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Pay Modernisation: Consultant Contract

Aneurin Bevan Health Board

Our overall conclusion is that with the exception of a small number of specialties, neither the Health Board nor its consultants are getting all the intended benefits from the consultant contract.

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.
2. 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.
3. 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 on 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 a mixture of Direct Clinical Care (DCC) sessions, such as clinics and ward rounds, and Supporting Professional Activities (SPAs), such as research, clinical audit and teaching. The amended contract stated that the working week would typically comprise seven DCC sessions and three SPAs, however, the actual DCC:SPA split should be informed by the specific requirements of each consultant's job and should be reviewed as part of the annual job plan reviews that are expected to be carried out as part of the contract.
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.

6. The Wales Audit Office has therefore undertaken work at each Health Board and NHS Trust that employs significant numbers of consultants, which seeks to answer the question: 'Are the intended benefits of the new consultant contract being delivered?' The audit has had a particular focus 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 extent to which the new contract was contributing to a more positive and equitable working environment of consultants, and the extent to which it has assisted recruitment and retention.

7. We undertook fieldwork at Aneurin Bevan Health Board (the Health Board) during October 2010. We interviewed key staff including the medical director, divisional directors, clinical directors, and key staff from HR and finance plus a sample of consultants selected by the Health Board. We also ran an online survey of all consultants which received responses from 80 of the Health Board's 318 consultants, a response rate of 24 per cent. We also reviewed a sample of consultant job plans.

8. Our overall conclusion is that with the exception of a small number of specialties, neither the Health Board nor its consultants are getting all the intended benefits from the consultant contract. In reaching this conclusion we have found that:

- with the exception of a few specialties, the Health Board is not using job planning as an effective tool to support service planning and modernisation; and
- more work is needed to ensure that the contract facilitates a positive and fairer working environment for all consultants.

Recommendations

9. 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	The Health Board needs to take action to successfully embed the new model of clinical leadership and through this ensure that all its consultants understand the value of job planning and how it is to be used to support the delivery of the Health Board, strategic objectives and operational targets. As part of this the benefits of effective job planning for both the consultant and the Health Board should be clearly identified.
R2	Business processes should be reviewed to ensure that all consultants have an up to date job plan that accurately reflects the work that they do, and which is reviewed on an annual basis. Appropriate monitoring and reporting arrangements should be developed to provide Board members with the appropriate assurances that this is happening.

R3	The Health Board needs to ensure that staff undertaking job plan reviews have the necessary support in terms of: • supporting corporate guidance; • training; and • creation of a Clinical Directors Forum or similar to share learning and experiences.
R4	The job planning process needs to be strengthened by: • ensuring the job planning process takes account of clinical demand and activity and flexes consultant sessions accordingly; • developing and agreeing the necessary activity and outcomes indicators for different specialties to inform job planning and performance review; • having a clearly identified role for directorate managers within the job planning process; • defining what constitutes an SPA, and how the value from SPAs may be measured; • promoting job planning across specialties where there are clear inter-relationships; • promoting job planning on a team basis, where this is seen to add value; and • reviewing and implementing the recommendations from the 2008 internal audit report on job planning.
R5	Where directorates such as Radiology have developed sound approaches to job planning, learning from this should be shared across the Health Board.
R6	Job planning should support equitable sharing of work within consultant teams and strategies and action plans should be put in place to reduce excessive workloads.
R7	The Health Board should closely monitor the progress being achieved by the six month programme of work being delivered by the Head of Workforce Development to ensure that it is delivering the intended benefits and addresses the issues highlighted in this report.

With the exception of a few specialties, the Health Board is not using job planning as an effective tool to support service planning and modernisation

There are weaknesses in the way the Health Board currently manages consultant job planning

There is a need for greater consistency in job planning approaches across divisions and directorates

10. There is an organisation wide system for job planning supported by annual guidance issued by the Medical Director. The guidance sets out what preparatory work is needed and what considerations need to be assessed at each job plan review, for example:
    - Is the DCC/SPA balance right?
    - Could any work be transferred to other roles?
    - For consultants with more than two SPAs – are they clearly accounted for?
    - No job plan should include more than 13 sessions.
    - Good evidence of SPA activity should be evident at appraisal.
11. This is a good starting point for establishing a job planning framework. However, turning this guidance into practice is the real challenge facing the Health Board.
12. Whilst job planning is evident in most directorates, the intensity and frequency with which it is delivered is highly variable, and very much dependent on the Clinical Director or Divisional Director driving the process, rather than the process itself:
    - some job planning is done in teams (eg, neurology, radiology);
    - some reviews are very structured (eg, obstetrics and gynaecology, cardiology, community medicine);
    - some job plans are adjusted in-year thereby demonstrating that job planning is a live process (eg, general surgery);
    - some directorates have admitted to a very adhoc approach being in place resulting in many not having had a job plan review for several years (ophthalmology, rheumatology):
    - some directorates appear to ‘pay lip service’ to job planning (anaesthetics, gastroenterology); and
    - some specialities realise they need to do job planning at a sub-speciality level to make it deliverable (eg, trauma and orthopaedics).

13. There is an enthusiasm amongst Clinical Directors to implement a more consistent approach to job planning across the Health Board but they recognise that they need the tools (eg, training) to make this happen.

