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Pay Modernisation: NHS Consultant Contract

Abertawe Bro Morgannwg University Health Board

Contents

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Summary

1. The NHS consultant contract is the national framework that governs the working conditions and salary grades of consultants. The Amendment to the National Consultant Contract in Wales came into effect on 1 December 2003, and was the first major change to consultants' terms and conditions since 1948. The contract brought in a number of benefits for consultants: a new salary scale; improved arrangements for on-call remuneration; new arrangements for clinical commitment and clinical excellence awards; and a commitment to improve flexible working. The intention of all these benefits was to aid recruitment and retention of consultants.
2. Effective job planning underpins the implementation of the amended contract and is mandatory for all consultants. The job planning process is designed to ensure the individual consultant and their employer agree the content and scheduling of activities that comprise the working week. The contract is based upon a full-time working week of 37.5 hours, equivalent to 10 sessions of three to four hours each, bringing them in line with other NHS staff. The working week should typically comprise seven sessions of Direct Clinical Care (DCC), such as clinics and ward rounds, and three sessions for Supporting Professional Activities (SPAs), such as research, clinical audit and teaching. Job plan reviews are expected to be carried out annually as part of the contract.
3. The amended contract was introduced explicitly to help deliver the following benefits:
   - to improve the consultant working environment;
   - to improve consultant recruitment and retention; and
   - to facilitate health managers and consultants to work together to provide a better service for patients in Wales.
4. In 2004, the Audit Commission in Wales was commissioned by the Assembly Government to review the implementation of the consultant contract, with a focus on the job planning process. Since then, the Assembly Government has monitored implementation of the contract through an annual reporting process which ended in 2009.
5. Significant sums of money have been involved in implementing the contract in Wales through set-up costs, additional session payments to consultants and funding a Consultant Outcome Indicators project (COMPASS), which has now been discontinued. However, no independent external audit work has been done to examine whether the intended benefits from the amended contract are being achieved, and in particular whether job planning is now fully embedded as an organisational tool in NHS bodies to help define and review consultants' contribution to service delivery. This audit was undertaken at each health board and NHS Trust that employs significant numbers of consultants.

6. In April 2008, the former Bro Morgannwg and Swansea NHS Trusts merged bringing together services and consultants teams which often had different working practices. This merger was quickly followed in 2009, by the NHS reorganisation, and formation of Abertawe Bro Morgannwg University Health Board (the Health Board). At the time of our audit in June 2010 the Health Board employed around 450 consultants, who were managed within 14 directorates and provided services across four hospital sites.

7. This audit seeks to answer the question: 'Are the intended benefits of the new consultant contract being delivered?' In particular we focused on the extent to which job planning was embedded in the Health Board as an annual process and how effective it was in facilitating service improvement. We also considered the working environment of consultants, which was part of the contract's wider aim for the NHS to provide ongoing improvements to the quality of consultants' working lives. As the intention of all these benefits was to aid recruitment and retention of consultants we also considered this as part of the audit.

8. Appendix 3 provides further details of our audit methodology. This included an online survey for all consultants and 110 responded (26 per cent).

9. We found that at the Health Board the consultant contract has generally delivered against its objectives through the use of annual job planning which facilitates development of service improvements. In particular we found that:

- annual job plan reviews are established across all directorates although the effectiveness of job plan reviews is variable;
- working relationships between consultants and managers are generally good and the contract is contributing to changes in service delivery that are in line with the modernisation agenda; and
- consultants have benefited from improved pay and the Health Board has few problems with recruitment and retention although other factors, such as the European Working Time Directive, are causing problems.

Recommendations

10. This review has identified a number of recommendations which could help the Health Board improve its current approach to job planning and delivering consultant contract outcomes.

R1	All consultants who are managing the job planning process should have access to appropriate training that supports the delivery of effective job plans.
R2	The Health Board should encourage all directorates to undertake annual appraisals for all consultants and they should take place before the annual job planning review meeting.
R3	Where a specialty does not have access to good quality performance information, for example the theatre management system, the Health Board should strengthen existing arrangements or develop new outcome indicators with these specialties.

R4	The Health Board's strategic objectives should be embedded more effectively in the job planning process.
R5	The Medical Director needs to set out a clearer message about what constitutes SPA activity and that all SPAs have clearly defined outcomes included in the annual job plan review.
R6	The Health Board should encourage clinical directors and consultants to develop meaningful outcome measures for all job plans.
R7	The Health Board should establish a consistent approach to managing leave arrangements for consultants with annualised hour contracts.
R8	The Health Board should approach the university to establish better engagement in job planning and appraisal for consultants on academic contracts.

Annual job plan reviews are established across all directorates although the effectiveness of job plan reviews is variable

The Health Board set out a standard approach to job planning which directorates can adapt to meet their own circumstances

11. To support the 2010-11 job planning process the Health Board developed guidance based on the British Medical Association's standards. At a corporate level the process was led by the Assistant Medical Director of Secondary and Specialist Services.

12. Embedding the job planning process has been part of the Medical Workforce Board's agenda since December 2009. As part of this process a Clinical Directors' group initially led on development of the job planning process. This group no longer meets as the Health Board is confident that the process is now embedded.

13. This year no specific training was given to clinical directors, lead clinicians and managers responsible for delivering job plans because most had some experience from previous years. Consultants and managers new to the process were supported by more experienced staff. Most of those interviewed confirmed the reasonableness of this approach, although in one specialty (Gynaecology and Obstetrics) the majority of lead consultants were new to the process and some felt training would have helped.

