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# Managing NHS hospital consultants

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# Summary

**1** NHS consultants (consultants), the majority of which work in hospitals: treat NHS patients; manage clinical work in hospitals; and undertake work that benefits the NHS (for example, training future doctors). At September 2012, the NHS employed 40,394 consultants (38,197 on a full-time equivalent basis) across a range of specialty areas. The total employment cost of consultants was £5.6 billion in 2011-12, of which 81 per cent was consultants' earnings, with employer pension and employer National Insurance contributions each accounting for 9.5 per cent. In 2011-12, consultants made up 4 per cent of all NHS hospital and community health service full-time equivalent staff, accounting for 13 per cent of related employment costs.

**2** In October 2003, the Department of Health (the Department) introduced a new consultant contract (the contract). By 2012, an estimated 97 per cent of consultants were on the contract. The contract was designed to provide:

- a career structure and remuneration package that rewards and incentivises consultants who make the biggest contribution;
- a stronger contract framework so managers can better plan consultants' work; and
- better arrangements for consultants' professional development.

**3** The General Medical Council will introduce 'revalidation' in December 2012, to regulate licensed doctors and ensure they are fit to practise. The Council will revalidate doctors every five years through regular appraisals, and aims to revalidate the majority of licensed doctors for the first time by March 2016.

**4** The Department has estimated that, to keep pace with demand and live within its tighter means, the NHS must make recurrent efficiency savings of up to £20 billion between 2011-12 and 2014-15. Consultants play a vital role within the NHS, and managing consultants effectively will help to make some of these savings.

**5** In August 2010, the Secretary of State of Health commissioned the Review Body on Doctors' and Dentists' Remuneration to review compensation levels and incentive schemes for consultants. On 17 December 2012 the Government published the report, as a basis for discussion with the medical profession and NHS Employers. Recommendations include:

- Rewards for clinical excellence should be linked to performance including patient feedback.
- Rewards for clinical excellence should be capped nationally at £40,000 and locally at £35,000.

- Rewards should reward current excellence, not past performance – awards should be awarded for no more than five years nationally and normally one year locally.
- A new ‘principal consultant’ grade should be introduced, to reward very senior and outstanding doctors (capped at 10 per cent of consultants across the country).
- Progression through the current consultant grade should be based on performance rather than time served.
- Awards should also continue to recognise excellence in medical education, teaching and research – including work to support the Royal Colleges and NHS system improvement.

### **The scope of this study**

**6** This report examines: how far the expected benefits of the contract have been realised (Part One); whether consultants are managed effectively and consistently across NHS trusts (Part Two); and how far the Committee of Public Accounts’ recommendations of 2007, designed to improve the management of consultants, have been implemented (Part Three). Our methods are set out in Appendices One and Two. Central to our findings are a census of all acute trusts and a survey of consultants in acute trusts. The trust census achieved an 85 per cent response rate. We requested a response agreed by senior management including, for example, the Chief Executive, Medical Director, Director of Human Resources and Finance Director. Our survey of consultants in acute trusts achieved a response rate of 28 per cent (8,808 responses).

### **Key findings**

#### **On managing consultants under the 2003 contract**

**7** The contract is one of a range of the tools available to get the best out of consultants, for patients and taxpayers. Some trusts have used the contract’s provisions alongside other good management practices to, for example: engage consultants to improve performance; achieve trust objectives; and provide services within activity, financial and quality boundaries (paragraphs 1.6 and 1.11).

## On realising the contract's expected benefits

**8 The contract increased the cost of employing consultants.** An explicit objective of the contract was to invest additional resources into consultant pay at a time of real-terms growth in funding for the NHS. Between 2002-03 and 2003-04, the bottom of the consultants pay band increased by 24 per cent and the top by 28 per cent. This meant that the NHS invested up front for the expected benefits it hoped to achieve in the future. In addition, trusts stated that they now pay for work which was previously not paid for under the old contract. As a result, between 2002-03 and 2003-04, total earnings per full-time equivalent consultant increased by 12 per cent in real terms. Between 2003-04 and 2005-06, the Department gave the NHS £715 million (£839 million in 2011-12 prices) of funding to cover the additional cost of the contract. In 2005-06, the recurring additional funding to the NHS was in the region of £400 million a year, which covered the increased cost of the contract and the increased number of consultants. Although largely unrelated to the introduction of the contract, average (mean) pay in real terms has fallen over the past five years (paragraph 1.8).

**9 The contract has had a number of positive impacts.** Ninety-seven per cent of consultants now have a job plan (see Glossary) and 58 per cent of trusts stated that the contract had helped them to better manage consultants' time. Productivity is difficult to measure. However, while indicators show that consultant productivity has continued to fall after the new contract, the rate of decline has slowed significantly compared to before 2003. Consultants' private practice work has not increased. Most trusts stated that consultants, working ten programmed activities or less a week, work an additional programmed activity (see Glossary) at standard rates for the NHS, where required, before undertaking private practice work. The contract also reduced the speed of consultant pay progression and has, to some degree, helped to extend patient services. Furthermore, an explicit objective of the contract was to increase consultant participation rates. The consultant participation rate (the ratio of full-time equivalent consultants to headcount) has increased in line with the projections included in the business case, although it remains unclear as to what extent this has resulted in consultants doing more work for the NHS (paragraphs 1.12 to 1.25).

