside the scope of this framework.

81. An opportunity for formal training may occur through two routes:

- A doctor may apply for a job in a training grade and be accepted. In this situation the doctor will accept the placement and relinquish their current post. Terms and conditions for doctors in training will apply, subject to pay protection arrangements outlined below.

- To meet the requirements for entry to the Specialist Register under Article 14, a doctor may be offered a secondment from their current post to top-up training and hence, their existing terms and conditions apply whilst they undertake the secondment. Such secondment opportunities are not expected to be longer than 12 months.

MMC definitions of training provisions are attached to this document for reference purposes as Appendix 5.

Pay protection on return to training

82. Where a doctor accepts a training place they relinquish the tenure of their post in the career grade. However, in so doing there is provision for pay protection on re-entry to a training post from the career grade.

83. In considering the provision of protection arrangements, consideration has been given to the additional cost of taking such doctors back into training being borne by deaneries, removing much of the disincentive to the employer who might not otherwise be prepared to take on such a trainee and avoiding increased disparities between existing trainees and the re-entrant.

84. Protection on return to training ensures that the salary shall not be less than the doctor was receiving in their previous appointment subject to the same hours of work. The doctor will either:

i) have their pay while in the training post based on the pay point reached in their career grade contract, with total pay calculated as if their contracted training duties had been carried out under the terms of their previous career grade contract, the doctor would retain the current value of the pay point or threshold reached before re-entry to training, receiving general pay awards but not moving up the incremental scale; or,

ii) be placed on an appropriate point on a training grade pay scale (with future increments on that scale if appropriate) plus the banding supplement appropriate to the relevant training post.
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85. The general principle to be followed is that return to training should not generate an increase in pay where this is not justified by an increase in workload or out of hours working.

Secondment opportunities

86. Individuals who have been seconded to a training placement role will return to their existing post at the end of the placement and be paid for the hours worked during the secondment in accordance with their existing terms and conditions of service.

Implementation

87. The BMA and NHS Employers 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; and,
- To assess the most effective ways of supporting employers and doctors in working together to achieve the maximum benefits from the new contract.

Assimilation to the New Contract

88. The principles of assimilation and pay protection are outlined in Appendix 1.
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SECTION 3: BENEFITS OF THE NEW CONTRACT AND ASSOCIATE SPECIALIST PACKAGE

89. The BMA and NHS Employers are committed to working with the NHS and the profession to ensure that the proposal is implemented in such a way as to maximise benefits for NHS patient services and for the quality of doctors’ working lives in the NHS.

90. The proposal aims to provide benefits in the following areas:

i) Job Planning

<table>
<thead>
<tr>
<th>Benefits for the NHS</th>
<th>Benefits for doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved ability to manage doctors time in ways that best meet local service needs and priorities</td>
<td>Improved clarity of role and Responsibility</td>
</tr>
<tr>
<td>Greater clarity of objectives and more effective systems for engaging doctors in joint action to improve performance and modernise patient care</td>
<td>More input into work organisation and Planning</td>
</tr>
<tr>
<td>Opportunity to integrate doctors more within multi-disciplinary teams</td>
<td>Specific time allocated to development activities</td>
</tr>
<tr>
<td>Brings this group of doctors into line with reward systems operating for other senior doctors</td>
<td>Annual review and opportunity to set out achievements</td>
</tr>
</tbody>
</table>

ii) Working Week

<table>
<thead>
<tr>
<th>Benefits for the NHS</th>
<th>Benefits for doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>More efficient use of time</td>
<td>More recognition for hours worked</td>
</tr>
<tr>
<td>Greater opportunities and incentives to arrange care in the evenings and at weekends leading to improvement in patient access</td>
<td>Recognition for out of hours working at an enhanced rate</td>
</tr>
<tr>
<td>Consistency with other grades</td>
<td>More parity with other doctors groups</td>
</tr>
</tbody>
</table>