14. All directorates followed a similar approach to managing the process. Each meeting was attended by the consultant with the relevant clinical director or specialty lead consultant and the appropriate general manager.

15. In all directorates, we found that job planning review meetings were held in an appropriate location and were generally arranged for an hour in length. Our survey identified that 90 per cent of the respondents felt that the length of the review meeting was about right.

16. Prior to the meeting, most consultants were provided with performance information most of which was obtained from the Health Board's Hypercube[1]

[1] The Health Board has set up its own clinical data system, Hypercube, available to consultants and clinical directors on the Health Board's information portal which was developed in consultation with consultants. Data shown is performance against Annual Operating Framework productivity and efficiency indicators, eg, day surgery rates and crude death rates. Consultants can discuss and check printouts at their job planning meeting. They also use the CHKS Signpost product so that they can benchmark the data against other similar hospitals; it uses the same data but CHKS have more sophisticated modelling such as standardised mortality rates.

information system. The majority of consultants and managers reported that performance issues were regularly discussed throughout the year at directorate and team meetings. Consequently, job planning was seen as being linked to routine business management and not just a standalone process.

17. Our survey found that:
    - 85 per cent of respondents had had a job planning review in the previous 12 months;
    - 95 per cent thought that they had received adequate notice of the meeting;
    - 92 per cent said that the right managers were involved in the meeting;
    - 95 per cent said the meeting had a constructive and positive tone; and
    - overall, 84 per cent thought the job planning review meeting was very useful, useful or partly useful.

18. The majority of job planning interviews are conducted on an individual basis although the Learning Disabilities, Pathology and Cardiology specialties have taken a team-based approach. Consultants and managers in these specialties reported that this approach has allowed DCC sessions and service developments to be better managed. Consultants were also offered the opportunity to have an individual job plan review to deal with any specific issues.

19. For those consultants responding to our survey 22 per cent had a team-based job plan. However, of these consultants, over a third were not given the opportunity to agree individual commitments at a subsequent meeting. Whilst there are benefits in taking a team approach each consultant needs to be given the opportunity to discuss issues that specifically affect them as an individual. Without this it may be difficult for a consultant to agree their job plan.

20. Job plan review meetings are well embedded within the Health Board's processes and were generally well managed in most specialties and directorates. However, in one specialty, Histopathology, consultants have not agreed their job plans for two years because they do not think that their increase in workload has been adequately recognised. Although managers are trying to resolve the issues, it needs to be concluded quickly to enable job plans to be formally agreed.

The extent to which expected outcomes of sessions are covered in job planning reviews vary across directorates

Data on performance is available for the job planning meetings but is not always used

21. The Health Board guidance states that: 'Job planning will include a review of the current job plan, any changes being proposed, performance against the outcome measures agreed last year, their COMPASS report and the Personal Development Plan (PDP) from their most recent appraisal.' In addition: 'Consultants and clinical directors can access and download real-time performance information throughout the year and should bring it to appraisal.'

22. Our interviews with consultants, clinical directors and managers confirmed that many had made use of performance information from Hypercube, CHKS and NHS and professional benchmarking, for example, Intensive Care National Audit

and Research Centre (ICNARC). In most instances the main focus was performance against the Assembly Government's Annual Operating Framework (AOF) targets. Whilst this is relevant to the majority of specialties, some such as Radiology and Pathology had few or no AOF targets to discuss.

23. Our survey found that 59 per cent of respondents said they had access to information from local clinical/management information systems to support discussions about existing work. Anaesthetic consultants reported that they had very little in the way of activity information and, although the Health Board has a theatre management system, the information it produces cannot be used because it is inaccurate. There has been no incentive to accurately record performance information, for example, start and finish times.

24. The COMPASS data had been used in the past, but the majority of consultants express concern at its validity and accuracy. One consultant told us that his performance had been challenged using this data and the benchmark had turned out to be his own performance in the other part of the Health Board. Another reported that he had been congratulated on his effective outpatient performance although he was not undertaking any clinics. Our survey found 98 per cent of respondents had no confidence in the COMPASS data's accuracy.

25. To support discussions about workload and clinical practice the Health Board's guidance suggests that diaries can be used. Consultants and managers confirmed that diaries had been used in previous years but that a reasonable approach to their use had been adopted for 2010-11. Those who were new, had a significant change in their job plan, or where a consultant's clinical director had raised concerns about their performance, had to complete diaries. This was confirmed through our interviews with consultants. One consultant told us they were keeping a diary because they were concerned about the hours they were working. Another said that they had completed a diary to challenge their job plan and that this had been successful in getting changes made. Some consultants were concerned that diaries often focused on 'clock watching' rather than professional aspects of the job, with one reporting that in their specialty it had become destructive.

SPAs are not always discussed at the job planning review meeting

26. The guidance clearly states that: 'Evidence to justify the amount of SPA time in the job plan must be obtained. The level of that evidence will reflect the number of SPA sessions being offered/raised to ensure that the time allocated is fair and equitable.' However, in practice directorates were interpreting this differently:

- some had decided that it meant that anyone doing two or fewer sessions would not have to provide any documentary evidence unless they wanted to take on additional SPA time;
- others had asked all consultants to provide evidence on two A4 sheets of paper of the time spent on SPA activities and in some instances this information was not then discussed; and
- a third group said that they had to provide evidence that all their SPA activities were justified and that this was discussed in detail.