14. Our survey of consultants confirmed the variable approach to job planning; of the 78 consultants who responded to the survey, 44 per cent were not getting annual job plan reviews (compared to the Welsh average of 37 per cent), 28 per cent had their last review more than 18 months ago, and six per cent had never had a review since they were employed.

Job planning is not linked closely enough to wider divisional planning

15. The annual divisional service reviews set the tone for divisional planning by looking at performance over the past 12 months, and then what the future model of delivery should look like. The outcome of these reviews does not feature in job planning discussions. Consequently, the organisational benefits of using job planning to drive forward service improvements are not being realised.

16. Job planning meetings are generally retrospective and focused on the previous year's delivery. They need to be more forward looking. This would ensure that all job plans are more clearly aligned to meeting Annual Operating Framework (AoF) targets and the Health Board's wider plans for service modernisation and transformation.

There has been limited managerial involvement in the job planning process

17. Positive and close working relationships between clinicians and managers are important in securing the action needed to modernise services. This should include involvement of managers in job planning meetings. However, our interviews with clinicians identified that it is not standard practice for clinical directors and directorate managers to be jointly involved in job plan review meetings. Radiology was the only directorate we identified where there was such a joint approach. Directorate Managers often bring a fresh perspective and complementary skill set to a job planning meeting, which needs to be better utilised by the Health Board.

18. Worryingly, only 52 per cent of consultants surveyed stated that they had a positive relationship with managers. Only 16 per cent could concretely say that relationships between clinicians and managers had improved since the new contract came into being.

19. Information on productivity and outcomes to support job planning discussions is under-developed. Job plan meetings need to be based on agreed data sets, in order for a robust and objective discussion to take place. Consultants in the Health Board have different experiences of how data is used as part of the job plan meeting. Forty-four per cent of survey respondents stated that they did not have access to information from local clinical/management information systems to support discussions about existing work commitments.

20. In the job planning meeting some consultants reported that very little data was used, such as activity information. Whilst others received a good range of activity and performance data before the meeting to inform the discussion. The majority of consultants' experience varied between these two extremes. The Health Board will need to ensure that the good practice adopted by some job planning meetings is consistently applied to all meetings.

21. The all Wales COMPASS project to generate consultant outcome data was designed to provide data which had hitherto been missing from the job plan review process. However, the initiative has been abandoned following concerns about the accuracy and meaningfulness of the data that was produced. This has led some health boards, within their job planning frameworks, to identify their own minimum data set of indicators. Such an approach needs to be adopted within the Aneurin Bevan Health Board.

There is a lack of clarity over what constitutes a Supporting Professional Activity and under-developed mechanisms to check what value is gained from them

22. The SPA sessions are a significant investment that helps consultants improve their skills, undertake research, develop new techniques and build new services.

23. Exhibit 1 shows that in 2009-10, the average number of SPAs sessions in the Health Board was 2.83 which was above the Welsh average of 2.60. It should also be noted that the average number of consultant SPA sessions in the Health Board is now higher than it was in the predecessor Trust (Exhibit 2).

Exhibit 1: Health Board average sessions 2009-10

Health Board/Trust	DCC	SPA	Other	Management	Total
ABM	8.49	2.41	0.26	0.06	11.22
Cardiff & Vale	8.23	2.84	0.15	0.13	11.34
Cwm Taf	8.26	2.32	0.15	0.14	10.877
Aneurin Bevan	**8.20**	**2.83**	**0.01**	**0.22**	**11.25**
Hywel Dda	8.49	2.37	0.01	0.00	10.89
BCU Central & East	8.44	2.72	0.08	0.16	11.44
BCU West	8.65	2.28	0.37	0.09	11.38
PHW	7.65	2.86	0.03	0.00	10.55
Powys	7.87	1.67	1.26	0.36	11.16
Velindre	7.84	2.85	0.00	1.15	11.84
Wales Average	8.34	2.60	0.14	0.13	11.21

Source: Aneurin Bevan Health Board and the Welsh Assembly Government

Exhibit 2: Change in average sessions 2007-08 to 2009-10 for Aneurin Bevan Health Board

	DCC	SPA	Other	Management	Total
2009-10					
Aneurin Bevan Health Board	8.20	2.83	0.01	0.22	11.25
2008-09					
Gwent Healthcare NHS Trust	8.26	2.63	0.33	0.24	11.46
2007-08					
Gwent Healthcare NHS Trust	8.22	2.66	0.34	0.26	11.47

Source: Aneurin Bevan Health Board and the Welsh Assembly Government

24. Across the Health Board, there is no universal approach to monitoring SPAs and whether they are adding value. Consultants are generally not set specific SPA outcome measures. Discussions about SPA activities tend to be general and might cover clinical audit and teaching. It is normal for these topics to be discussed at an appraisal rather than job planning. Evidence to support whether SPA activity is actually being delivered is highly variable, ranging from a detailed portfolio of evidence to informal discussions. Of the consultants responding to our survey, only 26 per cent indicated they had a job plan that identified outcome measures from SPA sessions.

