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Consultant Contract in Wales: Progress with Securing the Intended Benefits



Consultant Contract in Wales: Progress with Securing the Intended Benefits

I have prepared this report for presentation to the National Assembly under the Government of Wales Act 1998 and 2006.

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Report presented by the Auditor General for Wales to the National Assembly on 28 February 2013



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Summary

- 1 The first consultant contract was introduced in 1948 and essentially remained unchanged until new contract negotiations started in 2000. These negotiations were the result of an increasing recognition by managers and consultants alike that the old contract no longer reflected working patterns and the needs of the modern NHS. Originally, these negotiations involved the four UK health departments, employers' representatives from the NHS Confederation, and the British Medical Association (BMA). These negotiations produced a first set of proposals that were published in February 2001, and were immediately rejected by doctors, leading to a second framework agreement in 2002. Although the second set of proposals was accepted by consultants in Scotland and Northern Ireland, they were rejected in England and Wales, preventing any national agreement from being introduced.
- 2 In Wales, following this rejection, the Welsh Government negotiated an amendment to the existing contract with the BMA and these were agreed by consultants following a 94 per cent 'yes' vote. Because the new Welsh contract is an amendment to an existing contract, it was binding on all consultants in Wales and became effective on 1 December 2003. This is different to the contracts agreed in the rest of the UK, where the new terms and conditions only applied to new consultants appointed after the separate agreement dates.
- 3 This amended contract brought in a number of benefits for Welsh consultants which included:
 - a a new salary scale;
 - b improved arrangements for recognising on-call commitments;
 - c new arrangements for Clinical Commitment and Clinical Excellence Awards; and
 - d a commitment to improve flexible working.
- 4 These new arrangements were designed to deliver three specific benefits for the NHS:
 - a improving the working environment for consultants;
 - b improved consultant recruitment and retention; and
 - c facilitating health managers and consultants to work more closely together to provide a better service for patients.
- 5 Underpinning the delivery of these benefits would be the introduction of a more vigorous approach to consultant job planning. This mandatory job planning process was designed to ensure the individual consultant and the employer had greater clarity on the content and scheduling of activities that comprise the working week, and the desired outcomes associated with these activities.



- 6 The amended contract in Wales is based upon a full time working week of 37.5 hours, equivalent to 10 sessions of three to four hours each. At the time of introducing the new contact arrangements, it was recognised that many consultants were working in excess of 10 sessions a week. The extent of these 'unrecognised' sessions was quantified through the first round of job planning which took place in NHS trusts between the autumn of 2004 and early 2005.
- 7 A key output from this first round of job planning was a bid from each NHS body to the Welsh Government for payment to cover the additional unrecognised sessions. The then Audit Commission in Wales was asked to review job planning approaches in NHS bodies to provide the Welsh Government with assurance that bids for additional sessions were based on robust and effective job planning. The result of this work was that NHS trusts had put a lot of effort into establishing sound job planning processes, although practices did vary, and in some NHS bodies, auditors identified a number of concerns about the arrangements.
- 8 There had been no independent review of the implementation of the amended consultant contract in Wales since the work of the Audit Commission in Wales in 2004-05. Local audit work was therefore undertaken at all NHS bodies in Wales that employ consultants between late 2010 and the end of 2011. In addition during 2012, depending on local issues, follow-up work was undertaken in some NHS bodies. This work sought to examine whether the intended benefits of the amended consultant contract in Wales are being delivered. The work had a strong focus on the extent to which consultant job planning had been embedded with NHS organisations, given its importance in underpinning effective implementation of the new contract arrangements.
- 9 Each NHS body has received a report setting out the findings of our local work, and in some cases, additional follow-up work has been undertaken to ensure that sufficient progress is made against local audit recommendations. Copies of local audit reports for NHS bodies are available on the Wales Audit Office website (www.wao.gov.uk).
- 10 This report summarises the findings from our local work to present a view of how the amended consultant contract is being implemented across Wales. The overall conclusion from our work is that all the intended benefits are not being achieved largely because the amended contract has not been underpinned by effective job planning.
- 11 The report considers:
 - a the key features of the amended consultant contract in Wales;
 - b the costs arising from its introduction;
 - c the extent to which the intended benefits that were originally identified are being delivered; and
 - d how effective consultant job planning is as a tool to underpin implementation of the contract and delivery of the intended benefits.
- 12 **Appendix 1** provides details of our audit approach, which included a survey of NHS consultants across Wales.

An amended contract was introduced for NHS consultants in Wales in 2003, with a number of intended benefits

- 13** The first consultant contract was introduced in 1948 and essentially remained unchanged until a new amended contract was introduced in Wales in 2003. Because it was an amendment to the existing contract, it was binding on all consultants in Wales. This is different to the contracts agreed in the rest of the UK, where the new terms and conditions are voluntary.
- 14** The aims of the amended consultant contract were ‘... to improve the consultant working environment, to improve consultant recruitment and retention, and to facilitate health managers and consultants to work together to provide a better service for patients in Wales. This is an integral part of the modernisation of NHS Wales.’
- 15** Expectations were that the culture of long working hours for consultants would be addressed, the recruitment of consultants in Wales would be improved, and that consultants would be more effectively engaged in efforts to modernise service delivery and improve patient care. Underpinning the delivery of these benefits would be the introduction of effective job planning.
- 16** Although there have been amendments, the pay structure for consultants remains complex with basic pay, based on the number of sessions agreed in the job plan plus any additional sessions as agreed by negotiation. In addition, pay can include Commitment Awards and Clinical Excellence Awards, on-call supplements, and other fees and allowances.

A significant amount of money has been spent implementing the contract

- 17** The Welsh Government originally set aside £18 million to fund the introduction of the amended contract. Following the first round of job planning and the assurance provided by the Audit Commission in Wales review, the Welsh Government provided an additional £17 million to fund the cost of additional sessions, bringing the total cost of implementing the contract to £35 million. The Welsh Government continued to centrally fund unrecognised additional sessions until 2009-10; after this, individual NHS bodies were responsible for meeting these costs.
- 18** Since the introduction of the amended contract, the overall pay bill which includes pay awards for consultants has increased from £250 million in 2004 to £331 million in 2010. This in part reflects increases in the number of consultant posts in the NHS over that period. However, over the same period, consultants’ average earnings have increased by 29 per cent as result of changes to consultants’ pay structure.
- 19** In September 2005, a Consultant Outcome Indicators (COIs) project was launched as a jointly sponsored initiative between the then NHS trust chief executives and the Welsh Government. The aim was to develop a suite of outcome indicators for individual consultants which could be used as a tool to inform job planning discussions.
- 20** The project was an innovative initiative that had the potential to significantly enhance job planning and appraisals. However, ongoing concerns about the quality of the indicators led to the project being closed down in 2009 without having achieved most of its intended aims with the exception of promoting a



greater awareness of outcome measures and the limitations of existing NHS information systems.

21 A number of factors contributed to the failure of the project to deliver its aims. A fundamental problem was that the data being used as the basis of the indicators came from Patient Administration Systems (PAS). This data was never intended to be used for clinical outcomes at individual clinician level and problems with data accuracy were quickly experienced.

22 Ultimately the decision not to continue with the project was a pragmatic one, given that a significant amount of additional time and resource would have been needed to address the concerns which were emerging. Given the problems that were experienced, it is perhaps surprising that the steering group overseeing implementation of the project did not take this decision earlier. The end result is that a standard set of acceptable outcome measures for all specialties to support job planning has not been produced. There is still a need for such an output, and it is important that learning from the project is not lost, but is instead used as a basis for fresh work to generate this important information.

Whilst there have been some notable changes, not all the intended benefits of the amended consultant contract have been realised

23 On average, a consultant's working week has reduced by just over four hours since the start of the contract. In 2004, consultants were working an average 46-hour working week. By 2010, the working week had reduced to an average of 42 hours. This reduction is mainly due to consultants undertaking less work as Direct Clinical Care (DCC) activity, mainly because work has been redistributed within the clinical team combined with more

consultants being employed. In overall terms, however, the total number of DCC sessions available to the NHS has increased by 3,160 per week.

24 In Wales, the amended contract's original intention was for all consultants to have a 37.5 working week. This was later relaxed and the expectation is that consultants should not work more than 12 sessions. Currently, only a third of consultants in Wales have 10-session contracts. This reflects the fact that many consultants are willing to work additional sessions to increase activity, take on management responsibilities or to help the development of their own clinical practice. This flexible arrangement directly benefits both the NHS and the individual consultant.

25 Some consultants are still working excessively long hours. A detailed analysis of reported job plans undertaken as part of our local audit work found that around one in six consultants are working 46.5 hours or more with the vast majority in this group working in excess of the 48-hour European Working Time Directive (EWTD) limit.

26 Recruitment and retention of consultants has improved and the level of reported vacancies has substantially reduced. Annual workforce information provided to the Welsh Government by NHS bodies shows that there has been a 37 per cent increase in the number of Whole Time Equivalent (WTE) NHS consultants between 2004 and 2011.

27 The increase in the numbers of consultants working in the NHS in Wales since the implementation of the amended contract has been accompanied by a reduction in the number of consultant posts which are vacant. On average across Wales, the percentage of consultant posts which are vacant has decreased from 8.4 per cent in 2004 to 2.1 per cent by March 2011.

- 28** Broadly speaking, the amended contract has not been the significant driver for service modernisation as was originally anticipated. Less than half the consultants who completed our survey felt that the amended contract and job planning had provided opportunities to discuss service modernisation and improvements to clinical practice, and even fewer felt it had improved patient care or changed the way they worked for the better.
- 29** This is disappointing given that much work was undertaken in the early stages of the contract's implementation to establish effective job planning arrangements to underpin the contract and help secure the intended benefits. Indeed, Wales was the only part of the UK to seek independent commentary on the robustness of the initial round of job planning at NHS bodies. This review was undertaken by the Audit Commission in Wales and completed in March 2005, and resulted in each of the then NHS trusts having a set of recommendations for improving and embedding their job planning arrangements.
- 30** Following the Audit Commission in Wales work, the Welsh Government introduced a requirement that each NHS body would prepare an annual report that set out the progress being made with implementation of the amended contract and how they were tackling the auditors' recommendations. The annual reporting requirement was in place between 2006 and 2009.
- 31** NHS trusts' annual reports were largely self-reported developments and the Welsh Government accepted these on face value on the basis that they had been signed off by the chief executives and agreed with the Local Negotiating Committee (LNC) representing the consultant body. Our interviews suggested this was not always the case although the Welsh Government, through discussions with the BMA and consultant representatives at the Joint Welsh Consultant Contract Committee, had tried to improve the arrangements. Our local audit work has subsequently shown that the descriptions of progress set out in the annual reports was overly optimistic and did not identify important issues such as the frequency of job planning and the quality of the processes that were in place to support it.
- In most health boards and trusts, implementation of the amended contract has not been underpinned by effective job planning arrangements**
- 32** Local audits found that many consultants do not have an annual job plan review. On average across Wales, only 61 per cent of consultants reported that their job plan was reviewed annually.
- 33** In 2004, most NHS trusts developed local guidance to supplement that produced by the Welsh Government and other bodies such as the BMA. This local guidance helped ensure that job planning was applied consistently within individual organisations. Over time, however, different approaches have been adopted, often on an informal basis. With NHS trust mergers and the subsequent NHS reorganisation, most health boards and trusts inherited a range of approaches to job planning from their predecessors.
- 34** An equally variable approach was observed in relation to the provision of training for staff taking part in job plan reviews. In 2004, the implementation of the amended contract was accompanied by comprehensive training on job planning in NHS trusts. However, because the same staff in these organisations were undertaking job reviews each year, the need for ongoing training tailed off. Successive organisational changes and the



recruitment of additional consultants and new clinical directors has meant that training has once again become important to ensure consistency.