27. Many consultants were concerned that although SPA time had been identified the pressure to deliver activity and their DCC commitments often made it difficult to make sufficient time in the working week. Several surgeons identified that they were using their SPA time to undertake surgical training, while others suggested that they were having to fit SPA time in and around their clinical commitments which was not ideal.

28. Our survey found that 60 per cent of respondents thought that their SPA activities were fairly recognised but only 27 per cent thought that their SPA outcomes were clearly identified. Often there was also a blurring of SPA, DCC and management activities.

Standardised job planning documentation is in place although the level of information recorded is inconsistent between directorates

29. The job plan template originally identified as part of the Assembly Government's guidance in 2004 and referred to as 'Appendix 1', is still the recommended template for recording a typical working week. Our review of job plans across each of the directorates identified that, in most cases, this document was the main tool for recording the job plan although the level of information completed for the job plan varied across directorates.

30. Within the Musculoskeletal Directorate, completed job plans included detailed timetabled sessions with locations clearly identified. Similar examples were also found in the Regional Surgery Directorate and the Intermediate Care and Reablement Directorate. Other directorates were less detailed and in one directorate the only job plan information we saw consisted of a simple table summarising the number of sessions by each of the categories/duties for each of the consultants.

31. Our survey identified 49 per cent of our survey respondents thought that their job plan accurately reflected their working hours and commitments while 42 per cent disagreed. During our interviews, we identified that many consultants felt that the job plan did not reflect their actual working hours and commitments because it was based on a typical week. Within the Cardiac Directorate we identified that they had adapted a five-week job plan to address this particular issue, allowing them to reflect the changes in working practices across the weeks and the impact of the 'consultant of the week' model (see Case Study 1).

Case Study 1

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

Source: Interview at the Health Board

Outcome measures were included in some consultant job plans but overall there was limited reference to them

32. The Health Board Consultant Job Planning Guidance states that: 'All consultants must have outcome measures agreed for the year ahead reflecting Health Board performance targets and utilisation of SPA time, as well as the consultant's PDP. It may be desirable to agree specialty-wide outcome measures if all parties agree.' A template for the outcome measures is provided in the guidance.

33. Where outcome indicators did exist these were often developed on a specialty-wide basis, for example Pathology, Obstetrics and Gynaecology, Trauma and Orthopaedics and Rheumatology. Outcome indicators were found to be directly linked to specialty/directorate objectives and the Health Board's own strategic objectives. Indicators also focused not just on DCC commitments but also SPA activities and direct links into an individual's PDP.

34. Many consultant job plans had no reference to outcome measures and documented evidence of job plan discussions would suggest that outcomes were not discussed as part of the job plan process in many specialties. Our survey found that 33 per cent of consultants who responded said that they had outcome indicators agreed at the job plan review while 67 per cent did not. The Health Board should encourage the development of outcomes for all consultants so that there is something to measure performance against at the next annual job plan review.

A more robust system is now in place to ensure that changes to consultants' job plans are communicated to payroll

35. The Health Board has recently strengthened its process for ensuring correct payments are made to consultants when changes are made to their job plans. Arrangements have been revised so that only Medical HR can process changes to a consultant's pay and Payroll are aware of the revised arrangement. Guidance for Directorates and Localities has been produced to support implementation of the new process and clarify the roles of staff involved in the process of changing pay, including reductions or increases to the number of

sessions per week worked. Further, a review of payments crossed-checked to job plans is being completed for each directorate to identify if there have been any over or underpayments. The review also includes validation of commitment awards and intensity payments. The results of this exercise are due to be reported to the Audit Committee on 25 November 2010.

36. To provide clarity for all concerned, the Health Board now prints the number of sessions that the consultant is contracted to work on their monthly pay slip.

Directorates have adopted their own approach to linking appraisals with job planning although some were not providing appraisals annually to all consultants

37. The consultant contract explicitly states that job planning is linked closely with the agreed appraisal scheme for consultants. Both the appraisal and the job plan review are informed by information on the quality and quantity of the consultant's work over the previous year. Both processes involve discussion of service outcomes, and are linked to the consultant's PDP, and its realisation.

38. The approach to appraisal and its integration with the job planning process particularly around SPA discussion does vary considerably between directorates. Directorates such as Musculoskeletal had taken the opportunity to fully integrate the process with the job planning review meeting occurring straight after the appraisal discussion, while others, such as Anaesthetics, had kept it clearly separate. Consultants, clinical directors and managers reported that the approach they had taken met their specialty needs. However, the Medical Director is aware that the Health Board's annual appraisal rates have fallen in recent years. Some consultants reported that:

- they had not undertaken appraisals for a year or more;
- appraisals were not at an appropriate time to feed into job planning; or
- they could only have an appraisal if they requested one.

To improve the process the Health Board is piloting enhanced appraisal in some directorates using a web-based system developed by the Wales Deanery.

Engaging partners in the job planning process has been challenging

39. During our review, we met representatives from the Health Board Local Negotiating Committee (LNC) who represent the views of medical staff within employing organisations. Representatives were aware of some common themes related to the consultant contract per se. Following NHS reorganisation they felt that they had become disengaged from the job planning process. They thought that consultants who had concerns about their job plans were bypassing the LNC when they tried to resolve their concerns. Consequently, the LNC did not have oversight of the extent of any problems that may exist with the job plan review process. For this reason, the committee had been unable to support the LNC element of the consultant contract annual report submitted to the Assembly Government.