25. The value being derived from SPAs is currently a matter of priority for the Health Board, and is expected to be the subject of intense scrutiny in the coming months. The Medical Director has signalled to clinical directors that monitoring SPA activities was a priority for the next round of job planning. Our interviews confirmed that this message is filtering down to consultants and all understand the requirement to better evidence their SPA activity. However, there is some way to go before this is routinely done and the Health Board can demonstrate it gets value for money from SPA activity.

26. There are currently a number of anomalies regarding SPA allocation across the Health Board. Data presented in Appendix 1 shows that the average numbers of SPAs can vary significantly across specialties. We have also been made aware of individual consultants who decline to undertake any SPA sessions at all.
The Health Board's consultant database shows a number of specialties that have, on average, more than three SPAs. These averages are typically higher than the all Wales average for the corresponding specialty (Exhibit 3).

27. These anomalies need to be reviewed, and where necessary addressed, as part of the next job planning round. Divisional and Clinical Directors need to be given the necessary corporate support and guidance on how to review the extent of SPA activity and where necessary to challenge and tackle any anomalies that are apparent. We are aware that at a corporate level, there are discussions taking place about the value of reducing typical SPA allowances from three to two.

Exhibit 3: Specialties within the Health Board which have more than three SPAs on average

Specialties	DCC	SPA	Other	Management	Total
Anaesthetics	7.67	3.11	0.00	0.22	10.99
Welsh Average	*8.27*	*2.64*	*0.04*	*0.08*	*11.03*
Chemical Pathology	7.50	4.50	0.00	0.50	12.50
Welsh Average	*7.91*	*2.89*	*0.02*	*0.27*	*11.08*
Dermatology	7.45	3.15	0.00	0.37	10.97
Welsh Average	*7.62*	*2.66*	*0.09*	*0.13*	*10.49*
ENT	8.77	3.06	0.00	0.17	11.99
Welsh Average	*8.78*	*2.55*	*0.17*	*0.05*	*11.55*
Learning Disabilities	8.27	3.88	0.00	0.00	12.15
Welsh Average	*7.87*	*3.41*	*0.07*	*0.06*	*11.41*
Mental Illness	7.51	3.22	0.00	0.26	10.98
Welsh Average	*7.58*	*2.66*	*0.21*	*0.22*	*10.66*
Ophthalmology	7.55	3.08	0.00	0.00	10.63
Welsh Average	*8.13*	*2.56*	*0.08*	*0.13*	*10.90*
Orthodontics	8.01	3.21	0.00	0.00	11.22
Welsh Average	*8.19*	*2.74*	*0.02*	*0.19*	*11.14*
Paediatrics	7.79	3.29	0.00	0.45	11.53
Welsh Average	*7.90*	*2.68*	*0.19*	*0.23*	*11.01*

Source: Aneurin Bevan Health Board and the Welsh Assembly Government

28. Any corporate review of SPA activity through job planning or related corporate activity should incorporate a 'reality check' to compare what is listed in consultant job plans and what is actually being delivered in practice. Many consultants have commented that they use SPA time to backfill DCC time. Forty-nine per cent of survey respondents felt that time spent on clinical care had increased, whilst 42 per cent disagreed that their job plan reflected accurately their working week / commitments. This can potentially compromise important SPA activities such as audit and quality review, and means that job plans understate the extent of DCC that these consultants are undertaking and potentially overstate SPA activity.

29. Consultants also raised concerns that their SPA time is being used to back fill sessions as a result of uncoordinated annual leave. The Health Board needs to set a clear steer on what it expects from SPA activities and reduce any inequities that exist. Robust data is required to inform discussions where consultants have more than three SPAs. There also needs to be a clear distinction between what is SPA/CPD time and what is management time.

30. The benefits of getting consultants to readily use SPA time to support service developments/service improvement should be explored and where possible strengthened. There are already a number of consultants who are developing better links to primary care thereby reducing inappropriate referrals or becoming

involved in service line management data. This needs to become systematic, rather than ad hoc.

31. Team job planning and annualised job planning is also an option that needs to be explored as it provides an opportunity to better align SPA activity to the Health Board's strategy, secures better value for money for the Health Board and protects consultants' SPA time. In particular, planning SPA activity across a directorate rather than by consultant could deliver significant benefits for the Health Board.

Inter-relationships between specialities are not considered as part of the job planning process

32. We found little evidence of specialities considering how their job planning arrangements might impact on other specialities, for example how a surgeon's decision to increase his day surgery sessions might impact on an anaesthetist's weekly timetable. Concerns were also raised that the impact of service changes on support services such as radiology and pathology are not always factored in, which leads to reactive job planning.

There are logistical challenges for the larger directorates in scheduling and delivering job plan reviews

33. At interview, it became clear that those directorates which were more fully engaged with job planning tended to be the smaller directorates, which often have a greater team ethos. Larger directorates such as trauma and orthopaedics and anaesthetics continue to struggle to deliver an annual review process because of the sheer number of consultants involved. However, with appropriate prioritisation and advance planning, these challenges should not be insurmountable.

Whilst there is evidence that job planning is being used to support service development in certain specialties, this was not a typical finding

The more constructive use of job planning as a tool to support service development was seen in smaller specialties

34. During our audit, we identified a number of specialities which were proactively using the job planning process as a team to support the operational requirements of the Health Board whilst being mindful of the working environment of their consultants. They include: radiology, obstetrics and gynaecology, neurology and paediatrics. Radiology was in fact identified as an area of good practice back in 2008, as part of an Internal Audit report into job planning.