- 35** The local audits found that for the majority of consultants, the practical arrangements associated with their job planning meetings were appropriate. Less positively, our audits found that job planning for many consultants is hampered by a lack of information to inform the discussion at these review meetings. The failure of the COI project has meant that meaningful data on outcomes is still missing for the majority of consultants.
- 36** Without access to the appropriate information, job planning discussions will inevitably focus more on timetabling of activities, rather than on the outcomes that need to be achieved from these activities.
- 37** A wide range of staff can be involved in job planning discussions. As a minimum, the consultant will need to meet with an appropriate clinical manager. However, to ensure that job planning becomes an integral part of business and service delivery planning appropriate input is also needed from directorate or general managers. Our audit work found managers were often not involved in discussions, which would appear contrary to one of the key aims of the amended contract which is to foster closer working between consultants and NHS managers.
- 38** The contents of job plans can vary significantly and very few contain identifiable and measurable outcomes. Where there are wide variations in the number of sessions in job plans, consultants with fewer sessions told us they were aware of the discrepancies and felt they were not being treated fairly.
- 39** Supporting Professional Activities (SPAs) form an important element of a consultant's working week, and NHS bodies need to ensure an appropriate amount of SPA sessions are included in consultant job plans.
- 40** When the amended contract was introduced in Wales it indicated that full-time consultants should 'typically' have three SPA sessions per week. This had the effect of creating an expectation in some quarters that three weekly SPAs would be the norm, regardless of the professional needs of the clinician, or the business needs of the organisation. This debate has moved on, and in reality very few consultants have three SPAs per week. However, the legacy of this is that much of the debate within NHS bodies has focused on the number of SPA sessions rather than looking more holistically at what type of SPAs are needed and how the value of them can be demonstrated.
- 41** In overall terms, our local audits found that there is considerable scope to improve the management of SPA sessions through better job planning to ensure both the consultant and the NHS are realising the full benefit from this investment.

Recommendations

Strengthening job planning processes within NHS bodies

- 1 Many of the intended benefits from the amended consultant contract in Wales are predicated on effective job planning processes being in place. Local audit work has shown that there is much that still needs to be done within NHS bodies to embed robust approaches to consultant job planning. **In order to strengthen current arrangements we recommend that NHS bodies in Wales that employ consultants should ensure that:**
 - a All consultants have a job plan that is reviewed annually to ensure that it reflects the business needs of the NHS organisation and the continuous professional development of the consultant.
 - b Where changes to NHS services are occurring following public consultation, consultant job plans should be updated and agreed to reflect new service models. This should happen as an integral part of the process to redesign services, rather than a retrospective activity that occurs after the new services are in place.
 - c Job planning is supported by up-to-date local guidance material and regular training for all staff who participate in the process.
 - d There is involvement in consultant job planning from general managers to ensure that wider organisational objectives, service improvements and financial issues are considered when agreeing consultants' job plans, and
- to help managers understand what resources and support consultants need to deliver their job plan commitments.
- e While job planning and appraisal are separate processes, there is a clear linkage between appraisal outcome and job planning when meeting the development needs of a consultant. NHS organisations will need to ensure the two separate processes are appropriately aligned and integrated to support the requirements for the new General Medical Council (GMC) revalidation requirements that will be introduced in 2013.
 - f They work jointly with universities in agreeing job plans for consultants that have academic contracts such that the expectations and requirements of both organisations are properly and fairly considered; similar arrangements should be in place for consultants working for two or more NHS organisations.
 - g They have monitoring processes in place to check that all consultants have an up-to-date job plan, and that job planning is being undertaken in accordance with guidance that has been issued; monitoring processes should include an update report to the Board, at least annually, that demonstrates the extent to which consultant job planning is embedded across the organisation as a routine management practice.



2 Whilst consultant job planning is primarily an activity that needs to take place between a consultant and his or her employing organisation, it is important that a consistent approach to job planning is adopted across NHS organisations in Wales. The Welsh Government has a role to play in helping to ensure that consultant job planning is undertaken consistently and in line with recognised good practice. **We therefore recommend that the Welsh Government:**

- a** Updates and reissues the all-Wales guidance that was previously developed in 2003; it may be beneficial to convene a working group with representation from different NHS organisations, professional groups and employee representative organisations to oversee this process, and to ensure that the updated guidance reflects good practice that has been successfully adopted in individual NHS bodies in Wales in respect of job planning.
- b** Includes, as part of its revised guidance, job plan template documentation that supports consistency in the way that the components of a consultant's job plan are described, and the way in which desired outputs and outcomes are articulated and measured.

Using the right information to inform job planning

3 For job planning to be meaningful, clinicians and managers need access to local data and information on key factors such as demand for services and current capacity so that job plans can reflect the delivery arrangements that are necessary to achieve organisational aims. Basing job plans on historic levels of activity is no longer sufficient to meet the needs

of a modern and evolving NHS.

We therefore recommend that NHS bodies develop an information 'framework' to support job planning, on a specialty-by-specialty basis. Clinicians and managers will need to work together to identify the components that need to be included in such a framework for each speciality but it would be expected to include: information on activity; cost; performance against local and national targets; quality and safety issues; workforce measures; and plans and initiatives for service modernisation and reconfiguration.

Using job plans to clarify expectations and support service delivery

4 Job planning needs to be much more than a simple agreement of a timetable of activities. The job plan needs to be a prospective agreement that sets out the consultant's duties, responsibilities and outcomes for the year, with a clear link between the consultant's objectives and the organisation's outcomes. Clearly articulating a consultant's objectives and outcomes will help clarify what is expected of them, and what support and resources the consultant needs to deliver them. **We recommend that NHS bodies ensure that they have clear and robust processes in place to discuss and agree objectives and outcomes for consultants as part of the job planning process. It will be important to ensure that clinicians and managers involved in setting these objectives and outcomes receive the appropriate training and support to undertake effective job planning with consultants.**

5 When agreeing job plan contents and expected outputs and outcomes, specific attention needs to be given to SPAs. Collectively SPAs represent a significant investment of time and resource and it is

important that there are clear and tangible benefits for the organisation, the consultant and the patient resulting from SPA activity. Local audit work has shown that there has been too much focus on the number of SPAs rather than what is achieved from them. **We therefore recommend that:**

- a NHS bodies ensure their job planning process includes a clear and informed discussion on the SPA needs of individual consultants, recognising that these will not be the same at different stages in a consultant's career. The job planning discussion should specify the SPA activities to be included in the job plan, and identify the outputs and outcomes that should be achieved, and the location where these activities will be carried out.**
 - b The Welsh Government issues clear guidance to NHS bodies reinforcing the importance of SPA activities and the need for the number and type of SPA activities to vary from consultant to consultant to reflect the needs of individual clinicians and those of the NHS organisation they work in.**
- 6** A key aim of the consultant contract was to improve the working environment for consultants and to facilitate improved working arrangements to deliver better services for patients. As clinicians frequently work in teams there are a number of advantages to adopting a team-based approach to job planning such as helping to clarify the roles of individuals within teams and ensuring that there is an even and fair distribution of work. Despite these potential benefits, local audit work showed that team-based job planning was not frequently employed. **It is therefore recommended that NHS bodies should look to adopt a team-based approach to**

job planning where it can be shown that this would be beneficial. Consultants would need to be persuaded to participate rather than coerced, based on a clear explanation of the benefits associated with a team-based approach, and should still retain the right to agree an individual job plan with their employing organisation.

Developing a clearer focus on benefit realisation

- 7** The lack of a clear and sustainable framework for monitoring implementation of consultant contract in Wales has made it difficult to comment comprehensively on benefit realisation. The annual reporting mechanism that operated between 2005 and 2009 did provide a means to track progress with securing the intended benefits but there has been nothing similar since. In addition, the decision to terminate the outcome indicator project means that there are no specific indicators which can be used to gauge whether intended benefits are being realised. More fundamentally, specific benefits associated with performance and productivity were not stated aims of the amended contract. With the above as context, it is recommended that the Welsh Government develops a fresh approach to assessing the ongoing benefits that are being realised by the amended contract. **This approach should include:**
- a undertaking a formal evaluation of the consultant outcomes indicators project to fully understand the reasons why it failed, and also to identify where there were positive aspects of the project that could be built upon;**
 - b using the lessons learnt from the outcome indicators project to inform fresh work that identifies specific and measurable outcomes that will help assess whether the intended benefits are being realised;**



- c** where relevant, establishing all-Wales groups to identify the core data sets that form the information frameworks for each specialty, and to identify where data can be sourced centrally from NHS Wales informatics systems to complement locally available data; and
 - d** identifying fair and meaningful measures of consultant productivity that can inform debate on benefits realisation and enable a clearer assessment to be made of the value for money that is being achieved from the pay modernisation that resulted from the amended consultant contract.
- 8** Locally, individual NHS bodies need to have a strategic approach to benefits realisation and **we recommend that there is a more explicit demonstration of how consultant job planning is being used to support the delivery of service improvement and modernisation, and the achievement of organisational priorities and performance target.**

Part 1 - An amended contract was introduced for NHS consultants in Wales in 2003, with a number of intended benefits

1.1 This section outlines the key elements of the amendments to the consultant contract in Wales, and contrasts them to those introduced in other parts of the UK. Changes to consultants' pay structures and their working week are considered, along with the intended benefits that the amended contract sought to deliver.

Different consultant contract arrangements have been implemented across the UK

1.2 The first consultant contract was introduced in 1948 and essentially remained unchanged until new contract negotiations started in 2000. These negotiations were the result of an increasing recognition by NHS managers and consultants alike that the old contract no longer reflected working patterns and the needs of the modern NHS.

1.3 Originally, the contract negotiations involved the four UK health departments, employers' representatives from the NHS Confederation, and the BMA. These negotiations produced a first set of proposals that were published in February 2001, and were immediately rejected by doctors, leading to a second framework agreement in 2002. Although, the second set of proposals was accepted by consultants in Scotland and Northern Ireland, they were rejected in England and Wales preventing any national agreement from being introduced.

1.4 In Wales, following this rejection, the Welsh Government negotiated an amendment to the existing contract with the BMA which was accepted by the profession following an overwhelming 'yes' vote in a ballot of consultants.

1.5 The amended contract in Wales is based upon a full time working week of 37.5 hours, equivalent to 10 sessions of three to four hours each. A consultant's working week comprises of a mixture of DCC sessions, such as clinics and ward rounds, and SPA sessions, such as research, clinical audit and teaching. The amended contract identified that the working week would 'typically' comprise seven DCC sessions and three SPA sessions.

1.6 The amended contract in Wales became effective on 1 December 2003. Because it was an amendment to the existing contract it was binding on all consultants in Wales. This is different to the contracts agreed in the rest of the UK, where the new terms and conditions only applied to new consultants appointed after the separate agreement dates.

1.7 Shortly after the amended contract was introduced in Wales, new consultant contract arrangements were also introduced in England, Northern Ireland and Scotland. This has resulted in some differences in terms and conditions covering the hours worked and how consultants were remunerated across the UK countries. The different contract arrangements are summarised in [Exhibit 1](#).



Exhibit 1 - Contract differences between Wales and the rest of the UK

Wales	England	Scotland	Northern Ireland
Implemented 1 December 2003	Introduced October 2003 and implemented April 2004	Implemented April 2004	Implemented April 2004
Binding on all consultants	The new contract is available to all consultants but they were not obliged to transfer to it	The new contract is available to all consultants but they were not obliged to transfer to it	The new contract is available to all consultants but they were not obliged to transfer to it
Typically 7 DCC 3.0 SPA split	Typically 7.5 DCC 2.5 SPA split	Typically 7.5 DCC 2.5 SPA split	Typically 7.5 DCC 2.5 SPA split
Based on a 37.5-hour working week	Based on a 40-hour working week	Based on a 40-hour working week	Based on a 40-hour working week
Core hours not defined	Core hours 7am to 7pm	Core hours 8am to 8pm	Core hours not defined
Introduced a new Commitment Award and Clinical Excellence Awards Scheme on top of the basic salary	Introduced a new Clinical Excellence Awards Scheme on top of the basic salary. This scheme includes local awards agreed with the employer effectively providing a similar scheme to the Commitment Award.	Retained Distinction Awards which are reviewed every five years.	The Northern Ireland Clinical Excellence Awards Scheme was introduced in 2005 and is broadly similar to the English scheme
Consultants undertaking private practice are not required to offer additional work to the NHS	Consultants undertaking private practice and remaining eligible for pay progression must be prepared to work an additional programmed activity to the NHS	Consultants undertaking private practice and remaining eligible for pay progression must be prepared to work an additional programmed activity to the NHS	Consultants undertaking private practice and remaining eligible for pay progression must be prepared to work an additional programmed activity to the NHS

Source: NHS England, Northern Ireland, Scotland and Wales Consultant Contract guidance

The amended contract in Wales identified a number of specific benefits for both consultants and the NHS more widely

- 1.8** The aims of the amended consultant contract were ‘... to improve the consultant working environment, to improve consultant recruitment and retention, and to facilitate health managers and consultants to work together to provide a better service for patients in Wales. This is an integral part of the modernisation of NHS Wales.’
- 1.9** This was against a background of shared concerns of the service, the Welsh Government, and the BMA that increasingly consultants were unable to make the necessary contribution to service delivery requirements in Wales. Concerns over mounting service pressures, recruitment difficulties, the low level of attention given to the old job plans, and the lack of an effective structured engagement of individual clinicians with their employers about their work commitments, were all felt to be factors that needed to be addressed through the amended contract.
- 1.10** Expectations were that the culture of long working hours for consultants would be addressed, the recruitment of consultants in Wales would be improved, and that consultants would be more effectively engaged in efforts to modernise service delivery and improve patient care.
- 1.11** The amendments to the consultant contract in Wales were designed to create:
- a** a basic full-time working week of 37.5 hours, in line with other NHS staff;
 - b** a better definition of the working week;
 - c** organisational clarity through a revised job planning process;
 - d** a new salary scale with enhancements and additional increments;
 - e** improved arrangements for on-call pay;
 - f** new arrangements for clinical commitment and clinical excellence awards;
 - g** a commitment to improve flexible working; and
 - h** a shared commitment to enhance the quality of service for the benefit of patients.
- 1.12** Underpinning the delivery of these benefits would be the introduction of effective job planning. This mandatory job planning process was designed to ensure the individual consultant and the employer agree on the outcome, content and scheduling of activities that comprise the working week.