40. Some consultants are on academic contracts and as a matter of course the university is invited to job planning discussions as a shared employer. In all but very few instances the university had declined to attend, although their involvement in appraisals was better. Clinical directors and managers reported that the university's absence had created some challenges in ensuring commitment outcomes were fully identified.

Working relationships between consultants and managers are generally good and the contract is contributing to changes in service delivery that are in line with the modernisation agenda

41. An explicit outcome of the consultant contract in Wales was to facilitate health managers and consultants to work together to provide a better service for patients. One of the benefits of an annual job planning review meeting is that clinical staff and managers have an opportunity to meet at least once a year. Most consultants found this a positive experience and the working arrangement between them and managers is good, enabling them to work together to develop services and meet Health Board targets. Most departments also had regular monthly meetings between clinicians and managers to facilitate service modernisation.

42. Although it is often difficult to quantify good working relationships, managers and individual consultants interviewed provided a range of examples of how they had worked together to deliver new services. When asked, 56 per cent of our survey respondents identified that the job planning review had provided an opportunity to discuss modernising services and introducing innovation and new ways of working. While it is difficult to tease out whether the changes to the contract have been a driver for change, or whether job planning reviews are a tool for documenting the outcome of changes to working arrangements in the job plan, we were provided with the following examples of service change that in respondents' views have been assisted by the consultant contract:
    - moving mental health and learning disability services away from institutions and into the community;
    - reconfiguring paediatric services in Swansea;
    - establishing consultant of the week and increasing the number of consultant-led ward rounds;
    - restricting the clinical biochemistry commitments and introducing clinical scientist posts;
    - introducing consultant biomedical scientist posts in Histopathology and Cytology;
    - extending the role of radiographers; and
    - introducing clinical nurse specialists in a range of services.

43. The survey also identified that 54 per cent of consultants agreed that they had a positive relationship with management although 16 per cent disagreed. When asked if the contract had improved the relationship between clinicians and

managers, 27 per cent of respondents disagreed, 18 per cent agreed but 55 per cent neither agreed nor disagreed implying that the contract is not the main factor in the relationship between clinicians and management.

44. Some consultants, however, expressed concern that they did not know what the strategic direction of the Health Board was following the various mergers and changes in organisational structure. Some also said that they were planning new ways of working in one direction and then it was completely changed so they had to start planning again which was wasted time.

Consultants have benefited from improved pay and the Health Board has few problems with recruitment and retention although other factors, such as the European Working Time Directive, are causing problems

The average number of sessions per consultant has reduced since 2007-08

45. One aim of the consultant contract was to improve the working conditions of consultants by reducing the working week to 10 sessions over 37.5 hours and to promote flexible working. For this reason, all Health Boards are working with consultants to reduce the number of sessions that they work to 10 a week. Most newly appointed consultants are appointed on 10 sessions with a split of seven DCCs and three SPAs.

46. The average number of sessions for all consultants at the Health Board reduced between 2007-08 and 2008-09 from a high at Bro Morgannwg of 11.52 sessions to an average of 11.19 sessions which remained the same in 2009-10. This reduction has been mainly brought about by reducing the DCC commitment and equalising commitments within teams (Exhibit 1).

Exhibit 1: Change in average sessions[2] 2007-08 to 2009-10 for Abertawe Bro Morgannwg University Health Board

	DCC	SPA	Other	Management	Total
2009-10					
ABM UHB	8.49	2.41	0.26	0.04	11.19
2008-09					
ABM NHS Trust	8.47	2.40	0.26	0.06	11.19
2007-08					
Bro Morgannwg NHS Trust	9.00	2.35	0.10	0.07	11.52
Swansea NHS Trust	8.41	2.44	0.40	0.04	11.29

Source: Welsh Assembly Government

[2] Sessions are calculated as whole-time equivalents to enable comparisons.

47. The total sessions identified in the Health Board's job plans are just below the Welsh average. The DCC sessions are slightly higher than the Welsh average and slightly less for the combined SPA, other and management sessions (Exhibit 2).

Exhibit 2: Health Board/Trust average sessions[3] 2009-10

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

Source: Welsh Assembly Government

48. The Health Board currently has six specialties where the average number of sessions exceeds 12. For all of these specialties, the Welsh average position is lower and the average for Forensic Psychiatry, Oral Surgery, Trauma and Orthopaedic, and Urology is below 12. A detailed analysis of all specialties can be found in Appendix 1.

49. The Health Board expressed concern that it is difficult to move DCCs from consultants who work in excess of 10 sessions to create a new post as they only get seven DCC sessions so need to find the additional three SPA sessions to make a new post.

Pay has improved but other working conditions have not improved

50. The consultant contract set out to improve consultants' salaries and this objective has been achieved. Opinions over remuneration were mixed among consultants with most believing that while they are earning more money they are working harder, and our survey found 29 per cent believe remuneration does not reflect their workload.

[3] Sessions are calculated as whole-time equivalents to enable comparisons.

51. When consultants were asked in our survey what they thought of their working environment most did not believe things had improved:
    - 15 per cent of respondents said that the working environment had improved for the better;
    - 16 per cent of respondents said that the contract had changed the way in which they worked for the better; and
    - only 13 per cent said that they had been able to reduce their working hours, compared to 69 per cent who said that they had not.
52. Regarding working time, most consultants said that they were able to take their annual leave with 71 per cent telling our survey that they can take most or all of their annual leave although this still leaves 18 per cent saying that they could not.