35. In neurology, job planning discussions have enabled a shift away from outpatient service provision with its inherent delays, to delivering a more reactive acute based service. This ensures that patients are seen on a more timely basis because the service no longer relies on the referral process. It is an approach which is expected to reduce inappropriate admissions and reduce hospital length

of stay. It is an approach which the Health Board should review as a potential model of engagement for other directorates and specialities.

As a rule job planning is not a key driver in shaping service development and modernisation

36. A significant amount of service modernisation is happening at the Health Board but job planning is not typically a key driver of this. It is the regular directorate meetings and working groups such as care pathway groups, rather than job plan meetings where clinicians and managers work together to modernise and improve the service. The consultant survey results showed that:
    - Fifty-one per cent did not feel that the job plan review provided an opportunity for them to discuss service modernisation/new ways of working; and
    - only 34 per cent could agree with the statement that they had clear personal objectives linked to service improvements.
37. Despite having an integrated Health Board, many consultants commented that they would like stronger links to primary care colleagues, and SPAs could be used to support this process. We identified some examples of specialist groups in place but nothing wholesale. For example, Cardiology run a special interest group which aims to bridge the secondary/primary care divide. A project has been developed whereby cardiologists audit referrals from GPs and offer advice via phone or e-mail. It is hoped that the project will reduce inappropriate referrals, thereby minimising reliance on waiting list initiatives to meet current levels of demand.
38. Given that GP referrals are increasing five per cent year on year, robust links between primary and secondary care are needed across all specialties if the organisation is to successfully tackle inappropriate referrals and better manage demand for services. Future job planning discussions need to take these issues into account.

The Health Board is aware of the need to improve its job planning arrangements and is taking action to strengthen its arrangements

The Health Board is confident that job planning will be strengthened through initiatives to address wider medical staffing challenges

39. Medical staffing is both a valuable and costly resource for the Health Board. Its importance in helping the Health Board to tackle the significant financial challenges ahead is clearly recognised by the Executive Team. The Head of Workforce Development has been tasked with developing and implementing a six month programme of work which will help inform the Health Board's plans. This includes:
    - ensuring there is compatibility between job planning activity and clinical/service demand;

- moving towards output driven SPA sessions;
- looking at all job plans greater than 12 sessions and working with Clinical Directors to identify ways of reducing individuals' commitments;
- reviewing whether the clinical leadership model is working; and
- ensuring that consultant productivity metrics feed into job planning discussions.

40. This is important given that only 18 per cent of survey respondents agreed that medical workforce planning has improved since the amended contract was introduced.

Initiatives are in place to improve the information that is generated to support job planning

41. The Workforce and OD Division maintains a consultant contract database where all appraisals, job planning and Personal Development Plan (PDP) information are centrally collated. This is good practice. The Health Board has also recently agreed to purchase an e-rostering tool. Both systems will enable medical workforce information to be used more intelligently to help the Health Board better understand how the medical workforce is utilised, and whether it is delivering value for money.

The new clinical leadership model has the potential to improve the effectiveness of job planning but more work is needed to ensure that is it effectively embedded and that the added investment delivers the intended benefits

42. The Health Board has recently introduced a new clinical leadership model. The appointment of Divisional Directors and Clinical Directors means that the Divisions are now being led by clinicians rather than managers, as was previously the case. This is seen as an important stepping stone in improving clinical engagement in service modernisation.

43. The Health Board has invested significant sums of money so that the Divisional Directors and Clinical Directors have protected management time to provide clinical leadership. However, at interview, many consultants commented that they were not clear what benefits the new clinical leadership model is expected to bring.

44. These new roles therefore need to be more widely understood by consultants, because in the new clinical leadership structure they are expected to have a key role in improving the links between job planning and service modernisation.

45. At the time of our fieldwork, there was no forum for Clinical Directors to share their experiences and learning which would help promote the value of job planning and embed it into working practices. Given the important role that this staff group will have going forward, thought should be given to addressing the potential gap.

More work is needed to ensure that the contract facilitates a positive and fairer working environment for all consultants

Recruitment and retention of consultants were generally seen as positive by the Health Board, however, there can be perceived inequities within and between clinical teams resulting from the way new posts are advertised

46. In general, consultant recruitment and retention at Aneurin Bevan are seen as positive by senior executives. Despite having two very busy hospitals, particularly the Royal Gwent, the Health Board continues to be seen to be offering a positive working environment. At the time of the audit, only nine consultant posts were vacant (equivalent to three per cent of the consultant workforce).

47. What is not clear is whether this broadly positive picture is due to the consultant contract and how it has been implemented, or other factors. There is anecdotal evidence to suggest that consultants have historically been attracted to an organisation where more than 10 sessions per week are available, both from a financial and learning perspective.

48. New consultant jobs at the Health Board are advertised on a 10 session basis. Within these 10 sessions, the ratio of DCC sessions to SPA sessions varies significantly, from a BMA recognised 7:3 split to a 9:1 split, which the BMA considers to be clinically unsafe because it does not allow a new consultant any professional development time.