The amended contract more clearly defines a consultant's working week

- 1.13** In Wales, the working week for a full-time consultant is divided into 10 sessions with a timetabled value of three to four hours each. The contract states that the working week should ‘typically’ comprise of seven sessions of DCC commitments and three SPA commitments. The contract also states that any variations to this split will need to be agreed by the employer and the consultant at the job planning review.



1.14 Essentially, the DCCs represent the amount of time spent on delivering services. The SPAs cover time spent on the equally important work of service development and improving the quality of services and clinical care, education and developing the consultant's own expertise plus that of junior doctors and the wider team.

1.15 The work undertaken by a consultant can be varied and it was recognised that consultants made a considerable contribution to managing and improving services as well as undertaking roles that benefited the wider NHS. This work would be recognised either as additional responsibilities or as other duties.

1.16 Any time recognising additional responsibility must be included in the job plan whether it is paid separately or forms part of the consultant's main contract and replaces some of the DCC sessions. This is different to recognising the time spent on other duties. Although this time may benefit the NHS, it can impact on local service delivery. To overcome this conflict, including other duty sessions in a job plan must be specifically agreed with the employer. **Exhibit 2** summarises some of the activities which could be included in the final job plan under the various headings.

Exhibit 2 - Typical duties and responsibilities included in sessions

DCC	SPAs	Additional responsibilities	Other duties and activities within the wider NHS
<ul style="list-style-type: none"> Emergency duties (including emergency work carried out during or arising from on-call) Operating sessions including pre and post-operative care Ward rounds Outpatient clinics Clinical diagnostic work Other patient treatment Public health duties Multidisciplinary meetings about direct patient care Administration directly related to patient care (eg, referrals, notes) 	<ul style="list-style-type: none"> Training Continuing professional development Teaching Audit Job planning Appraisal Research Clinical management Local clinical governance activities 	<ul style="list-style-type: none"> Medical directors, clinical directors and lead clinicians Caldicott guardians Clinical audit leads Clinical governance leads Undergraduate and postgraduate deans, clinical tutors, regional education advisor Regular teaching and research commitments over and above the norm, and not otherwise remunerated Professional representational roles 	<ul style="list-style-type: none"> Trade union duties Acting as an external member of an advisory appointments committee Reasonable quantities of work for the royal colleges in the interests of the wider NHS Specified work for the GMC Undertaking inspections for health regulatory bodies

Source: Amendment to the National Consultant Contract in Wales

Although there have been amendments, the pay structure for consultants remains complex

1.17 Under the amended contract, a consultant's total pay is made up of the following elements:

- a** basic pay, based on the number of sessions agreed in the job plan plus any additional sessions as agreed by negotiation;
- b** Commitment Awards;
- c** Clinical Excellence Awards which replace the previous system of discretionary point/distinction award payments;
- d** on-call supplements; and
- e** other fees and allowances.

1.18 **Exhibit 3** sets out more information on each of the elements and details of the remunerations associated with them are shown in **Appendix 2**.



Exhibit 3 - Elements of consultants' NHS pay

Element of pay	Further information
Basic pay	The amended contract introduced a new salary scale putting all consultants on the same six-point incremental pay scale.
Commitment awards	<p>The amended contract ended the discretionary points and distinction awards scheme replacing them with Commitment Awards and cClinical Excellence Awards.</p> <p>Commitment awards are available to all consultants as a form of regular pay progression once they have reached the top of their incremental scale. Payment of the award is subject to a satisfactory job plan review or the absence of an unsatisfactory job plan review.</p> <p>All consultants will be eligible for a Commitment Award once they have completed three years' service after reaching Point 6 on the Consultant Pay Scale, and then at three-yearly intervals after they have received their previous Commitment Award, until they have achieved the eight Commitment Award levels available under the scheme.</p>
Clinical Excellence Awards	<p>A national Clinical Excellence Award Scheme operates for England and Wales. An Advisory Committee on Clinical Excellence Awards makes these awards. Objectives, criteria and eligibility for awards are set nationally. Consultants who have at least one years' experience at consultant level are eligible for Clinical Excellence awards.</p> <p>There are four levels of Clinical Excellence Award (Platinum, Gold, Silver and Bronze) worth an accumulative amount per annum ie, once the first level of Clinical Excellence Award is made, this replaces any Commitment Awards previously made to the consultant and higher Clinical Excellence Awards replace any existing Clinical Excellence Award the consultant is then receiving.</p>
On-call supplements	Unpredictable emergency work is to be handled through on-call arrangements. There are intensity banding payments (paid annually) reflecting the 'disturbance factor' for a consultant having to be available for work when on-call. Actual work done for regular on-call commitments is included within DCCs in the job plan.
Planned additional sessions	Consultants may be requested by their employer to carry out additional sessions from time to time in excess of their contracted sessions. These additional sessions will be voluntary. They may be undertaken during the working week in uncontracted time within an agreed overall annual total. Remuneration for such work will be locally negotiated between the employer and the consultant.
Other fees and allowances	Waiting list initiatives work may be requested by the employer to be carried out in addition to the consultant's contracted sessions. These additional sessions will be voluntary. Such sessions may be undertaken in uncontracted time. Remuneration for such work will be at the rate set out in the terms and conditions of service when carried out on trust premises.

Source: Amendment to the National Consultant Contract in Wales

Part 2 - A significant amount of money has been spent implementing the contract

2.1 This section of the report provides information on the costs associated with implementation of the amended contract in Wales. Trends in consultant pay are considered along with the work that was undertaken to introduce a framework of outcome indicators for consultants.

Initially, £35 million was spent introducing the new contract

2.2 Most provisions of the amended consultant contract in Wales were implemented immediately upon the contract becoming effective on 1 December 2003, including new pay scales and terms and conditions of employment. An important aspect of the implementation of the amended contract was the payment of previously unrecognised consultant sessions over and above those in the standard 10-session week. The Welsh Government had set funds aside for this but had indicated to NHS bodies that they would only be released once assurance could be taken that the job planning processes which had identified those sessions were sufficiently robust.

2.3 The Welsh Government asked the then Audit Commission in Wales to provide an independent assessment on the robustness of job planning arrangements in each NHS trust that existed at the time. Formal audits of job planning arrangements were undertaken between December 2004 and March 2005, after which the Welsh Government were able to confirm funding decisions for additional

sessions to individual NHS trusts. The release of funding to some trusts was held back until assurance could be obtained that they had addressed concerns identified by the external audit.

2.4 The Welsh Government originally set aside £18 million to fund the introduction of the amended contract. Following the first round of job planning and the assurance provided by the Audit Commission in Wales review, the Welsh Government provided an additional £17 million to fund the cost of additional sessions, bringing the total cost of implementing the contract to £35 million.

2.5 The Welsh Government indicated to NHS trusts that it expected them to implement actions to reduce the amount of additional sessions worked by consultants over time, through measures such as clarifying consultants' working patterns through job planning, rebalancing work across consultant teams, recruitment of additional consultants where necessary and transfer of activities to other staff groups where appropriate.

2.6 The Welsh Government continued to centrally fund additional session payments until 2009-10, after which time payment of additional sessions was met by local NHS bodies via their baseline allocations. Year-on-year reductions in additional sessions worked by consultants were achieved between 2005-06 and 2009-10, although in 2010, the figure still stood at 2,145 ([Exhibit 4](#)).



Exhibit 4 - Welsh Government funding for additional consultant sessions

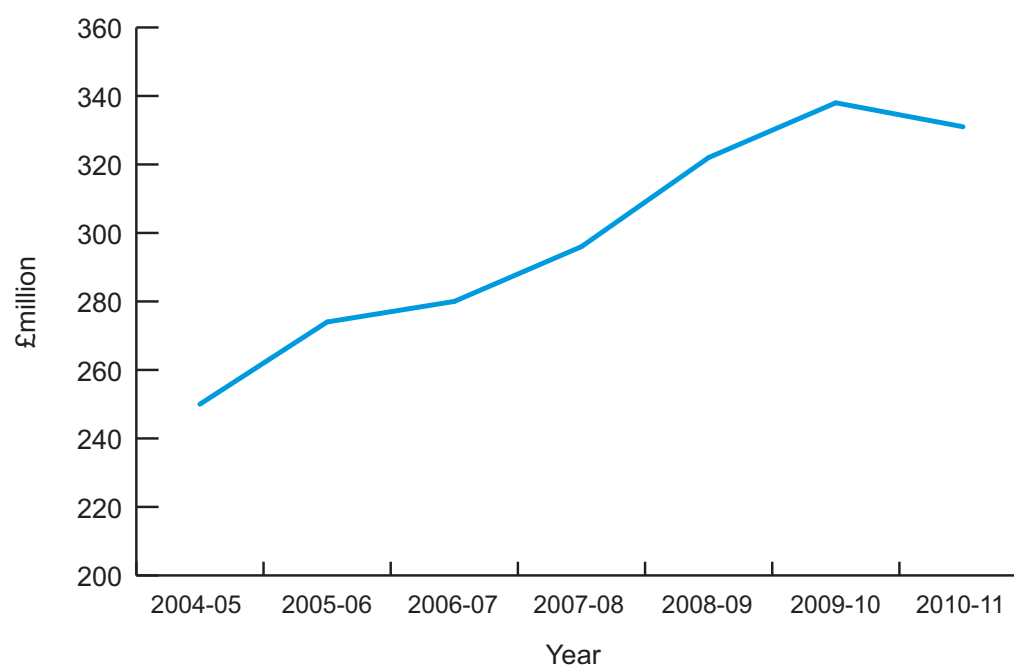
Year	Additional sessions worked across Wales
2006	2,901
2007	2,518
2008	2,268
2009	2,233
2010	2,145

Source: Welsh Government

The overall pay bill for consultants and average consultant pay has increased since the introduction of the amended contract

2.7 Since the introduction of the amended contract, the overall pay bill which includes pay awards for consultants, has increased significantly, rising from £250 million in 2004 to a peak of £338 million in 2009 falling back to £331 million in 2010 ([Exhibit 5](#)). Over the same period, consultants' average earnings increased by 29 per cent.

Exhibit 5 - Annual total pay bill for consultants



Source: Welsh Government

2.8 The increase in the overall consultant pay bill is, in part, simply a product of an increase in the numbers of consultants working in the NHS (see **Part 3** of this report). However, other factors have also contributed (**Exhibit 6**). Under the amended contract arrangements, commitment awards replaced discretionary points and effectively used the same pot of money that had previously been available for the latter. In addition, Clinical Excellence Awards replaced Distinction Awards with the increasing costs for the former being counterbalanced by the reductions in the latter.

Exhibit 6 - Factors contributing to changes in consultant pay

Element of consultant pay	Changes since 2004
Basic pay	Over the six years to 2010, total pay for consultants increased 29.1 per cent. Over the same period there has been an increase in WTE consultants of 30.6 per cent.
Additional session payments	In 2010, health boards and trusts agreed to pay consultants an additional 1,897 sessions above the contracted 10-session week for additional work and commitments. These sessions accounted for around £15.7 million of the total pay budget, based on a midpoint session cost.
Commitment awards	In 2010, 1,136 consultants had received a commitment award accounting for £9.7 million of the total wage bill.
Clinical excellence awards	These awards replaced Distinction Awards. In 2004, the total pay bill for clinical excellence awards was £1.7 million. By 2010, this had increased to £9.0 million spread among 170 consultants.
Distinction awards	In 2004, 159 consultants had a distinction award amounting £7.4 million of the total wage bill; by 2010, because of retirement, this had reduced to 32 costing £1.8 million. This award is closed to new entrants.