Availability of office support is mixed across the Health Board

53. The contract states that the NHS should be seeking to make ongoing improvements to the quality of consultants' working lives which included ensuring suitable consultant office space and support is available. During our review we sought to find out whether consultants had appropriate office support to allow them to undertake their commitments without being disturbed. On the whole, most consultants felt that they had sufficient access to suitable office accommodation and access to library and electronic journals. However, availability of secretarial support, particularly in the bigger specialties was an issue. For example in Anaesthetics, consultants said that despite significant increases in the number of consultants, the level of secretarial support had not increased at the same rate.
54. All consultants that we interviewed identified that they had some office space, although some did share with colleagues. However, working across split sites meant for many consultants that they were often working in one site but had their dedicated office space in another, which sometimes caused challenges when trying to fit their SPA commitments around clinical commitments. Paediatrics specifically identified a problem in that the transfer of paediatric services had moved to the Morriston site although the office base for many of the consultants remained at the Singleton site.
55. We are aware that the Director of Acute Care is currently undertaking a project to review the availability of office support across the whole of the Health Board to ensure that there is equity in the distribution of suitable office space.

Flexible contracts are more widely available although they are causing problems in some directorates

56. The contract explicitly aims to improve flexible working by 'supporting consultants who wish to work in more flexible ways, for instance by enabling consultants to organise elements of their work at different times in the week, subject to service needs, or to work on a part-time basis to reflect personal circumstances, and using annualised hours or similar approaches, where appropriate, to fit around childcare or other responsibilities, or introducing job shares'.

57. Our survey found that flexible working has been encouraged to some extent with 29 per cent of consultants agreeing that the contract: 'Allows you to work more flexibly, for example, by varying the clinical commitment, allowing for part-time, term-time working, and "chunking" time?'

58. During our job plan review, we found that a number of consultants had moved to annualised hours which had been reflected in the job plans that had been agreed. A number of consultants were also working part-time hours and were flexing their sessions over longer days and evening commitments.

59. With the amalgamation of the former Bro Morgannwg NHS Trust and Swansea NHS Trust in 2008, some of the historic differences in the way in which the consultant contract had initially been implemented are still presenting challenges to some directorates. The different ways of working, for example annualised hours is one such area where there are discrepancies being worked through. The lack of clarity over how annual leave is calculated when a consultant does a full-time working week over four days instead of five is also a challenge for the Health Board.

Neither managers nor consultants highlighted retention as an issue and vacancies were seen as an opportunity to modernise services

60. The Health Board reported that at any one time they would hold around 30 vacancies. They thought that retention was not an issue and did not believe that the contract had assisted or hindered recruitment or retention.

61. There were problems recruiting in a small number of specialties although this is frequently a Wales-wide problem. Vacancies are no longer just replaced like with like and directorates will consider alternative ways of delivering a service before deciding that a consultant needs to be replaced. Directorates are now required to prepare a business case for all new consultant posts.

There are concerns about the impact of the European Working Time Directive on contact with junior doctors

62. Clinical directors and consultants felt following the contract's introduction working conditions began to improve. However, most thought that these early benefits had been lost when the impact of the European Working Time Directive and changes to junior doctors' working hours were introduced. Particular issues raised during the interviews included:

- in some specialties, such as Paediatrics, consultants were spending more time covering on-call gaps in the rota;
- working across several sites meant consultants had very little time to work with junior staff face to face and some stated they had still not met all of their team; and
- conflicts between junior doctor rota commitments and the consultant's commitments meant junior doctors had to miss scheduled training sessions.

Session benchmarking

Health Board specialty analysis 2009-10

Specialty	DCC	SPA	Other	Management	Total
Accident and Emergency	8.86	1.90	0.54	0.00	**11.30**
Anaesthetics	8.32	2.49	0.11	0.02	**10.94**
Cardiology	8.86	2.74	0.06	0.06	**11.73**
Cardiothoracic Surgery	7.67	2.33	0.00	0.00	**10.00**
Cellular Pathology	8.86	2.86	0.00	0.00	**11.71**
Chemical Pathology	7.00	3.00	0.00	0.00	**10.00**
Clinical Biochemist	9.00	3.00	0.00	0.00	**12.00**
Clinical Oncology	8.47	2.29	0.57	0.00	**11.33**
Dermatology	7.31	2.67	0.11	0.00	**10.08**
Endocrinology	6.98	2.07	1.22	0.01	**10.28**
ENT	8.81	2.30	0.00	0.00	**11.11**
Forensic Psychiatry	7.79	3.28	0.00	0.97	**12.04**
Gastroenterology	8.07	2.22	0.25	0.00	**10.54**
General Medicine	7.27	2.79	0.05	0.00	**10.12**
General Surgery	10.17	1.99	0.32	0.00	**12.48**
Genito Urinary Medicine	7.51	3.08	1.01	0.00	**11.60**
Geriatric Medicine	8.40	2.48	0.08	0.00	**10.95**
Gynaecology	8.06	2.46	0.31	0.09	**10.91**
Haematology (Clinical)	8.19	2.24	1.32	0.00	**11.75**
Histopathology	9.00	2.00	0.00	0.00	**11.00**
Learning Disabilities	7.69	4.13	0.00	0.00	**11.82**
Medical Microbiology	8.00	2.50	0.00	0.00	**10.50**
Medical Oncology	8.00	1.60	0.67	0.00	**10.27**
Mental Illness	7.48	2.11	0.43	0.07	**10.08**
Nephrology	10.28	1.65	1.48	0.00	**13.41**
Neurology	8.24	2.36	0.30	0.00	**10.90**
Neurosurgery	9.64	2.00	0.00	0.00	**11.64**
Occupational Medicine	10.80	1.20	0.00	0.00	**12.00**
Old Age Psychiatry	7.40	2.82	0.65	0.00	**10.88**
Ophthalmology	8.48	2.89	0.00	0.00	**11.37**
Oral Surgery	9.71	2.83	0.00	0.00	**12.54**

