



National Audit Office

Pay Modernisation: A New Contract for NHS Consultants in England

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Pay Modernisation: A New Contract for NHS Consultants in England

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SUMMARY

1 Consultants are highly trained, senior doctors who determine the majority of the care delivered in hospitals. In September 2005, approximately 32,000 consultants worked for the NHS in England, primarily within NHS acute and mental health hospitals¹. Pay for hospital consultants accounted for £3.8 billion of expenditure in the NHS in England in 2005-06.

2 The need for better planning of consultants' work was highlighted in 1991 when the Department of Health (the Department) introduced a requirement for hospitals to use job plans, setting out the details of consultants' working arrangements with their hospital. However, in 1995 and 1996 the Audit Commission highlighted concerns about a perceived lack of commitment of many consultants to the NHS, and the general failure

in most NHS trusts to plan the work of their consultants effectively, including a lack of adherence in some trusts to the use of job plans (Appendix 1).

3 In 1997 the British Medical Association (BMA), the doctors' professional association, wrote to the Government highlighting the need for a new contract². In response, the Government acknowledged that the contract for consultants had not kept pace with medical advances or with changes in the NHS and announced its intention to increase consultants' participation and productivity in the NHS by negotiating the first major revision of the consultant contract since the establishment of the NHS in 1948³. In 2000 a survey by the NHS Confederation, who represent NHS organisations, showed that employers wanted more control over their consultants' working week⁴.

4 In the NHS Plan (2000), the Department outlined the vision of a health service designed around the patient with more and better paid staff using new ways of working. The Plan acknowledged that modernising NHS pay was central to achieving the NHS reform agenda. One key aspect of this pay modernisation was the need for an updated consultant contract to reward consultants more appropriately for their NHS work whilst improving the way they are managed⁵.

5 The contract was negotiated nationally between representatives of the UK Health Departments, the NHS Confederation, and the BMA. Implementation of the nationally agreed terms and conditions was the responsibility of individual employers. The Government's aim was to introduce a stronger unambiguous contractual framework with greater management control, in return for a career structure and pay system rewarding those consultants who made a long term commitment to the NHS and the biggest contribution to service delivery and improving health services⁶. In 2002, during the initial negotiations, the then Secretary of State for Health, Alan Milburn MP, announced:

*"It is a something for something deal, where consultants earn more, but only if they do more for NHS patients. And it will be for NHS employers to make sure that is what the contract delivers"*⁷.

6 The Department set out its aims of the consultant contract in the business case sent to HM Treasury in 2002⁸. The contract was expected to benefit consultants, through better pay and recognition of their NHS work; employers, through greater control and increased productivity; and patients, through more flexible and responsive services. These benefits were predicated on the introduction of a new rigorous job planning process. Mandatory job planning would provide a prospective agreement, setting out a consultant's duties, responsibilities and objectives for the coming year based on three or four hour blocks of activities known as programmed activities.

7 In 2002, consultants in Scotland and Northern Ireland voted to accept a new contract proposal but consultants in England and Wales rejected it. Over the next 12 months the Department agreed a number of changes to the new contract in return for increased commitment to direct clinical care and, by the end of October 2003, six out of every ten consultants in England had voted in favour of the new contract. Individual NHS employers were then responsible for implementing the contract by the end of March 2004.



8 Given the importance of pay modernisation to the NHS reform agenda we examined the development and implementation of the new contract to determine its costs and realisable benefits. The main methodology for the study included a survey of all acute and mental health trusts and a survey of a random sample of 6,000 consultants, to which we received 2,361 responses (39 per cent); visits to a sample of trusts; a literature review; and consultation with key stakeholders (Appendix 2). Relevant aspects of the implementation in Scotland and Wales are summarised in Appendix 3 and referred to, where appropriate, at specific points in the main report. **Figure 1 overleaf** compares the key facts and figures in England before the introduction of the new contract with the outcome in 2005-06.

Key findings

9 By 2000, there was a general consensus between NHS employers, consultants and the Government on the need for a new consultant contract. However, the terms of the new contract presented some difficulties for the parties to resolve and negotiations did not reach a conclusion until October 2003. Although the contract was optional, the Department expected trusts to implement the contract for as many consultants as possible by April 2004. To incentivise consultants to switch to the new contract, the Department authorised trusts to provide a sliding scale of backdated pay.

1 Key facts about the use of consultants in the NHS

Key facts about the use of consultants in the NHS in England (pre-contract agreement in October 2003)



- In 2000, there were 24,400 consultants (headcount) within the NHS; by October 2003 this had increased by 4,350 to 28,750.
- The Department's NHS Plan (2000) predicted an increase of 7,500 consultants in four years.
- The cost of consultants had increased from £2.0 billion in 2000-01 to £2.4 billion in 2002-03.
- Average pay of consultants had increased from £78,292 in 2000-01 to £86,746 by 2002-03.
- There was limited information on how many consultants had job plans, or the extent of their commitment to NHS work.
- There was a wide variation in consultants' workloads, which was not recognised in terms of pay.
- The Department believed the new contract would cost an additional £565 million over three years.
- Trusts estimated that approximately 50 per cent of their consultants had job plans.
- Three-quarters of trusts agree that the old contract was not fit for purpose, and 43 per cent of consultants were unhappy with the old contract. (Source: National Audit Office surveys of consultants and all trusts).

Source: National Audit Office

10 In 1998 MORI carried out a survey for the Doctors' and Dentists' Review Body, based on consultants' self-reported diaries, to identify the consultant workload⁹. This suggested that consultants were working on average between 50 and 52 hours a week, depending on managerial responsibility. The Department modelled the new contract based on a diary exercise from 2000 which suggested consultants were working 47 hours. Given that one of the aims of the contract was to decrease consultants' workload, the Department made assumptions on the number of hours of work and emergency responsibilities of consultants needed under the new contract. As part of the negotiation, the Department and the BMA agreed that funding of the new contract would be based on consultants working an average of 43 hours a week. However, the Department did not test with sufficient rigour its assumptions with NHS trusts. Consultants' workloads under the new contract were higher than anticipated in the modelling.

11 In 2003 the Department estimated that the new contract would cost them an additional £565 million over the first three years (2003-04 to 2005-06). On 20 October 2004 in response to suggestions from trusts that the contract was costing more than anticipated, the Department announced an uplift to the tariff for 2005-06 of £150 million. However, subsequent analysis of trust data returns from 29 October 2004 led the Department to conclude that the estimated extra cost of the contract was £90 million although the full uplift in tariff remained.

12 Whilst the Department had published a number of documents on the reasons for and aims of the new contract since the publication of the NHS Plan in 2000 (Appendix 5); many trusts felt that the Departmental guidance was issued too late or lacked clarity^a. Trusts also believed that the implementation timetable was rushed and the process resource intensive. In most trusts, the responsibility for implementing the new contract was delegated to clinical managers and directors, with finance managers' involvement lagging behind.

^a In our survey of all NHS trusts, 32 and 58 per cent disagreed or strongly disagreed that the guidance from the Department was useful and timely, respectively.

Keys facts about the use of consultants in England in 2005-06

- In September 2005, there were 31,990 consultants within the NHS in England – an increase of 3,250 since March 2003 and 7,600 since the NHS Plan (published in 2000). (Source: Information Centre).
- The cost to NHS trusts of employing consultants had increased from £3.0 billion in 2003-04 to £3.8 billion in 2005-06.

Findings from our study including a survey of 2,361 consultants and NHS trusts as at July 2006

- Consultants who switched to the new contract were reported to have received an annual pay increase that year of £12,454. (Source: Hospital Doctor and Medix UK survey, 2004).
- In 2005-06 the average pay of consultants was £109,974 (an increase of 27 per cent in three years).
- NHS consultants are paid at a higher rate than in many other countries, but we have fewer consultants per head of population and international comparisons of specialists are difficult due to differences in their roles (Appendix 4).

- Ninety-six per cent of consultants responding to the survey who were on the new contract said that they had an agreed formal job plan.
- In the two years following contract agreement, the number of consultants had increased by 13 per cent and the amount of consultant-led activity had increased by nine per cent." (Source: Information Centre and Department of Health NHS activity data).
- The amount of private practice work undertaken by consultants has remained relatively unchanged.
- The number of hours worked by full time consultants for the NHS has decreased by an average of 1.4 hours per week since the introduction of the new contract (from 51.6 to 50.2 hours).
- Twelve per cent of consultants reported that the time they spend on clinical care has increased.
- By the end of 2005-06, the Department had allocated £715 million to fund the contract (£150 million more than originally expected), although our survey showed that 84 per cent of trusts believe that the contract had not been fully funded.

13 Clinical managers tended to concentrate on getting their fellow consultants to change to the new contract rather than focussing on the number and type of programmed activities^b that might be needed. Indeed, in our discussions with trusts, the view amongst clinical managers was that they often lacked the time and sometimes the skills and information to negotiate job plans effectively. Consequently, job planning throughout most of the NHS was a diary recording exercise rather than a way of using programmed activities to improve service delivery and meet future needs.

14 Under the new contract, the Department advised that, as a rule of thumb, a whole time consultant would receive around 11 programmed activities per week. The cost envelope was modelled on funding for 10.7 programmed activities and anticipated savings from a range of payments being made to consultants under the old contract including payments for extra activity (for example waiting list initiatives)¹⁰. Locally managers

negotiated a higher than expected number of programmed activities (on average 11.17¹¹) and larger proportion of higher on-call availability supplements^c, resulting in an increase in the cost of consultants' pay. In the absence of any cost boundaries for individual negotiations, managers agreed more hours than the trust had budgeted to pay for, leading to the cost over-runs.

15 In our survey in 2006, 84 per cent of trusts believed that the contract had not been fully funded by the Department. Measuring the possible additional cost to the NHS is complex and can only be done by developing counterfactual models based on plausible sets of assumptions about what would have happened without the contract. Appendix 6 shows the outcome from two approaches to this modelling which suggests that over the first three years of the contract the additional cost may have been between £649 million and £765 million, compared to the uplifted allocation of £715 million.

b The new consultant contract organises a consultant's working week into programmed activities (PAs). The basic contract for a full-time consultant is ten four-hour PAs per week. There are four types of PAs: direct clinical care, supporting professional activities, additional NHS activities, and external duties.

c On-call availability supplement - If a consultant is required to participate in an on-call rota, they will be paid a supplement in addition to basic salary in respect of their availability to work during on-call periods. A higher rate is paid to consultants required to return to the hospital to provide care.

16 So far, the main benefit of the new contract is that it has increased the transparency for managing the work of a consultant, which is an important precondition for improving their value to the NHS. Seventy-three per cent of trusts responding to our survey confirmed that job planning has been of real benefit to the organisation. However, the increased transparency of the work plans only tells management theoretically what a consultant is expected to be doing. We found that where job plans were in place, in some cases clinical managers did not know if job plans were up-to-date or reflected in-year needs of the trust. In particular, although supporting professional activities (such as formal teaching and audit) are scheduled into job plans under the new contract, trusts reported that they are often unaware of what type and how much of these activities are actually being undertaken.

17 Despite regular communications on progress with negotiations from the Department, the NHS Confederation and the BMA, nearly half (48 per cent) of trusts in our survey replied that the aims of the contract negotiations were not presented to them clearly and fully during the development of the contract. For example, the Department predicted in the business case to HM Treasury in 2002 that the new contract would drive an increase in productivity, yet only 43 per cent of trusts in our survey cited productivity gains as an intended benefit of the new contract. Most trusts have yet to develop indicators for measuring the benefits of the contract and do not measure productivity locally. In comparison, the contract in Wales requires trusts to measure certain outcome indicators (see Appendix 3).

18 In April 2000, the Department commissioned the University of York to look at the feasibility of using available NHS data to measure consultants' productivity. The first report on this work was issued to NHS trusts in December 2002, and whilst this could prove helpful in negotiating job planning we found no evidence that this is being used for this purpose at the moment. In April 2004, the Department also launched their Productive Time Programme which was aimed at delivering efficiency gains across the NHS. The Programme (part of the overall cross-Government Gershon Efficiency programme) is intended to encourage an integrated approach from people, process and technology to realise benefits that are aimed at improving services for patients.

19 The high numbers of programmed activities negotiated per week in the first year of the contract was seen by many consultants as finally rewarding them for the actual hours that they worked. However, trusts reduced the number of programmed activities in the subsequent two years (from 11.17 to 10.83). In our survey three-quarters of trusts told us that they are now planning to reduce the number of programmed activities that they are contracting, citing expected increases in consultant productivity; improved management of consultant time; and financial pressures as the main reasons.

20 The number of programmed activities paid by trusts has reduced and 58 per cent of consultants in our survey believe that their current contract does not reflect their current working hours. As a result of the reduction in contracted hours, some consultants told us that they are reluctantly developing a "clockwatching attitude" to their work.

21 There was an expectation in the negotiating framework that the new contract would improve the link between pay and performance. However, during our visits to trusts we found that the appraisal process and job planning process were not carried out in a coordinated way. Another benefit expected from the new contract was an improvement in recruitment and retention. Whilst vacancy rates have improved overall, 69 per cent of trusts in our survey felt that recruitment had stayed the same and 88 per cent that retention had stayed the same.

22 Overall, few consultants or trusts believed that patient care had improved as a result of the new contract. Our surveys found that only 19 per cent of trusts and 12 per cent of consultants agreed that patient care had improved due to the contract.

23 The success of the contract in realising the Department's expectations has been mixed. Against the main benefits outlined in the Department's business case to HM Treasury, we believe that the NHS can demonstrate that the contract has contributed to achieving four of its targets (green in **Figure 2**); it has not achieved two (red), whilst it is less clear of the effect of the contract (amber) or too early to measure (blue) in the remainder.

2 Comparison of the Department's expectation and the National Audit Office's assessment of the benefits achieved due to the new contract

Indicator	Expected Benefits	Impact
Management of Consultants' Time	Improved management, which could then lead to improved productivity.	<ul style="list-style-type: none"> 64 per cent of trusts reported that the contract has improved the management of consultants (Figure 13) but it is as yet too early to tell its impact on productivity (see below).
Private Practice	Prevention of increase in private practice amongst existing consultants.	<ul style="list-style-type: none"> On average the amount of private practice carried out by consultants has reduced slightly (paragraph 3.6).
Securing Extra Work	Extra work bought at plain-time rates.	<ul style="list-style-type: none"> The number of additional programmed activities that trusts agreed has been bought at plain-time rates (paragraph 2.9).
Participation	New contract will increase number of full-time equivalent consultants above the normal rate of expansion by 250 (2003-04), 350 (2004-05), and 550 (2005-06) through increased recruitment and retention.	<ul style="list-style-type: none"> Although initial targets for this benefit were not met, the number of consultants has increased above the normal rate of expansion – the net increase in consultants in 2005-06 was 853 (paragraph 3.2).
Waiting Times	Better work planning can be expected to lead to sustained reductions in waiting times.	<ul style="list-style-type: none"> Whilst waiting times have improved, our surveys showed that only 12 per cent of trusts and 21 per cent of consultants attribute improvements in waiting times to the new contract. We are therefore unable to attribute improvements in waiting times to the new contract (Figure 17).
Productivity	Year-on-year consultant productivity gains of 1.5 per cent against a decreasing trend, through efficiency gains and quality improvements.	<ul style="list-style-type: none"> Productivity figures for 2005 and 2006 are not currently available, so it is too early to tell the full effect of the contract on productivity (paragraphs 3.7 – 3.10).
Pay Drift	Decrease the cost of consultants moving up the pay scale by 0.20 per cent until 2008-09.	<ul style="list-style-type: none"> Although pay drift decreased in 2005-06, it is too early to say if this is sustainable (paragraph 3.16).
Extending Patient Services	Greater provision of evening clinics or operating lists.	<ul style="list-style-type: none"> Trusts and consultants report no change in services delivered due to the contract (paragraph 26).
Direct Clinical Care	Greater scope to increase the time spent on direct clinical care with an expectation that full-time consultants will typically spend around 7.5 programmed activities per week on direct clinical care. The contract sets out, indicatively, that consultants should spend 75 per cent of their programmed activities on direct clinical care.	<ul style="list-style-type: none"> Our survey of consultants (Figure 16) and our comparison of data on hours spent on direct clinical care before and after the new contract indicate that there has been no increase in direct care. The latest Department survey in 2005 showed that 7.93 programmed activities (72.6 per cent of hours) were spent in direct clinical care compared to 8.27 (74 per cent) in 2004¹.

● the contract has contributed to achieving the stated benefit ● not achieved the expected benefit
● less clear of the effect of the contract in achieving the stated benefit ● too early to measure

Source: National Audit Office

NOTE

¹ The Department does not agree with the finding that there has been no increase in direct clinical care. Within the context of achieving the aim of reducing the hours worked by individual consultants, the Department believe that the proportion of consultant time devoted to direct clinical care has increased since 1998 (when a survey showed 34.1 out of 49.8 hours, or 68 per cent, was spent on direct clinical care).