iii) New Pay Structure

<table>
<thead>
<tr>
<th>Benefits for the NHS</th>
<th>Benefits for doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement in recruitment and retention</td>
<td>Increase in starting salary for grade</td>
</tr>
<tr>
<td>More incentive for high quality Performance</td>
<td>Integration of optional/discretionary Points to the maximum of the new scale.</td>
</tr>
<tr>
<td></td>
<td>Provides a more transparent opportunity for pay progression with equity of access to points beyond the</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>current maximum of scale</th>
<th>Significant pay increase for flexible working arrangements</th>
</tr>
</thead>
</table>

iv) Career Development

<table>
<thead>
<tr>
<th>Benefit for the NHS</th>
<th>Benefit for doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued professional development for doctors contributing to quality of patient care</td>
<td>Specific allocation of time for personal development</td>
</tr>
</tbody>
</table>
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ANNEX 1

The New Grade Payscale

<table>
<thead>
<tr>
<th>(at 2005/06 rates)</th>
<th>(at 2006/07 rates)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payscale</td>
<td>Payscale</td>
</tr>
<tr>
<td>£33,331</td>
<td>£34,131</td>
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<tr>
<td>£36,265</td>
<td>£37,135</td>
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<tr>
<td>£39,199</td>
<td>£41,040</td>
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<tr>
<td>£42,132</td>
<td>£43,133</td>
</tr>
<tr>
<td>£45,066</td>
<td>£46,148</td>
</tr>
<tr>
<td><strong>Threshold 1</strong></td>
<td><strong>Threshold 1</strong></td>
</tr>
<tr>
<td>£48,000</td>
<td>£49,152</td>
</tr>
<tr>
<td>£51,000</td>
<td>£52,224</td>
</tr>
<tr>
<td>£54,000</td>
<td>£55,296</td>
</tr>
<tr>
<td><strong>Threshold 2</strong></td>
<td><strong>Threshold 2</strong></td>
</tr>
<tr>
<td>£57,000</td>
<td>£58,368</td>
</tr>
<tr>
<td>£60,000</td>
<td>£61,440</td>
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<tr>
<td>£63,000</td>
<td>£64,512</td>
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</table>

ANNEX 2

The New Associate Specialist Payscale

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<thead>
<tr>
<th>(at 2005/06 rates)</th>
<th>at 2006/7 rates</th>
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</thead>
<tbody>
<tr>
<td>Payscale</td>
<td>Payscale</td>
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<tr>
<td>£47,087</td>
<td>£48,217</td>
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<tr>
<td>£50,953</td>
<td>£52,176</td>
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<td>£54,819</td>
<td>£56,135</td>
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<tr>
<td>£59,923</td>
<td>£61,361</td>
</tr>
<tr>
<td>£64,348</td>
<td>£65,892</td>
</tr>
<tr>
<td><strong>Threshold 1</strong></td>
<td><strong>Threshold 1</strong></td>
</tr>
<tr>
<td>£66,185</td>
<td>£67,733</td>
</tr>
<tr>
<td>£68,581</td>
<td>£70,227</td>
</tr>
<tr>
<td>£70,977</td>
<td>£72,680</td>
</tr>
<tr>
<td><strong>Threshold 2</strong></td>
<td><strong>Threshold 2</strong></td>
</tr>
<tr>
<td>£73,371</td>
<td>£75,132</td>
</tr>
<tr>
<td>£75,767</td>
<td>£77,585</td>
</tr>
<tr>
<td>£78,164</td>
<td>£80,040</td>
</tr>
</tbody>
</table>
Principles of assimilation

1. When an employee moves on to a new contract there is a general assumption that there will be no detriment to the individual arising from the move. As the term ‘no detriment’ is open to interpretation by the parties to the contracts we have given a definition for the purposes of assimilation from the old contract to the new.

2. Our definition of 'no detriment' is that, subject to the work contracted for in the new contract being of the same time and nature as work done under the old contract, then any remuneration paid to an individual doctor under the national contract in force at the time would be protected.

3. In practice we expect few, if any, doctors to require protection on transfer to a new contract because the new contracts recognise and reward work which is not formally acknowledged in the current national contracts. On any further change following assimilation local pay protection arrangements would apply.