**10 More could be done to achieve better value for money in fully realising the benefits set out in the Department's business case.** The contract, for example, states that work agreed as part of a consultant's job plan, including the first additional programmed activity above ten where a consultant wishes to conduct private practice work, should be paid at contractual rates. However, the average paid programmed activities across trusts is over 11 with most trusts using locally agreed rates of pay for additional work outside that agreed in job plans. Average rates over the last 12 months range from £48 to £200 per hour with a mean of £119 and median of £114. Based on the top and the bottom of the consultant pay scale, contractual rates range between £36 and £64 per hour. In addition, pay progression is not linked to consultant performance in most trusts (paragraphs 1.23 and 1.25).

On responsibility for achieving the contract's expected benefits

**11 Realising most of the contract's expected benefits depends on how well individual NHS trusts manage consultants.** NHS non-foundation and foundation trusts are responsible for managing their consultants. The Department has no power to direct NHS foundation trusts. It can direct NHS non-foundation trusts, but the Department does not intervene in day-to-day operational management, which includes managing consultants. For example, managing consultants' time better depends on how far NHS trusts implement effective job planning. Academic literature also links trust performance and clinical outcomes to a range of management practices. These include: how well trusts engage consultants to meet trust objectives; the quality of clinical management within trusts; and using performance management processes, such as annual appraisals, effectively (paragraphs 2.1 and 2.2).

**12 The Department established a partial baseline for 2002 from which to assess progress in realising the contract's expected benefits.** The lack of a comprehensive baseline made it difficult to assess the overall impact of the contract. While the Department held data in areas such as the number of consultants, participation rates and contract costs, it did not hold data on the number of consultants with job plans, the extent of consultant private practice work and the amount of direct clinical care (paragraphs 1.9 and 1.10).

On how trusts can further improve the utilisation of the contract and better manage consultants

**13 The Department and NHS Employers issued guidance to help implement the contract, but some was not timely and some has been discontinued.** NHS Employers issued a range of guidance after the contract was introduced. For example, job planning guidance was introduced in 2005 and updated in 2011. In addition, although the Department published a toolkit to compare individual consultant activity levels for 2005-06 and 2006-07, this was then discontinued. While 66 per cent of trusts stated that there was effective national guidance on job planning, only 8 per cent of trusts stated that there was effective national guidance on measuring consultant productivity (paragraphs 1.20 and 2.23).

**14 While most of the expected benefits of the contract have been either fully or partially realised, there remains significant room for improvement in the management of consultants.** While our case studies highlighted areas of good practice and our survey results showed that many trusts had implemented some aspects of good practice, there are still significant gaps with many trusts not managing consultants effectively.

#### **Consultant engagement:**

- We found some differences in opinion between consultants and trusts' senior management over the level of consultant engagement. Most trusts stated there was a shared sense of purpose and a high level of collaboration between management (both clinical and non-clinical) and consultants. Consultants supported this view in relation to clinical managers, but less than half thought there was a shared sense of purpose and a high level of collaboration between consultants and non-clinical managers. Only 41 per cent of consultants stated that their trust motivates them to achieve the trusts' objectives (paragraph 2.4).

#### **Clinical management:**

- Most consultants are managed by fellow consultants, usually clinical directors. Our survey results and case study focus groups with clinical directors showed that many clinical directors have insufficient time, training and administrative support to do this effectively (paragraphs 2.6 to 2.8).

#### **Performance management:**

- Seventy-nine per cent of trusts reported monitoring direct clinical care activity levels of consultants across all or most specialty areas, with 82 per cent monitoring clinical outcomes. However, it is often difficult to assess individual consultant performance due to consultants working in integrated specialty teams (paragraphs 2.9 to 2.10).
- Despite 66 per cent of consultants stating that comparing their performance against their peers motivated them, around a fifth of trusts either do not benchmark clinical outcomes for consultants in the same specialty area or do so less than once a year (paragraph 2.11 and Figure 11).
- Pay progression is the norm. Less than a third of trusts stated that pay progression for all or most consultants either depended on achieving objectives set out in job plans or achieving objectives from appraisals (paragraphs 1.23 and 2.18).

- Clinical Excellence Awards reward performance above and beyond the norm. While most trusts thought awards reflected exceptional performance, less than half of consultants agreed. The Prime Minister and Secretary of State for Health, informed by recommendations from the Review Body on Doctors' and Dentists' Remuneration, determine the value of employer-based awards that trusts must fund and distribute. While there is no obligation on trusts to distribute the full amount, the Advisory Committee on Clinical Excellence Awards takes the view that trusts should spend the minimum investment each year. There is no limit to the maximum number of employer-based awards that a trust can allocate. Currently 61 per cent of consultants hold an award (47 per cent hold an employer-based award with 14 per cent holding a national award). While the Advisory Committee on Clinical Excellence Awards reviews national awards every five years, employer-based awards are not reviewed to ensure that they continue to reflect performance above the norm with the exception of Level Nine awards which are reviewed every five years (paragraphs 2.18 and 2.19).