Specialty	DCC	SPA	Other	Management	Total
Orthodontics	7.60	2.97	0.00	0.00	**10.57**
Paediatrics	8.14	2.36	0.25	0.00	**10.76**
Palliative Medicine	6.15	2.43	1.32	0.29	**10.19**
Plastic Surgery	8.75	2.04	0.56	0.00	**11.34**
Radiology	8.17	2.54	0.00	0.15	**10.87**
Rehabilitation	8.00	2.00	1.00	0.00	**11.00**
Restorative Dentistry	8.80	2.25	0.00	0.00	**11.05**
Rheumatology	8.58	2.06	0.00	0.00	**10.64**
Thoracic Medicine	7.28	2.73	0.89	0.00	**10.89**
Trauma and Orthopaedic	9.98	1.97	0.17	0.00	**12.12**
Urology	10.77	1.98	0.10	0.00	**12.84**
LHB Total	**8.49**	**2.41**	**0.26**	**0.04**	**11.19**

All Wales specialty analysis 2009-10

Specialty	DCC	SPA	Other	Management	Total
Accident and Emergency	8.07	2.58	0.18	0.12	**10.95**
Anaesthetics	8.27	2.64	0.04	0.08	**11.03**
Audiological Medicine	7.62	2.69	0.00	0.00	**10.31**
Cardiology	8.79	2.58	0.06	0.15	**11.58**
Cardiothoracic Surgery	9.76	2.70	0.00	0.00	**12.46**
Cellular Pathology	8.86	2.86	0.00	0.00	**11.71**
Chemical Pathology	7.91	2.89	0.02	0.27	**11.08**
Child and Adolescent Psychiatry	7.94	2.47	0.24	0.14	**10.80**
Clinical Biochemist	9.00	3.00	0.00	0.00	**12.00**
Clinical Genetics	7.75	3.33	0.31	0.10	**11.48**
Clinical Immunology and Allergy	9.00	3.00	0.00	0.00	**12.00**
Clinical Neuro-physiology	7.00	3.00	0.00	0.00	**10.00**
Clinical Oncology	8.16	2.61	0.13	0.90	**11.81**
Clinical Pharmacology and therapeutics	9.33	3.33	0.69	0.38	**13.74**
Community Medicine	7.08	2.69	0.00	0.38	**10.15**
Dental Medicine Specialties	7.82	2.97	0.00	0.18	**10.96**
Dermatology	7.62	2.66	0.09	0.13	**10.49**
Endocrinology	7.50	2.62	0.39	0.12	**10.63**
ENT	8.78	2.55	0.17	0.05	**11.55**
Forensic Psychiatry	7.95	2.75	0.24	0.55	**11.49**
Gastroenterology	8.10	2.57	0.16	0.05	**10.87**

Specialty	DCC	SPA	Other	Management	Total
General Medicine	8.35	2.61	0.05	0.11	**11.12**
General Surgery	9.38	2.29	0.19	0.14	**12.00**
Genito Urinary Medicine	7.70	2.69	0.27	0.00	**10.66**
Geriatric Medicine	8.48	2.72	0.19	0.09	**11.47**
GP Other	7.00	3.00	0.00	0.00	**10.00**
Gynaecology	8.47	2.56	0.13	0.10	**11.27**
Haematology (Clinical)	8.61	2.45	0.31	0.11	**11.48**
Haematology (non-clinical)	8.50	2.50	0.00	0.50	**11.50**
Histopathology	9.03	2.60	0.32	0.04	**11.98**
Infectious Diseases	10.17	3.63	1.00	1.33	**16.13**
Learning Disabilities	7.87	3.41	0.07	0.06	**11.41**
Medical Microbiology	7.93	2.82	0.07	0.01	**10.84**
Medical Oncology	7.92	2.60	0.17	0.15	**10.84**
Mental Illness	7.58	2.66	0.21	0.22	**10.66**
Nephrology	8.72	2.94	0.32	0.05	**12.03**
Neurology	8.06	2.75	0.19	0.00	**11.01**
Neurosurgery	9.35	2.28	0.20	0.00	**11.83**
Occupational Medicine	7.71	2.59	0.07	0.00	**10.37**
Old Age Psychiatry	7.19	2.90	0.39	0.05	**10.53**
Ophthalmology	8.13	2.56	0.08	0.13	**10.90**
Oral Surgery	8.86	2.84	0.02	0.05	**11.76**
Orthodontics	8.19	2.74	0.02	0.19	**11.14**
Paediatric Dentistry	7.82	2.18	0.00	0.00	**10.00**
Paediatric Neurology	9.29	2.38	1.13	0.00	**12.80**
Paediatric Surgery	10.54	2.00	0.12	0.00	**12.66**
Paediatrics	7.90	2.68	0.19	0.23	**11.01**
Palliative Medicine	7.14	2.76	0.41	0.48	**10.79**
Plastic Surgery	8.75	2.04	0.56	0.00	**11.34**
Psychotherapy	8.08	2.31	0.00	0.00	**10.38**
Public Health Medicine	7.54	2.88	0.06	0.00	**10.48**
Radiology	8.47	2.54	0.13	0.15	**11.29**
Rehabilitation	8.00	2.40	0.40	0.43	**11.23**
Restorative Dentistry	7.81	2.72	0.01	0.00	**10.54**
Rheumatology	7.58	2.82	0.07	0.16	**10.63**
Thoracic Medicine	7.48	2.98	0.33	0.07	**10.86**
Trauma and Orthopaedic	9.03	2.27	0.06	0.05	**11.41**
Urology	9.57	2.28	0.06	0.08	**11.99**
All Specialties average	**8.34**	**2.60**	**0.14**	**0.13**	**11.21**