Source: Welsh Government



£1.9 million was spent on developing a Consultant Outcome Indicators project that ultimately did not deliver the desired outputs

The Consultant Outcome Indicators project was an innovative initiative that had the potential to significantly enhance job planning and appraisals

- 2.9** In September 2005, a COI project was launched as a jointly sponsored initiative between the then NHS trust chief executives and the Welsh Government. The aim was to develop a suite of outcome indicators for individual consultants which could be used as a tool to inform job planning discussions and appraisal as part of the implementation of the amended consultant contract in Wales.
- 2.10** At its inception the project was seen as an innovative initiative and reflected widespread comments from clinicians and the service that they would welcome a framework for discussing outcomes that was holistic, based on outcomes rather than inputs, specialty-specific, and consistent across Wales.
- 2.11** CHKS, an organisation already providing benchmarking services to NHS Wales, was commissioned to run the COI project, which became known as Compass. Each NHS trust entered into a five-year agreement with CHKS, with funding for the work being provided by the Welsh Government, totalling £1.9 million over the period of the agreement.
- 2.12** The project was launched following the successful completion of pilot exercises undertaken by the former North West Wales and Bro Morgannwg NHS trusts.
- Ongoing concerns about the quality of the indicators led to the project being closed down in 2009 without having achieved its intended aims**
- 2.13** The first full set of outcome indicator reports was sent to consultants in July 2006. Feedback from consultants highlighted a number of concerns with the information that was being generated. Concerns included reports with too many indicators, or with indicators that were out of date or which simply did not provide information which was useful for job planning or appraisal.
- 2.14** It would be unrealistic to have expected the outputs to be perfect first time around, and a programme of engagement was set up. This gave each consultant in Wales an opportunity to contribute to the ongoing development of robust and meaningful indicators within their specialty.
- 2.15** Despite this, the engagement of consultants remained variable, both across and within NHS trusts. In some organisations levels of engagement, as judged by the completion of the online returns, was high at over 80 per cent. However, in other organisations, this response rate had dropped to less than 20 per cent by 2008-09.
- 2.16** There were also significant variations in engagement with the project across different specialties reflecting ongoing difficulties identifying meaningful indicators in specific clinical areas such as anaesthetics, mental health, radiology and pathology.
- 2.17** Several consultants interviewed as part of local audit work indicated that they had lost confidence in the quality of the information that was being presented to them, stating that it did not properly reflect their work. There were also anecdotal examples of consultants being

given outcome indicators on clinical activities they did not perform. Responses to a survey conducted as part of our local audit work are particularly telling – on average, 77 per cent of respondents indicated that they had used the outcome indicators but only nine per cent had any confidence in the accuracy of the information.

- 2.18** At the end of 2009, following a request from the then NHS trust medical directors, the Welsh Government agreed that it would not fund a two-year extension to the initiative and that the all-Wales project would come to an end in December 2009.

A number of factors contributed to the failure of the project to deliver its aims

- 2.19** It is of concern that large sums of money were invested in a project that ultimately did not achieve its overall aims, and which as a result, did not provide value for money.
- 2.20** A fundamental problem was that the data being used as the basis of the indicators came from the PAS. This data was never intended to be used for clinical outcomes at individual clinician level, and for many specialties, CHKS was unable to turn this data into indicators that clinicians could recognise as useful or meaningful.
- 2.21** A steering group had been convened to oversee the implementation of the project. Although the group considered the increasing number of problems and tried to resolve them, it then became increasingly clear that the NHS Wales information system limitations were beyond the power of the steering group to resolve. It would seem reasonable to expect that it should have considered closing the project much earlier once the extent of the problems with the indicators became clear.
- 2.22** The fact that it did not is surprising, particularly since the project has been running for several years. However, this is partly explained by the fact that in some specialties it was felt that good progress was being made with the development of the indicators, and given more time, further improvements would have been made. Indeed, the chair of the steering group had written to the then Medical Director of NHS Wales, setting out the reasons why the project should be extended.
- 2.23** Ultimately the decision not to continue with the project was a pragmatic one, given that a significant amount of additional time and resource would have been needed to address the concerns which were emerging. The issue of whether to ask the supplier for a partial refund or to continue to work to deliver the commissioned outputs without any additional funding does not appear to have been considered by the steering group or the Welsh Government.
- 2.24** The end result is that a standard set of acceptable outcome measures for all specialties to support job planning has not been produced. One outcome is that the project promoted a greater awareness of outcomes and the strengths and limitations of existing information systems. However, there is still a need for such an output, and it is important that learning from the Compass project is not lost, but is instead used as a basis for fresh work to generate this important information.



Part 3 - Whilst there have been some notable changes, not all the intended benefits of the amended consultant contract have been realised

- 3.1** As indicated in **Part 1** of this report, the amended contract was introduced with the intention of securing a number of specific benefits, chiefly that:
- a** consultants' working environment would be improved, most notably by more clearly defining the working week, and addressing the culture of long working hours;
 - b** recruitment and retention of consultants would be improved; and
 - c** consultants would be better engaged with health service managers in efforts to modernise health services and deliver improvements to patient care.
- 3.2** This section of the report describes the progress that has been made in securing these intended benefits.

The working week has reduced overall but some consultants are still working long hours

On average, a consultant's working week has reduced by just over four hours since the start of the contract

- 3.3** In 2004, analysis of job plans by the Audit Commission in Wales showed that consultants were working an average 46-hour working week containing 9.3 DCC sessions and 2.2 SPA sessions. By 2010, the working week had reduced to an average of 42 hours with 8.3 DCC sessions and 2.6 SPA sessions, with total average weekly sessions reducing from 12.4 to 11.2 (**Exhibit 7**).

Exhibit 7 - Changes in consultant weekly working patterns between 2004 and 2010

Year	Average weekly sessions				Total DCC sessions	Total SPA sessions
	DCC	SPA	Additional and other	Total		
2004	9.30	2.20	2.20	12.40	15,223	3,601
2010	8.34	2.60	2.70	11.21	18,383	5,731
Difference	-0.96	0.40	0.50	-1.19	3,160	2,129

Source: Welsh Government Consultant Contract Database

3.4 The reduction in the working week is mostly due to consultants undertaking less work as DCC activity, mainly because work has been redistributed within the clinical team combined with more consultants being employed. In overall terms, however, the total number of DCC sessions available to the NHS has increased by 3,160 per week. Similarly, the overall number of SPA sessions has increased by 2,129 per week.

3.5 In Wales, the amended contract's original intention was for all consultants to have a 37.5 working week. This was later relaxed and the expectation is that consultants should not work more than 12 sessions. Currently, only a third of consultants in Wales have 10-session contracts. This reflects the fact that many consultants are willing to work additional sessions to increase activity, take on management responsibilities or to help the development of their own clinical practice. This flexible arrangement directly benefits both the NHS and the individual consultant.

Some consultants are still working excessively long hours

3.6 Whilst working additional sessions can be of benefit to both consultants and the NHS, it is generally accepted that to avoid excessive workloads, consultants' weekly sessions should not exceed 12.

3.7 A detailed analysis of reported job plans undertaken as part of our local audit work found that around one in six consultants are working 12.5 sessions (46.5 hours) or more with the vast majority in this group working in excess of the 48-hour EWTD limit. The proportion of consultants working in excess of 12 sessions a week varies significantly across NHS bodies in Wales ([Exhibit 8](#)).

3.8 Working excessive hours is not confined to full-time consultants and the audit identified 23 consultants on part-time contracts working 10 sessions or more, making them full-time posts in reality.

3.9 The audit found that in some circumstances, additional sessions were the result of a consultant taking on management responsibilities over and above their clinical commitments, whilst in others, the consultant was a single-handed practitioner with a high workload. However, in general terms, none of the health boards or trusts had undertaken any detailed work to understand why some consultants had excessive workloads, or whether these sessions were needed in the first place. Without such review, NHS bodies may be failing to identify risks associated with excessive clinical workloads, or missing opportunities to secure better value for money by challenging whether some additional sessions are necessary.

3.10 Only Cardiff and Vale University Health Board had any formal arrangements in place to review job plans that exceeded 12 sessions and this arrangement was relatively new at the time of audit. Whilst in Velindre NHS Trust, job plan reviews were being prioritised such that that they started with those consultants with the highest number of sessions.

3.11 Across Wales, consultants are providing an additional 334 sessions above the 12 session threshold. If these additional sessions had to be undertaken by employing new consultants based on seven DCCs, an additional 47 consultants would be needed. This raises concerns about the long-term sustainability of this arrangement and the impact on service delivery and the quality of care if this position is not actively managed.



Exhibit 8 - Consultants working more than 12 sessions in 2010

Health board/ NHS trust	12.5- 12.9	13.0- 13.4	13.5- 13.9	14.0- 14.9	15.0- 15.9	16.0- 16.9	≥17.0	Total	Percentage
Abertawe Bro Morgannwg UHB	27	24	7	5	1	1	0	65	13.8%
Aneurin Bevan HB	12	24	1	3	10	0	0	50	14.5%
Betsi Cadwaladr UHB	15	42	14	12	1	0	0	84	20.1%
Cardiff and Vale UHB	14	34	12	16	7	2	1	86	16.1%
Cwm Taf HB	7	2	5	2	0	0	0	16	7.2%
Hywel Dda HB	4	18	0	2	0	0	0	24	11.2%
Public Health Wales NHS Trust	0	1	0	0	0	0	0	1	1.3%
Powys THB	0	1	0	0	0	0	0	1	25.0%
Velindre NHS Trust	0	3	0	2	1	1	0	7	20.0%
Wales	79	149	39	42	20	4	1	334	14.4%

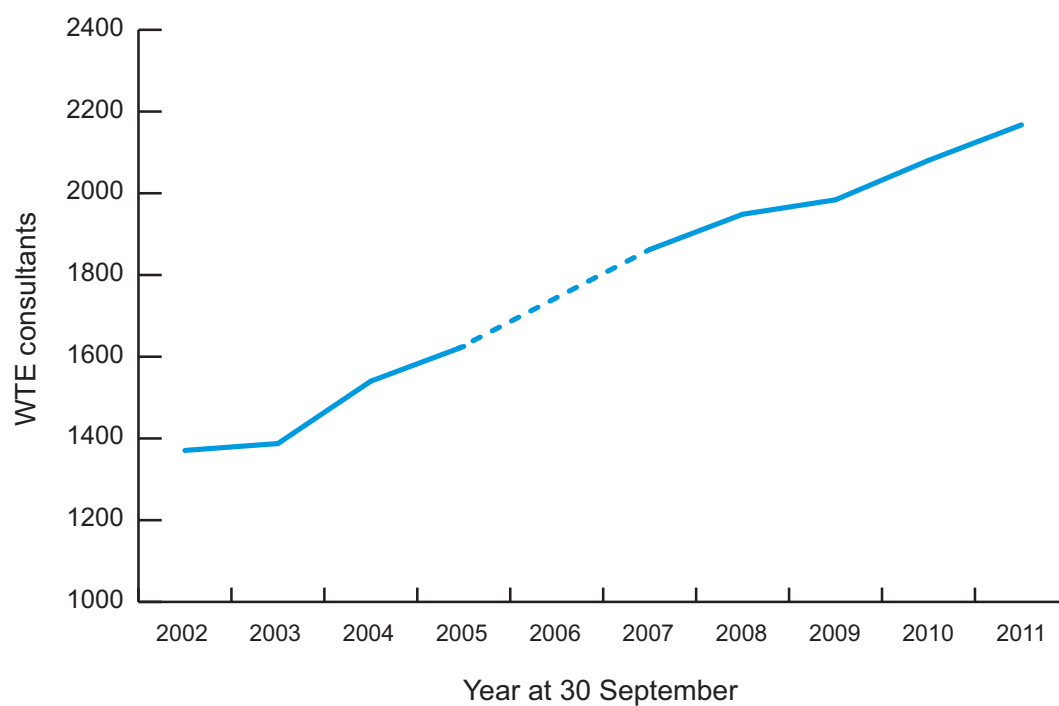
Source: Welsh Government Consultant Contract Database, 2009-10

Recruitment and retention of consultants has improved and the level of vacancies has substantially reduced

- 3.12** There has been a steady year-on-year increase in the number of consultants working in Wales since the amended contract was implemented, and a related drop in the number of vacant posts.
- 3.13** Annual workforce information provided to the Welsh Government by NHS bodies shows that there has been a 37 per cent increase in the number of WTE NHS consultants between 2004 and 2011 ([Exhibit 9](#)). However, these workforce returns represent an underestimate of the actual numbers of consultants working in the NHS in Wales as they only measure consultants with a permanent contract. This means that consultants on fixed term, locum or honorary contracts are excluded. Up until 2010, the Welsh Government kept a separate database recording the job plan of all consultants in Wales. In 2010, this showed that there were 2,316 consultants working in Wales, compared to the 2,179 posts recorded as part of the annual workforce return for that year.
- 3.14** The increase in the numbers of consultants working in the NHS in Wales since the implementation of the amended contract has been accompanied by a reduction in the number of consultant posts which are vacant. On average across Wales, the percentage of consultant posts which are vacant has decreased from 8.4 per cent in 2004 to 0.4 cent in 2010 although long-term consultant vacancies had increased to 2.1 per cent by March 2011 ([Exhibit 10](#)).
- 3.15** Before the contract was amended, Wales was experiencing significant difficulties recruiting consultants with long-term vacancies peaking at 170 at 31 March 2002. In overall terms, at the time of our audit, none of the health boards or trusts reported difficulties in recruiting consultants to vacancies or new posts, other than to specialties that were proving more difficult to recruit due to national shortages, such as in emergency medicine, mental health, and paediatrics.
- 3.16** In overall terms, Wales has experienced improved consultant recruitment and retention and whilst it is difficult to measure the direct impact of the consultant contract on this issue, the marked improvement in recruitment and retention since its introduction strongly suggests it has been a significant contributory factor.