#### **Job planning:**

- Ninety-seven per cent of consultants now have a job plan, although 16 per cent of these have not been reviewed in the last 12 months. Many trusts are not implementing the good practice guidance published jointly by NHS Employers and the British Medical Association in 2011. For example, only 18 per cent of trusts stated that all or most job plans contain SMART (specific, measurable, achievable and agreed, realistic, timed and tracked) objectives. Only 56 per cent of trusts confirmed that individual and trust objectives are aligned in all or most job plans. Around two-fifths of trusts do not set objectives for supporting professional activities for all or most consultants, with only 23 per cent monitoring their completion for all or most consultants (paragraphs 2.21 to 2.24 and 2.28).

On implementing the Committee of Public Accounts' recommendations

**15 There has been limited progress in implementing the Committee of Public Accounts' recommendations, designed to better manage consultants.** There were 12 recommendations in the Committee's 2007 report on the contract:

- One was addressed solely to the Department and has been implemented.
- One was addressed to the Department and NHS Employers and has been partly implemented.
- Three were for NHS Employers with one fully, one partly and one not implemented.
- Six were for NHS trusts. One of which was not accepted by the Department. Of the remaining five, one was partly implemented and four not implemented.
- One was directed at consultants and has been partly achieved (paragraph 3.3).

## Conclusion on value for money

**16** NHS consultants play a key role in treating patients. Under the 2003 consultant contract, the NHS increased consultants' pay, investing up front for future benefits it hoped to achieve. Most of the expected benefits of the contract have been either fully or partly realised which has improved the value for money of consultants to the NHS.

**17** Despite some good practice, it is reasonable to expect that more progress would have been made in improving trusts' management of consultants and realising the full benefits of the contract. We cannot, therefore, conclude that value for money has been fully achieved. There are still, for example, a number of trusts who have not fully implemented key elements of the contract and good practice management. Less than a third of trusts stated that pay progression for all or most consultants either depended on achieving objectives set out in job plans or achieving objectives from appraisals. Trusts reported that 19 per cent of consultants have not had an appraisal in the last 12 months. In addition, most trusts continue to use locally agreed rates of pay well above defined contractual rates to secure extra work from consultants.

## Recommendations

**18** The Department, NHS Employers and trusts must review and implement the Committee of Public Accounts' recommendations made in 2007. We make a number of further recommendations to improve the management of consultants and, therefore, value for money.

- a** **Trusts should ensure that consultants are engaged in meeting trusts' objectives and held to account for their performance.** Given the key role played by consultants across the NHS, trusts and consultants need to work together if the NHS is to achieve the Department's significant efficiency savings over the next four years. In particular, trusts should:
- devolve responsibility and accountability to consultants for designing and providing services, for example through service-line reporting and management;
  - ensure the trust's objectives and consultants' individual objectives are clearly aligned;
  - ensure good communication between senior management and consultants; and
  - hold consultants to account for meeting the objectives and activity levels agreed in job plans through the appraisal process and pay progression.



- b Trusts should ensure that clinical managers have the right skills and support to get the best out of consultants.** Giving clinical managers more time, training and support should ensure that consultants are better managed. This should improve patient care and help to meet trust objectives. In particular, trusts should:
- ensure clinical managers have sufficient time to undertake their role;
  - give appropriate financial and administrative support to help clinical managers better plan and allocate consultant time, within activity and financial boundaries; and
  - give clinical managers formal financial, administrative and management training, as well as on-the-job training and coaching.
- c Trusts should implement the joint NHS Employers and British Medical Association guidance on job planning.** Job planning is the key way to manage consultants' time. Implementing the latest guidance, including SMART (specific, measurable, achievable and agreed, realistic, timed and tracked) objectives, should ensure job planning is collaborative and trust and consultant objectives are aligned to make service and productivity improvements.
- d The Department and NHS Commissioning Board should work with trusts to improve the quality and use of information to better understand and improve consultant performance.** Robust information will improve transparency and improve how well trusts assess consultant's performance, for example, through benchmarking performance within specialty areas.
- e The Department and trusts should ensure that consultant's financial rewards reflect performance.** Pay progression in most trusts is not linked to performance. With the annual national and employer-based Clinical Excellence Awards costing £500 million in 2011-12, it is important that awards accurately reflect exceptional performance. In particular:
- trusts should ensure that pay progression is linked to consultant performance; and
  - the Department should instruct the Advisory Committee on Clinical Excellence Awards to review national awards more often than every five years and trusts to begin to regularly review Level One to Level Eight employer-based awards.