Overall conclusions

24 By 2000, there was general agreement on the need for a new consultant contract. Consultant pay was falling behind that of other comparative professions, and the NHS needed to increase the size and commitment of the consultant workforce if it was to deliver the NHS reform agenda and comply with the requirements of the European Working Time Directive to reduce consultants' hours. There was also poor information and understanding on the amount and type of work that consultants actually did. Whilst the Department had introduced job planning in 1991, this was poorly complied with and was more of a diary exercise than a prospective agreement between the consultant and managers.

25 By the end of March 2006, the Department had spent £715 million on the new consultant contract (27 per cent more than the original estimate of £565 million). The additional cost, over and above the original cost estimates, has been caused partly by consultants' baseline workload under the new contract being higher than anticipated (in terms of the number of programmed activities being worked and levels of on-call responsibility). It has also been caused by many trusts implementing the contract without sufficient reference to the additional funding for the contract allowed for in primary care trust allocations and the tariff for elective and non-elective care. In October 2006, the Department acknowledged to the Committee of Public Accounts that it could have improved the way it costed some of its policies¹².

26 We conclude that the contract is not yet delivering the full value for money to the NHS and patients that was expected from it although the Department believe that it is too early to judge this. The contract has helped to align consultants' pay levels with their contribution to the NHS. Some consultants are actually working the same if not fewer hours for more money. Whilst this may be in line with the Department's objective to reward consultants more appropriately for their NHS work, our survey showed that consultants' morale has been reduced in the process of implementing the contract. There is little evidence that ways of working have been changed as a result of the new contract and, although most consultants now have job plans, few trusts have used job planning as a lever for improving participation or productivity.

27 The contract has delivered some benefits in management of consultant time, prevention of an increase in private practice, securing extra work at plain-time and increasing participation. The contract has the capacity to provide some new levers for further enhancing management control (for example, on pay progression) although these have yet to be fully utilised. Greater attention also needs to be applied to assessing activities such as research, clinical audit and teaching, in order to introduce further clarity and evaluate their value to both the consultant and trusts.

28 Consultants, in general, are not yet working in a sufficiently different way and some of the benefits that the Department envisaged in its national strategy have yet to be achieved. Initially, this was due to the short timeframe in which trusts had to implement the contract and their lack of attention or indeed awareness, as to the aims of the contract. Our survey highlighted that many trusts still lack clarity as to what the intended benefits are.

29 Full and effective implementation has been undermined by the lack of effective links between performance and outcomes. NHS managers and consultants do not, on the whole, consider such factors in the job planning process and have so far missed the chance to improve their flexibility in responding to external pressures. There is scope for the NHS trusts to make much more of the opportunity presented by the annual renegotiation of job plans to reach a win-win situation with consultants and devise a set of agreed job plans that will deliver more efficient and effective services to patients.

Recommendations

For future policy reforms

New policies should be based on an accurate assessment of the current situation (including, in the case of workforce contracts, robust evidence on levels of activity)

- a** Before negotiating a new policy, the **Department** should ensure that it has analysed sufficient contemporaneous evidence from relevant stakeholders. In many cases this will involve consultation, modelling and in some case piloting policies.

All possible scenarios for new policies should be fully financially modelled before they are implemented

- b** The **Department** should ensure it models all significant policy changes at key points to ensure that all different scenarios are better understood and fully costed.

The purpose and detail of new policies should be communicated to the NHS in a timely manner

- c** The **Department** should communicate clearly the aims and objectives of new policies to NHS organisations before implementation commences. Where relevant, communications should be developed and agreed jointly with other parties involved in developing the policy.
- d** **NHS trusts** should ensure that they have a consistent understanding of the proposed benefits and are able to measure the intended outcomes of the new policy.

For future rounds of job planning

There should be a full local assessment of what is needed from consultants, in terms of levels of activity and patient outcomes, bounded by a cost envelope

- e** **NHS trusts** should ensure that they have a strategic approach to job planning based on organisational priorities, including input from finance and human resources as well as medical and clinical directors, general managers and the local primary care trust. Trusts should use job plans in partnership with consultants to help re-design services to improve the patient experience.
- f** **NHS trusts** should set an affordability boundary for their consultant workforce and job plans should be costed in relation to the cumulative impact on the whole organisation before being approved.
- g** **NHS trusts, working with NHS Employers and the BMA**, should share practical information and good practice examples on how job planning has been used to improve productivity and participation. NHS Employers should evaluate existing tools such as those produced by the University of York (see paragraph 18) to determine their effectiveness in helping integrate productivity into the job planning process.

The local NHS should aggregate consultant job plans to indicate what clinical teams and the consultant body as a whole should be providing

- h** **NHS Employers** should review information technology solutions that would enable NHS trusts to administer, collate and regularly update consultants' job plans.

Individual job plans should reflect the needs of the local NHS

- i** **NHS trusts** should ensure that job planning remains a flexible tool for achieving patient needs, balanced with demands of the trust. To do this job plans need to be seen as active documents, and job plans should take into account the patient needs expressed in speciality or overarching trust plans.

Job plans should be applied with a suitable level of rigour

- j** The **Department and NHS Employers** should provide support and guidance to NHS trusts to help them develop a formal link between appraisals and job plans. They should also evaluate the systems and processes in Wales whereby trusts agree with their consultants clear indicators of performance as part of the job planning process.
- k** **NHS trusts** should review supporting professional activities to ensure that they are appropriately linked to the appraisal process and any spare capacity should support patient care where possible. Where development needs are identified, these should be recognised in the supporting professional activities of consultants.
- l** Clinical management needs to be strengthened within **NHS trusts** ensuring that medical and clinical directors undertaking job planning have received suitable training and have the skills and time to implement the process. In particular, medical and clinical directors should be selected following a transparent recruitment process and trusts should ensure that they have a clear career path underpinned by sound support structures and collaborative working with non-clinical directors.



PART ONE

Introduction of the new contract for consultants in England

1.1 Consultants are highly trained, senior doctors. In September 2005, there were approximately 32,000 consultants within the NHS. Around 95 per cent of these consultants work in hospitals for NHS trusts, where they take clinical responsibility for the majority of the treatment delivered. The other five per cent work for primary care trusts, strategic health authorities and special health authorities, such as the Health Protection Agency. In 2005-06 over 14 million consultant-led episodes of care were carried out in the NHS in England¹³.

1.2 Consultants' salaries cost NHS acute and mental health trusts in England a total of £3.8 billion in 2005-06^d. On average, the cost of employing consultants accounted for approximately nine per cent of NHS trusts' income and 14 per cent of staff costs within acute and social care hospitals¹⁴. In March 2006, the average NHS salary of a consultant was £110,000 compared to £86,700 in 2002-03.

1.3 The need for better planning of consultants' work was highlighted in 1991 when the Department introduced a requirement for hospital managers to introduce job planning. The job planning process required managers and consultants to agree the consultants' duties, responsibilities and work programme for a 'typical week', including the time that would be spent on direct patient care and other agreed activities such as on-call duties and training commitments¹⁵. However, two Audit Commission reports in 1995 and 1996, *The Doctors' Tale: The work of hospital doctors in England and Wales* and *A Doctors' Tale Continued: The audits of hospital medical staffing*, highlighted weaknesses in this job planning process, including the fact that a quarter of consultants did not have agreed job plans and 30 per cent of job plans had not been reviewed recently¹⁶ (a summary of these reports is at Appendix 1).

1.4 In November 1997 the doctors' professional association, the British Medical Association (BMA), motivated by concerns over the excessive hours that many consultants reported they were working, wrote to the Government highlighting the need for a new consultant contract. In 2000, a survey by the NHS employers' representative, the NHS Confederation, showed that NHS managers wanted more control over the consultant working week, more direct clinical care and the removal of the outdated disciplinary procedures. The key issue for employers related to accountability, clarity and transparency over consultants' commitment to the NHS. In 1998 the Government acknowledged that the existing contract had not kept pace with medical advances or changes in the NHS.

1.5 In 2000, the NHS Plan set out the Government's strategy for delivering care in the NHS for the next ten years. The Plan reported that the Department's public consultation found that the public wanted to see "more and better paid staff using new ways of working" and announced that the March 2000 Budget settlement would fund extra investment including 7,500 more consultants. At this time there was also an expressed need to reduce consultant hours to adhere to the European Working Time Directive.

1.6 The NHS Plan acknowledged that in order to achieve the Government's aims for NHS reform, the way in which NHS staff were employed would need to be modernised. In October 2000, the BMA Central Consultants and Specialists Committee published their detailed proposals building on the NHS Plan. In February 2001, the Department issued *The NHS Plan: proposal for a new approach to the consultant contract*. This represented the first major reform to the terms of consultants' employment for over 50 years. It stated that the primary objectives of reforming the consultant contract were:

^d This figure includes an estimation for foundation trusts.

- a career structure and remuneration system which rewards and incentivises consultants who are making the biggest contribution to service delivery and improving health services and who make a long term commitment to the NHS; and
- a stronger, unambiguous framework of contractual obligations, which will provide greater management control over when consultants work for the NHS and over their performance and, for the consultant, better arrangements for supporting their professional development and greater clarity and transparency about their time commitments to the NHS.

1.7 In 2002, the Department published *Delivering the NHS Plan* which reiterated the requirement for new contracts for NHS staff, including for consultants¹⁷. The Department also published *HR in the NHS Plan*¹⁸, which outlined what the NHS needed to do to become a model employer. The proposed reforms included a plan to improve productivity, by increasing the efficiency of the people employed by the health service, and to restructure the way that jobs and roles are defined and rewarded through modernisation of pay and conditions for staff.

1.8 The Department submitted a business case on pay modernisation to HM Treasury in April 2002¹⁹, including proposals on the consultant contract. It estimated that the new contract would cost an additional £575 million (revised to £565 million once the terms of the contract had been agreed) but that in return it expected to achieve year-on-year productivity gains against a falling trend and improve recruitment, retention and commitment of consultants to the NHS. The productivity gains, expected to accrue for eight years, were thought to be feasible given the new tools and incentives available to managers in the new contract and the existing variation in consultant “productivity”^e. Efficiencies would be achieved through better management of consultant time; increases in direct clinical care; extending patient services; and higher quality of emergency care. At the same time, the final Wanless report supported the need for the NHS to invest in more doctors and emphasised the importance of “ensuring taxpayers’ money is being used efficiently and effectively through regular and rigorous independent audit of all health care spending”²⁰.

1.9 Given the importance of the consultant contract to the NHS reform agenda and the cost to the NHS of improving the pay and conditions of this important workforce, we decided to carry out a value for money study into the development, implementation and outcomes of the new contract. The methodology for this study is outlined in Appendix 2. This part of the report evaluates the development of the new contract.

Negotiating a new contract

1.10 Previous attempts to reform consultant contracts had historically been unsuccessful. However, by 2000 there was a general consensus that a new contract was needed. The new contract was negotiated by the four UK Health Departments, employers’ representatives from the NHS Confederation, and the BMA. The exact terms of the contract presented some difficulties for all of the parties involved in the negotiation and, consequently, the talks were more complex and slower to conclude than any of the parties would have liked. Starting in February 2001, it took two and a half years before an agreement was reached, at which point individual NHS employers became responsible for implementing the agreed terms (**Figure 3 overleaf**).

1.11 The first set of proposals, published in February 2001, included a seven year indenture to the NHS for consultants during which time they could not perform private work. This was met with opposition by both consultants and junior doctors. This indenture period did not appear in the Framework Agreement between the Department and the BMA in June 2002. Instead, the Framework Agreement included a requirement that established consultants offer four hours extra service per week to the NHS before private work could be undertaken and new consultants offer eight. Thus, under these new proposals, the NHS would have initial priority on any consultant overtime.

1.12 Though these second set of proposals were accepted by consultants in Scotland and Northern Ireland, opposition from consultants in England and Wales prevented their national acceptance and implementation. Some of the main reasons that consultants in England gave for their resistance were the perceived threat of management interference in clinical work and the potential to be forced to work unsociable hours.

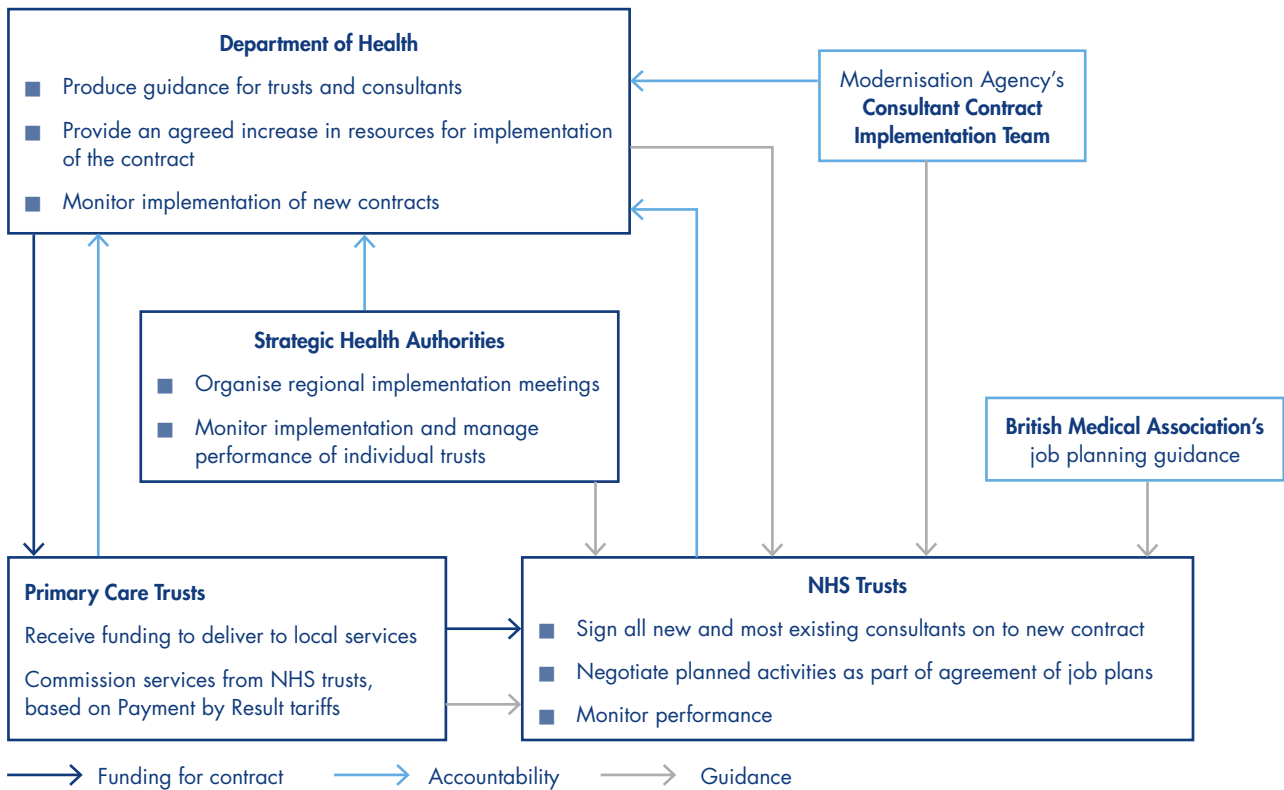
^e In December 2003, the Department issued charts of consultant productivity to NHS trusts in England. These showed large variation in clinical activity by consultant. Appendix 8 shows sample 2004/05 data issued in 2006.

3 Roles, responsibilities and accountabilities for negotiating and implementing the new contract

Contract Negotiation 2002 to July 2003 (date when terms agreed)



Implementation October 2003 (when consultants voted to accept terms) to March 2004 and beyond



Source: National Audit Office

Other types of contract were considered but were not supported in any material way

1.13 The chosen method for the contract, whereby consultants are paid by fixed salary, is not the only model for employment. Other methods include ‘fee-based service’, which pays the consultant a set fee for each finished consultant episode above the average; and target payments, in which doctors are paid for achieving a set level of service provision.

1.14 When consultants rejected the original contract in October 2002 the then Secretary of State for Health announced that there would be no further negotiations on the contract. Instead, he proposed that resources for the new contract should be given to local employers who were recommended to implement the draft contract locally or introduce incentives for consultants, such as ‘fee-based service’ payments. In the event, employers’ response to this was that such schemes were complicated and not viable and an NHS Confederation survey showed strong support for maintaining a national framework.

1.15 Although the Department went on to commission a pilot of ‘fee-based service’ schemes in 2003, a report on these pilots, published in 2005, concluded that none of the schemes produced any significant activity gains, and the Department announced that it had no further plans for ‘fee-based service’.

In July 2003 the negotiating parties agreed the terms of the new consultant contract

1.16 After a three month hiatus, the new Secretary of State re-initiated negotiations and this time the negotiating parties were able to reach an agreement on the terms of the new contract. In England the Department, supported by the NHS Confederation, finally agreed the terms of the new contract with the BMA negotiators in July 2003.