Exhibit 9 - Increase in numbers of consultants (WTEs)



Note

Data missing for 2006 hence dotted line

Source: Welsh Government Stats Wales

Exhibit 10 - Total number of WTE consultant posts vacant for three months or more

Year at 30 September	2004	2005	2006	2007	2008	2009	2010	2011
Total number of consultant vacancies	145	112	61.3	57	29.8	25.0	11	45.1
% posts vacant	8.4	6.2	3.2	2.8	1.3	1.0	0.4	2.1

Note

Data for 2011 is for 31 March as the Welsh Government ceased collecting this data.

Source: Welsh Government Stats Wales

The amended contract has not been a significant factor in driving service modernisation and better working relationships between consultants and NHS managers

- 3.17** One of the key aims behind the introduction of the amended contract was to facilitate better engagement between consultants and NHS managers in the modernisation and improvement of NHS services. However, our local audit work has indicated that the amended contract and its associated job planning activities have had only limited success in securing these benefits.
- 3.18** NHS trusts between 2006 and 2009 provided annual reports to the Welsh Government on progress and outcomes with the implementation of the amended contract. These reports did identify examples of service

modernisation that were attributed to the amended contract arrangements ([Exhibit 11](#)). Local audit work also found examples of where services had been modernised and although it was difficult to attribute change directly to the impact of the new contract, managers and clinicians said it was certainly a contributory factor. [Case Study 1](#) provides an example from local audit work of the impact of different ways of working and modernising services.

- 3.19** Broadly speaking, however, the amended contract has not been the significant driver for service modernisation as was originally anticipated. Less than half the consultants who completed our survey felt that the amended contract and job planning had provided opportunities to discuss service modernisations and improvements to clinical practice, and even fewer felt it had improved patient care or changed the way they worked for the better ([Exhibit 12](#)).

Exhibit 11 - The number of NHS trusts reporting specific modernisation examples

Development	2006	2007	2008	2009
Extended role nurse	1	3	1	1
Other professions extended role	3	2	2	1
Consultants involved in service reconfiguration design	4	8	7	7
Increased capacity	1	7	5	6
Additional consultant posts created	1	4	2	3
Improved patient management	4	7	8	7
Reducing locum usage	1		1	

Source: Welsh Government consultant contract annual reports



Case Study 1 - Five-week job plan at Abertawe Bro Morgannwg University Health Board

The cardiologists in secondary care at the health board's district general hospitals have followed a structured process for their job planning review meetings for the last three years. Before the merger, the cardiologists in the Princess of Wales Hospital decided what service they wanted to deliver and how many DCC sessions they had available across the whole team. They agreed that they would all work to a five-week job plan which consisted of each of the cardiologists working one week of ward rounds, one week of clinics, one week of angiography, etc. They also have time planned for their own specialisms. The advantages are that it provides continuity of care on the wards through daily ward rounds resulting in reduced lengths of stay for patients and improved job satisfaction for the consultants. The five-week job plan has been rolled out to other hospitals in the health board.

Source: Interview at the Abertawe Bro Morgannwg University Health Board

3.20 Local audit work identified variations in the extent to which clinicians and managers had worked together to provide better services. Whilst there were plenty of examples of this happening across Wales, there were also examples of where consultants had found it difficult to engage with managers in developing new services or ways of working.

3.21 Of some concern is the finding that only 55 per cent of consultants who responded to our survey reported that they had a positive working relationship with managers and that less than one in five consultants thought that since the introduction of the contract the relationship had improved. In overall terms, our audit work found the relationship between consultants and managers to be very variable within and between organisations.

Exhibit 12 - Consultants' views on the extent to which the new contract has supported service modernisation

Statement	Percentage of consultants who answered yes, or either agreed or strongly agreed
Job plan review has provided an opportunity to discuss modernising services and introducing new ways of working	47%
Job plan review has provided a stimulus to discuss steps that could be taken to improve clinical practice	46%
The consultant contract and job planning improved patient care	28%
The consultant contract and job planning changed the way I work for the better	20%

Source: Wales Audit Office survey of NHS consultants

Whilst the Welsh Government had an identified approach to assess benefits realisation, it was not sufficiently challenging

- 3.22** Wales was the only part of the UK to seek independent commentary on the robustness of the initial round of job planning at NHS bodies that was part of the implementation of the amended contract. The work undertaken by the Audit Commission in Wales provided the Welsh Government with the necessary assurances that the bids for additional session payments were based upon sound job planning processes.
- 3.23** Following the completion of the work of the Audit Commission in Wales in March 2005, the Welsh Government introduced a requirement that each NHS body would prepare an annual report that set out the progress being made with implementation of the amended contract.
- 3.24** The annual reporting mechanism was a key part of the Welsh Government's approach to assessing whether the benefits of the amended contract were being realised. ~Annual reporting started in 2006 and continued until 2009, although in 2010, health boards were required to update the Welsh Government's database of consultant sessions. This database summarises the number of sessions each consultant has in their job plan. Guidance produced by the Welsh Government set out the requirement for the annual reports to be discussed by the health body's senior executive team, signed off by the chief executive and reported to the board before being submitted to the Welsh Government's Pay Modernisation Unit (PMU).
- 3.25** The reports identified an improving position and indicated that job planning was becoming increasingly embedded in NHS organisations. These annual reports were largely self-reported developments and the Welsh Government accepted these on face value as they were meant to be signed off by the chief executives and agreed with the LNC representing the consultant body. Our local audit work found that this was not always the case.
- 3.26** Within the reporting arrangements the Welsh Government used the year-on-year changes to individual job plans recorded in the all-Wales database as a proxy to assess the quality of job planning locally. Regular and significant changes to the number of DCCs and SPAs were seen to be indicative of a meaningful job planning process, whilst the absence of any changes suggested that local processes were less effective. Whilst the proxy arrangements measured change, they did not identify the quality of the job planning process and any associated outcomes. Our local audit work has subsequently shown that the descriptions of progress made in annual reports at times was overly optimistic and did not fully identify issues around the frequency and quality of job planning.



The NHS has not developed any productivity measures that allow the trends in consultant activity to be accurately measured

3.27 The implementation of the amended contract was not associated with any explicit intention that consultant 'productivity' would be improved as a result. Nonetheless this is something that bears consideration when looking at the wider benefits that could or should be accrued for the additional expenditure that has been invested as a result of the new contract arrangements.

3.28 In global terms the new contract has resulted in job plans which show an increase in clinical activity, as measured by DCCs, across Wales as a whole. As shown earlier the total number of DCC sessions per week has increased by 3,160 between 2004 and 2010. If an average session is taken as 3.5 hours that equates to an additional 11,060 hours of consultant-led clinical activity a week.

3.29 However, this assumes that the content of job plans accurately reflects what consultants actually do, and we know from our local audit work that this is not always the case. In Wales, there is very little data available to directly measure the work consultants undertake, and hence it is difficult to evidence the impact of the new contract arrangements on activity.

3.30 Proxy measures of consultant activity which can be used are Finished Consultant Episodes (FCEs)¹, and the number of new outpatient attendances. There have been increases in both these measures between 2004 and 2010 mirroring the overall increase in DCC sessions recorded in job plans ([Exhibit 13](#)).

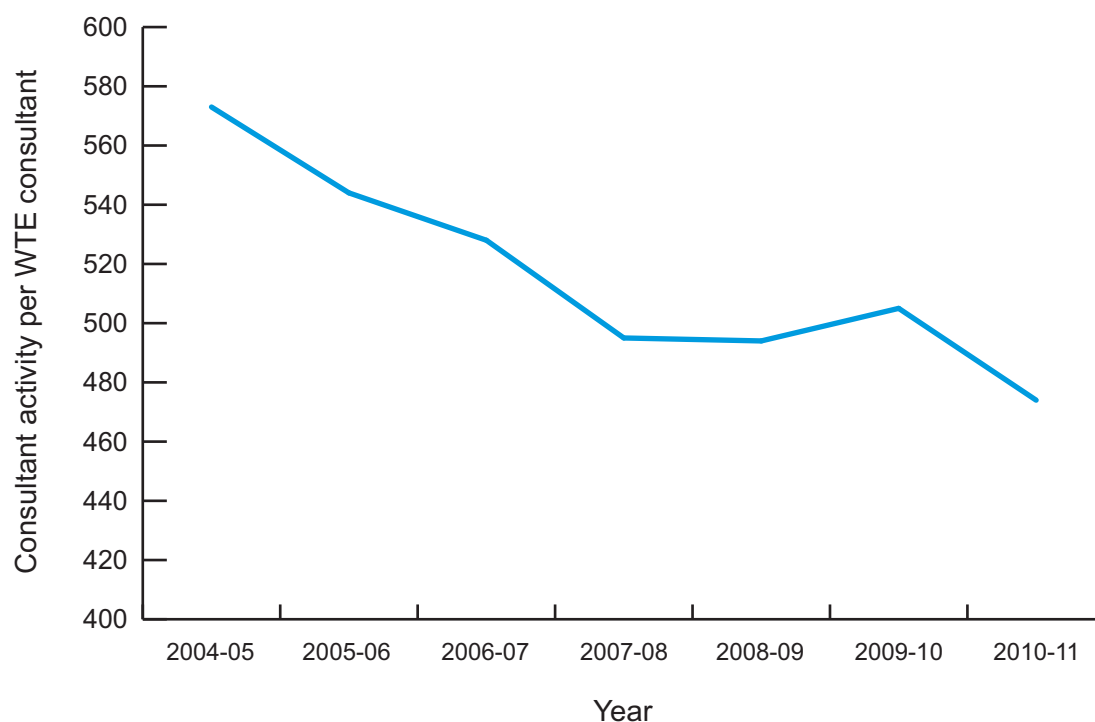
3.31 Whilst there have been global increases in activity, the average numbers of DCCs a consultant undertakes each week has reduced since 2004, as has the average number of FCEs ([Exhibit 14](#)). This is to be expected given the stated aims of the amended contract in relation to reducing excessive hours of work for consultants and improving recruitment.

Exhibit 13 - Trends in FCEs and new outpatient attendances

Activity indicator	2004	2010	% change
FCEs	896,000	1,023,000	+12%
New outpatient attendances	67,500	77,800	+14%

Source: NHS Wales Informatics Service

¹ A period of admitted care under a consultant.

Exhibit 14 - Change in the average number of FCEs 2004 to 2011

Source: NHS Wales Informatics Service

3.32 Current measures of activity are too crude to properly inform debate and do not reflect productivity. For example, FCEs reflect the number of patients admitted to hospital for care but they do not include all activity such as anaesthetic intervention or the work of diagnostic specialties. In addition, when a patient attends for a new outpatient appointment, they may not always see a consultant.

3.33 The Office for National Statistics produces an annual measure of UK NHS productivity which does not disaggregate Wales from England. This data shows that NHS productivity fell by an average of 0.2 per cent a year since 2000,

and by an average of 1.4 per cent a year in hospitals. However, the data is not universally accepted, and has been criticised for not taking into account important considerations such as increased time doctors spend with patients, and reductions in mortality rates and waiting times.

3.34 Thus there is little consensus about what constitutes a meaningful measure of productivity, and in the absence of accepted measures of outcomes, it is difficult to make an assessment about the value for money that has been achieved from the additional investment in the amended consultant contract.