4. Not covered by the definition is the aspiration of any individual to potential or future pay or terms and conditions that they were not entitled to at the time of transfer, e.g. an assumption of progression from Staff Grade to Associate Specialist at some future date.

5. The components of assimilation and the nature of pay protection are explained further in paragraphs 6 to 8 below.

Assimilation of other grades of staff to the new grade

6. Current Staff Grades, CMOs, SCMOs, non GP Clinical Assistants and Hospital Practitioners will assimilate to the Specialty Doctor grade and terms and conditions of service if they accept the new contract.

Associate Specialists are invited to accept the new contract for the Associate Specialist grade.

Components of Pay

7. The following elements need to be considered:

- **Salary** - incremental point on which the doctor is paid including optional or discretionary points.
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- **Additional Hours** – paid as temporary notional additional half days or sessions.

- **Additional Responsibilities** – where either TANHDs have been paid for increased responsibilities and not in recognition of additional time worked, or TANHDs have been awarded instead of an optional or discretionary point to recognise a continuing responsibility, they should be taken into account in assimilation.

- **Adjustment of hours** – rebasing contracts to a standard working week of 40 hours. Assessment of pay on a pro-rata basis for doctors working fewer than 40 hours.

- **Work outside the normal working week** – not formally recognised for AS doctors under current contracts. Some recognition for staff grades under an assessment of additional hours.

- **London weighting**

- **Occasional payments** – Payments made in addition to existing national contractual frameworks may continue to be paid by local agreement but would not form part of the basis for salary assessment for assimilation purposes. For example: locum payments when acting at a higher grade and waiting list payments (although regular payments for additional hours worked could be offered as additional programmed activities) or community contraceptive services fees. This list is not exhaustive. Employers would still be able to offer these payments by local agreement where necessary.

- **Fee Payments for work done during Programmed Activities** as a general rule payment should be made once only for any period of time and activities carried out during a contracted programmed activity should not attract additional fees. Examples include domiciliary visits and Family Planning work. This work should be factored into the job plan and paid accordingly.
8. The diagram above illustrates how current payments could assimilate to the proposed new arrangements. This would apply for both new contracts (new grade and Associate Specialists)

Practical Assimilation

9. The following steps will need to be followed:

- The HR department should assess payment for each individual doctor in the relevant grades (SG, AS, CMO, SCMO and non GP HPs and CAs) under their current contract, identifying the elements as in paragraph 5.
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- Select appropriate basic pay point from the new pay scale - this will almost always be equal to the point on the current pay scale and the doctor should therefore keep their existing incremental date.

- As noted above current payments for responsibility may be factored in to basic salary by local agreement (as indicated by dual arrows to the box marked ‘scale point’ in the diagram). However, where payments for ‘time’ continue, they should be converted to additional programmed activities.

10. There will be joint discussion and agreement between the doctor and their clinical manager on a prospective job plan. A doctor will be paid in accordance with the agreed prospective job plan.

Pay Protection on Assimilation

11. It is envisaged that the majority of doctors will receive an increase in pay under these arrangements. However, pay protection arrangements on assimilation for those who require them are as follows: Subject to the definition in paragraph 2 above, pay based on the current nationally agreed contracts would be protected. Protection would be at mark time of the value of payments as of 31 March 2006 plus the value of any annual pay increase recommended by the Doctors and Dentists Review Body and accepted by the Secretary of State for Health on behalf of the Health Departments in Great Britain for the 2006/7 year only.\(^7\)

12. The period of protection will end when the total level of payments under the new arrangements exceeds the level of protected pay. The diagram below illustrates how this would work in practice.

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\(^7\) Doctors’ and Dentists’ Review Body not in force in Northern Ireland
13. Doctors and dentists on current contracts would have their protected level of pay calculated for the current year at point A in the above diagram. In April 2006 they would receive an increase in basic pay as recommended by DDRB and accepted by the Secretary of State for Health. From 1 April 2006 onwards their protected level of pay would then remain at this mark time level subject to hours and intensity remaining the same.