1.17 In October 2003, 60 per cent of consultants voted to accept these terms. The contract included a reduction in out-of-hours sessions to three hours, and an additional holiday allowance. In return, consultants would normally devote an average of 7.5 programmed activities to direct clinical care based on a standard 10 programmed activity contract. The consultant contract template and guidance indicates that typically 75 per cent of programmed activities will be devoted to direct clinical care.

1.18 The contract is optional and, on introduction of the new contract, existing consultants were given the choice to remain on the old contract or to move to the new. The Department expected trusts to implement the new contract for as many consultants as possible by April 2004. Those that chose to move to the new contract by 31 October 2003 had their pay increases backdated to 1 April 2003, while those that committed to the new contract between 31 October 2003 and 31 March 2004 had their pay backdated by three months from the point of commitment (conditional upon agreeing a job plan within three months).

1.19 Whilst most aspects of the agreed terms of the contract are similar across the UK, there are minor differences in the contracts. For example, Wales has introduced stronger links between pay and performance through the embryonic use of Consultant Outcome Indicators (Appendix 3) which allows there to be more focus to the job planning process (**Case Example 1**).

CASE EXAMPLE 1

Best practice example: the use of outcome-based measures in the consultant contract in Wales

In Wales, there is a greater emphasis on linking pay and performance through the job planning and appraisal process. Indeed, some of the conditions, and additional pay, of the new contract have been conditional on audited progress on the job planning.

Since implementing the contract, a formal structure for developing and implementing Consultant Outcome Indicators has been put in place. Consultant Outcome Indicators have been developed by a private company in conjunction with practitioners in the various specialities to identify appropriate measures of performance for a consultant. They are supported through appropriate software and help a trust record and review the performance of consultants with specific speciality based measures. These form part of the appraisal and job planning process.

Summary: In Wales, the conditions of the new contract meant that increased hours (and pay) were dependant on audited progress of trusts. In addition, the Consultant Output Indicators have become an important focus for job planning in Wales, which has increased the link between performance and pay.

Source: National Assembly for Wales, Consultant Contract Annual Report 2006

Details of the new contract

1.20 Under the terms of the new contract the basic working week for a full-time consultant is ten four-hour blocks (known as programmed activities^f). This basic 40 hour working week compares to a documented 38.5 hours under the old contract (Figure 4 compares the negotiated contract with the old contract). The principle of the new contract is that consultants are paid in relation to the hours they are contracted to work. This has proved to be a financial advantage for consultants who switched to the new contract, as their basic NHS salaries increased from £52,600-£68,505 in 2002-03 to £65,035-£88,000 in 2003-04. The basic maximum salary for consultants who stayed on the old contract is 25 per cent lower than for those on the new contract (Part 3 provides more detail on the increase in salary).

1.21 In addition to the basic contract, the trust and the consultant have the option of agreeing additional programmed activities, which are paid at normal time rates. Consultants can also receive additional sums in the form of recruitment and retention premia, clinical excellence awards (which are available to consultants on the new and old contract) and on-call availability supplements. Unsociable hours are also recognised under the new contract. During these times (7pm-7am Monday to Friday and anytime during weekends and public holidays) a programmed activity constitutes three rather than four hours.

1.22 In return for increased financial rewards and recognition of work done, the contract provides potential for greater management control in planning consultants' work. This process is made more stringent by setting out a formal job plan reflecting the agreements reached on all categories of consultants' work. The Department determined that for the new contract job planning would be made mandatory with pay progression dependent on achieving the objectives of the job plan. Job planning therefore requires managers to reach a prospective agreement with each consultant setting out the consultant duties, responsibilities and objectives for the coming year, based on an agreed number of programmed activities. This is at the heart of the new contract but also applies to consultants who choose to remain on the old contract.

1.23 Prior to the new contract, consultants could forego 1/11 of their NHS salary in exchange for unrestricted private practice. Under the new contract consultants wishing to undertake private practice work and remain eligible for pay progression must first offer an additional four hours per week service to the NHS and no private patients can be seen whilst they are on-call. As part of agreeing the new contract, the relationship between private practice and NHS work was clarified in *A Code of Conduct for Private Practice: Recommended Standards of Practice for NHS Consultants*. Adherence to this code forms part of the eligibility criteria for clinical excellence awards and pay progression.

Trusts believed that a new contract was needed, but despite the fact that they were represented in negotiations, felt that they could have been further consulted

1.24 Our survey of trusts confirmed that few (only four per cent) agreed that the old contract was fit for purpose. However, only 12 per cent felt that the Department's consultations prior to the negotiations were adequate.

1.25 However, the NHS Confederation, as the NHS employers' representative, was fully involved throughout the contract negotiations. The Confederation's negotiating team also included a chief executive, a medical director and a director of human resources. In hindsight, the Confederation acknowledges that their negotiating team may have needed more financial input from the service. Beyond direct involvement, the Confederation also involved NHS organisations (around 200 staff) in reference groups to test out emerging thinking. Nevertheless, the Confederation acknowledges that although it, the Department and the BMA issued regular updates on the progress with negotiations, senior managers did not fully grasp the implications until they were into the implementation process and many of the difficulties only emerged during implementation. Part 2 of the report examines trusts' implementation of the contract.

^f The basic contract for a full-time consultant is ten four-hour programmed activities (PAs) per week. PAs are separated into four types: direct clinical care including emergency duties and on-call work, operating sessions, ward rounds and out-patient clinics; supporting professional activities (SPAs) including training and continuing professional development, teaching, audit, job planning and appraisal; additional NHS responsibilities such as medical director or clinical governance lead; and external duties such as trade union duties.

4 Comparison of the old and new contracts

	Old contract	New contract
Working week (full-time)	Minimum of ten 3.5 hour sessions. A contract was often based on a typical 38.5 hours per week.	Ten programmed activities (PAs) of four hours (or three hours in premium-time). A typical basic contract based on 40 hours per week.
Additional work	British Medical Association survey showed that on average consultants had a working week of 51 hours which is approximately an additional 12 hours per week without extra pay.	Any additional work above 10 PAs by mutual agreement and paid at plain-time rates (unless in premium-time).
Job planning	Not determined nationally, although job planning has been a requirement since 1991 (health circular HC 1990-16).	PAs agreed between clinical manager and consultant. Job plans separated into Direct Clinical Care; Supporting Professional Activities; Additional NHS Responsibilities; and External Duties. Pay progression dependent on achievement of the individual objectives in the consultant's job plan.
Direct clinical care	The contract distinguished only between work that should be carried out during fixed commitments (regular scheduled NHS activities) and supporting work that can be undertaken flexibly (e.g. administration, audit). Consultants were expected to have between five and seven fixed commitments per week in their job plan.	Average 7.5 PAs expected to be devoted to direct clinical care based on a standard 10 PA contract. (Indicatively 75 per cent of PAs will be spent on direct clinical care, although this is agreed locally).
Premium-time	No differentiation in terms of remuneration for work done during 'normal' or unsocial hours.	After 7pm and before 7am during the week or any time during the weekend programmed activities are reduced to three hours (rather than four) or the rate of pay increases to "time-and-a-third".
Part-time	Part-time contract allowable.	Allowable under contract (pay proportional to the typical full-time of 10 PAs).
On-call work	Not specifically set out how on-call work should be recognised.	Recognised and paid at a rate determined by the complexity and frequency of the on call work.
Basic pay	£52,640 to £68,505 (in 2002-03).	£65,035 to £88,000 (in 2003-04).
Private practice	On a full-time contract – private practice was allowable up to 10 per cent of NHS earnings. On a part-time contract – no maximum income from private practice but the NHS salary was reduced by 1/11th.	Allowable, but first additional PA must be offered to the NHS. A consultant could decline an offer of an extra PA and still work privately, but with risk to NHS pay progression for that year. Private practice code of conduct for contracts is introduced.
Recruitment and retention bonuses	Not in contract, although mechanisms available.	New payment which can be up to 30 per cent of starting salary.
Annual leave	30 days.	30 days (initially). Consultants with seven years service will receive an additional two days annual leave.

Source: Department of Health



Implementing the new contract

2.1 Once terms had been agreed, the Department began to issue various documents detailing the terms of the contract, together with implementation guidance, and asked trusts to start to move consultants on to the new contract with the aim of achieving as high an uptake as possible by April 2004. This included trust managers having to negotiate individual job plans with each and every consultant. This part of the report examines the overall costs to the NHS of the new contract and how these costs were affected by both the Department's assumptions and NHS trusts' implementation, including job planning.

The planning assumptions regarding consultants' NHS workload were not tested

2.2 In 1998 MORI carried out a survey for the Doctors and Dentists Review Body, based on consultants' self-reported diaries, to identify the consultant workload²¹. This suggested that consultants were working on average between 50 and 52 hours a week, depending on managerial responsibility. The Department modelled the new contract based on a diary exercise from 2000 which suggested consultants were working 47 hours. Given that one of the aims of the contract was to reduce the number of hours that consultants worked, including aligning with the Working Time Directive^g, the Department based its funding assumptions on consultants working an average 43 hours (10.7 programmed activities of four hours each per week) and that less than a third of consultants would be eligible for the higher on-call supplement for emergency care. However, this assumption was not tested with the NHS in a rigorous way²².

The costs of the new contract were higher than originally estimated

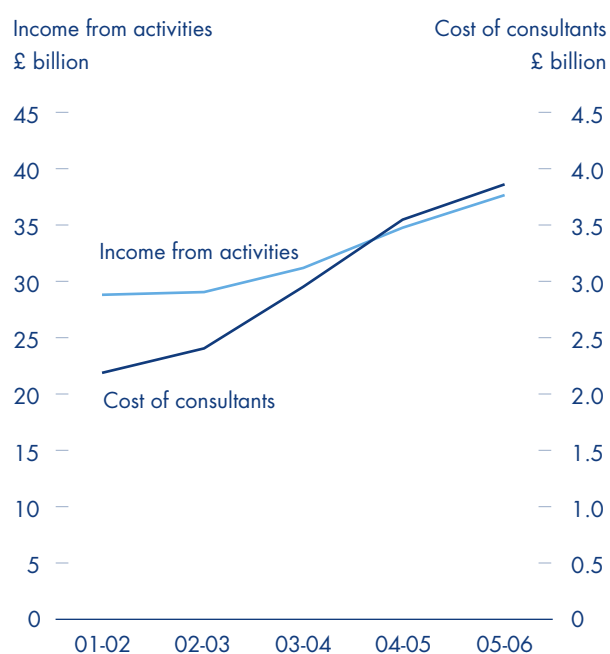
2.3 The Department allocated primary care trusts an additional £133 million for 2003-04, £182 million for 2004-05 and £250 million for 2005-06 (totalling £565 million for the first three years). Primary care trusts use their allocations to commission services from providers; this funding, together with anticipated savings from securing activity in less expensive ways, was expected to cover the estimated additional costs of the new contract.

2.4 In 2004 and 2005 NHS trusts reported that the contract was creating cost pressures beyond the funding envelope. In response, the Department increased the tariff (payments made to providers by primary care trusts) for 2005-06 by £150 million. The Department told the Health Select Committee in December 2005 that it had subsequently estimated, based on survey returns from 95 per cent of trusts, that the actual cost pressure was nearer to £90 million at October 2004, although the full tariff uplift remained.

2.5 Between April 2003 and the end of March 2006 the total cost to trusts of employing consultants was £10.4 billion²³. **Figure 5** shows the year-on-year increase in total costs of employing consultants compared with the increase in trusts' income. An estimated breakdown of the costs of employing consultants and how this has changed over time, disaggregated into inflationary pay settlements, increases in consultant numbers, the cost of consultants moving up pay thresholds (pay drift) and changes to the employers' contribution is at **Figure 6**.

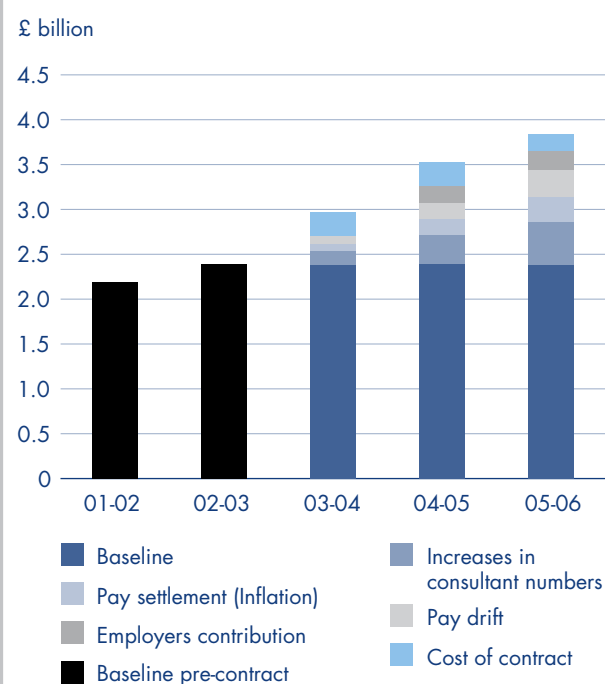
^g The Working Time Directive of the European Union (Council Directive 93/104/EC, 23 November 1993, amended by Directive 2000/34/EC of the European Parliament, 22 June 2000) is a collection of regulation concerning workers' hours. A key part of the Directive is the 48 hour maximum length of a working week, which applies to all member states; although in the United Kingdom it is possible to "opt out" of this 48 hour limit.

5 A comparison between the income from activities and cost of employing consultants within NHS trusts



Source: Summarisation schedules, NHS Summarised Accounts (2001-02 – 2004-05) and Consolidated Accounts of Foundation Trusts

6 A breakdown of the increase in costs of employing consultants since the introduction of the new contract



Source: National Audit Office (see Appendix 6)

2.6 The NHS has spent £10,353 million on consultants pay in the first three years of the new contract. If the Department had not negotiated the new contract and consultants had continued to be paid on the old contract we estimate, on the basis of a plausible range of assumptions, that trusts might have spent between £9,587 million and £9,704 million over the same three year period (adjusting for pay drift, inflation and increases in employers' contribution and consultant numbers). We estimate, therefore, that the contract may have cost the NHS between £649 million and £765 million more than if consultants had remained on the old contract (see Appendix 6). This compares to Departmental funding of £715 million (including the £150 million uplift referred to in paragraph 2.4).

2.7 However the do-nothing scenarios used in the costing models would not have addressed the problems, such as the potential exodus of consultants from the NHS²⁴, associated with the existing contract which was one intention of the new contract. There may also have been a need for larger pay rises to achieve the NHS Plan's aim of meeting the public demand and Government commitment of "more better paid staff". Part 3 examines the extent to which these benefits have been realised.

2.8 Our survey of trusts suggests that the new contract for consultants may have created financial pressure for some trusts. In 2006, 84 per cent of trusts responding to our survey believed that the contract was not fully funded. Of the 35 trusts reporting a deficit, 29 claimed that the contract had contributed to this, although we did not audit these calculations. Furthermore, in June 2006, the joint National Audit Office/Audit Commission report on "Financial Management in the NHS" found that the reasons for trust financial deficits were extremely complex. However, the report highlighted that the implementation of workforce contracts had placed financial pressure on a small number of NHS trusts, although some were better able to manage these pressures. In 2006, the Department acknowledged to the Committee of Public Accounts that it could have improved the way it costed some policies, for example the reforms to the pay system²⁵.

One of the reasons for cost over-runs is that trusts initially agreed higher levels of activities than allowed for by the Department's assumptions

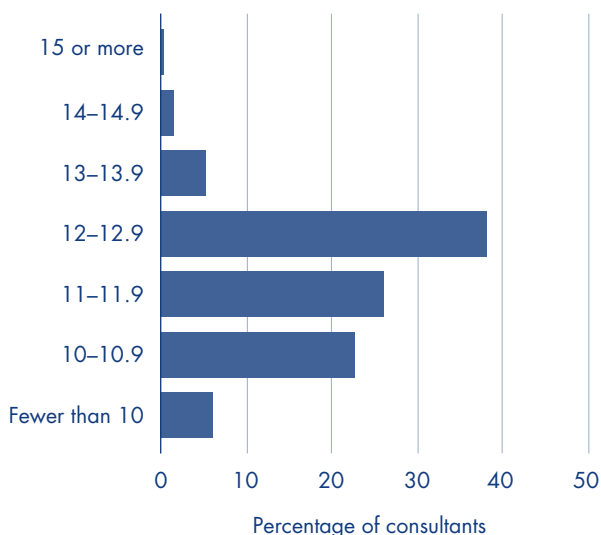
2.9 The average number of programmed activities per consultant that trusts told us they had paid for was 11.1 (or 11.3 if part-time consultants are excluded) (Figures 7 and 8 refer) which is above the level of 11 the Department had planned. Seventy-seven per cent of trusts told us they planned to reduce the number of programmed activities worked by consultants each week. The Department's own surveys in October 2004 showed an average of 11.17 programmed activities (based on returns from 95 per cent of trusts) reducing to 10.83 in October 2005 (returns from 58 per cent of trusts).