49. We were also made aware that this practice can cause tensions when newly appointed consultants discover that colleagues delivering similar workloads have job plans that contain more than 10 sessions, and consequently have more time for professional development. Sometimes this has led to job plans being re-negotiated (typically to increase the number of sessions for the new consultant), whilst at other times the inequity is allowed to remain.

50. The Health Board therefore needs to ensure that its recruitment and retention processes are equitable and reasonable.

Many consultants are still working in excess of 10 sessions per week

51. Although new posts are advertised on a 10 session basis, many consultants at the Health Board have job plans in excess of the standard contract of 10 sessions. According to the Health Board's own consultant database, 28 per cent (98) are on more than 12 sessions and 33 of those are on more than 13 sessions. The specialities most affected by the latter are anaesthetics, general medicine, paediatrics and mental health.

52. In addition, data submitted by the Health Board to the Assembly Government identified a further four specialities, where consultants work more than 12 sessions per week.

Exhibit 4: Specialties within ABHB exceeding 12 sessions on average

Specialties	DCC	SPA	Other	Management	Total
Chemical Pathology	7.5	4.50	0.00	0.50	12.50
Welsh Average	*7.91*	*2.89*	*0.02*	*0.27*	*11.08*
Endocrinology	10.0	2.0	0.00	0.50	12.50
Welsh Average	*7.50*	*2.62*	*0.39*	*0.12*	*10.63*
Histopathology	10.13	2.44	0.00	0.06	12.63
Welsh Average	9.03	2.60	0.32	0.04	11.98
Learning Disabilities	8.27	3.88	0.00	0.00	12.15
Welsh Average	*7.87*	*3.41*	*0.07*	*0.06*	*11.41*

Source: Aneurin Bevan Health Board and the Welsh Assembly Government

53. There is no evidence of the Health Board trying to reduce consultant job plans to closer to 10 sessions. In fact there has been a steady creep upwards across most disciplines, to the point that a 12 session job plan is now considered to be the 'norm' for many specialities, given the activity levels they have to process. Some specialities have had some success at reducing consultant sessions within their directorates eg, General Surgery and Paediatrics, but this is the exception, rather than the norm.

54. The consultant survey findings highlighted that whilst 71 per cent felt there was an appropriate balance between DCC and SPA work:

- sixty-three per cent have not been able to reduce their working hours;
- fifty-eight per cent did not feel that the job plan review helped them to prioritise their workload or reduce excessive workloads; and
- only 32 per cent felt the job plan allowed more flexible working eg, part time working/term time working.

55. Moving forwards, there is limited appetite within the Health Board to try and reduce all consultants to a 10 session job plan. Not only would this be highly expensive as it would require additional consultants to be appointed; it would also affect the Health Board's ability to deliver its AoF targets. The Health Board is looking to adopt an approach whereby all job plans will be reviewed to assess their merit, even those which are on 10 sessions. This is to ensure that demand led specialities are not being unfairly penalised.

56. Corporate guidance is now required on how best to review all job plans to make sure they reflect actual activity, as well as tackling those with job plans in excess of 12 sessions. Given how busy the Royal Gwent Hospital in particular is, there needs to be a clear steer on what an acceptable number of sessions should look like, because 10 sessions is not considered to be achievable for many specialities. A different approach may be required for those specialities which have easily definable fixed sessions such as orthopaedics, versus those that do not, for example Mental Health.

The contract is not being used as a vehicle to address variances in consultant productivity

57. As noted earlier, meaningful information on outcomes from activities in consultant job plans is largely absent. This hampers any attempts to accurately measure a consultant's activities compared to their peers. Anecdotal evidence suggests that there is significant variation in how 'productive' consultants are, however with no agreement on how this could be adequately measured the ability to review this further is limited. The consultant survey identified that 70 per cent of respondents had not agreed any outcome indicators and only 30 per cent felt that the Health Board could measure their performance and contribution.

58. Where outcome measures for consultants have been set, in many instances the objectives do not meet the 'SMART' (Specific, Measurable, Achievable, Realistic and Timed) criteria – see Appendix 3 for examples taken from existing job plans.

59. At interview, many consultants were frustrated that the amended consultant contract had not been used in this way. Consultants and managers were concerned that whilst the Health Board may have lots of consultants on more than 10 sessions, some performance and activity data was comparatively lower than expected which suggests more information is need to measure efficiency and address any underlying causes.

The European Working Time Directive is resulting in some consultants taking on additional unplanned work, which is impacting on their ability to deliver scheduled job plan commitments

60. Consultants are becoming increasingly aware of the need to move from consultant led services to consultant delivered services as a result of the European Working Time Directive (EWTD). However, job plans have yet to mirror this direction of travel. At interview, many consultants commented that they are being paid for one session of on-call, but in reality are delivering much more.

61. Most consultants interpret a session as anywhere between three and four hours, with the default position often being set at 3.75 hours. Due to having to take on additional unplanned work because of a lack of available juniors, sometimes a ward round or clinic which should take four hours will in fact take much longer. Some consultants feel that this is impacting on their ability to deliver planned commitments and in the long term will reduce activity levels. This issue should be investigated further by the Health Board.