14. Prior to assimilation to the new contract the HR department will assess pay for each individual doctor. If the level of pay under the new contract is less than the protected level of pay they will continue to receive their protected level of pay from April 2006. Their underlying level of pay under the new contract will continue to attract an uplift in April every year. The period of protection will end when the total level of payments under the new contract exceeds the level of protected pay at point B. In the diagram above this would occur in April 2008.

15. This section does not cover pay protection on return to training from the new grade and Associate Specialist. Those arrangements are dealt with in paragraphs 82-85 of the Summary Agreement document and appendix 3.
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Appendix 2

Window of Opportunity

Proposals

1. That from the start date of the new contract there will be a defined period for those doctors who meet the criteria by 1 October 2007 to either have their current application processed by their employer or have the opportunity to apply for regrading to Associate Specialist providing they meet the existing criteria.

2. The doctor must have been undertaking a job at the level of an Associate Specialist doctor and be personally operating at a level above and beyond Staff Grade or equivalent level (for example demonstrated by having received optional points at the top end of the scale). In determining this it will be helpful to consider existing Associate Specialist job descriptions and person specifications.

3. Funding has been allocated within the cost envelope to give doctors the opportunity to apply to regrade to Associate Specialists if they are successfully assessed as meeting the criteria.

4. Employers will be required to follow the procedure set out in EL(97)25 (in England), NHS MEL (1998), appendix 3, paragraph 11-17 (in Scotland) DGM (96)158 (in Wales) and HSS(TC8)12/1992 (in Northern Ireland) and advise all doctors of these provisions. In these circumstances, to enhance process transparency, a senior Associate Specialist may be requested to take part in the trust’s appointment committee.

5. Doctors will be required to submit their application by 1 October 2007 and the process should be completed without undue delay. The date the application for regrading is submitted shall be the effective date of regrading.

6. Where a doctor is successful in their application to be regarded to Associate Specialist, prior to [date the contract becomes effective], they shall be regraded to the ‘old’ Associate Specialist TCS and their salary shall be determined in accordance with the ‘old’ TCS (paragraphs s 127 and 133). This will be the salary which is used to determine basic salary on assimilation to the new 2006 AS pay scale. The effective assimilation date for pay purposes would therefore be the [date the contract becomes available].

7. Where a doctor is successful in their application to regrade to Associate Specialist after [date the contract becomes effective], their most recent pay point on the ‘old’ TCS will be the salary which is used to determine basic salary on assimilation to the 2006 AS scale.

8. Acceptance of the transfer would be a voluntary decision.
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9. Once this deadline has passed there will be no further facility for regrading beyond the new career grade given that it is proposed that the Associate Specialist grade be closed.
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Appendix 3

Pay Protection on Re-Entry to a Training Position from a Career Grade Post

Issue

1. Evidence suggests that the current pay protection arrangements are having an adverse impact on the return to training of senior doctors as the high costs are deterring employers from accepting trainees from outside the training grades.

2. This agreement proposes a solution to this issue which would also remove the present anomaly between doctors in Hospital medicine and those in Public Health and the Community.

3. While this is an issue involving doctors in training, as this provision affects only seniors returning to training, and mainly doctors from SASC grades, it is, therefore, properly an issue for this contract negotiation, rather than for JNC(J) and agreement across craft groups has been obtained.

Background

4. Current TCS for senior hospital doctors and dentists in hospital medicine allow for the protection of existing basic salary on return to formal training, augmented by a banding supplement appropriate to the training post which is paid as a proportion of the protected salary. In a typical training post this can currently be an additional 50% to 80% of basic salary.

5. Pay protection on return to training for doctors in Public Health and the Community is provided for differently under the current TCS. This group of doctors receive the appropriate training grade salary with its supplement, or his or her protected salary, whichever is the greater.

Reasoning for modification

6. Under the current arrangement, salaries payable to doctors on return to training are not merely protected but can be very significantly enhanced by the addition of banding payments.