3.35 What is generally accepted is that new ways of working are going to be necessary to improve efficiency and sustainability of current services. Given that so much NHS money is tied up in staff costs, workforce contracts need to be used to best effect. For the consultant contract this will not happen unless job planning is effectively embedded within NHS organisations, and properly linked to consultants' appraisals. The progress that has been made with this is considered in **Part 4** of this report.

Part 4 - In most health boards and trusts, implementation of the amended contract has not been underpinned by effective job planning arrangements

4.1 This section of the report considers the extent to which the implementation of the amended contract in Wales is being underpinned by effective job planning. The key aims of job planning are considered, and findings are presented on:

- a** how guidance and training are being used to support effective job planning;
- b** the way in which job planning is being conducted;
- c** what outputs are being generated from job planning discussions; and
- d** how job planning is linked to consultants' appraisals.

Successful implementation of the amended contract was predicated on a more vigorous approach to job planning

4.2 Job planning arrangements for consultants were first introduced in 1991 and were just a timetable of commitments which rarely reflected actual working patterns and responsibilities. It was recognised that for the amended contract in Wales to be implemented as intended, it would need to be underpinned by a more vigorous approach to job planning which was mandatory for all consultants.

4.3 Effective job planning was therefore at the centre of much of the guidance that was produced to support the implementation of the amended contract in Wales. The key aims and objectives of the revised approach to job planning in Wales are summarised in **Exhibit 15**.

4.4 The new job planning process began in earnest in NHS bodies in Wales between autumn 2004 and early 2005. This followed the issue of detailed guidance on job planning, developed jointly by the BMA, Welsh Government and the service, and an extensive programme of training in each NHS organisation, supported by the Welsh Government's PMU. Each NHS body established a local implementation team with a dedicated project manager to oversee the introduction of the new job planning processes. The importance of job planning in the context of securing payment for additional consultant sessions meant that there was a strong organisational focus on job planning within NHS bodies when the amended contract was initially implemented.

4.5 Collectively the arrangements described above, together with the formal reviews of job planning by the Audit Commission in Wales, provided NHS bodies with a sound platform and framework from which to develop and embed robust job planning arrangements. However, our local audit work indicated that over time the focus on job planning within NHS bodies in Wales has gradually diminished such that it has not been embedded into normal management activity in the way that



Exhibit 15 - Aims and objectives of job planning

Definition	A consultant job plan should be a prospective agreement that sets out a consultant's duties, responsibilities and expected outcomes for the coming year. In most cases, it will build upon the consultant's existing NHS commitments.
Overall aims	<p>Effective job planning should be based on a partnership approach enabling consultants and employers to:</p> <ul style="list-style-type: none"> • better prioritise work and reduce excessive consultant workload; • agree how a consultant or consultant team can most effectively support the wider objectives of the service and meet the needs of patients; • agree how the NHS employer can best support a consultant in delivering these responsibilities; • provide the consultant with evidence for appraisal and revalidation; and • comply with working time regulations.
Content of job plans	<p>Consultant job plans should:</p> <ul style="list-style-type: none"> • set out agreed expected personal outcomes and their relationship with the employing organisation's wider service objectives; • set out how the employer will support consultants in delivering agreed commitments eg, through providing facilities, training, development and other forms of support; • include a work schedule that covers all professional work, including teaching, research, management or other service responsibilities and clinical governance activities, and takes into account discussion on any non-NHS commitments that could affect this; • set out agreed arrangements for the location(s) at which consultants carry out their duties and responsibilities, including identifying work that can be carried out flexibly; • set out agreed arrangements for carrying out Category 2 work (eg, work for government departments and other NHS organisations) and other similar work, based on the underlying principles that such work should not disrupt NHS duties and that there should be no 'double payment'; • be reviewed annually; and • be undertaken on a team basis, where this is likely to be more effective.

Source: Joint BMA and Welsh Government Job Planning Guide, December 2003

the amended contract intended. This has been exacerbated by reorganisations within the NHS in Wales, which have disrupted continuity and resulted in new NHS bodies inheriting a range of different approaches to job planning from predecessor organisations.

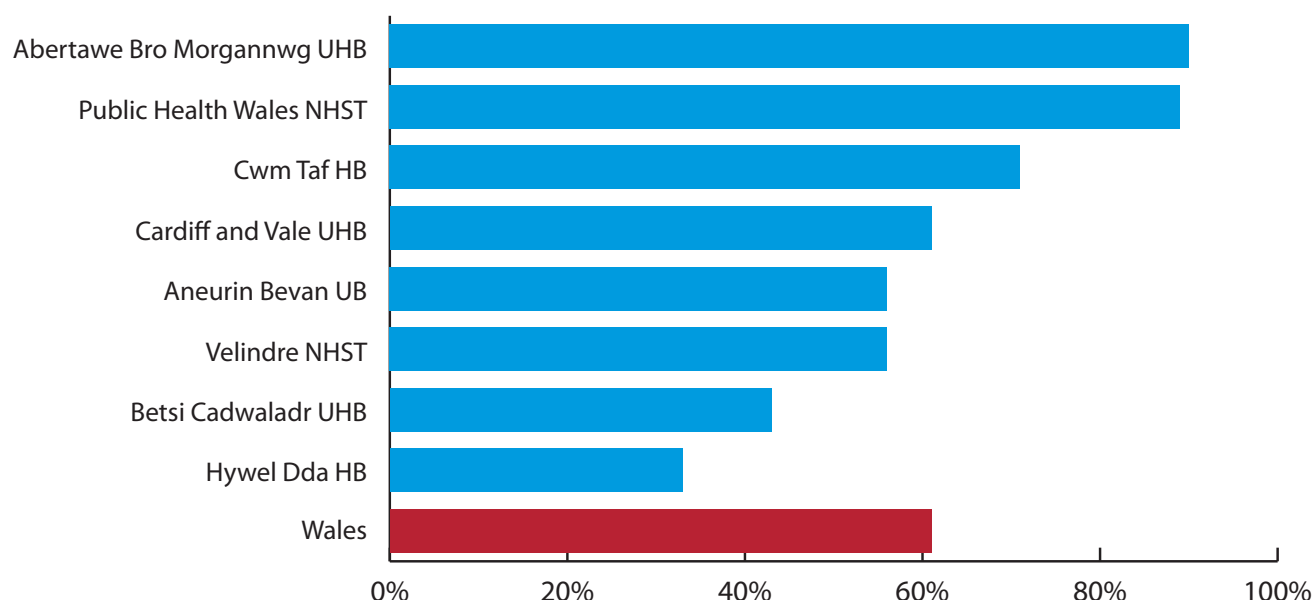
There is scope to increase the frequency of job plan reviews for many consultants

- 4.6** Guidance issued to support implementation of the amended contract made it clear that job planning should be undertaken annually. This should allow consultants and their employers to ensure that job plans take account of changing patterns of service delivery, evolving organisational and personal objectives, and advances in technology and medical practice.
- 4.7** In reality, the local audits found that many consultants do not have an annual review. On average across Wales only 61 per cent of consultants reported that their job plan was reviewed annually. Within this figure there

were significant variations across individual NHS bodies, with almost all consultants receiving an annual job plan review in Abertawe Bro Morgannwg University Health Board compared to a much smaller proportion in Hywel Dda Health Board and Betsi Cadwaladr University Health Board ([Exhibit 16](#)).

- 4.8** Responses to our survey also revealed that a number of consultants had never had a job plan review (ranging from two per cent of consultants in Abertawe Bro Morgannwg University Health Board to 14 per cent in Cardiff and Vale University Health Board).

Exhibit 16 - Proportion of consultants who said that their job plan was reviewed annually



Source: Wales Audit Office survey of consultants



The extent to which job planning is supported by local guidance and training has varied significantly

4.9 In 2004, most NHS trusts developed local guidance to supplement that produced by the Welsh Government and other bodies such as the BMA. This local guidance helped ensure that job planning was applied consistently within individual organisations. Over time, however, different approaches have been adopted within organisations, often on an informal basis. With NHS trust mergers and the subsequent NHS reorganisation to create new health boards, existing NHS bodies in Wales inherited a range of approaches to job planning from their predecessor bodies which created anomalies within specialties (this is considered further later in this section).

4.10 The extent to which updated local guidance has been introduced varies across NHS bodies. In some NHS bodies this was done soon after the 2009 NHS reorganisation, whilst in others it has only been a relatively recent development, and was still being worked on at the time of the local audits.

4.11 An equally variable approach was observed in relation to the provision of training for staff taking part in job plan reviews. In 2004, the implementation of the amended contract was accompanied by comprehensive training on job planning in NHS trusts. However, because the same cadre of staff in these organisations were undertaking job reviews each year, the need for ongoing training tailed off. Successive NHS reorganisations and the recruitment of additional consultants and new clinical directors has meant that training has once again become important, particularly to ensure that staff are aware of revised local guidance where this has been introduced.

4.12 Local audits found the extent to which training had been provided both for consultants in general, and for those tasked with reviewing the job plans of others, varied between and within the organisations. The position at each NHS body in Wales at the time of audit in relation to the production of local guidance and training is summarised in [Exhibit 17](#).

The approach to job plan review meetings can vary considerably within and between health bodies

4.13 For job plan review meetings to be effective, a number of factors need to come into play:

- a** there needs to be adequate preparation time ahead of the job plan meeting;
- b** consultants and reviewers need access to appropriate information on activity and outcomes to support the discussion;
- c** sufficient time needs to be allowed to conduct the review meeting and an appropriate location chosen; and
- d** the right people need to be involved in the meeting, particularly when consultants have more than one employer.

Whilst the practical arrangements for job planning meetings were typically sound, discussions were often hampered by a lack of appropriate management information

4.14 The local audits found that for the majority of consultants, the practical arrangements associated with their job planning meetings were appropriate. Of those consultants who responded to our survey:

- a** 88 per cent indicated that they had sufficient time to prepare for the meeting;

- b** 94 per cent felt that the meeting took place in an appropriate location, free from interruption;
- c** 79 per cent felt that the time allocated for the meeting was about right; and
- d** 85 per cent indicated that the meeting was conducted in a constructive and positive tone.

4.15 Less positively, our audits found that job planning for many consultants is hampered by a lack of information to inform the discussion at the review meetings. The failure of the COI project, as described in **Part 2**, has meant that meaningful data on outcomes is still missing for the majority of consultants. More generally, our review found very little evidence of information being used effectively

to support job planning. This finding was confirmed by the survey which found only around half (53 per cent) of the consultants had access to information from local clinical or management information systems to support job planning discussions. Few consultants (three per cent) relied solely on the health board/trust's information with most taking their own (52 per cent) or using the health board/trust's information plus their own (28 per cent). The remainder (11 per cent) took a range of different sources of information while seven per cent took no information at all to the meeting.

4.16 However, the audit did find that some NHS bodies have been successful in developing approaches to generate information to support job planning (**Box 1**).

Exhibit 17 - Development of guidance and training for job planning

Organisation	Position in 2011
Abertawe Bro Morgannwg UHB	New guidance developed and in place for 2010-11. This guidance was supported by access to training for consultants new to the process.
Aneurin Bevan HB	Updated guidance in place supported by a training programme which was scheduled to be rolled out during 2012.
Betsi Cadwaladr UHB	No health board wide guidance in place. Job planning approaches based on three distinct approaches inherited from the predecessor NHS trusts.
Cardiff and Vale UHB	New guidance developed and issued in 2010 supported by comprehensive training and ongoing communication.
Cwm Taf HB	New system set up in 2009-10 with detailed guidance for clinical directors and managers but was not issued to all consultants. Training provided to senior staff.
Hywel Dda HB	New guidance developed and being introduced supported by training for reviewers.
Public Health Wales NHST	No formal guidance or training in place as in most areas the same reviewers have been providing annual reviews since 2004.
Velindre NHST	New medical director introduced revised job planning procedures in 2010 although they provided no guidance or training for consultants.

Source: Wales Audit Office



Box 1 - Examples of information being used to support job planning

Abertawe Bro Morgannwg University Health Board had developed its own clinical data system, Hypercube, which can be used to support job planning. Hypercube is available to consultants and clinical directors on the health board's information portal and was developed with input from consultants. The system allows performance against key indicators of quality and efficiency to be monitored. Consultants also have access to CHKS Signpost data which allows benchmark comparisons to be made against other similar hospitals.

In **Velindre NHS Trust**, job planning in the Cancer Centre is informed by activity and patient outcome data. Most of the consultants interviewed said that they could access the data and that it was robust. While it was rather basic, they all agreed that it was a useful starting point for discussing activity.