Consultant survey

Question number	Question	Answer	Percentage giving answer	Number giving answer
Q4	Percentage who felt they received adequate notice of the date of their last job plan review meeting?	Yes	95.4%	103
Q5	Percentage who felt they had information from local clinical/management information systems to support discussions about their existing work?	Yes	57.4%	58
Q6	The main type of information used to prepare for job plan review meetings?	Health Board or Trust information	15.6%	17
Q7a	Percentage that felt they had sufficient time before the meeting to consider last year's work?	Yes	92.5%	98
Q7b	Percentage that felt they had sufficient time before the meeting to consider their current pattern of work and activities?	Yes	96.3%	104
Q7c	Percentage that felt they had sufficient time before the meeting to consider pressures and constraints that were causing them difficulties?	Yes	92.4%	97
Q7d	Percentage that felt they had sufficient time before the meeting to consider any clinical governance and clinical audit issues that have arisen?	Yes	84.3%	86

Question number	Question	Answer	Percentage giving answer	Number giving answer
Q7e	Percentage that felt they had sufficient time before the meeting to consider the impact of internal and external initiatives (eg, NHS reform, changes in health needs of the community and junior doctor training requirements)?	Yes	68.9%	71
Q7f	Percentage that felt they had sufficient time before the meeting to consider any ideas they had for improving the service?	Yes	88.6%	93
Q7g	Percentage that felt they had sufficient time before the meeting to consider their own personal development plan from their appraisal?	Yes	81.0%	85
Q8	Percentage that felt they had a chance to see and comment on the information that was used by the managers involved in their review?	Yes (either all or some of the information)	56.0%	61
Q9	Percentage that has the NHS as their primary employer?	Yes	93.6%	102
Q10	Percentage that hold an academic contract?	Yes	13.6%	15
Q11	Percentage of those holding an academic contract, where the University was involved in the process to agree a single overall job plan?	Yes	17.6%	3
Q12	Percentage that have their job plan reviewed annually?	Yes	89.9%	98

Question number	Question	Answer	Percentage giving answer	Number giving answer
Q13	Percentage that responded that their last job plan review was:	Within the last three months	27.3%	30
		Between three months and six months ago	37.3%	41
		Between six months and 12 months ago	20.0%	22
		Between 12 months and 18 months ago	12.7%	14
		More than 18 months ago	0.9%	1
		I've never had a job plan review	1.8%	2
Q14	Percentage that responded that their last job plan review lasted:	Less than one hour	62.4%	68
		One to two hours	36.7%	40
		More than two hours	0.9%	1
Q15	Percentage that responded that their last job plan review was:	About right?	89.9%	98
Q16	Percentage that felt the right managers involved in the job plan review?	Yes	91.7%	99
Q17	Percentage that responded that their last job plan review was undertaken as part of a team?	Yes	21.7%	23
Q18	Percentage of those that responded that their last job plan review was undertaken who were given the opportunity to agree individual commitments at a subsequent meeting?	Yes	64.0%	16
Q19a	Percentage that felt their job plan review was conducted in a constructive and positive tone?	Yes	94.4%	101
Q19b	Percentage that felt their job plan review was held in an appropriate location?	Yes	94.5%	103

Question number	Question	Answer	Percentage giving answer	Number giving answer
Q19c	Percentage that felt their job plan review helped to prioritise work better and reduce an excessive workload?	Yes	41.0%	41
Q19d	Percentage that felt their job plan review provided a stimulus to discuss steps that could be taken to improve clinical practice?	Yes	51.5%	52
Q19e	Percentage that felt their job plan review provided an opportunity to discuss modernising services and introducing innovation and new ways of working?	Yes	56.4%	57
Q19f	Percentage that felt their job plan review allowed discussion of the constraints and pressures they face and agree the actions to address them?	Yes	66.3%	69
Q19g	Percentage that felt their job plan review identified issues relevant to other staff groups, clinical teams or service providers?	Yes	56.7%	55
Q19h	Percentage that felt their job plan review helped in delivering their personal development plan from their appraisal?	Yes	52.9%	55
Q20	Percentage that said a set of outcome indicators been agreed for their job plan?	Yes	33.0%	35
Q21	Percentage that have confidence with the accuracy of the outcome indicator information?	Yes	25.8%	16
Q22	Percentage that felt that the outcomes indicators used are appropriate and provide a true reflection of the work?	Yes	20.6%	14

