



National Audit Office

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.	● 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.	● 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.	● 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.	● 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.	● 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.	● 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.	● 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.	● 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.	● 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 2004 ¹ .

● 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.