2.10 Another factor that has contributed to the higher than expected cost for trusts is the allocation of on-call availability supplements. The cost of the on-call supplement is a percentage of salary, the level of which depends on the frequency and category (A or B) of their on-call commitments.^h Compared to the Department's and the BMA's estimation, trusts allocated a higher number and payment level of these supplements to consultants. The Department and the BMA expected that only 30 per cent of consultants would receive the higher A rate of on-call availability supplements. However, trusts' returns showed that 68 per cent of all consultants were on the higher rate in 2005. Our survey of consultants found that 71 per cent of respondents to this question had on-call responsibility at the higher band.

2.11 Some of the responsibility for the cost over-run is due to the failure of some trusts to set affordability limits based on the Department's assumptions. The result of negotiating job plans without these limits is that some trusts have not balanced the increase in costs to the additional funds allocated. The reasons trusts did not set or keep within these affordability limits are discussed below.

7 The average number of programmed activities by full-time consultant for the NHS

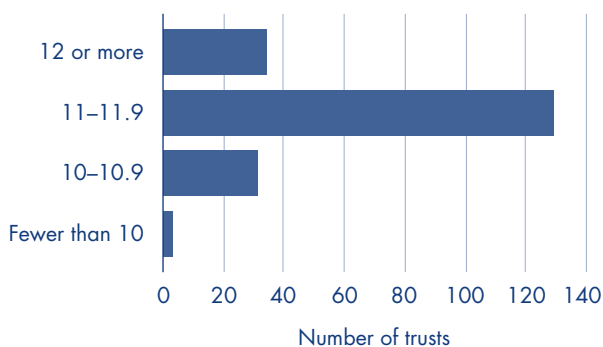
Number of programmed activities



Source: National Audit Office survey of consultants

8 The average number of programmed activities paid for by individual NHS trusts

Average number of programmed activities paid by the trust



Source: National Audit Office survey of trusts

^h Of the two on-call availability supplements, A and B, the A rate applies where the consultant is typically required to return immediately to site when called or has to undertake interventions with a level of complexity similar to those carried out on site. The B rate applies where the consultant can typically respond by giving telephone advice and/or return to work later. Payment levels are three to eight per cent of the consultant's salary for Category A and one to three per cent for Category B.

Although the Department provided regular communications, only half of NHS trusts were clear about the aims of the new contract

2.12 Our trust survey showed that around half of trusts felt that the aims of the contract negotiations were presented clearly and fully during the development of the contract. This was confirmed in our interviews with managers who said that the aims of the contract were only now becoming clear. The NHS Confederation considered that given the myriad of pressures on trusts it was understandable that many senior managers did not fully grasp the implications until they were in the implementation process.

2.13 Of those trusts that did feel they understood the aims, 43 per cent cited the main aims as to match the work done by consultants to their pay and improve efficiency/productivity. A fifth cited greater transparency, clarity and control over consultants and only five per cent cited improving recruitment and retention.

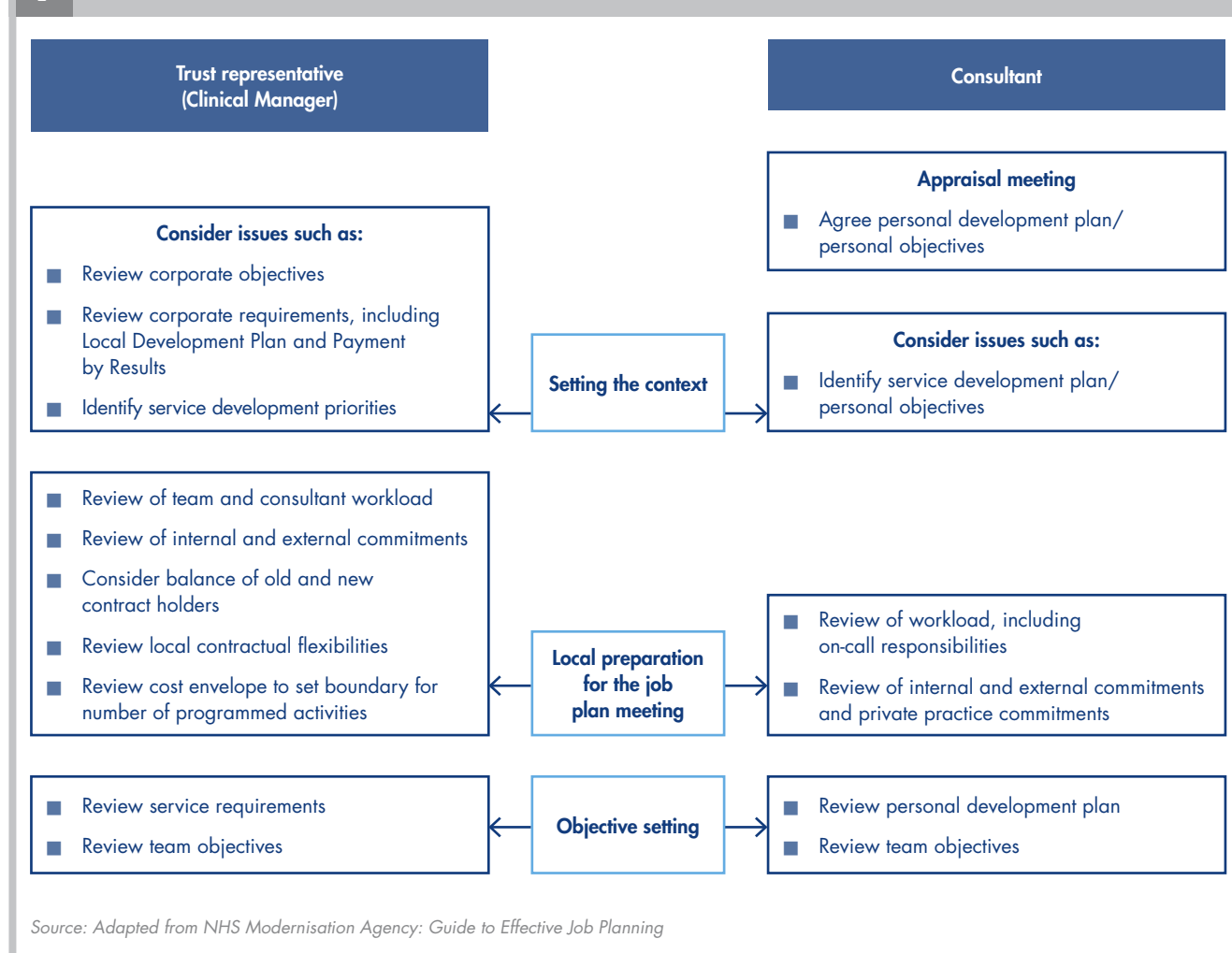
2.14 The Department has, however, communicated its expectations of productivity gains as part of the Productive Time Programme, which encourages an integrated (People, Process, Technology) approach to implementing change programmes in the NHS. However, the Productive Time Programme reports to the Office of Government Commerce on a range of measures such as length of stay, day case rates, staff absence and technological initiatives, rather than overall service improvement in the NHS. The Department believes it is on course to meet the Productive Time target of £2.7m by March 2008.

Although trusts moved the majority of consultants on to the new contract, they generally failed to take a prospective view of the consultants' workload

2.15 The Department and the NHS Confederation expected trusts to move as many consultants as quickly as possible to the new contract. By May 2005, the BMA found that 87 per cent of consultants had moved to the new contract. This had increased to 89 per cent by the time of our survey in summer 2006.²⁶ The main reasons cited for moving to the new contract were increased pay and improved control over hours worked. Almost a third of consultants gave improved pay as a reason for signing the new contract. Of the 12 per cent that had not moved, the reasons given for not signing the new contract included: a fundamental disagreement with the contract (40 per cent); inability to agree a job plan (10 per cent); and being too close to retirement (12 per cent).

2.16 However, as highlighted by our trust visits, the focus for most trusts was on getting consultants on to the new contracts. Trusts concentrated on agreeing job plans without knowing what amount and type of activity they required to run their organisation efficiently. Early job planning guidance encouraged diary exercises to be the start of the process. Consultants were asked to record, in a diary, the activity they carried out over the course of a number of weeks. Trusts were expected to use these diaries as the starting point for negotiation rather than as job plans themselves. However, the majority of job plans remain largely determined by the consultants' own diary exercises. **Figure 9 overleaf** describes some of the issues which should be considered as part of the job planning process.

9 Flow diagram which shows things to be considered in the job planning process



2.17 Also, despite an improvement since the contract was introduced, over two fifths of consultants who responded to our survey still did not think that their job plans had clear objectives linked to organisational improvements. The organisational objectives of acute or mental health trusts are often defined by the commissioners of the services they provide, predominantly primary care trusts. However, 97 per cent of NHS trusts' chief executives and 83 per cent of primary care trust chief executives believed that commissioners did not have a role in the consultant job planning process.

2.18 By basing job plans on previous activities and not engaging commissioners, trusts have not aligned consultants' activities to their future needs. The Commissioning Framework for the NHS (2006) emphasises that commissioning should be based on need rather than relying on a system that lets resources flow according to unchallenged historically based patterns.

Few trusts have a view of the totality of their job planning for consultants' work and hence the overall financial implications

2.19 Trusts tried to set some boundaries and limits for negotiating job plans but this was not always effective and most clinical managers negotiated job plans individually without knowing the overall implications for the trust. The NHS Confederation reported that the implementation process worked best where there was high-level management leadership and involvement in the implementation team, and that difficulties occurred when the engagement of financial and general management teams lagged behind that of medical managers.

2.20 The majority of job plans are negotiated individually between a consultant and a clinical director (85 per cent), and our visits highlighted that few trusts had systems in place to be able to take an overview of all consultants' job plans. This can mean that trusts do not know what job plans have been agreed. Therefore, as was often the case under the old contract, trusts can find it difficult to know if there are gaps in service provision or if the job plans cumulatively meet the strategic priorities of the trust. It was within every trust's control to be able to manage this process and set appropriate financial boundaries. Yet many trusts did not, and still do not, have the processes in place for monitoring the financial implications of the negotiated job plans prior to their being agreed.

2.21 The lack of trust-wide systems can lead to variability in approaches to job planning, and some trusts have a good job planning process in one department but can be weak in others. Negotiation on an individual consultant basis without any benchmarks can also lead to poor rationale behind some job plans and pressure from consultants based on what they believe their peers negotiated in the same or neighbouring trust.

2.22 Good information systems can aid the job planning process. Some trusts have developed the use of IT systems to enable them to monitor and oversee the job planning process (**Case Example 2**). Forty-nine per cent of trusts in our survey highlighted poor information systems as being a barrier to consultants working differently. Furthermore, 40 per cent of trusts responding to our survey cite the lack of 'integration with other initiatives' and 'job plans not advanced enough at present' as barriers to working differently.

CASE EXAMPLE 2

Developing an IT system to match needs to job plans of consultants: Portsmouth Hospitals NHS Trust

Portsmouth Hospitals NHS Trust established a Consultant Contract Benefits Realisation Group to develop a more effective job planning process and increase the benefits of the contract. This is being achieved through:

- Regular meetings of the **Consultant Contract Benefit Realisation Group**, to discuss all aspects of the contract and its development. The Group comprises of senior representatives of the Clinical Management, Performance, Finance, Workforce and Organisational Development functions.
- A **Consultant Contract Update Programme**: a series of half-day workshops, designed to improve the knowledge and develop the skills of those actively involved in the job planning process (clinical managers, individual consultants, human resources managers and general managers).
- The development of a **Consultant Resource Management System** with a private sector IT developer. The database holds records of all consultant job plans and work diaries, and enables more efficient management of the consultant resource through, for example, the central organisation of annual leave and the collection of data on the costs and activity of specialties and individuals.

Source: Consultants Contract Benefits Realisation Team and case study visit

Trusts found that implementing the contract was resource intensive and, going forward, have concerns about management capacity to carry out job planning effectively

2.23 Trusts told us that they under-estimated the time taken to negotiate the job plans and implement the contract. Moreover, there was no recognition by the Department of the internal costs to trusts – in terms of managerial and administrative time. We therefore requested data from 18 randomly selected trusts to try and identify the extent and cost. Of the nine trusts that were able to provide any data, they estimated that an average of 144 hours of managerial and administrative time was spent each week – the equivalent of four full-time workers – in the eight months following the agreement of the terms of the contract. The amount of administrative and managerial burden on those trusts ranged from 39 to 356 hours per week. As a result, those trusts were unable to use resources in a way that would maximise the contract’s potential benefits.

2.24 Trusts do not always have the capacity to complete the job planning process effectively. The NHS Confederation acknowledge that some clinical managers lacked sufficient experience or skills in the process of job planning and that there needed to be more support and development for clinical managers involved in local negotiations. During our case study visits, managers reported that the process can be difficult and in some cases there is potential for weak management because of time factors and a lack of training in the job planning process. The role of the clinical and medical directors is crucial in developing job plans that meet the needs of the trusts. However, some clinical and medical directors are only appointed temporarily on rotation and will return to being a consultant at the end of their rotation. This can lead to an inherent conflict of interest, and consultants have told us that there is an incentive to be naturally sympathetic to their colleagues’ wishes.

NHS trusts’ opinion on the guidance offered to them by the Department was mixed

2.25 Most trusts found the guidance produced by the Department to be useful; however, approximately half felt that it was not timely. Due to the nature of the negotiations, the majority of the Department’s guidance (Appendix 5) was issued after consultants had voted to accept the new contract, in October 2003. In particular, our survey found that 47 per cent of trusts found that the Department’s guidance regarding on-call allowance was unclear.

2.26 In particular, trusts told us that some parts of the guidance for implementing the contract were ambiguous. For example, although the Department did provide working definitions for some of the terms used in the guidance, the use of the word “typically” was felt by trusts to be open to interpretation. Trusts also told us that the BMA’s guidance in January 2004 was more useful and local representatives of the Association to be better informed than management at trusts.

2.27 The Department believe that whilst appropriate guidance was available throughout the process it was not always fully utilised by trusts. In April 2003, once the parties to the negotiation had reached agreement, the Department issued information and explanatory documents, including on job planning, to trusts. Also, once consultants had voted to accept the contract, further detailed guidance was issued. The 2006 King’s Fund Report ‘*Assessing the new NHS Consultants contract*’ concluded, based on a small sample of trusts, that implementing the contract had “not been helped by absent, delayed or unclear guidance from the centre”.²⁷

2.28 The NHS Confederation commented that the strong message it received from NHS trusts was that they would prefer joint guidance since the separate guidance from the Department and the BMA had caused real problems and that inconsistencies led to confusion amongst its members.

2.29 In late 2003, the Department’s Modernisation Agency established a Consultant Contract Implementation Team to aid the implementation of the contract. Following its establishment, the Team held over 70 events, including seminars and workshops to support trusts in delivering the new contract. The Team issued the job planning toolkit to support the negotiation of individual job plans, and developed a consolidated set of all previously issued guidance in January 2005. Trusts found that the support and information offered by the Team, including personal visits and interventions, was very helpful. Strategic Health Authorities also supported trusts in implementing the contract.



PART THREE

Not all of the intended benefits of the contract have been fully realised yet

3.1 The NHS Plan (2000) outlined the aim that the NHS would become a more consultant delivered service, with a new contract for consultants that:

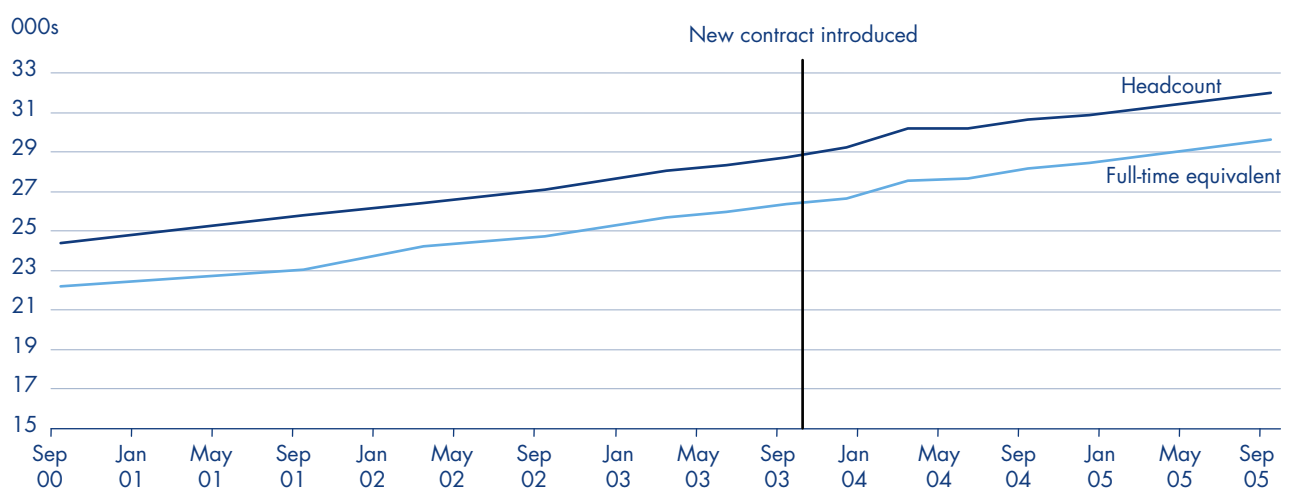
- rewarded and incentivised consultants who made the biggest contribution to service delivery and improving health services; and
- provided greater management control over consultants' NHS work.