Session benchmarking

Aneurin Bevan specialty analysis 2009-10

Specialty	DCC	SPA	Other	Management	Total
Accident and Emergency	8.21	2.46	0.22	0.12	11.02
Anaesthetics	7.67	3.11	0.00	0.22	10.99
Cardiology	9.25	1.92	0.00	0.67	11.83
Chemical Pathology	7.50	4.50	0.00	0.50	12.50
Child and Adolescent Psychiatry	8.63	2.66	0.00	0.00	11.29
Community Medicine	7.10	2.63	0.00	0.45	10.18
Dental Medicine Specialties	8.50	3.00	0.00	0.00	11.50
Dermatology	7.45	3.15	0.00	0.37	10.97
Endocrinology	10.00	2.00	0.00	0.50	12.50
ENT	8.77	3.06	0.00	0.17	11.99
Gastroenterology	7.80	2.40	0.00	0.40	10.60
General Medicine	9.00	2.28	0.00	0.14	11.43
General Surgery	8.65	3.00	0.00	0.20	11.85
Geriatric Medicine	8.71	2.84	0.00	0.27	11.82
GP Other	7.00	3.00	0.00	0.00	10.00
Gynaecology	8.67	2.81	0.00	0.16	11.64
Haematology (Clinical)	8.10	2.47	0.00	0.38	10.96
Histopathology	10.13	2.44	0.00	0.06	12.63
Learning Disabilities	8.27	3.88	0.00	0.00	12.15
Medical Microbiology	8.38	2.63	0.00	0.13	11.13
Mental Illness	7.51	3.22	0.00	0.26	10.98
Neurology	8.22	2.58	0.00	0.00	10.80
Occupational Medicine	7.00	3.00	0.00	0.00	10.00
Ophthalmology	7.55	3.08	0.00	0.00	10.63
Oral Surgery	7.00	3.00	0.00	0.00	10.00
Orthodontics	8.01	3.21	0.00	0.00	11.22
Paediatrics	7.79	3.29	0.00	0.45	11.53
Palliative Medicine	8.00	2.00	0.00	0.00	10.00
Radiology	7.99	2.92	0.00	0.24	11.15
Rheumatology	7.21	2.79	0.00	0.23	10.23
Thoracic Medicine	8.60	2.40	0.00	0.00	11.00

Specialty	DCC	SPA	Other	Management	Total
Trauma and Orthopaedic	8.32	2.42	0.00	0.13	10.88
Urology	9.56	2.19	0.00	0.19	11.94
LHB Average	**8.20**	**2.83**	**0.01**	**0.22**	**11.25**

Welsh Averages 2009-10

Specialty	DCC	SPA	Other	Management	Total
Accident & 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 & 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 & 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 & 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
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

Specialty	DCC	SPA	Other	Management	Total
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 & 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

Source: Aneurin Bevan Health Board and the Welsh Assembly Government

Consultant survey

No.	Question	Answer	Aneurin Bevan number giving Answer	Aneurin Bevan % giving Answer	All Wales % giving Answer
1	Total number of responses		80	…	580
4	Percentage of consultants received adequate notice of the date of their last job plan review meeting	Yes	68	90.7%	87.8%
5	Percentage of consultants that had access to information from local clinical/management information systems to support discussions about their existing work	Yes	42	56.8%	53.4%
6	Percentage of consultants that use each of the following categories of information to help prepare for their job plan review meetings:	Health Board or Trust information	0	0.0%	26.2%
		Your own information	64	80.0%	67.2%
		None	4	5.0%	5.7%
		Other *	6	7.5%	8.4%
7a	Percentage of consultants that prior to the job planning meeting were able to consider last year's work	Yes	66	89.2%	89.6%

No.	Question	Answer	Aneurin Bevan number giving Answer	Aneurin Bevan % giving Answer	All Wales % giving Answer
7b	Percentage of consultants that prior to the job planning meeting were able to consider their current pattern of work and activities	Yes	71	98.6%	95.9%
7c	Percentage of consultants that prior to the job planning meeting were able to consider pressures and constraints that were causing them difficulties	Yes	64	87.7%	88.2%
7d	Percentage of consultants that prior to the job planning meeting were able to consider any clinical governance and clinical audit issues that have arisen	Yes	60	85.7%	85.1%
7e	Percentage of consultants that prior to the job planning meeting were able to consider the impact of internal and external initiatives (e.g. NHS reform, changes in health needs of the community and junior doctor training requirements)	Yes	50	72.5%	68.7%
7f	Percentage of consultants that prior to the job planning meeting were able to consider any ideas they had for improving the service	Yes	54	76.1%	80.1%
7g	Percentage of consultants that prior to the job planning meeting were able to consider their own personal development plan from their appraisal	Yes	56	80.0%	81.7%

