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Auditor General for Wales

# NHS Consultant Contract: Follow-up of previous audit recommendations – **Abertawe Bro Morgannwg University Health Board**

Audit year: 2015

Date issued: November 2016

Document reference: 401A2016

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Job planning remains highly inconsistent across the Health Board and some of the initial benefits to emerge from the contract have eroded over time, although recent organisational changes and plans to introduce electronic job planning may help to strengthen arrangements.


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# Summary report

## Background

1 The consultant contract is the national framework that governs the working conditions and salary grades of consultants. The amended NHS Wales Consultants' Contract (the contract) came into effect on 1 December 2003, and was the first major change to consultants' terms and conditions since 1948.[1]

2 The contract was designed to deliver three specific benefits for the NHS:

- improve the working environment for consultants;
- improve consultant recruitment and retention; and
- facilitate health managers and consultants to work more closely together to provide a better service for patients.

3 Underpinning the delivery of these benefits is an effective job planning process. Job planning is a mandatory process designed to ensure that individual consultants and their employers are clear on the nature and scheduling of their work activities and what they are seeking to achieve. Job planning can align the objectives of the NHS, the organisation, clinical teams (and in the case of clinical academics, their higher education institution) with individually agreed outcomes. It can help consultants, clinical academics, managers, and the wider NHS team to plan and deliver innovative and high-quality care.

4 The contract is based on a full-time working week of 37.5 hours, equivalent to 10 sessions of three to four hours. Consultants are paid overtime for any contracted work over these hours. A consultant's working week comprises direct clinical care (DCC) sessions, such as clinics and ward rounds, and supporting professional activities (SPA) sessions, such as research, clinical audit and teaching. Under the amended contract, the working week typically comprises seven DCC sessions and three SPA sessions.

5 During 2010, the Auditor General reviewed how well NHS employers were using the job planning process to realise the wider benefits of the contract, other than the pay elements which were the responsibility of the Welsh Government. We reviewed all health bodies except Powys Teaching Health Board and the Welsh Ambulance Services NHS Trust, and issued reports during 2011.

[1] **Amendment to the National Consultant Contract in Wales,** NHS Wales and the Welsh Assembly Government, December 2003.

6 In February 2013, the Auditor General published a national report entitled, **Consultant Contract in Wales: Progress with Securing the Intended Benefits**. It summarised the findings from the local work and set out how the contract was being implemented across Wales. It contained a number of recommendations in the following areas:

- strengthening job planning processes within NHS bodies;
- using the right information to inform job planning;
- using job plans to clarify expectations and support service delivery; and
- developing a clearer focus on benefit realisation.

7 The Public Accounts Committee (PAC) held evidence sessions based on the Auditor General's findings during 2013. The PAC's own report[2], published in September 2013, recommended the Welsh Government strengthen its leadership on the job planning process by producing guidance and training for health organisations. The PAC also recommended that the Welsh Government should work with a range of NHS organisations to develop an information framework on desired consultant outcomes.

8 In response to the Auditor General's findings and the PAC inquiry, the Welsh Government, NHS Wales employers, and BMA Cymru produced updated guidance (the guidance) on job planning for health boards and NHS trusts in Wales in 2014[3].

9 As previously stated, we have done targeted follow-up audit work in relation to the contract at a number of NHS bodies. But, we have not comprehensively assessed progress in implementing the previous audit recommendations. The Auditor General therefore included a mandated follow-up review within his 2015 programme of local audit work.

10 Between January and March 2016, we undertook the follow-up work at the Abertawe Bro Morgannwg University Health Board. The review sought to answer the question: 'Has the organisation implemented fully, audit recommendations for strengthening job planning processes to achieve the potential benefits of the amended consultant contract in Wales? The approach taken to delivering the review is set out in in Appendix 1.

[2] **The Consultant Contract in Wales: Progress with securing the intended benefits**, the National Assembly for Wales Public Accounts Committee, September 2013.

[3] **The National Health Service in Wales Effective Job Planning for Consultant Medical and Dental Staff**, the Welsh Government, NHS Wales Employers, BMA Cymru Wales, April 2014.