The Department's business case submitted to HM Treasury in 2002²⁸ set out a number of explicit intended gains for the consultant contract, categorised into productivity benefits (including the better management of consultant time) and participation benefits (such as increases in retention). This part of the report examines how successful the NHS has been at achieving the stated benefits of the new contract.

Consultant participation in NHS work has increased as intended, but at a similar rate as under the old contract

3.2 The business case expected that the number of full-time equivalent consultants would increase, above the normal rate of expansion, by 250 (in 2003-04), 350 (2004-05) and 550 (2005-06). Although the targets for the initial two years were not met, the net increase in the number of consultants in 2005-06 was 853. The Department also predicted that between the publication of the NHS Plan (in 2000) and 2004 there would be an increase of 7,500 consultants, with further acceleration in number thereafter. This target was achieved by December 2004. The March 2005 census showed this target had been exceeded by 389 (**Figure 10**).

10 Consultant numbers have continued to rise at a similar rate since 2000



Source: Information Centre

3.3 The increase in numbers is principally attributable to improved recruitment of consultants (see paragraph 3.18). Twenty-three per cent of acute trusts that responded to our survey noted that recruitment had improved and the remainder that it had stayed the same. However, only five per cent of acute trusts identified an improvement in retention and five per cent a worsening, with the majority (90 per cent) indicating there had been no change. The reported improvement in recruitment is supported by the change in the three month vacancy rate for consultants, which was 1.9 per cent in March 2006, down from 4.4 per cent two years previously.²⁹

3.4 The impact of the contract on retention is unlikely to be seen for a number of years, although the potential exodus of consultants from the NHS has not happened. Some trusts reported that they were concerned that there may be an increase in retirements once consultants reach the upper pay threshold. The Department believes that, since consultants at the top of the pay threshold will continue to increase their pension entitlement, there is no basis for the concerns over potential increases in the number of retirements.

3.5 Few trusts used recruitment premia – a feature of the new contract consisting of a single payment intended to aid consultant recruitment – to encourage consultants to fill specific vacancies. Rather, in some cases trusts have offered consultants higher pay – in terms of extra programmed activities or entering on a higher pay threshold – to encourage recruitment.

3.6 In accordance with the Department's explicit expectation that private practice would not increase, our consultant survey found that the average amount of private work carried out by individual consultants has reduced slightly (from an average of 4.7 hours to 4.6 hours).³⁰ The success in achieving this proposed benefit was echoed in our trust survey.

It is too early to tell the full effect of the new contract on the productivity of consultants

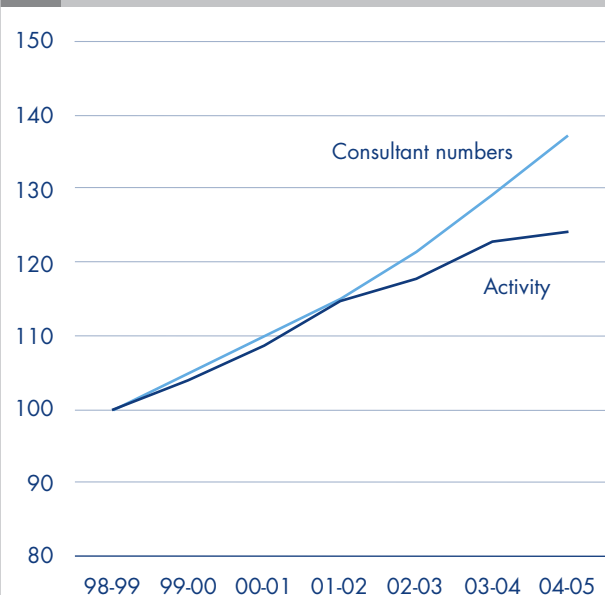
3.7 The business case (2002) set out the Department's expectation that, despite the legal requirement to restrict hours under the Working Time Directive, the new job planning framework would result in the NHS getting more outputs (activity) from consultants. However, activity in consultant-led procedures has risen at a lower rate than the increase in number of full-time equivalent consultants (**Figure 11**), which suggests that there has not been an increase in individual consultants' output.

3.8 In particular, the business case set out the expectation that the contract would halt the downward trend in consultants' clinical activity in the first year of the contract, with further efficiency gains in the following years. However, **Figure 12** shows that the number of finished consultant episodes per consultant continued to decrease until 2005-06. The contract has, therefore, yet to demonstrate that it is achieving the Department's tenet that it is 'vital to ensure the NHS is getting the maximum contribution possible from both existing and new consultants'.³¹

3.9 The Department estimated that they would achieve year-on-year consultant productivity gains of 1.5 per cent against a decreasing trend, through the expected efficiency gains and, also, improvement in the quality of consultant work. It calculated this productivity measure by multiplying the total expected NHS productivity by the ratio of consultant to total pay bill (Appendix 7). Based on the Office of National Statistics' productivity measure used at the time that the business case was developed, overall NHS productivity had been falling by 0.5 per cent year-on-year from 1997 to the end of 2004³². In 2006, the Office of National Statistics introduced a revised

11

The increase in consultant numbers has not been matched by an equal increase in consultant-led activity



Source: National Audit Office (based on Department of Health data). Activity and consultant numbers normalised at 100 for 1998-99.

productivity measure which measures two aspects of quality: health gain (reflecting safety and effectiveness) and patient experience (which includes aspects of responsiveness, user focus, acceptability, access and timeliness). This adjusted measure shows that productivity for the whole NHS has actually increased by between 0.9 and 1.6 per cent year-on-year from 1997 to 2004.

3.10 It is difficult to say how much of the aggregate increase in NHS productivity, if any, can be assigned to consultants and the new contract. It is difficult to evaluate the effect of the contract on the quality of consultants' work since the NHS does not systematically measure patient outcomes. Also, productivity figures for 2005-06 are not currently available.

Whilst most consultants now have job plans, managers and consultants views on the benefits differ

3.11 Following the introduction of the new contract, the number of consultants with job plans has increased considerably. Trusts estimated that only 50 per cent of their consultants had a job plan before the new contract was introduced and that, by July 2006, 96 per cent of consultants had an agreed job plan.

3.12 Although 75 per cent of trust chief executives felt that the expectations of the new contract were unrealistic, two thirds agreed that the new contract had improved the management of consultants³³, and a slightly higher percentage that job planning has been of benefit to the trust (**Figure 13**). The main reasons given for the latter was that it has improved the transparency of consultants' planned workload. This in turn has allowed managers to improve the flexibility and clarity of consultants' activities.

3.13 Just under 50 per cent of consultants who responded to our survey disagreed or strongly disagreed that they have clear objectives linked to service improvements or that the contract has changed the way they work for the better. And around 60 per cent of consultants disagreed or strongly disagreed that the new contract has led to them working more flexibly or that services are more responsive to patient needs. Whilst we identified a small number of examples where job plans have been used flexibly to deliver services in new ways (for example where trusts have undertaken team job planning to ensure that the needs of a particular speciality were met), from the consultants perspective, the contract has not yet led to a widespread change in ways of working.

12 The increase in consultant numbers has not been matched by an equal increase in finished consultant episodes

Finished episodes per consultant



Source: Department of Health, based on Hospital Episode Statistics

13 Trust chief executives' opinions on the impact of the new contract

	Strongly agree or agree %	Neither agree nor disagree %	Strongly disagree or disagree %	Too early to say %
The benefits expected were realistic	12	11	75	2
The new contract has improved the management of consultants	64	18	12	6
The performance of consultants is now measured	58	26	12	5
Job planning has been of real benefit to the trust	73	15	6	6

Source: National Audit Office survey of trusts

NOTE

Figures expressed as a percentage of the valid sample.

3.14 There was an expectation set out in the negotiating framework that the new contract would better link pay to performance. Whilst the new contract links pay to the achievement of the objectives in the job plan and, in theory, performance, we found that in reality the link to performance or outcomes of the individual consultants is rarely used. Despite the explicit link between the contract and appraisals, the trusts that we visited thought that the appraisal process and job planning process were not carried out in a coordinated way. They felt that this lack of coordination limits the trusts' ability to reward performance in an evidence based way. Although we acknowledge that appraisals should be based on consultants' development, coordinating job planning with appraisals could improve the link between pay and performance.

3.15 Consultants' opinions on the benefits of the new contract are divided (**Figure 14**), although they told us that their attitude to the new contract has been affected by the reduction in the number of programmed activities a trust is now prepared to pay. Consultants reported they were disillusioned by the way the new contract was implemented and see trusts' attempts to reduce the number of programmed activities as a pay cut, driven by finance considerations rather than a reduction in their workload. Consequently, many consultants are less willing to choose to work beyond their contractual hours.

3.16 Under the old contract, consultants moved up pay scales at a rate that was greater than the Department would have liked (pay drift). The consequence of moving up the pay scale was that pay increased significantly above inflation. One of the aims of the new contract was to reduce this pay drift, which is calculated by subtracting the increase in cost of consultants' salaries from the annual pay increase awarded by the Review Body on Doctors' and Dentists' Remuneration. After the initial sharp increase in consultants' salaries in the first year of the new contract, pay drift has decreased over the subsequent two years of the new contract; it is too early to say if this reduction is sustainable.

3.17 The cost incurred by trusts when trying to secure additional time from their consultants is less under the new contract. Prior to the new contract, any extra scheduled activities from consultants would be bought at locally negotiated rates, which were often at the same rate as consultants received for private practice work. However, the new contract allows for trusts to buy additional work at the same rate as for their other NHS work, and in a transparent manner.

3.18 One of the Department's aims of the new contract was to improve recruitment and retention of consultants and our survey confirmed that two-thirds of trusts reported that they had either recruitment or retention problems prior to the introduction of the new contract. Following the introduction of the new contract, 31 per cent of trusts said recruitment had improved and 69 per cent that it had stayed the same. But, in relation to retention, only seven per cent stated that it had improved and 88 per cent that it had stayed the same.

3.19 As part of the new contract direct clinical care has an indicative ratio of 75 per cent, to 25 per cent other programmed activities, to be agreed locally. Other programmed activities include supporting professional activities, additional NHS responsibilities, and external duties. Trusts have told us that they do not believe that the supporting activities of consultants are always used effectively, arguing that some consultants may need more supporting professional activities whereas others may need less. Our survey of consultants showed that when a job plan contains more than 10 programmed activities the ratio between direct clinical care and supporting activities drops below the typical 3:1 ratio.

Impact on consultants

Whilst the consultants' contribution is now better recognised, many felt that their job plans do not adequately reflect their workload

3.20 Prior to the new contract, over a third of consultants who were unhappy with the contractual arrangements said that this was because it failed to recognise their workloads. By agreeing individual consultants' duties and activities during job planning, the contract recognises the consultants' contribution to the NHS. After the introduction of the contract, 70 per cent of consultants reported that their salary better reflects their workload, although 62 per cent responded that their job plans do not adequately compensate for their working activities and responsibilities.

3.21 The contract provides more effective recognition of consultants' on-call duties. Consultants cited a lack of recognition of on-call responsibilities as a problem with the old contract. Yet when questioned about the impact of the new contract, 39 per cent of consultants agreed to some extent that their emergency workload is fairly recognised (compared to 29 per cent who disagreed or strongly disagreed). This reflects our survey finding that under the new contract 88 per cent of respondents have on-call responsibilities and, of these, 71 per cent are paid at the higher rate of on-call payment.ⁱ

ⁱ Corresponding figures from the Department's survey in October 2005 showed that 83 per cent of consultants have on-call responsibilities and, of these, 82 per cent are paid at the higher rate of on-call payment.

3.22 Consultants pay has increased significantly as a result of the new contract. The change to the salaries of consultants, as shown at **Figure 15**, is reflected in a survey carried out in 2004 which showed that the reported average annual pay increase that year for consultants switching to the new contract had been £12,454.³⁴

Furthermore, 45 per cent of respondents to the survey had received over £5,000 in back pay, with a third of these consultants receiving between £10,000 and £14,999. The Department's figures show that the average NHS earnings for consultants increased by an average of 8.2 per cent per annum between 2002-03 and 2005-06. Our survey revealed that two-thirds of consultants now agree, to some extent, that their salary better reflects their workload.

3.23 A review of consultants' (or their equivalents') pay reveals that their earnings in the United Kingdom are above the average for OECD countries, and the highest

amongst salaried (as opposed to self-employed) specialists^j (Appendix 4). The pay of consultants in England at the date of implementation was higher than in Wales but the same as in Scotland (Appendix 3).

Impact on patient care

It is difficult to show an explicit link between improvements in patient care and the new contract

3.24 The effects of the contract on patient experience are hard to disentangle from the existing trends and other factors influencing patient care. Certainly, the implementation of the contract has coincided with a number of other pay modernisation policies and other major reforms throughout the NHS.

14 Consultants' opinions on the new contract

	Strongly agree or agree %	Neither agree nor disagree %	Strongly disagree or disagree %	Too early to say %
I feel my work for the NHS is appropriately valued	37	19	43	1
Job plan does not reflect my working hours	49	15	35	1
I have an improved relationship with management	9	46	45	1
My salary better reflects my workload	70	15	15	0

Source: National Audit Office survey of consultants

15 The average pay for consultants has increased by 27 per cent since 2002-03

	Average consultant pay	Minimum basic pay (new contract)	Maximum pay, including local and national awards
2002-03	£86,746 (+3.8 per cent on previous year)	£52,640	£133,585
2003-04	£99,168 (+14.3 per cent)	£65,035	£155,180
2004-05	£103,648 (+4.5 per cent)	£67,133	£160,185
2005-06	£109,974 (+6.1 per cent)	£69,298	£165,351

Source: Department of Health and NHS Employers

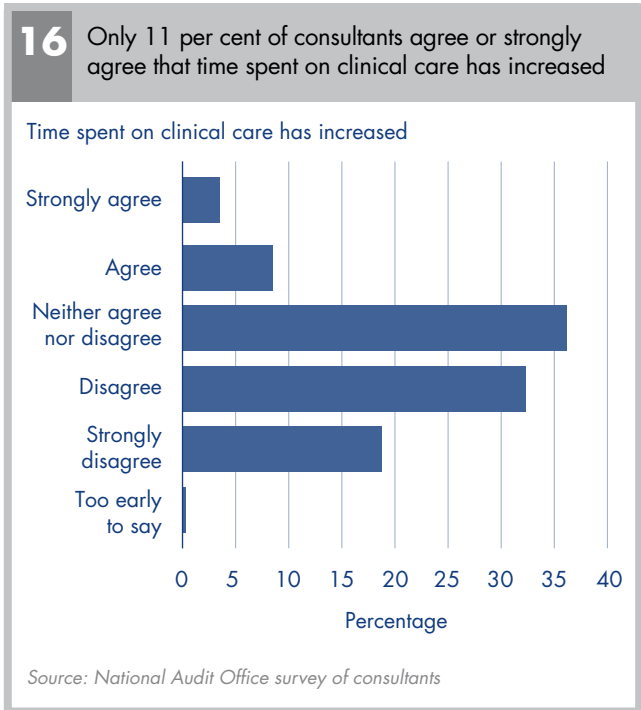
j Based on 2004 figures for specialists' average earnings as a ratio of GDP per capita.

3.25 We found that the contract has not increased the amount of direct clinical care offered by each consultant (**Figure 16**). Likewise, 69 per cent of full-time consultants responding to our survey reported that they had more than the expected 25 per cent of their contracted hours assigned to supporting professional activities (and therefore not on direct clinical care). This is reflected in a reduction in the rate of increase in consultant-led NHS activities (at Figure 11). In 2005, a Department survey showed that 73 per cent of consultants' programmed activities were allocated to direct clinical care.

3.26 This reduction in the amount of clinical care offered by individual consultants has affected the achievement in attaining some of the other proposed benefits of the contract. Our surveys showed that more consultants and trusts disagreed than agreed that waiting lists, patient care and service responsiveness have improved as a result of the new contract (**Figure 17**).