7. This was not the intention of the TCS. Guidance issued in 1981 states that ‘the provisions…are intended to provide flexible and sensitive arrangements for protecting the salaries of practitioners who take a post in a lower grade in order to pursue a recognised programme of training. In applying this scheme, authorities should bear in mind the primary educational purpose which lies behind this provision.’ (PM(81)30)

8. As a consequence we have been made aware of the following issues,

   - the additional costs to employers have made it difficult to justify taking such doctors back into training, and the deanery usually only pays basic salary at the grade mid-point. The actual cost to the training employer can be considerable and can present a significant disincentive to an employer who might otherwise be prepared to take on such a trainee;
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- the disparity in salary between existing trainees and the re-entrant is a source of dispute on the basis of equal pay for equal work; and

- the disparity in salary between a re-entrant and the consultants providing supervision, who even with Distinction or Clinical Excellence Awards can still be on a lower salary than the re-entrant, has provoked considerable ill-feeling.

9. We agree that the protection of basic salary is entirely appropriate. We also agree that doctors returning to training posts should be rewarded for undertaking out-of-hours work and for the intensity of the post. We do, however, believe that the significantly enhanced salaries being rewarded under the current arrangements can be a considerable disincentive for employers to take senior doctors back into training posts.

Proposal

10. The pay protection provisions on return to training are to be harmonised across Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service. The following paragraphs will replace paragraphs 132 and paragraph 135e. Paragraph 135f is deleted. This has been agreed across all craft groups.

11. The general premises are:

- For the purposes of this note and revised paragraphs 132 and 135e:
  - The term ‘training grade’ refers to accredited training appointments in the grades of SHO, SpR and StR.
  - The term ‘career grade’ is a reference to any NHS medical practitioner appointment on national terms and conditions of service other than those in training grades.

- on return to a training contract, a doctor will assume the terms and conditions applicable to a doctor in training: but
  - for pay purposes a doctor may either; be placed on an appropriate point on a training grade pay scale; or
    - their pay while in the training post may be based on the pay point reached in their career grade contract, with total pay calculated as if their contracted training duties had been carried out under the terms of their previous career grade contract, and
    - the practitioner retains the current value of the pay point or threshold reached before re-entry to training, receiving general pay awards but not moving up the incremental scale.

- Continuous service of less than 13 months in a substantive career grade post immediately prior to re-entering training will not be recognised for pay protection purposes.
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- The ‘appropriate authority’ recognising posts under paragraph 132 will normally be the responsible Deanery.
- These provisions will come into force with effect from and including 1st August 2007. New contracts of employment agreed after that date will be subject to these new provisions which will apply both to practitioners already protected under current arrangements and to practitioners starting retraining.

REVISIONS TO PARAGRAPHS 132 and 135e

132. Where a practitioner in a career grade takes an appointment in a training grade which is recognised by the appropriate authority as being for the purpose of obtaining approved training (which may include training to enable the practitioner to follow a career in another specialty) and the practitioner has given continuous service in a career grade post or posts for at least 13 months immediately prior to re-entering training, the practitioner shall, while in the training grade, continue to receive a salary protected on the incremental point or threshold the practitioner had reached in his or her previous career grade appointment. Such a practitioner shall receive the benefit of any general pay awards. On reappointment to a career grade post, the practitioner’s starting salary should be assessed as if the period spent in the approved training post had been continuing service in the previous career grade. Where a practitioner re-entering training from a career grade has held a recognised training post (or equivalent service overseas) in the 13 months prior to re-entering training, the intervening period spent in the career grade shall be taken as continuing service in the training grade, and the practitioner will be re-appointed on the appropriate incremental point of the training grade scale. Where pay in the earlier training post was already protected under these provisions, such protection shall continue. Practitioners whose previous appointment was in the Northern Ireland, Isle of Man or Channel Islands hospital service are eligible for protection of salary under the terms of this paragraph.