Question number	Question	Answer	Percentage giving answer	Number giving answer
Q23	Percentage that were involved in any discussion about the type and relevance of the indicators?	Yes	33.3%	26
Q24	Percentage that take part in the CHKS Compass Clinical Outcomes Indicator (COI) programme?	Yes	76.0%	76
Q25	Percentage that have confidence in the accuracy of the CHKS Compass COI reports?	Yes	2.2%	2
Q26	Percentage that felt their job plan:			
	Clarified the commitments expected of you?	Yes	75.5%	83
	Clearly scheduled your commitments?	Yes	69.1%	76
	Helped tackle excessive workload?	Yes	19.1%	21
	Identified the resources and support needed to deliver your job plan?	Yes	19.1%	21
	Provided an appropriate balance between the sessions DCC and Supporting SPA commitments?	Yes	52.7%	58
	Clearly identified the outcomes from your SPAs?	Yes	31.8%	35
	Allowed you to work more flexibly, for example, by varying the clinical commitment, allowing for part-time, term-time working, and 'chunking' time?	Yes	29.1%	32
Q27	In overall terms have you found job planning to be:	Either useful or very useful	33.0%	35
Q28a	Percentage that felt following the introduction of the new contract in 2003, the time they spend on clinical care has increased?	Either strongly agree or agree	56.7%	51

Question number	Question	Answer	Percentage giving answer	Number giving answer
Q28b	Percentage that felt following the introduction of the new contract in 2003, that patient care has improved?	Either strongly agree or agree	21.7%	20
Q28c	Percentage that felt following the introduction of the new contract in 2003, that they now have clear personal objectives linked to service improvements?	Either strongly agree or agree	16.8%	16
Q28d	Percentage that felt following the introduction of the new contract in 2003, that the Health Board/Trust is better able to plan clinical activity?	Either strongly agree or agree	18.5%	17
Q28e	Percentage that felt following the introduction of the new contract in 2003, that their work is better planned?	Either strongly agree or agree	27.5%	25
Q28f	Percentage that felt following the introduction of the new contract in 2003, that their working week is more transparent?	Either strongly agree or agree	59.1%	55
Q28g	Percentage that felt following the introduction of the new contract in 2003, that they are able to work more flexibly?	Either strongly agree or agree	26.4%	24
Q28h	Percentage that felt following the introduction of the new contract in 2003, that team working has improved in their speciality?	Either strongly agree or agree	19.3%	17
Q28i	Percentage that felt following the introduction of the new contract in 2003, that the Health Board/Trust is able to measure their performance and contribution to service delivery?	Either strongly agree or agree	26.3%	25

Question number	Question	Answer	Percentage giving answer	Number giving answer
Q28j	Percentage that felt following the introduction of the new contract in 2003, that their job plan now reflects the specific demands of their specialty?	Either strongly agree or agree	39.8%	37
Q28k	Percentage that felt following the introduction of the new contract in 2003, that their job plan accurately reflects their working hours and commitments?	Either strongly agree or agree	47.9%	45
Q28l	Percentage that felt following the introduction of the new contract in 2003, that the support and resources identified in their job plan to help deliver their objectives have been provided?	Either strongly agree or agree	12.4%	11
Q28m	Percentage that felt following the introduction of the new contract in 2003, that their emergency workload is more fairly recognised?	Either strongly agree or agree	35.1%	27
Q28n	Percentage that felt following the introduction of the new contract in 2003, that they have been able reduce their working hours?	Either strongly agree or agree	12.6%	11
Q28o	Percentage that felt following the introduction of the new contract in 2003, that they are able to take most or all of their annual leave?	Either strongly agree or agree	70.8%	68
Q28p	Percentage that felt following the introduction of the new contract in 2003, that their SPA commitments are fairly recognised?	Either strongly agree or agree	60.0%	57
Q28q	Percentage that felt following the introduction of the new contract in 2003, that their SPA outcomes are clearly identified?	Either strongly agree or agree	27.1%	26

Question number	Question	Answer	Percentage giving answer	Number giving answer
Q28r	Percentage that felt following the introduction of the new contract in 2003, that the relationship between clinicians and managers has improved?	Either strongly agree or agree	18.3%	17
Q28s	Percentage that felt following the introduction of the new contract in 2003, that they have a positive relationship with management?	Either strongly agree or agree	53.6%	52
Q28t	Percentage that felt following the introduction of the new contract in 2003, that the working environment has improved for the better?	Either strongly agree or agree	14.9%	14
Q28u	Percentage that felt following the introduction of the new contract in 2003, that medical workforce planning has improved?	Either strongly agree or agree	8.7%	8
Q28v	Percentage that felt following the introduction of the new contract in 2003, that some of the work they do now can be done by other staff groups or more junior doctors?	Either strongly agree or agree	28.6%	26
Q28w	Percentage that felt following the introduction of the new contract in 2003, that their salary better reflects their workload?	Either strongly agree or agree	39.8%	37
Q28x	Percentage that felt following the introduction of the new contract in 2003, that the balance between their NHS commitments and other commitments is clear?	Either strongly agree or agree	60.2%	50
Q28y	Percentage that felt following the introduction of the new contract in 2003, that the contract has changed the way they work for the better?	Either strongly agree or agree	15.9%	14

Appendix 3

Methodology

We interviewed over 50 staff from across the Health Board in June 2010. Those interviewed were the associate medical director, clinical directors, general managers, and staff from HR, finance and data management who were involved in job planning. We also interviewed a sample of consultants selected by the Health Board and the LNC.

We reviewed a sample of job plans from each directorate. We also reviewed relevant documentation provided by the Health Board.

We ran an online survey for all consultants and 110 responded (26 per cent of all consultants employed by the Health Board).

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