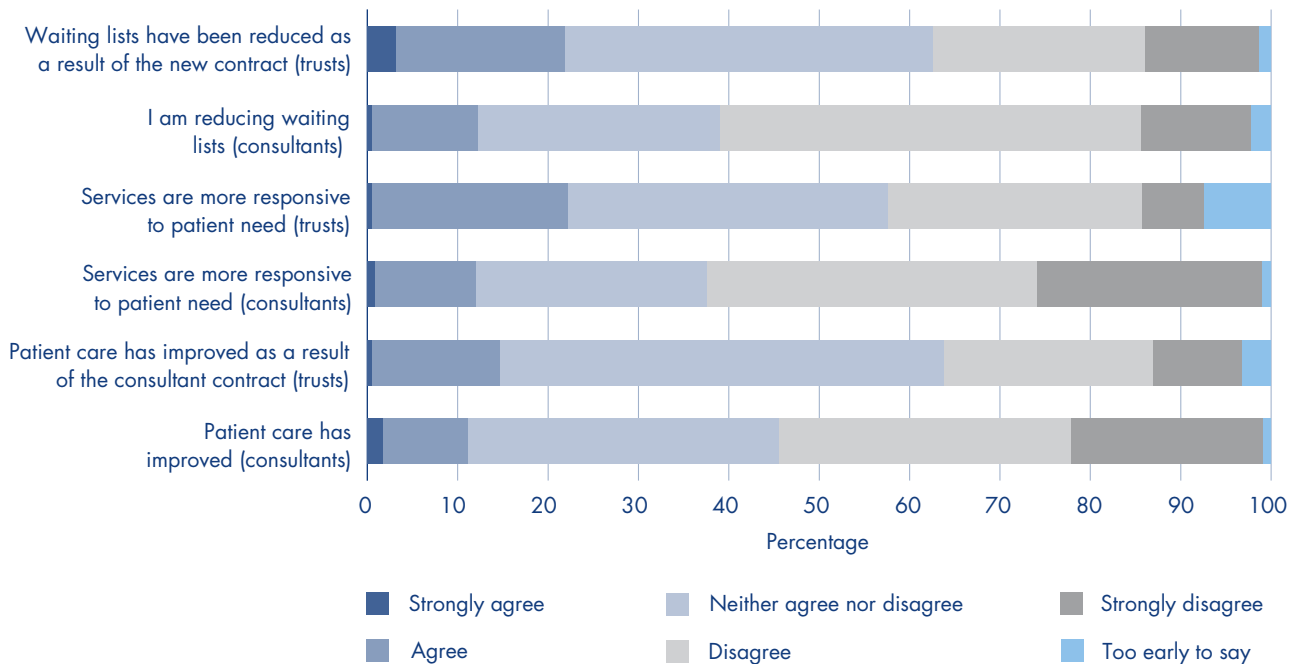
3.27 Only 12 per cent of trusts responding to our survey believed that the benefits expected from the contract were realistic compared to over two-thirds who did not think that they were. Trusts were unclear as to what benefits were expected from the contract and to what extent they should try to measure any impacts. The lack of time for the local implementation also restricted attempts to set up measures to evaluate impacts since resources were

instead used on setting up and agreeing job plans. As a result, trusts have not been able to adequately calculate or enhance the potential benefits offered by the contract.



17 On balance, consultants and trusts do not believe that the new contract has contributed to an improvement in waiting lists, service responsiveness or patient care

Level of agreement or disagreement about the benefits of the contract from our consultant and trust surveys



Source: National Audit Office survey of trusts and consultants

GLOSSARY

Acute Trust	An NHS trust which provides secondary or hospital based health care services. An acute trust can cover one or more hospitals.
Additional Programmed Activities	Additional Programmed Activities are not linked to spare professional capacity but may be paid to reflect regular, additional duties or activities (whether scheduled or unscheduled) that cannot be contained within a standard 10 Programmed Activities contract. They can be used, for example, to recognise an unusually high routine workload, or to recognise additional responsibilities.
Consultant Contract Implementation Team	The Consultant Contract Implementation Team was set up by the NHS Modernisation Agency to support trusts with implementation of the new contract. In April 2005, the team was split in two. Some staff moved to NHS Employers and were tasked with maintaining, amending and refining the 2003 contract. Other staff joined the newly created Consultant Contract Benefits Realisation Team, which was separate from NHS Employers and given a year's funding to support trusts in deriving benefits from the contract.
Clinical Excellence Awards	Financial payments made to consultants in recognition for the quality of the work over-and-above what is normally expected in their job. These can be awarded locally and nationally through the Clinical Excellence Awards Scheme.
Consultant Outcomes Indicators	These are measures of consultant performance, developed in consultation with trusts in Wales.
Direct Clinical Care	Work directly relating to the prevention, diagnosis or treatment of illness that forms part of the services provided by the employing organisation under section 3(1) or section 5(1)(b) of the National Health Service Act 1977. This includes emergency duties (including emergency work carried out during or arising from on-call), operating sessions including pre-operative and post-operative care, ward rounds, outpatient activities, clinical diagnostic work, other patient treatment, public health duties, multi-disciplinary meetings about direct patient care and administration directly related to the above (including but not limited to referrals and notes). The standard contract expects that a consultant should spend 75 per cent of their time on direct clinical care.
Extra Programmed Activities	Extra Programmed Activities are linked to spare professional capacity. Consultants wishing to undertake private practice as defined, and who wish to remain eligible for pay progression, are required to offer up the first portion of any spare professional capacity. There is flexibility to agree a fixed number of Extra Programmed Activities to be undertaken as required over the course of the year.

Foundation Trust	A new type of NHS trust that has greater management and financial freedoms to retain surpluses and invest in delivery of new services than other NHS trusts.
Job Plan	A prospective agreement that sets out a consultant's duties, responsibilities and objectives for the coming year. In a job plan a consultant's working week is separated into three or four hour blocks of activities known as Programmed Activities .
On-call Availability Allowance	If a consultant is required to participate in an on-call rota, they will be paid a supplement in addition to basic salary in respect of their availability to work during on-call periods. The supplement is paid based on rota frequency and category of on-call duties (either category A, where the consultant is required to return immediately to site when called, or category B, where the consultant can typically respond by giving telephone advice and/or by returning to work later).
Pay Drift	Pay drift is the calculation of increased pay due to movement up a pay grading system rather than as a result of inflation.
Productivity	The relationship between production of an output and one, some, or all of the resource inputs used in accomplishing the assigned task. It is measured as a ratio of output per unit of input. The Department produce a quality-adjusted measure for the productivity of the whole NHS but do not produce a separate metric for consultant productivity.
Productive Time Programme	The Productive Time Programme is part of the Gershon Efficiency Programme from the report "Releasing Resources to the Front Line" (July 2004).
Programmed Activities (PAs)	The new consultant contract organises a consultant's working week into programmed activities (PAs). The basic contract for a full-time consultant is ten four-hour PAs per week. There are four types of PAs: direct clinical care, supporting professional activities, additional NHS activities, and external duties. NHS Trusts can contract separately for additional PAs where a consultant has regular, additional duties that cannot be contained within a standard ten PA contract.
Review Body on Doctors' and Dentists' Remuneration	The role of the Review Body on Doctors' and Dentists' Remuneration (also referred to as the Review Body) is to make recommendations to the Prime Minister, the Secretary of State for Health, the Secretary of State for Scotland and the Secretary of State for Wales on the remuneration of doctors and dentists taking any part in the NHS. The Review Body must give regard to: the need to recruit, retain and motivate doctors and dentists; the effects of regional/local variations in labour markets on recruitment and retention; the UK health departments' output targets for the delivery of services and the funds available; the Government's inflation target; and evidence submitted by the Government, staff, professional representatives and others.
Recruitment and Retention Premium	These are additional payments that are used as incentives by NHS trusts when they have found difficulties in recruiting staff.
Supporting Professional Activities (SPAs)	Activities that underpin Direct Clinical Care . This may include participation in training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities. Typically, one-quarter of a consultant's working week will be given to SPAs.

APPENDIX ONE

Summary of the Audit Commission's reports: The Doctors' Tale (1995) and The Doctors' Tale Continued (1996)

1 In 1995, the Audit Commission published *The Doctors' Tale: The Work of Hospital Doctors in England and Wales* based on a study into the organisation and working practices of doctors in acute hospitals in England and Wales. The study involved carrying out interviews, surveys and analysing data from 26 NHS trusts.

2 One part of the report looked at the contribution of consultants to NHS work. The study highlighted that consultants have a pivotal role with hospitals and that they work long hours and 'have considerable autonomy to determine their work patterns'^k. Specifically, the study found that:

- only half of the hospitals surveyed had a complete set of job plans (p39);
- forty one per cent of consultants attended less than nine out of ten of their fixed commitments, even when accounting for leave and cancelled sessions (p40); and
- the upper quartile of consultants who had the most private practice work carried out less NHS work than their colleagues (p44);

The study recommended that all consultants should have job plans that: were comprehensive, consistent, monitored, regularly reviewed and distributed work evenly.

3 In the following year, the Audit Commission published *The Doctors' Tale Continued: The Audits of Hospital Medical Staffing*. This study involved conducting audits in most NHS trusts and directly managed units in England and Wales that provide acute hospital services. The results from the audits confirm the findings in *The Doctors' Tale* and, 'because the data comes from a much larger sample of acute hospital trusts, add weight to the original conclusions.'^l

4 In particular, regarding job planning, the follow up report found that:

- a quarter of consultants did not have job plans; and
- sixty per cent of consultant job plans had been reviewed in the previous year.

The report reiterated the recommendation that trusts should regularly review the job plans of all their consultants.

^k p38, Audit Commission, *The Doctors' Tale: The Work of Hospital Doctors in England and Wales*, 1995.
^l p3, Audit Commission, *The Doctors' Tale Continued: The Audits of Hospital Medical Staffing*, 1996.

APPENDIX TWO

Methodology

1 We designed this study to examine the following question – “Are the public and the NHS receiving the benefits of the new consultant contract and was it effectively implemented?” We used the following methods to help answer this question.

A census of all NHS acute and mental health trusts

2 We carried out a census of all NHS acute and mental health trusts to gather data on the implementation and perceived benefits of the new contract for consultants. We asked for the opinion of chief executives, medical directors, directors of finance and directors of human resources within trusts. We also collected quantitative data on costs and job plans. The data was analysed and is published on the National Audit Office website. We received responses from 208 of the 234 trusts to which we sent the survey. We have extrapolated expenditure figures in the report to cover the remaining trusts. A copy of the results of our trust survey is available on our website www.nao.org.uk

A survey of consultants in England

3 We sent out a survey to 6,000 consultants in England – selected through simple random sampling – to obtain views on the new contract. We received 2,361 responses (a 39 per cent response rate). The results were analysed and are also published on the National Audit Office website.

4 The figures used in this report are given as a percentage of the total valid responses given to the question. For example, “58 per cent of consultants in our survey believe that their current contract does not reflect their current working hours” (Executive Summary, paragraph 20) is based on: Q26. *Does the new contract accurately reflect current working hours?*

- 2,035 consultants on the new contract responded to the question. Adjusting for non-responses (blanks) there were 1,969 valid responses, of which there were 1,136 “No” responses (57.7 per cent of the 1,969). The 95 per cent confidence interval is [55.5 per cent, 59.9 per cent], so the result given in the report is +/- two per cent.

Case study visits to 13 NHS trusts (foundation and non-foundation) and nine Strategic Health Authorities

5 We visited 13 trusts in order to undertake more detailed cases studies of the way that the contract had been implemented in the NHS. At each trust we used semi-structured interviews with a variety of staff which included directors of human resources, directors of finance, medical directors, clinical directors and consultants. The trusts we visited were:

- Medway NHS Trust
- Moorfields Eye Hospital Foundation Trust
- Portsmouth Hospitals NHS Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- South Essex Partnership NHS Foundation Trust
- Walsall Hospitals NHS Trust
- West Suffolk Hospitals NHS Trust
- Ipswich Hospital NHS Trust
- Milton Keynes General Hospital NHS Trust
- Newcastle, North Tyneside and Northumbria Mental Health Trust
- Leeds Teaching Hospital NHS Trust
- Bedford Hospital NHS Trust
- North West London Hospitals NHS Trust

6 We interviewed staff from the Strategic Health Authorities (prior to the reorganisation in autumn 2006) that were responsible for supporting trusts to deliver the new contract for consultants. Nine health authorities were interviewed, which were:

- Avon, Gloucester and Wiltshire
- Cumbria
- North Central London
- Essex
- Birmingham and Black Country
- South West London
- Leicestershire, Northamptonshire and Rutland
- Hampshire and Isle of Wight
- Thames Valley

Meetings with key stakeholders

7 We consulted with a variety of external stakeholders during the study using semi-structured interviews. Stakeholders included the NHS Confederation, NHS Employers, British Medical Association, Royal Colleges and academics at York and Manchester Universities and the British Association of Medical Managers.

Data analysis

8 We used analysed data provided by trusts and the Department of Health. The metric for measuring consultant activity used in Figure 12 involved disaggregating the Department's data on NHS activity so that only consultant-led activities were included in the calculation. This method was developed with support from the Office of National Statistics. The figure for productivity was based on the method underlying the expected productivity benefit described in the Department's business case submitted to the HM Treasury in 2002. This method is based on multiplying the productivity measure for the whole NHS by the ratio of consultant pay to total pay. This method was used in order to isolate the productivity benefit from the new contract for consultants. We replicated this method using a quality adjusted productivity measure as this has replaced the previous measure of productivity (see Appendix 7).

Literature review

9 We reviewed existing literature and research from a variety of sources, including academic journals and Department of Health, BMA, the NHS Confederation, HM Treasury, and OECD publications.

Gaining expert input

10 We engaged an expert panel to provide advice to us during the study process, both in designing the fieldwork and providing feedback on the emerging findings. The expert panel consisted of:

- Department of Health
- Gill Bellord (NHS Employers)
- Dr Karen Bloor (University of York; Selby and York Primary Care Trust)
- Professor James Buchan (Queen Margaret University)
- Chris Cardwell (NHS Employers)
- Dr David Eccles (Portsmouth Hospitals NHS Trust)
- Nigel Edwards (NHS Confederation)
- Dr Jonathan Fielden (British Medical Association)
- Peter Gordon (British Medical Association)
- Alastair Henderson (NHS Employers)
- Derek E Jones (Welsh Assembly Government)
- Professor Alan Maynard (University of York; York NHS Trust)
- Claire Sweeney (Audit Scotland)

APPENDIX THREE

A comparison between new consultant contracts in England, Wales and Scotland

The differences in the terms of the contracts in England, Wales and Scotland

1 New consultant contracts were also implemented in Wales and Scotland. Although the aims of the contract were similar, the terms of the English, Welsh and Scottish contracts are not identical. In England the contract was available from 31 October 2003, whereas in Wales and Scotland the contract was effective from 1 December 2003 and 1 April 2004. The implementations of the Scottish and Welsh contracts were reviewed by Audit Scotland and the Wales Audit Office respectively. This appendix summarises the main differences in the three contracts.

2 In England and Scotland, consultants were not obliged to commit to the new contract and could remain employed under their existing contracts. However, in Wales the new contract was an amendment to the existing contract and, therefore, the new terms were binding on all consultants whether or not they voted for the change.

3 The pay structure and levels for England and Scotland are similar. However, in Wales the starting salary for consultants was £2,035 lower although the initial incremental annual increases are higher than in England and Scotland. Once consultants in Wales have reached the top of the basic pay scale, they are eligible for Commitment Awards. These awards, each worth £2,835 per annum, are accrued every three years (up to a maximum of eight awards) subject to satisfactory annual job plan reviews. Discretionary awards have been abolished in Wales. A comparison of the pay scales is at **Figure 18**.

18 The starting salary for consultants in Wales is lower than in England and Scotland

Years of seniority	England	Wales	Scotland
1	£65,035	£63,000	£65,035
2	£67,100	£65,035	£67,100
3	£69,165	£68,440	£69,165
4	£71,230	£72,395	£71,230
5	£73,290	£76,910	£73,295
6	£73,290	£79,485	£73,295
7	£73,290	£82,065	£73,295
10	£78,195	£82,065	£78,200
15	£83,100	£82,065	£83,105
20	£88,000	£82,065	£88,010

Source: British Medical Association

NOTE

Figures correct at date of implementation and excludes clinical excellence, discretionary awards and Commitment Awards.

4 In England, any consultant that committed to take up the new contract before it became available, on 31 October 2003, as granted six months back pay. Consultants who committed to the new contract between 31 October 2003 and 31 March 2004 had their pay backdated by three months. In Scotland, any consultant who committed to take up the new contract before it became available, on 1 April 2004, was entitled to back pay. This payment was equivalent to the difference between what consultants were actually paid under the old contract in 2003-04 and what they would have received if the new contract had been implemented in April 2003. However, in Wales there was no backdating of pay.

5 In England and Scotland, consultants are expected to provide 75 per cent of their time on direct clinical care. However, in Wales a full-time consultant will typically only undertake 70 per cent on direct clinical care.