135e. A practitioner entitled to protection under paragraph 132 shall continue to receive the leave entitlement of his or her previous post and shall receive the appropriate training grade salary plus the supplement or his or her protected salary, whichever is the greater, except that where the salary is protected at a point on the training grade scales the supplement for the new post shall be paid in any case. The appropriate training grade salary shall be determined as the point on the training grade incremental scale previously reached, plus recognition of service in the same or a higher grade subject to the provisions of paragraph 123 and such guidance as may be published from time to time. For career grade practitioners entering a training grade, the basic salary paid in the previous appointment shall also, for protection purposes, not include any payments for an additional notional half-day under paragraph 14, additional sessions under paragraph 16, payments for additional Programmed Activities, out of hours or on-call, or a salary supplement, as appropriate, for which the practitioner was contracted in that career grade appointment. The practitioner will, however, be entitled to have total pay in the training post calculated as if
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the duties contracted for in the training post had been carried out under the relevant terms of the career grade contract held before re-entry to training. For consultants in Wales this will not include the equivalent payments under paragraphs 2.27 and 2.46 of the Addendum to the Medical and Dental Staff (Wales) Handbook.
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Appendix 4

Definitions

Additional Programmed Activities: The annual rate for Additional Programmed Activities will be 10% of Basic Salary, where basic salary includes the pay thresholds. Where Part-time doctors have contracted to undertake Additional Programmed Activities these will be paid at 10% of full-time Basic Salary.

Basic Salary: Basic salary is the salary attributed to each point on the salary scale with no further additions. The documented salary is for a full-time (10 Programmed Activity week) doctor and part-time doctors will be paid a pro rata rate.

Contractual and Consequential Services: the work that a doctor carries out by virtue of the duties and responsibilities set out in his or her Job Plan and any work reasonably incidental or consequential to those duties. These services may include:
- Direct Clinical Care
- Supporting Professional Activities
- Additional NHS Responsibilities
- External Duties.

Direct Clinical Care: This is work that directly relates to the prevention, diagnosis or treatment of illness. It includes:
- emergency duties (including work carried out during or arising from on-call)
- operating sessions including pre-operative and post-operative care
- ward rounds
- outpatient activities
- clinical diagnostic work
- other patient treatment
- public health duties
- multi-disciplinary meetings about direct patient care
- Patient related administration linked to clinical work i.e. directly related to the above (primarily, but not limited to, notes letters and referrals)

Supporting Professional Activities: These are activities that underpin direct clinical care. This might include participation in:
- audit
- continuing professional development
- local clinical governance activities
- training
- formal teaching
- appraisal
- job planning
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Additional NHS Responsibilities: These are special responsibilities within the employing organisation not undertaken by the generality of SAS doctors, which are agreed between the doctor and the employer and which cannot be absorbed in the time set aside for supporting professional activities. These could include, for example, being a clinical manager, clinical audit lead or clinical governance lead.

External Duties: These are duties not included in the three foregoing definitions and not included within the definition of Fee Paying Services or Private Professional Services, but undertaken as part of the prospectively agreed job plan by agreement between the doctor and the employing organisation without causing undue loss of clinical time. They might include, for example, trade union duties, reasonable amount of work for the Royal Colleges or Government Departments in the interests of the wider NHS.

Doctor: A medical or dental practitioner, except where stated separately.

Emergency Work: Predictable emergency work: this is emergency work that takes place at regular and predictable times, often as a consequence of a period of on-call work (e.g. post-take ward rounds). This should be programmed into the working week as scheduled Programmed Activity. Unpredictable emergency work arising from on-call duties: this is work done whilst on-call and associated directly with the doctor’s on-call duties (except in so far as it takes place during a time for scheduled Programmed Activities), e.g. recall to hospital to operate on an emergency basis.

For the purposes of Schedule 4, paragraph 6, non-emergency work shall be regarded as including the regular, programmed work of doctors whose specialty by its nature involves dealing routinely with emergency cases, e.g. A&E doctors.

Fee Paying Services: any paid professional services, other than those falling within the definition of Private Professional Services, which a doctor carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 11 of the Terms and Conditions.

General Council Conditions: The National Health Service Staff conditions of service of general application as determined by the General Council of the Whitley Councils for the Health Services (Great Britain) as may be amended from time to time, or any provisions which may be agreed by a successor body to the General Council and may reasonably be considered to have replaced the current conditions of service.
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**Out-of-hours:** This is any time that falls outside the period of 07:00 to 19:00 Monday to Friday and any time on a Saturday or Sunday, or public holiday.