Source: Wales Audit Office

- 4.17** In general terms, the audit identified a very patchy approach to the generation of information to support job planning. More needs to be done to promote consistency within and between NHS bodies. Without access to the appropriate information, job planning discussions will inevitably focus more on timetabling of activities, rather than on the outcomes that need to be achieved from these activities.

General managers are not always involved in job plan discussions

- 4.18** A wide range of staff can be involved in job planning discussions. As a minimum, the consultant will need to meet with an appropriate clinical manager (medical director, clinical director or other lead clinician). However, to ensure that job planning becomes an integral part of business and service delivery planning, appropriate input is also needed from directorate or general managers. This is particularly important when considering the resource implications of consultant activities and links between corporate and directorate objectives.

- 4.19** Moreover, the absence of general management input to job planning discussions would appear contrary to one of the key aims of the amended contract in Wales which is to foster closer working between consultants and NHS managers.

- 4.20** Our audit work highlighted a variable approach to the involvement of general managers in job planning meetings. In four health boards (Abertawe Bro Morgannwg University Health Board, Cardiff and Vale University Health Board, Cwm Taf Health Board and Hywel Dda Health Board), general managers were always involved. In Aneurin Bevan Health Board, managers were rarely involved in job planning while in Public Health Wales NHS Trust they were never involved. In Velindre NHS Trust, non-clinical managers only attended if there were specific issues that required discussion.

- 4.21** Whilst there will be resource implications associated with both clinical and general managers attending job plan meetings, the benefits should outweigh the costs and go a long way towards achieving some of the key underpinning aims of the amended contract.

Job planning problems can arise when consultants have more than one employer

- 4.22** Some consultants are clinical academics who provide services jointly for the university and the NHS. Because of the complexity of working and dual nature of the working week, it is important that both the university and NHS employer are present at the job planning meeting to ensure that a single overall job plan is mutually agreed and that all parties are aware of the consultant's full range of commitments. There should be equal importance attached to NHS and university work, with clear delineations as to when a consultant is working for which employer.

4.23 Two health boards in Wales (Cardiff and Vale University Health Board and Abertawe Bro Morgannwg University Health Board) have a significant number of academic consultants although the audit found that university involvement in job planning was not widespread. For example, our survey found that of the 21 per cent of consultants who had an academic contract in Cardiff and Vale University Health Board, in only 35 per cent of cases had a representative from the university been involved in agreeing job plans. However, most consultants reported that university involvement was much better in the appraisal process.

4.24 The absence of university involvement has created some challenges in fully recognising the working week for these consultants. To overcome this, one health board – Cardiff and Vale University Health Board – recently agreed a joint job planning process with the Cardiff University partnership board.

4.25 Some consultants work for more than one NHS employer, and in these cases, it is important that the two organisations work together particularly when making changes to the consultant's responsibilities. This problem has been particularly acute for the Public Health Wales NHS Trust as it has a large number of consultants who work both for the Trust and for a local health board. There have been examples of job planning for public health consultants within a health board taking place without consideration of the consultant's commitments in the Public Health Wales NHS Trust. The inevitable clashes in commitments which occurred then required remedial action to resolve.

Team job planning has not been used extensively within directorates

4.26 Guidance issued to NHS bodies to support implementation of the amended contract highlighted that job planning should be undertaken on a team basis where this was likely to be more effective. Team job planning offers a number of potential benefits such as the ability to ensure that there is an appropriate and equitable allocation of activities to individuals to best achieve the overall goals of the team, whilst also maintaining individuals' professional development requirements.

4.27 Local audits identified a number of specialties within health bodies that were using team-based planning:

- a** Abertawe Bro Morgannwg University Health Board: Cardiology, Pathology and Learning Disabilities
- b** Aneurin Bevan Health Board: Neurology and Radiology
- c** Betsi Cadwaladr University Health Board: Anaesthetics in Central and Obstetrics and Gynaecology in West
- d** Cardiff and Vale University Health Board: Histopathology
- e** Cwm Taf Health Board: Accident and Emergency

4.28 However, across Wales as a whole, our survey found that only 17 per cent of consultants who responded were involved in any team-based job planning. This may be explained by the fact that job planning has traditionally been seen as process whereby a consultant reaches an individual agreement with his or her employer. It may also reflect the fact team job planning may take longer and be more difficult to set up than individual



job planning. However, as new NHS service models develop, it is likely that a greater focus on team job planning is going to be needed.

The contents of job plans can vary significantly and very few contain identifiable and measurable outcomes

There are inconsistencies in the way different types of sessions are defined and recorded in job plans

4.29 Job plans typically record consultant activities under four main categories: DCCs; SPAs; management sessions; and 'other'. Guidance to support implementation of the amended

contract contained definitions of the sort of activities which should comprise each of the categories (see [Appendix 3](#)). However, despite this guidance our review of job plans found that NHS bodies are not being consistent in the way they classify consultant activities. The most notable differences were in the way in which management and 'other' sessions were used ([Exhibit 18](#)).

4.30 The local audits noted some key differences in the way each of the different types of sessions are defined:

- a** DCC: Some directorates had applied their own definitions. This was often more of a problem for diagnostics, mental health and public health specialties where DCC is less well defined.

Exhibit 18 - Consultant sessions 2009-10

Health board/trust	DCC	SPA	Other	Management	Total
Abertawe Bro Morgannwg UHB	8.49	2.41	0.26	0.04	11.19
Aneurin Bevan HB	8.20	2.83	0.01	0.22	11.25
Betsi Cadwaladr Central and East UHB	8.48	2.72	0.08	0.16	11.44
Betsi Cadwaladr West UHB	8.65	2.28	0.37	0.09	11.38
Cardiff and Vale UHB	8.23	2.84	0.15	0.13	11.34
Cwm Taf HB	8.26	2.32	0.15	0.14	10.87
Hywel Dda HB	8.49	2.37	0.01	0.00	10.89
Public Health Wales NHST	7.65	2.86	0.03	0.00	10.55
Powys THB	7.87	1.67	1.26	0.36	11.16
Velindre NHST	7.84	2.85	0.00	1.15	11.84
Wales average	8.34	2.60	0.14	0.13	11.21

Source: Welsh Government database of sessions

- b** SPA: Management and 'other' activities were often included along with more recognisable SPA activity.
- c** Management time: Velindre NHS Trust made the most explicit use of management sessions in job plans, whilst other health bodies had incorrectly included some management time within DCC sessions rather than in the SPA or additional responsibility sessions.
- d** Other sessions: These were often poorly defined and their use was variable across NHS bodies.

Some health bodies have inherited different working patterns which, in some instances, have resulted in substantial variation in the job plan for similar workloads

- 4.31** As a result of the 2008 mergers, many of the new trusts inherited different working patterns, which have been carried through to the new health boards and trusts from October 2009. In some instances, this amounted to a full session difference. **Exhibit 19** sets out the job plans of the former trusts at the point of merger in 2008.
- 4.32** Whilst most health boards had recognised the problem, only Abertawe Bro Morgannwg University Health Board had made any significant progress in managing the issue. This was being done through more use of team-based reviews.
- 4.33** Where there are wide variations in the number of sessions in job plans, consultants with fewer sessions told us they were aware of the discrepancies and felt they were not being treated fairly.

There has been too much focus on the number of SPAs without looking at the quality and outcome of this investment

- 4.34** SPAs form an important element of a consultant's working week, and NHS bodies need to ensure an appropriate amount of SPA sessions are included in consultant job plans. The number and content of these sessions will need to change at different times throughout a consultant's career with the number and nature needing to be agreed each year in the annual job plan review. This position was reiterated in February 2011 when the Chief Medical Officer wrote to health board and trust medical directors confirming job plans 'should include reasonable SPA time for the consultant to be able to undertake their agreed and evidenced SPA activity, recognising that what these were will vary from person to person and, potentially, year to year'.
- 4.35** When the amended contract was introduced in Wales it indicated that full-time consultants should 'typically' have three SPA sessions per week. This had the effect of creating an expectation in some quarters that three weekly SPAs would be the norm, regardless of the professional needs of the clinician, or the business needs of the organisation.
- 4.36** This debate has moved on, and in reality very few consultants have three SPAs per week. However, the legacy of this is that much of the debate within NHS bodies has centred around the number of SPA sessions rather than looking more holistically at what type of SPAs are needed and how the value of them can be demonstrated.
- 4.37** Only two health boards had arrangements in place requiring consultants to evidence their SPA time and to monitor outcomes (Abertawe Bro Morgannwg University Health Board and Aneurin Bevan Health Board).



Exhibit 19 - Job plan differences in constituent trusts in 2008 prior to mergers

Trusts	DCC	SPA	Other	Management	Total
Abertawe Bro Morgannwg East	9.00	2.35	0.10	0.07	11.52
Abertawe Bro Morgannwg West	8.41	2.44	0.40	0.04	11.29
Betsi Cadwaladr Central	8.84	2.77	0.08	0.02	11.71
Betsi Cadwaladr East	8.19	2.61	0.14	0.23	11.16
Betsi Cadwaladr West	8.90	2.20	0.32	0.06	11.48
Cardiff and Vale*	8.55	2.83	0.24	0.14	11.76
Cwm Taf North	8.89	2.47	0.02	0.14	11.51
Cwm Taf South	7.74	2.33	0.25	0.23	10.54
Gwent Healthcare*	8.22	2.66	0.34	0.26	11.47
Hywel Dda Carmarthenshire	8.93	2.16	0.05	0.00	11.15
Hywel Dda Ceredigion	9.43	2.12	0.03	0.33	11.91
Hywel Dda Pembrokeshire and Derwen	7.90	2.50	0.03	0.28	10.71
Powys*	7.83	2.00	1.14	0.19	11.16
Velindre**	7.10	4.33	0.71	0.15	12.29
Wales average	8.45	2.61	0.25	0.14	11.46

* No change since 2008

** Later split into Public Health Wales NHS Trust and Velindre NHS Trust

Source: Welsh Government Consultant Contract Database

A further two had recently put new guidance in place to address the issue (Cardiff and Vale University Health Board and Cwm Taf Health Board). The remainder either had no guidance (Public Health Wales NHS Trust and Velindre NHS Trust) or were about to start developing guidance (Hywel Dda Health Board and Betsi Cadwaladr University Health Board).

4.38 Similarly, at the time of the audit, only two health boards (Aneurin Bevan Health Board and Cardiff and Vale University Health Board) had started working with consultants to try and link some SPA activity more explicitly to service objectives.

4.39 The amended contract allows for SPA sessions to be delivered off-site where appropriate for important activities such as preparing presentations and writing research reports. Recognising some of the practical implications of the amended contract arrangements and that not everything is done in the workplace, Welsh Government implementation guidance² suggested up to one SPA session per week could be agreed to be undertaken at home or away from the normal place of work. Our examination of job plans found that very few identified the location where any SPA would be delivered making this difficult to monitor.

4.40 Our survey and interviews found that many consultants felt that their clinical and additional commitments often meant that time for their SPA sessions was squeezed. Only 55 per cent of consultants responding to our survey thought there was an appropriate balance between their DCC and SPA sessions.

4.41 In overall terms, our local audits found that there is considerable scope to improve the management of SPA sessions through better job planning to ensure both the consultant and the NHS are realising the full benefit from this investment.

Very few job plans contain measurable outcomes

4.42 The joint guidance on job planning produced by the BMA and Welsh Government identified the need for job plans to set out agreed expected personal outcomes and their relationship with the employing organisation's wider service objectives. The nature of a consultant's expected personal outcomes will depend in part on his or her specialty, but they may include outcomes relating to:

- a** Activity and safe practice
- b** Clinical outcomes
- c** Clinical standards
- d** Local service requirements
- e** Management of resources, including efficient use of NHS resources
- f** Quality of care

4.43 However, our review of job plans found that in most cases there was no record of any expected outcomes. This finding was largely backed up by our survey of consultants in which just 34 per cent of respondents said they had agreed a set of outcome indicators as part of their job plan. The importance of including outcomes in job plans does appear to be recognised, and auditors found examples of local guidance that highlighted this, yet application of the guidance was inconsistent. Whilst there is much scope for improvement in this aspect of job planning across Wales as a whole, the audit did identify some examples of good and developing practice (**Box 2**).

² Implementation Procedure (dj/26.01.04) Welsh Government NHS Pay Modernisation Unit



Box 2 - Inclusion of outcome measures in job plans

In **Cwm Taf Health Board**, three-quarters of the job plans reviewed contained a range of objectives. Many of these referred to service improvements, for example, setting up new services or new ways of delivering existing services. Others referred to taking on new roles or delivering specific targets.