6 Under the new contracts in England and Scotland, a consultant who wishes to undertake private practice and remain eligible for pay progression should be prepared to work an extra programmed activity for their NHS employer organisation. However, in Wales, consultants wishing to undertake private practice are not required to offer to work additional NHS hours.

Summary of annual report on the impacts of the amended consultant contract in Wales

7 The amended consultant contract in Wales became effective on 1 December 2003. The National Assembly for Wales³⁵ produced a report covering the implementation and outcomes of the consultant contract in Wales up to March 2006, which followed up a previous report produced by the Wales Audit Office.

8 The report noted that the average weekly working hours of consultants in March 2006 was 44.3 (a reduction of two hours since the amended contract was made effective). There had also been a 16 per cent increase in consultant numbers in the two years up to September 2005 (compared to an 11 per cent increase in England). Similarly, vacancy rates for consultant posts in Wales were reported to have fallen from 9.5 per cent in September 2003 to 5.4 per cent in March 2006.

9 Since the introduction of the contract, a formal structure for developing and implementing Consultant Outcome Indicators had been put in place. These indicators allow trusts to measure and compare the quality of care provided by individual consultants. Such measures and targets are not included in job plans in England.

10 These Consultant Outcome Indicators are being delivered by a private health informatics company, which entered contractual arrangements with Welsh trusts in 2005. The contracts have been funded by the Welsh Assembly. All trusts in Wales have confirmed that they were involved in the Consultant Outcome Indicator programme, although it is 'likely to be a further two to three years before the Consultant Outcomes Indicators can effectively inform individual job planning, service commissioning, and performance management'.³⁶

11 Trusts in Wales also appear to have ensured that there is adequate management capacity to link job planning with their overall service modernisation agenda. As a result, trusts have been able to identify specific examples of service improvement related to job planning.

12 Although the amended contract in Wales has a reduction in the average amount of direct clinical care provided by a consultant, this potential reduction in activity has been offset by an increase in consultant numbers. As a result, only one trust reported that there had been a loss of consultant activity.

Summary of national review of the implementation of the consultant contract in Scotland

13 The new contract for consultants in Scotland became available on 1 April 2004. The report examining the implementation of this contract was published by Audit Scotland in March 2006.

14 The Scottish Executive Health Department estimated the cost of the contract based on the model provided by the UK Department of Health. This model estimated that the new contract would cost an additional £64 million over three years. In fact, the NHS in Scotland has spent an additional £235 million (or £273 million including inflation and on costs) on employing consultants in these three years.

15 Although the Scottish Executive Health Department outlined the expected benefits of the contract in 2002, it did not set out specific performance indicators and monitoring systems that could be implemented by consultant employers. The report on the implementation found that whilst the contract represented a change in the way that consultants work with their managers, the opportunity to improve patient care had not yet been taken.

16 In July 2005, the Scottish Executive Health Department set a requirement that boards (the equivalent of NHS trusts in England) must be able to demonstrate how they are using the pay modernisation reforms to achieve national priorities and improve patient care. However, the plans produced by NHS boards in Scotland are not comparable and do not show the direct intended benefits of the contract explicitly.

APPENDIX FOUR

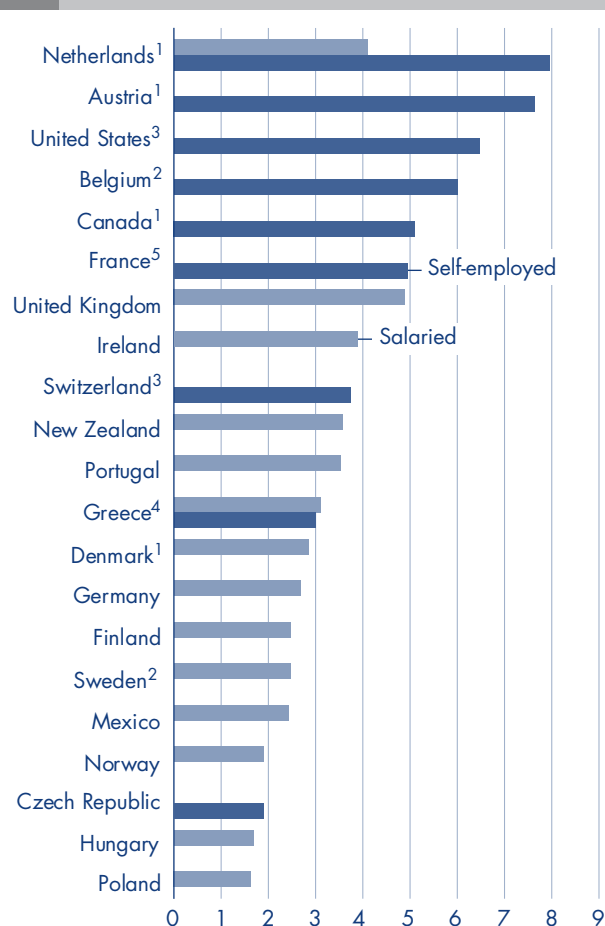
Comparison of consultant pay internationally

NHS consultants are paid at a higher rate than in many other developed countries

1 A comparison of the remuneration of specialist doctors, based on 2004 figures, reveals that the average pay in the United Kingdom, as a ratio of GDP per capita, is higher than in many other OECD countries (Figure 19). This position is accentuated when you consider only consultants who are paid by salary (rather than self-employed). However, the direct comparison between doctors in different countries needs to be treated with some caution because of the different nature and volume of the work and level of training.

2 A comparison of the pay of specialist doctors within other OECD countries also suggests that there is a correlation between the number of specialists per capita and their average pay (Figure 20). This trend reflects the combination of market forces, increasing pay and the increased seniority of specialist doctors in countries with fewer specialists per capita. However, the United Kingdom is above this trend and still appears to pay at a higher level than the other countries with salaried specialists.

19 Specialist doctors pay for developed countries in 2004, as a ratio of GDP per capita

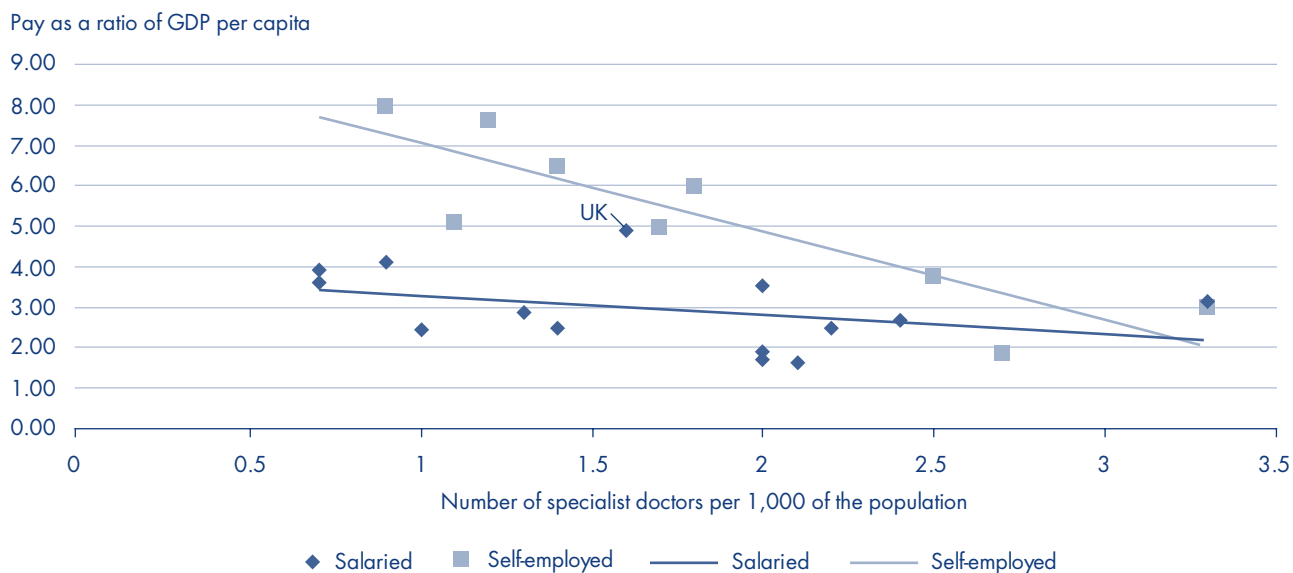


Source: OECD Data 2006

NOTES

- 1 Data for 2003.
- 2 Data for 2002.
- 3 Data for 2001.
- 4 Data for salaried doctors is for 2005.
- 5 Estimated figure for ratio to GDP per capita.

20 The relationship between pay of specialist doctors and the number of specialist doctors per head of population



Source: OECD Health Data 2006

APPENDIX FIVE

Chronology of circulation of guidance from the Department and representatives

Departmental Guidance

All the following information is available from DH Website: www.dh.gov.uk

24 June 2002	Contract Framework published " <i>A New Consultant Contract</i> " Contains the full text of the framework and supporting annexes.
5 August 2002	Letter from Department's Director of Human Resources to trust and PCT Chief Executives on the " <i>New Consultant Contract</i> ".
6 August 2002	Letter sent to Chief Executives, Directors and NHS trusts, PCTs and Health Authorities. " <i>New Consultant Contract</i> " Contains questions and answers, and highlights importance of local discussion and implementation.
24 September 2002	Explanatory note to the consultant contract framework document agreed between Department and BMA.
1 November 2002	Letter sent to Chief Executives in trusts, PCTs and HR Directors. Contains information about the "no" vote result of the ballot on the framework.
1 January 2003	Document published outlining arrangements in the new contract to allow part-time working <i>New NHS Consultant Contract: Part-time and Flexible working</i> .
1 January 2003	New model contract published.
4 February 2003	Letter from Department's Director of Finance to trust and PCT Chief Executives.
April 2003	<i>DH Job planning: Standard of Best Practice</i> published.
17 April 2003	Letter sent to NHS Chief Executives, SHAs, PCTs, and HR Directors. " <i>Improving Rewards for NHS Consultants</i> " Contains information about stage of framework agreement, where to go for information and what to do next, encourages local discussion with consultants.
1 August 2003	Letter to Chief Executives of NHS Trust, PCTs, SHAs, WDC, Medical Directors, and HR Directors. " <i>Consultant contract update</i> " Explaining situation following Heads of Agreement (17th July 2003). Encourages local discussion, contains model contract, and next steps.
September 2003	Transitional arrangements – a briefing.
11 September 2003	Letter to all NHS Chief Executives, Medical Directors, and HR Directors. Letting them know final documentation agreed by DH, BMA, and NHS Confederation to go for vote.
October 2003	Frequently Asked Questions guidance, followed in the same month by an update. Step-by-step, annualised, and suggested approached to difficult situations job planning guidance.

1 October 2003	Guidance for application of contract for clinical academic published.
20 October 2003	Letter to NHS Chief Executives, Medical Directors and HR Directors. Contains information about the yes vote, summary of framework agreement job planning, backdating, and where to go for further information.
20 October 2003	Consultant Contract – formal terms and conditions and various formal guidance published.
10 November 2003	Consultant contract: Questions and answers - revised edition 10 November 2003.
December 2003	Guide to Implementation – Workbook and CD Rom. Consultant contract financial assumptions briefing note. Introductory note on key pay elements.
18 December 2003	Letter formally confirms the pay arrangements for those NHS medical and dental consultants employed on the new 2003 national terms and conditions.
19 December 2003	Letter from Department's Pay Reform Director to Strategic Health Authority Chief Executives.
22 December 2003	Consultant Clinical Academic Contract Documentation published.
January 2004	Consultant contract guide to costs and funding.
15 January 2004	Letter from Andrew Foster to NHS Chief Executives about arrangements for funding the additional costs of implementing the new contractual arrangements for consultant clinical academics.
19 January 2004	Revised Terms and Conditions of Service for NHS Consultant Clinical Academic published (2003) (PDF, 199K).
27 January 2004	Further guidance on contract for clinical academics published.
March 2004	Practical guide to calculating on call work. Frequently Asked Questions update. Mediation in job planning – a protocol.
April 2004	Guide to contracting for Additional programmed activities. Guide to job planning for clinical academics.
May 2004	Joint protocol for implementation support.
12 May 2004	Letter from Department's Director of Human Resources to Strategic Health Authority Chief Executives on the <i>"Implementation of the consultant contract"</i> .
28 May 2004	A further letter from Department's Director of Human Resources to Strategic Health Authority Chief Executives.
June 2004	Model protocol for appeals.
July 2004	Joint guide for appeals panels.
August 2004	Guide to determining on call availability supplements. Appeals guide and resources CD Rom.
8 September 2004	HR Directors Bulletin, Issue 92 published containing guidance on contract mediation and appeals.
December 2004	Guide to Supporting Professional Activities.
January 2005	Consultant job planning toolkit and CD Rom. Effective job planning: a concise guide for consultants.

NHS Modernisation Agency Guidance

All the information below is available from the following website: <http://www.wise.nhs.uk/sites/workforce/retaininganddevelopingstaff/Consultant%20Contract%20Document%20Library/Forms/Description.aspx>

Updates issued by Consultant Contract Implementation Team (CCIT)

Date	Update number	Summary of key guidance and details in update
29 August 2003	01	Details of SHA/WDC Leads and good practice development trusts
8 October 2003	02	Included information sheet on consultant contract
16 October 2003	03	British Association for Medical Managers support for Job Planning; and principles for clinical academics
22 October 2003	04	BMA ballot result; Note on appointment of new consultants; and Resources and support for job planning
3 November 2003	05	Performance management by SHAs
7 November 2003	06	Survey of consultants intentions
14 November 2003	07	Online help service from CCIT announced
21 November 2003	08	Implementation Workshops announced
28 November 2003	09	Update on consultant intentions survey; FAQs published; and new online resources on job planning announced
8 December 2003	10	Launch of online implementation guide; and financial assumptions information
22 December 2003	11	Pensions arrangements for MPT consultants; and results of survey on consultant intentions
12 January 2004	12	Sample job plans published
20 January 2004	13	CCIT guide to costs and funding; and Departments policy on external duties
30 January 2004	14	CCIT guide to costs and funding
6 February 2004	15	Recruitment advertising terminology
8 March 2004	16	Contracting for extra PAs; and calculating on-call work
26 March 2004	17	Mediations and Appeals
5 April 2004	18	General update
19 April 2004	19	Contract for additional PAs; and introduction of New online resource for Clinical Academics
11 May 2004	20	CCIT/BMA Joint support protocol; New FAQs including guidance on category A & B on call duties.
3 June 2004	21	Model protocol for appeals

21 June 2004	22	Pensions - extension for arrears contributions
30 June 2004	23	Access to mediation and appeals; and revised 'Ready Reckoner' published
27 July 2004	24	CCIT/BMI Joint guide for appeal panels
13 August 2004	25	Additional PAs - contracts and job plans
26 August 2004	26	Guide to determining on-call supplements
22 October 2004	27	Appeal panel training workshops
24 November 2004	28	Changes to national tariff
22 December 2004	29	Guide to Supporting Professional activities
11 April 2005	30	Announcement of the reorganisation of CCIT

Other Documents and Guidance published on the Modernisation Agency website:

December 2003	Guide to Local Contractual Flexibilities
June 2004	Key Pay Elements (amended)
December 2004	Guide to Supporting Professional Activities
December 2004	Updated Frequently Asked Questions
March 2005	Complete Training Package
March 2005	Guide Annualised Job Plans
January 2005	Evaluation Framework
January 2005	Consultant Job Planning Tool Kit.
January 2005	Effective Job Planning: A Concise Guide for Consultants
January 2005	Web Pages on Mediation and Appeals
December 2005	Powerpoint presentation on Effective Job Planning training
December 2005	Briefing on 2003 Consultant Contract, Explanation of key points; overview of job planning process; aims and objectives; and explanation of consultant job planning

APPENDIX SIX

Calculating the cost of the new contract

1 This appendix sets out the two sets of plausible alternative methods, referred to in the report, for calculating the cost of the contract. Both methods are based on considering a counterfactual whereby all consultants remained employed on the old contract. The calculations consider only the cost of employing consultants and, therefore, do not evaluate the contract outcomes.

2 The scenario, in which consultants remained on the old contract, would not have addressed the rationale behind the need for a new contract, such as to prevent the potential exodus of consultants from the NHS. There may also have been a need for larger pay rises to achieve the NHS Plan's commitment to meet the public demand of "more better paid staff".

3 We calculated the actual cost of employing consultants since 2002-03 using financial returns from NHS trusts and some additional data from a number of foundation trusts. For 2005-06, the cost to foundation trusts was extrapolated based on their previous year's expenditure.

Method One

4 This model uses pay settlements that have actually been awarded for those consultants who have stayed on the old contract – counterfactual A – which were generally in-line with other public sector pay settlements. Specifically, the model takes into account the:

- Actual rise in number of consultants since 2002-03 (20 per cent up to 2005-06);
- Actual inflationary pay settlements since 2002-03 (between 2.5 and 3.225 per cent per annum);

- Estimated effect of pay drift^m under the old contract (averaging 2.9 per cent per annum); and
- The increase in employers' contribution (from 7 to 14 per cent in 2004-05).