**Private Professional Services (also referred to as “private practice”):** such services as include:

- the diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under section 65(2) of the National Health Service Act 1977), excluding fee paying services as described in Schedule 10 of the terms and conditions
- work in the general medical, dental or ophthalmic services under Part II of the National Health Service Act 1977 (except in respect of patients for whom a hospital medical officer is allowed a limited “list”, e.g. Members of the hospital staff).

**Professional and Study Leave:** professional leave or study leave in relation to professional work including:

- study (usually but not exclusively or necessarily on a course or programme)
- research
- teaching
- examining or taking examinations
- visiting clinics
- attending professional conferences
- training.

**Programmed Activity:** This is a scheduled period, normally equivalent to four hours, during which a doctor undertakes Contractual and Consequential Services.

**Working Week:** A standard full-time working week will be based on a Job Plan containing ten Programmed Activities.
Modernising Medical Careers – Definitions

‘Choice and opportunity’ aims to professionalise the SAS pathway. Modernising Medical Careers (MMC) aims to provide a good practice guide to help organisations, and doctors entering this pathway, understand the principles defined in the policy document.

Structured Specialty Training Programmes

Structured Specialty Training Programmes offer a trainee doctor a series of approved, coordinated posts that will enable them to gain and demonstrate the competences required to achieve a Certificate of Completion of Training (CCT), as defined by the specialty and approved by Postgraduate Medical Education and Training Board (PMETB).

Entry to Structured Specialty Training Programmes will lead directly from the Foundation Programme launched in August 2005.

Once doctors have successfully competed for and gained entry to a training programme, subject to satisfactory demonstration of progress, they would all leave the programme with a CCT.

Doctors must understand that training opportunities will continue to be determined by service requirements.

Time Limited Training Contracts

As well as run-through training, there will be an alternative training provision, comprising time limited fixed term contracts, likely to be no more than two years in length. This offer doctors training with competences defined through curricula specifically for these years, which may be referenced to the equivalent specialty training curricula. One objective is to prepare the individual to undertake a service post although there will be further opportunities for these doctors to compete for run-through programmes.

These programmes may give further exposure to a range of clinical specialties and may in some cases differ significantly from the early specialty training programmes. Nevertheless competences obtained will be taken into account if a doctor leaving time-limited training obtains a run through post.

There will not be any competitive advantage in undertaking a time-limited post as opposed to competing directly for entry into specialist or GP training. It is likely that time-limited posts will cover less specific specialty ground than run-through posts. Trainees leaving Foundation Programme Year 2 (F2) will in principle only apply for a time-limited post if, following competition of F2, they do not gain admission into a specialty or GP training programme. It may also be that the trainee did not gain admission into the programme of their choice.
and wishes to try again. Some, for whatever reason, may not wish to apply for specialty or GP training from F2.

**Service Posts**

When a doctor leaves a structured training programme and enters a service post this is not the end but the start of their professional development within a service delivery role. Through continuous professional development (CPD) doctors will develop their competences to enable them to seek further promotion through competition. As in any employment situation, however, the primary aim of the post is to undertake the job required. Doctors in service posts who develop the necessary competences can apply to the PMETB to gain access to the Specialist Register via the Article 14 route.

Best practice would ensure that every doctor can have access to meaningful appraisal that in turn supports their CPD. The structures which will support this are described as follows

**Continuing Professional Development**

CPD enables the doctor to continue to develop within their chosen profession, gaining skills and knowledge that will facilitate them in the delivery of quality patient care in the job they are appointed to. It should also be recognised that a doctor in this pathway will have aspirations to develop the competences that will help them become eligible for entry to the Specialist Register. It would be best practice for an employer to support a doctor in their development. This will work best when the development needs are identified and shared by both parties, however, it should also be possible for a doctor to develop further competences out with those required by their employer, that will help them progress in their future career as long as this does not impact on the doctors ability to meet the requirements agreed jointly between themselves and their employer.