In **Hywel Dda Health Board** the outcomes section of job plans of pathologists and haematologists based in the former Carmarthenshire NHS Trust area had been well completed with appropriate SMART objectives to improve ways of working.

Cardiff and Vale University Health Board was seeking to improve its use of outcomes by developing a template which provides a basis to assess delivery. All consultants have to have outcome measures agreed for the year ahead reflecting the UHB performance targets and utilisation of SPA time, as well as the consultant's Personal Development Plan (PDP). A suggested format is provided as a template in the job planning guidance with sections on: hours in week; outcome measure; actions to achieve outcome measure; success criteria/measures; agreed review process and timetable; and support required.

Exhibit 20 - Problems with job planning documentation

- no NHS body used a single job plan template and the quality of templates within organisations varied considerably;
- many job plans lacked clarity and transparency about duties and responsibilities;
- many were incomplete and did not specify the review date or the period they covered;
- most job plans had not been formally signed off;
- some identified activity but not the hours;
- documentary evidence of the discussions was often missing; and
- few were centrally reviewed and there was a lack of corporate intelligence about the content and desired outcome.

Source: Wales Audit Office

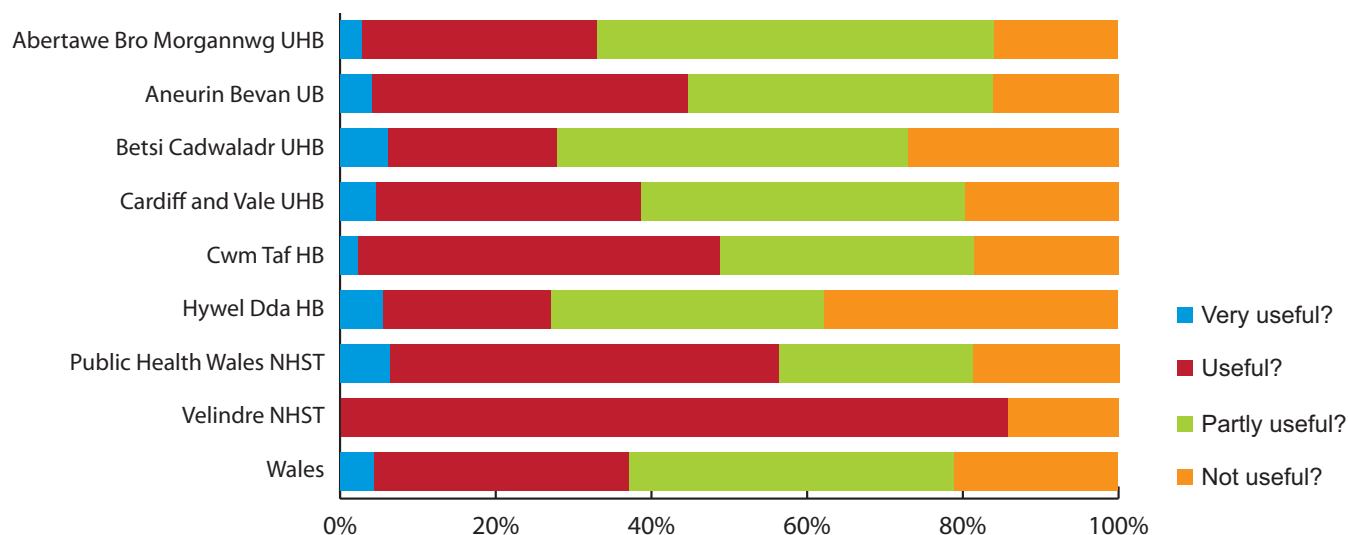
The quality of job planning documentation was typically poor

- 4.44** It is important that NHS organisations develop appropriate documentation and record keeping arrangements in relation to consultant job plans. This will help ensure that there is clarity over duties, responsibilities and desired outcomes, and that there is a record of what was agreed and when. In addition, the use of job plan templates can help ensure consistency in the way job planning is undertaken within and across organisations.
- 4.45** As part of our local work, auditors reviewed the quality of job planning documentation across NHS bodies in Wales. In most instances, the quality of documentation was found to be poor. For most job plans that were viewed there was no evidence to indicate that they had been formally signed off, and in some cases, job plans had been lost altogether as a result of reorganisation of NHS services. **Exhibit 20** highlights the specific problems with job planning documentation identified during the audit.

Consultants' views on job planning are mixed

- 4.46** The responses from our survey on NHS consultants highlighted some very mixed views of the usefulness of job planning. In overall terms, 37 per cent of respondents said that they found job planning to be useful or very useful. However, the picture varied across NHS bodies and the figure was typically lower in those NHS bodies where job planning was less frequent (**Exhibit 21**).
- 4.47** The majority of respondents (65 per cent) indicated that job planning had clarified the commitments expected of them. However, the fact that a sizeable minority did not agree with this statement is a worry given that this is the prime aim of job planning.

Exhibit 21 - Consultants' views on usefulness of job planning



Source: Wales Audit Office

4.48 NHS organisations are responsible for ensuring that consultants have the necessary support to deliver the commitments set out in their job plan. Job planning and job plan reviews should be used to identify what sort of support is needed in terms of facilities, training and development, and other resources. Job planning should also be used to identify any potential barriers to the achievement of job plan commitments.

4.49 Responses to the consultant survey indicated that job planning is still not fully effective in these areas. Whilst 62 per cent of respondents felt that job planning allowed pressures and constraints to be considered and agree actions to address them, only 20 per cent felt that it identified resources and support needed to deliver their job plan.

Appraisal and job planning are not always linked

4.50 With the first phase of revalidation³ due to start in Wales in April 2013, it is important that health boards are clear that appraisal and job planning are separate but linked processes. Recent guidance from the Wales Deanery states that the doctor should bring the most recent job plan to appraisal so that the appraiser can develop an understanding of the doctor's clinical practice and help identify any learning needs related to the service objectives or planned activities. These should be documented in the PDP and subsequent appraisals should be used to demonstrate how these have been addressed.

³ Revalidation will be the GMC's method of regulating licensed doctors that will give extra confidence to patients that their doctors are up to date and fit to practise. Licensed doctors will have to revalidate, usually every five years, by having regular appraisals that are based on GMC core guidance for doctors, Good Medical Practice.



- 4.51** Much of the information required to support the two processes will be duplicated and the common elements between the two are the personal objectives of the consultant. The objectives which are considered during the job planning review will be derived from the corporate/directorate priorities of the organisation and from the consultant's PDP. **Exhibit 22** provides further information on the purposes of job planning and appraisal.
- 4.52** Whilst appraisals and job planning need to be linked, how this happens in practice can be determined by individual NHS bodies and should be linked to the business and planning cycles in directorates and the wider organisation. They can be distinct processes that occur at different times and with different personnel, or they can be carried out at the same time by the same person. Whichever approach is adopted there must be logical and clear links between the two processes.
- 4.53** Our audits found that there was no standard approach to appraisal. While some consultants had undertaken appraisals annually, others said that they only had an appraisal when they asked for one or had never had an appraisal. In some areas, we found that appraisal had a higher priority than job planning.
- 4.54** The audits also found that the links between the job plan review meeting and appraisal varied, with some areas running the meetings back to back while others kept them separate. Interestingly, many consultants were not clear on how job planning and appraisal were linked and only just over half (55 per cent) of the respondents to our consultant survey felt that their job plan review helped in delivering the PDP agreed at their appraisal.

Exhibit 22 - Job planning and appraisal

Purpose of job planning	Purpose of appraisal
<p>Job planning is a systematic activity designed to produce clarity of expectation for employer and employee about the use of time and resources to meet individual and service objectives.</p> <p>It is prospective in nature.</p>	<p>Appraisal is a systematic approach to review a consultant's achievements and to consider their continuing progress and to identify developmental needs.</p> <p>For NHS consultants, it is also a prime form of evidence required for licensing and revalidation purposes.</p> <p>It is a retrospective review of professional activities with a prospective element and the development of a PDP. The resources required to deliver this will need to be discussed at the job planning meeting.</p>

Source: *Effective Job Planning, NHS Modernisation Agency, 2005*

Appendix 1 - Study methodology

The audits were delivered locally at all health boards and trusts that employ significant numbers of consultants. Auditors selected a sample of specialities within each health board/trust and interviewed medical directors, clinical directors, general managers and staff from HR, Finance and Data Management who were involved in job planning. We also interviewed a sample of consultants selected by the health board/trust and the LNC.

The audit reviewed documents provided by the health boards/trusts such as:

- information and guidance provided to consultants and managers in undertaking the most recent round of job planning reviews;
- reports sent to the board on consultant contract issues and job planning over the last year;
- outcome monitoring reports for the job planning process; and
- any internal audit reviews related to the consultant contract.

We sent a web-based questionnaire to all consultants at health boards and trusts participating in the audit in Wales in September 2010. A total of 580 responses were received with an average response rate of 25 per cent.

We reviewed a sample of five job plans from each directorate that was audited. The job plans were reviewed against a number of criteria to understand what evidence was provided by the consultant and to establish how the sessions had been calculated. We also looked to see if the job plan had been signed by the consultant.

Benchmarking tool – Each year following the introduction of the contract, health boards and trusts provide the Welsh Government's PMU with data relating to each consultant's commitments split between DCC, SPAs, management responsibilities and other responsibilities agreed with the organisation. This information was collated by the Wales Audit Office and we built a database to analyse this data for the years 2007-08, 2008-09 and 2009-10. Auditors could review the Welsh comparison and specialty analysis within the organisation.

All the local reports were issued between January and May 2011. They have progressed through their health board/trust audit committees and were published on the Wales Audit Office website in September 2011. In addition to these reports, during 2012, in some NHS bodies follow-up audits have been undertaken to assess the progress being made with local issues.



Appendix 2 - Elements of NHS consultants' pay

Six-point incremental pay scale 2010-11						
0	1	2	3	4	5	6
£72,205	£74,504	£78,350	£82,818	£87,918	£90,827	£93,742

Source: Review Body on Doctors' and Dentists' Remuneration. Thirty-Ninth Report 2010.

Commitment awards scale and number of awards held by consultants 2010-11							
1	2	3	4	5	6	7	8
£3,204	£6,408	£9,612	£12,816	£16,020	£19,224	£22,428	£25,632
469	220	127	103	72	60	32	53

Source: Review Body on Doctors' and Dentists' Remuneration. Thirty-Ninth Report 2010.

Clinical excellence awards and number of awards held by consultants 2010-11			
Level 9 (Bronze)	Level 10 (Silver)	Level 11 (Gold)	Level 12 (Platinum)
£35,484	£46,644	£58,305	£75,796
114	38	10	8

Source: Review Body on Doctors' and Dentists' Remuneration. Thirty-Ninth Report 2010.

Distinction awards and number of awards held by consultants 2010-11		
B award	A award	A+ award
£31,959	£55,924	£75,889
17	13	1

Source: Review Body on Doctors' and Dentists' Remuneration. Thirty-Ninth Report 2010.

Intensity supplements for consultants (paid annually)		
Band 1 (low intensity)	Band 2 (medium intensity)	Band 3 (high intensity)
£2,213	£4,426	£6,637

Source: Review Body on Doctors' and Dentists' Remuneration. *Thirty-Ninth Report 2010*.

Waiting list initiative

Paid at a standard rate of £565 per session.



Appendix 3 - Typical duties and responsibilities included in sessions

Direct clinical care	Supporting professional activities	Additional responsibilities	Other duties and activities within the wider NHS
<ul style="list-style-type: none"> Emergency duties (including emergency work carried out during or arising from on-call) Operating sessions including pre and post-operative care Ward rounds Outpatient clinics Clinical diagnostic work Other patient treatment Public health duties Multidisciplinary meetings about direct patient care Administration directly related to patient care (eg, referrals, notes) 	<ul style="list-style-type: none"> Training Continuing professional development Teaching Audit Job planning Appraisal Research Clinical management Local clinical governance activities 	<ul style="list-style-type: none"> Medical directors, clinical directors and lead clinicians Caldicott guardians Clinical audit leads Clinical governance leads Undergraduate and postgraduate deans, clinical tutors, regional education advisor Regular teaching and research commitments over and above the norm, and not otherwise remunerated Professional representational roles 	<ul style="list-style-type: none"> Trade union duties Acting as an external member of an advisory appointments committee Reasonable quantities of work for the royal colleges in the interests of the wider NHS Specified work for the GMC Undertaking inspections for health regulatory bodies

Source: Amendment to the National Consultant Contract in Wales