The costs of the contract using these assumptions are reported in **Figure 21**. The model suggests that the contract has cost the NHS an additional £50 million above the £715 million allocated to them, which correlates with the views of trust chief executives that the contract was not fully funded.

Method Two

5 The second model extrapolates forward the average trend of unit cost of employing a consultant from 1998-99 to 2002-03 (counterfactual B) to predict what would have happened to consultants' pay without the new contract. Specifically, this model takes into account the:

- Actual rise in numbers of consultants since 2002-03 (20 per cent up to 2005-06);
- Estimated increase in the cost of employing a consultant (pay settlements and pay drift, averaging 6.6 per cent per annum); and
- The increase in employers' contribution (from 7 to 14 per cent in 2004-05).

The costs of the contract using these assumptions are reported in **Figure 22**. This model suggest that the contract was fully funded.

^m Pay drift is the calculation of increased pay due to movement up a pay grading system rather than as a result of inflation.

21 The estimated difference between cost and funding of the new contract (Method One)

	2000-01 £m	2001-02 £m	2002-03 £m	2003-04 £m	2004-05 £m	2005-06 £m	Total since 2002-03 £m
Expenditure on consultants pay (1)	1,966	2,192	2,395	2,964	3,539	3,850	10,353
Counterfactual A (2)				2,707	3,251	3,627	9,587
Estimated difference (1-2)				256	287	222	765
Additional Funding allocated to NHS				133	182	400	715
Difference between cost and funding				123	105	(178)	50

22 The estimated difference between cost and funding of the new contract (Method Two)

	2000-01 £m	2001-02 £m	2002-03 £m	2003-04 £m	2004-05 £m	2005-06 £m	Total since 2002-03 £m
Expenditure on consultants pay (1)	1,966	2,192	2,395	2,964	3,539	3,850	10,353
Counterfactual B (2)				2,716	3,294	3,694	9,704
Estimated difference (1-2)				248	245	155	649
Additional funding allocated to NHS				133	182	400	715
Difference between cost and funding				115	63	(245)	(66)

APPENDIX SEVEN

Calculating productivity of the whole NHS and the consultant contract

1 Productivity estimates for the NHS are based on the ratio of volume of NHS outputs to volume of NHS inputs. Estimates on the productivity of the NHS vary depending on the measure of inputs and outputs. Using output data without including adjustments for quality of care (health outcomes) or the increase in value of health, estimates that NHS productivity had decreased by 1.5 per cent year-on-year. When these adjustments are included the productivity measure estimates an average annual increase of 1.6 per cent (see Figure 23 and 24).

2 The two ranges of productivity measure shown above are aggregate, whole-system productivity. It is difficult to disentangle the contribution of individual factors of production, such as capital and labour, to the overall productivity gain. It is therefore also difficult to isolate the contribution made by particular types of labour, for example consultants or nurses.

3 The calculation underpinning the expected benefit expressed in the business case submitted to HM Treasury in 2002 uses the ratio of consultant pay bill (£2.4 billion) to NHS pay bill (£21.1 billion) to factor the contribution of

consultants to the change in whole system productivity. If consultant productivity had increased by 1.5 per cent net it would have increased whole system productivity growth by 0.17 per cent per annum.

4 The Department was also set a Public Service Agreement target for a global, whole system efficiency of two per cent per annum, of which one per cent would be quality enhancing and one per cent cost reducing. The Department was not asked to measure the contribution of individual efficiency drivers but rather to measure and deliver the overall objective. Subsequently the Public Service Agreement target was overtaken by the Gershon Productive Time efficiency target of 2.8 per cent per annum which came into effect in 2004-05.

Recent trends on Consultant Clinical Activity

5 Consultant activity has fallen every year from 2000-01 to 2004-05. In 2005-06 this trend was halted, with activity per consultant holding constant (Figure 25).

23 Comparison of adjusted and unadjusted NHS productivity measures

	1999	2000	2001	2002	2003	2004	Average annual growth %
Not including adjustments to output measure for quality or value of health ¹	100	100.2	98.4	96.6	93.9	92.5	-1.5
Including adjustments for both quality and value of health ²	100	102.5	104.5	105.8	105.8	108.5	+1.6

Source: Office of National Statistics (2006) Sources and methods for Public Service Productivity: Health article

NOTES

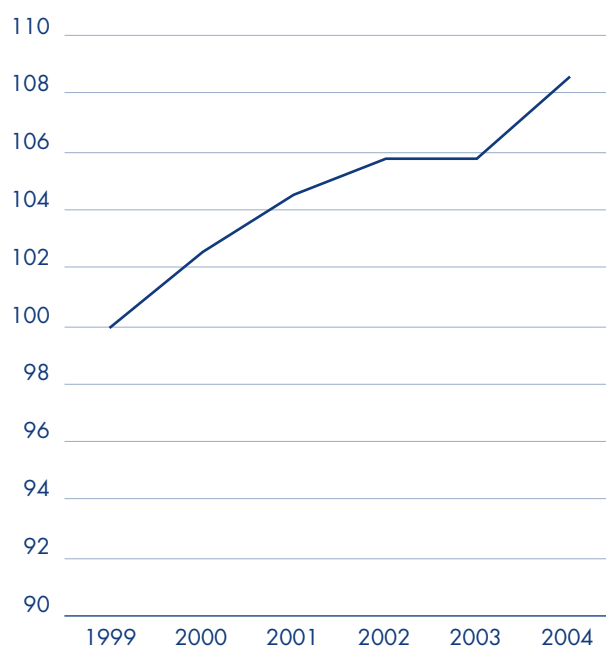
- 1 Using Paasche Price Index; indirect volume of labour measure; and capital services measure.
- 2 Using Net Ingredient Cost; direct volume of labour measure; and capital consumption measure.

24 Graphical comparison of adjusted and unadjusted NHS productivity measures

Unadjusted NHS productivity



Adjusted NHS productivity



Source: Office of National Statistics

25 Inpatient activity per consultant 2000-01 to 2005-06

	Total inpatient activity (Finished Consultant Episodes, FCEs) million	Total number of consultants (Full-Time Equivalents)	FCEs per Consultant	Percentage change in FCEs per Consultant %
2000-01	12.3	22,186	553	
2001-02	12.4	23,064	536	-3.1
2002-03	12.8	24,756	515	-3.8
2003-04	13.2	26,341	500	-2.9
2004-05	13.7	28,141	487	-2.6
2005-06	14.4	29,613	487	0.0

Source: Hospital Episode Statistics Online and NHS Workforce Census

NOTES

- 1 Hospital Episode Statistics data quality lower in earlier years.
- 2 Total number of consultants includes Directors of Public Health.

6 However, consultant activity is a crude measure of performance and should not be interpreted as consultant productivity. There are a number of factors on both the input side and the output side that would need to be standardized for an accurate measure of comparative productivity:

- Change in number of hours worked by consultants. Evidence indicates that consultants are working shorter hours with the implementation of the consultant contract and the European Working Time Directive;
- Change in level of support from other staff groups (e.g. nurses, junior doctors);
- The measure of clinical activity is based on inpatient care only and does not take account of other workload demands, such as outpatient care, diagnostics;
- Teaching and training commitments, clinical governance, research and management functions;
- Change in case-mix, accounting for the increasing complexity of consultant workload,
- Fundamentally, the measure does not take into account improvements in the quality of care provided (for example falling mortality rates, improving waiting times and patient experience).

Cross-sectional data reveal a large variation in inpatient consultant activity

7 The evidence base for the productivity estimates in the original business case was derived partly from Department analysis of Hospital Episode Statistics data. This new data used individual-level consultant identifiers in Hospital Episode Statistics to reveal large variation in inpatient activity per consultant.

8 **Figure 26** below shows the average number of finished consultant episodes per consultant in 2001-02 for five big surgical specialities. General surgeons averaged 1139 finished consultant episodes each but the interquartile range was 1.85, i.e. the 75 percentile consultant was doing 1.85 times more finished consultant episodes than the 25th percentile consultant. The variation was similar even after adjusting for case mix.

- The Department issued charts showing the performance of consultants in these five surgical specialties in December 2002. The charts indicated consultants' individual performance, based on finished consultant episodes. Similar caveats that applied to the time series data in Figure 25 also apply to these data (see paragraph 6). A sample of the data that was sent to Medical Directors in 2006 is at Appendix 8.

26 Finished Consultant Episodes per consultant

Speciality	Mean	SD	Interquartile variation
General surgery	1,139	548	1.85
Urology	1,129	509	1.85
Trauma and ortho	668	268	1.60
ENT	824	405	1.69
Ophthalmology	643	337	1.82

Source: Department of Health

APPENDIX EIGHT

Example of consultant activity benchmark information issued to NHS trusts in 2006

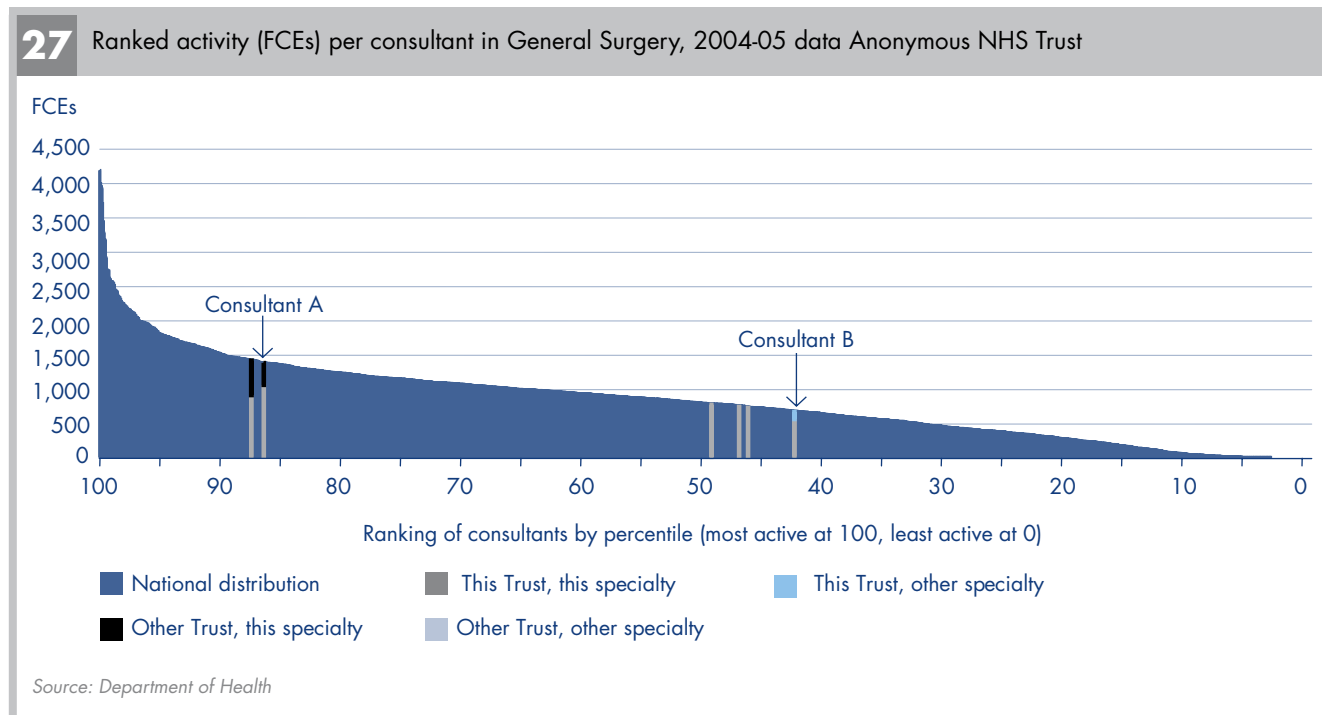
“The Department of Health and the NHS are committed to improving efficiency in health care provision. A significant proportion of these savings, to be reinvested in patient care, will come through improving the ‘productive time’ of front-line staff, using initiatives to increase the time spent by health care professionals (clinicians, managers and administrators) on activities related to better patient care.

Improving productive time includes encouraging NHS organisations to focus on the characteristics of high performing clinical systems, processes and practices by providing benchmarking information, in this case, consultant activity.

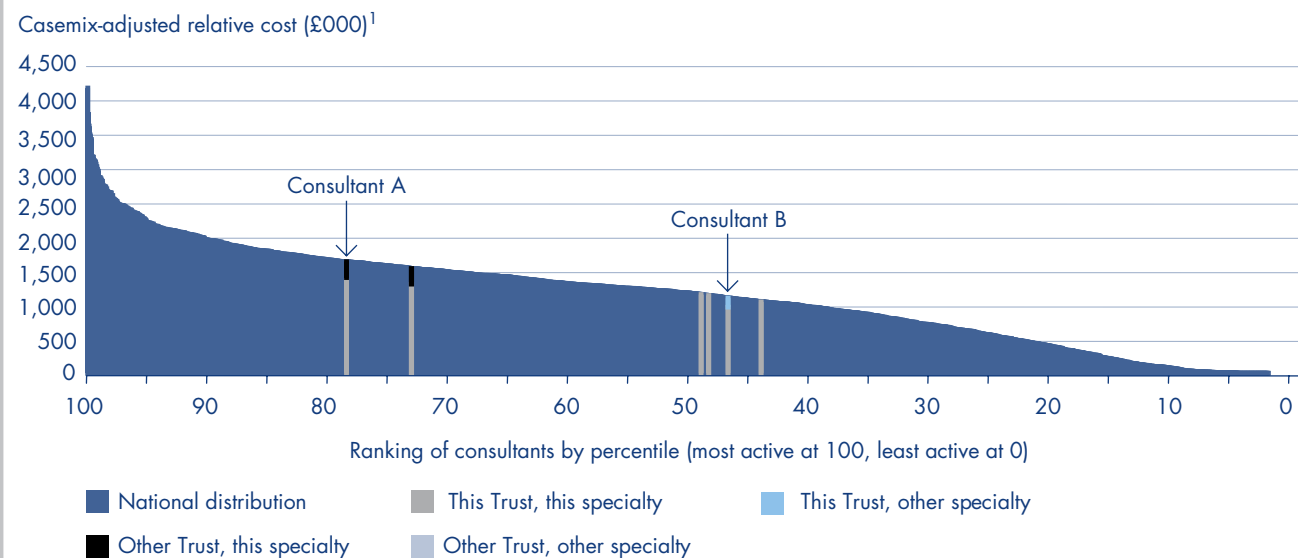
This comparison tool aims to help organisations consider where their efforts might best be applied to achieve greatest productive time improvements.

Consultant activity data

Figure 27 below and Figure 28 overleaf, which are hypothetical examples, show activity rates of general surgery consultants in an anonymous Trust, compared with the national distribution. The key below the charts describe the information.



28 Ranked activity (casemix adjusted¹) per consultant in General Surgery, 2004-05 data Anonymous NHS Trust



Source: Department of Health

NOTE

¹ FCEs x Tariff Cost based on HRGs (see guidance notes).

The highlighted lines on the first chart above show finished consultant episodes (FCEs) of six consultants in this anonymous Trust. Using two examples:

Consultant A's time is mainly spent in this Trust, with some time in a different Trust but working solely on general surgery.

Consultant B works full time in this Trust, the majority on general surgery, a smaller proportion in a different speciality.

The second chart presents the same information, though with a case mix adjustment based on HRGs. Consultant A moves up in the local distribution of "productivity" but moves down slightly in the national distribution. Consultant B moves up in both the national and local distribution.

Data validation

When looking at these results there are a number of factors that should be taken into account:

- Is the data accurate? For example, a line (consultant) at the tail of the distribution could arise from under-reporting (failing to include correct consultant identifiers in the HES dataset) or by mis-reporting (perhaps these episodes should have been coded in a different speciality (e.g. accident and emergency), or perhaps they were coded to a registrar rather than the responsible consultant).

- Do any of these general surgeons have substantial teaching responsibilities?
- Do any of these general surgeons have substantial administrative responsibilities?
- Are there differences in the size of surgical teams within general surgery, which could account for variations in activity rates?
- Do some of the general surgeons focus on inpatient activity, and some on outpatient activity? Remember these data are only inpatient episodes.
- Are there institutional or organisational reasons for the observed variation? For example, are there differences in access to operating theatres?
- Do any of these general surgeons work part-time or were any employed for only part of the year?

How should this data be used?

Once you are content with the data, you can use it to compare the performance of consultants within your Trust to those in other Trusts. It is also possible to compare consultant activity across speciality areas.

You are encouraged to identify the highest performing consultants in your Trust. It is then possible to identify the working practices and techniques that are enabling high performance.”

Source: Department of Health, example of Consultant Activity benchmark information issued to NHS trusts in 2006

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