**Meaningful Appraisal**

Every professional should be subject to annual appraisal. Best practice should have appraisal at the centre of a professional’s development. It requires a dialogue between two trusting parties, one of whom must have influence within the organisation to support that doctor in achieving the outcomes agreed in their personal development plan (PDP). The PDP should be the output from the appraisal and each year a review of achievements against the goals set within this plan will inform future PDPs. The process should focus on the individuals needs, be based on evidence, take into account the requirements of the posts and the aspirations of the individual.

For a doctor in this new pathway this process should focus on their personal development and should take into account the needs that have been identified to help them perform effectively in their job. Appraisal should also support identifying and addressing future development needs and agreeing an approach for an individual to achieve their professional aims. Best practice
would place the doctor at the centre of this process, enabling the doctor to drive their own appraisal and facilitating their ongoing professional development.

**Evidence and Competence**

For a doctor to progress they must be able to demonstrate that they have the required competences. A doctor in this new pathway must therefore be supported in gathering evidence on their performance, this could be data relating to their service delivery, and direct evidence of competence, best demonstrated through approved, standardised assessments recognised by PMETB, but not purely so. As a doctor develops in this profession their evidence will form the basis of an evidence portfolio that can be used to support their application to PMETB under Article 14 and provide evidence when they seek to progress within the career pathway.

**Return to training**

MMC will be defining the opportunities that will be available for movement between specialty training programmes and the new pathway. It is likely that re-entry to specialist training programmes will be by competition and determined by service need and availability of posts in training programmes.

The support systems in place for personal development should facilitate any doctors in this pathway who wish to gather evidence of their competence in order to meet the requirements of Article 14. This should not be at the expense of the doctor meeting the agreed targets set by their employer which must take precedence as these are the targets against which they will be assessed for progression within their grade. The two need not be mutually exclusive. Best practice would ensure that any documentation that the trust supports is aligned with that required by PMETB and all doctors in this pathway should be able to access the information they require that will help them prepare for their Article 14 submissions.
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Appendix 6

Portfolio

The purpose of the portfolio is to provide an ongoing record of a doctor's achievements and development. As part of this process, these doctors should have opportunities for training (although not in the formal accredited schemes) and development. This would be identified at appraisal and should form part of the job plan.

The doctor will develop a portfolio of evidence as they progress from entry through thresholds one and threshold two, and on to the top of the grade. The portfolio will contain evidence of work undertaken and skills development in the Continuing Professional Development (CPD), appraisal and Job Plan documents. This will be used to demonstrate that they have achieved the requirements for passing through the thresholds (see below), and will include the completion of appraisals and job plans. These requirements are generic, i.e. they are not specialty specific.

Those doctors who wish to move into formal training towards obtaining a Certificate of Completion of Training (CCT), could amass additional evidence as part of their portfolio, to demonstrate that they meet the requirements for training towards the CCT in the relevant specialty, checking against the requirements for that specialty. This would be discussed at appraisal and form part of the job plan. Gathering evidence for the portfolio can be through methods other than a formal accredited training scheme e.g. workplace based/in-post training etc. It is also intended to inform the GMC’s revalidation scheme and provide evidence to support any doctor wishing to re-enter training with evidence of the standards they have reached and their experience to date.

The portfolio will have 2 parts. The first part will include the formal documentation required for verifying that the threshold criteria have been met. The second part will contain personal evidence of skill development and experience.

In essence, the portfolio may include:

- Confirmation that the annual appraisal has taken place;
- Evidence of annual job plans;
- Confirmation that a 360 degree appraisal has taken place in the year preceding thresholds one and two;
- Personal development plan;
- reflective notes, according to the relevant specialty and usually included as part of the appraisal (form to be developed)
- other relevant evidence/papers in relation to the ability to take decisions and carry responsibility without immediate or direct supervision and of contributions to a wider role within the department or nationally. These might relate to teaching, research, management, innovation etc. including published papers, theatre or clinic lists (to
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demonstrate ‘independent’ working, for example) (required for progression through threshold 2).