No.	Question	Answer	Aneurin Bevan number giving Answer	Aneurin Bevan % giving Answer	All Wales % giving Answer
8	Percentage of consultants that 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)	34	44.7%	44.1%
9	Percentage of consultants where the NHS is their primary employer	Yes	79	100.0%	93.6%
10	Percentage of consultants that hold an academic contract	Yes	5	6.3%	11.3%
11	Percentage of consultants holding an academic contract, where the University was involved in the process to agree a single overall job plan	Yes	1	14.3%	21.6%
12	Percentage of consultants that have their job plan reviewed annually	Yes	44	56.4%	61.5%
13	Percentage of consultants that whose last job plan review was:	Within the last 3 months	9	11.4%	14.4%
		Between 3 mths and 6 mths ago	11	13.9%	14.7%
		Between 6 mths and 12 mths ago	21	26.6%	26.3%
		Between 12 mths and 18mths ago	11	13.9%	17.2%
		More than 18mths ago	22	27.8%	19.1%
		I've never had a job plan review	5	6.3%	8.3%
14	Percentage of consultants whose last job plan review lasted:	Less than one hour	43	57.3%	60.7%
		One to two hours	28	37.3%	35.7%
		More than two hours	4	5.3%	3.6%

No.	Question	Answer	Aneurin Bevan number giving Answer	Aneurin Bevan % giving Answer	All Wales % giving Answer
15	Percentage of consultants that said that their last job plan review was	About right?	56	74.7%	78.6%
16	Percentage of consultants that said that the right managers involved in the job plan review	Yes	58	81.7%	87.3%
17	Percentage of consultants whose last job plan review was undertaken as part of a team	Yes	9	12.9%	17.4%
18	Percentage of consultants whose last job plan review was undertaken as part of a team that were given the opportunity to agree individual commitments at a subsequent meeting	Yes	3	23.1%	52.8%
19a	Percentage of consultants that felt their job plan review was conducted in a constructive and positive tone	Yes	57	77.0%	85.4%
19b	Percentage of consultants that felt their job plan review was conducted was held in an appropriate location	Yes	70	94.6%	93.9%
19c	Percentage of consultants that felt their job plan review was conducted helped to prioritise work better and reduce an excessive workload	Yes	30	43.5%	36.1%
19d	Percentage of consultants that felt their job plan review provided a stimulus to discuss steps that could be taken to improve clinical practice	Yes	35	50.7%	46.3%

No.	Question	Answer	Aneurin Bevan number giving Answer	Aneurin Bevan % giving Answer	All Wales % giving Answer
19e	Percentage of consultants that felt their job plan review provided an opportunity to discuss modernising services and introducing innovation and new ways of working	Yes	36	50.7%	47.1%
19f	Percentage of consultants that felt their job plan review allowed discussion of the constraints and pressures they face and agree the actions to address them	Yes	48	67.6%	61.9%
19g	Percentage of consultants that felt their job plan review identified issues relevant to other staff groups, clinical teams or service providers	Yes	40	56.3%	53.0%
19h	Percentage of consultants that felt their job plan review helped in delivering their personal development plan from their appraisal	Yes	43	59.7%	54.6%
20	Percentage of consultants that said a set of outcome indicators been agreed for their job plan	Yes	23	31.9%	34.3%
21	Percentage of consultants that felt they have confidence with the accuracy of the outcome indicator information	Yes	10	23.8%	26.8%
22	Percentage of consultants that felt that the outcomes indicators used are appropriate and provide a true reflection of the work	Yes	9	22.0%	23.4%

No.	Question	Answer	Aneurin Bevan number giving Answer	Aneurin Bevan % giving Answer	All Wales % giving Answer
23	Percentage of consultants that were involved in any discussion about the type and relevance of the indicators	Yes	16	37.2%	31.8%
24	Percentage that take part in the CHKS Compass Clinical Outcomes Indicator (COI) programme?	Yes	48	69.6%	77.0%
25	Percentage that have confidence in the accuracy of the CHKS Compass COI reports?	Yes	4	6.3%	8.5%
26	Percentage of consultants that felt their job plan:		answered yes	answered yes	answered yes
		Clarifies the commitments expected of them	50	62.5%	65.0%
		Clearly schedules their commitments	56	70.0%	60.2%
		Helps to tackle excessive workloads	21	26.3%	18.6%
		Identifies the resources and support needed to deliver their job plan	17	21.3%	19.7%
		Provides an appropriate balance between the sessions Direct Clinical Care (DCC) and Supporting Professional Activity (SPA) commitments	56	70.0%	54.7%
		Clearly identifies the outcomes from their SPAs	21	26.3%	27.1%
26	Percentage of consultants that felt their job plan:		answered yes	answered yes	answered yes

No.	Question	Answer	Aneurin Bevan number giving Answer	Aneurin Bevan % giving Answer	All Wales % giving Answer
		Allows them to work more flexibly, for example, by varying the clinical commitment, allowing for part time, term time working, and “chunking” time	26	32.5%	24.7%
27	Percentage of consultants that in overall terms have found job planning to be:	Either useful or very useful	33	44.6%	37.2%
28a	In relation to the consultant contract and job planning, percentage that agreed: The time I spend on clinical care has increased	Either strongly agree or agree	34	47.2%	53.7%
28b	In relation to the consultant contract and job planning, percentage that agreed: Patient care has improved	Either strongly agree or agree	17	23.3%	28.1%
28c	In relation to the consultant contract and job planning, percentage that agreed: I now have clear personal objectives linked to service improvements	Either strongly agree or agree	24	33.3%	26.2%
28d	In relation to the consultant contract and job planning, percentage that agreed: The Health Board/Trust is better able to plan clinical activity	Either strongly agree or agree	22	31.4%	23.8%
28e	In relation to the consultant contract and job planning, percentage that agreed: My work is better planned	Either strongly agree or agree	27	37.0%	32.4%
28f	In relation to the consultant contract and job planning, percentage that agreed: My working week is more transparent	Either strongly agree or agree	41	56.2%	55.0%

No.	Question	Answer	Aneurin Bevan number giving Answer	Aneurin Bevan % giving Answer	All Wales % giving Answer
28g	In relation to the consultant contract and job planning, percentage that agreed: I am able to work more flexibly	Either strongly agree or agree	22	31.0%	27.1%
28h	In relation to the consultant contract and job planning, percentage that agreed: Team working has improved in my speciality	Either strongly agree or agree	20	27.8%	30.0%
28i	In relation to the consultant contract and job planning, percentage that agreed: The Health Board/Trust is able to measure my performance and contribution to service delivery	Either strongly agree or agree	22	30.1%	25.0%
28j	In relation to the consultant contract and job planning, percentage that agreed: My job plan now reflects the specific demands of my specialty	Either strongly agree or agree	34	47.9%	41.5%
28k	In relation to the consultant contract and job planning, percentage that agreed: My job plan accurately reflects my working hours and commitments	Either strongly agree or agree	33	45.8%	40.4%
28l	In relation to the consultant contract and job planning, percentage that agreed: The support and resources identified in my job plan to help deliver my objectives have been provided	Either strongly agree or agree	12	16.4%	15.0%
28m	In relation to the consultant contract and job planning, percentage that agreed: My emergency workload is more fairly recognised	Either strongly agree or agree	16	24.6%	32.7%

No.	Question	Answer	Aneurin Bevan number giving Answer	Aneurin Bevan % giving Answer	All Wales % giving Answer
28n	In relation to the consultant contract and job planning, percentage that agreed: I have been able reduce my working hours	Either strongly agree or agree	13	18.8%	13.6%
28o	In relation to the consultant contract and job planning, percentage that agreed: I am able to take most or all of my annual leave	Either strongly agree or agree	58	80.6%	75.9%
28p	In relation to the consultant contract and job planning, percentage that agreed: My SPA commitments are fairly recognised	Either strongly agree or agree	45	60.8%	26.9%
28q	In relation to the consultant contract and job planning, percentage that agreed: My SPA outcomes are clearly identified	Either strongly agree or agree	18	25.0%	26.9%
28r	In relation to the consultant contract and job planning, percentage that agreed: The relationship between clinicians and managers has improved	Either strongly agree or agree	12	16.4%	18.3%
28s	In relation to the consultant contract and job planning, percentage that agreed: I have a positive relationship with management	Either strongly agree or agree	38	52.1%	55.3%
28t	In relation to the consultant contract and job planning, percentage that agreed: The working environment has improved for the better	Either strongly agree or agree	10	14.3%	17.2%

No.	Question	Answer	Aneurin Bevan number giving Answer	Aneurin Bevan % giving Answer	All Wales % giving Answer
28u	In relation to the consultant contract and job planning, percentage that agreed: Medical workforce planning has improve	Either strongly agree or agree	13	18.1%	13.3%
28v	In relation to the consultant contract and job planning, percentage that agreed: Some of work I do now can be done by other staff groups or more junior doctors	Either strongly agree or agree	24	33.8%	32.1%
28w	In relation to the consultant contract and job planning, percentage that agreed: My salary better reflects my workload	Either strongly agree or agree	21	28.8%	31.7%
28x	In relation to the consultant contract and job planning, percentage that agreed: The balance between my NHS commitments and other commitments is clear	Either strongly agree or agree	31	47.7%	44.0%
28y	In relation to the consultant contract and job planning, percentage that agreed: The Contract has changed the way I work for the better	Either strongly agree or agree	15	21.4%	20.4%

Appendix 3

Examples of outcome measures set for radiology consultants

Radiology – Consultants Expected Outcomes – 20 job plans reviewed	
Continue to provide the same (high quality) level of service	14
Present an audit in the next 12 months	9
Maintain plain film reporting standards	6
Maintain plain film reporting standards but increase percentage of CTs when new appointment made	1
Work to improve gynaecology MDT	1
Develop international radiology service	1
Provide head and neck MDT	1
Work towards delivery of new service	1
Continue to lead the paediatric radiology service	2
Continue to develop voice recognition and sonographer reporting	1
Continue to audit aspects of clinical practice	1
Monitor CT workload and plain film workload	1
Improve plain film reporting output	1
Continue with clinical radiology meetings	1
Continue with training medical staff and physios	2
General reports of approximately 100 exams per session, averaging two sessions per week	1
Continue to develop MSK service and improve range of MSK ultrasound skills	1
Continue to be audit lead	1
Continue contributions to development of stroke service	1
Clinical director role to achieve directorate and divisional goals	1
Continue with RCR roles	2
CT reporting level to be maintained in view of increase from 10 to 11 sessions	1
Continue to develop the agreed service	1
Develop and lead head and neck radiology	1
Maintain audit activity	1
Continue to attend discrepancy meetings	1
Reduce plain film reporting	1
Review CT lists in November	1
Continue with teaching	1
Continue appraisal of consultant radiologists	1

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