# Our main findings

11 We concluded that job planning remains highly inconsistent across the Health Board and some of the initial benefits to emerge from the contract have eroded over time, although recent organisational changes and plans to introduce electronic job planning may help to strengthen arrangements:

12 In reaching this conclusion we found that:

- National guidance on the job planning process is inconsistently applied, although, changes in organisational roles and the introduction of electronic job planning may help to strengthen arrangements

13 a minority of consultants have a job plan, and there is no corporate information to determine which job plans have been reviewed in the last 12 months, although the introduction of electronic job planning has been approved to help address this situation;

  - while the Health Board is updating corporate guidance, there is no training programme for job planning;
  - a significant minority of job planning meetings take place without the presence of both clinical and service managers, and there is little participation from academic institutions and other employers for those consultants that work for more than one organisation;
  - information is not being used consistently to help set and monitor outcomes from DCCs, and many job planning meetings take place on the basis of limited supporting information;
  - the Health Board has set out a clear linkage between job planning, appraisal, and revalidation in principle, although this is not consistently achieved in practice; and
  - corporate monitoring of the job planning process is not robust, although the introduction of electronic job planning should help to strengthen arrangements.

- While some of the intended benefits from the contract were seen initially, they have been eroded over time:
  - it is unclear whether job planning is supporting better dialogue between managers and clinicians to clarify expectations and support service modernisation;
  - there is little evidence to suggest that the number and type of SPAs is being managed and monitored effectively;
  - the percentage of Health Board consultants working 12 or more sessions has increased since 2010, although flexible working opportunities are regarded positively; and
  - the contract and job planning are not perceived to have made any difference to the recruitment and retention of staff.

14 Detailed findings from the audit work are summarised in the main body of this report, and a summary of progress in relation to each of the previous recommendations is included in Appendix 2.

# Recommendations

15 The Health Board still has work to do in 19 of the 20 recommendations previously set out in the Auditor General's national and local reports. These recommendations are re-stated in Exhibit 1, and further information on the progress that has been made is set out in Appendix 2.

16 To focus on delivering ongoing and outstanding work, the Health Board needs to ensure these recommendations feature on its Audit Committee's tracker. The Health Board should identify senior officer responsibility and a target timescale for implementing each of the recommendations.

Exhibit 1: National and local recommendations still to be achieved at January 2016

| National and local recommendations still to be achieved at January 2016 |
|---|
| **Processes to review job plans annually** |
| R1 NHS bodies should ensure that all consultants have a job plan that is reviewed annually to ensure that it reflects the business needs of the NHS organisation and the continuous professional development of the consultant. (Auditor General for Wales National Report, Rec 1a) |
| **Guidance and training** |
| R2 NHS bodies should ensure that job planning is supported by up-to-date local guidance material and regular training for all staff who participate in the process. (Auditor General for Wales National Report, Rec 1c) |

| National and local recommendations still to be achieved at January 2016 |
|---|
| **Appropriate involvement** |
| R3 NHS bodies should ensure that there is involvement in consultant job planning from general managers to ensure that wider organisational objectives, service improvements and financial issues are considered when agreeing consultants' job plans, and to help managers understand what resources and support consultants need to deliver their job plan commitments. (Auditor General for Wales National Report, Rec 1d) |
| R4 All consultants who are managing the job planning process should have access to appropriate training that supports the delivery of effective job plans. (Abertawe Bro Morgannwg UHB Local Report, 2011, Rec1) |
| R5 NHS bodies should ensure that they work jointly with universities in agreeing job plans for consultants that have academic contracts such that the expectations and requirements of both organisations are properly and fairly considered; similar arrangements should be in place for consultants working for two or more NHS organisations. (Auditor General for Wales National Report, Rec 1f) |
| R6 The Health Board should approach the university to establish better engagement in job planning and appraisal for consultants. (Abertawe Bro Morgannwg UHB Local Report, 2011, Rec 8) |
| **Information and outcome setting** |
| R7 NHS bodies develop an information 'framework' to support job planning, on a speciality-by-speciality basis. Clinicians and managers will need to work together to identify the components that need to be included in such a framework for each speciality, but it would be expected to include:<br>• information on activity;<br>• cost;<br>• performance against local and national targets;<br>• quality and safety issues;<br>• workforce measures; and<br>• plans and initiatives for service modernisation and reconfiguration.<br>(Auditor General for Wales National Report, Rec 3) |
| R8 Where a speciality 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 within these specialties. (Abertawe Bro Morgannwg UHB Local Report, 2011, Rec 3) |
| R9 NHS bodies should ensure that they have clear and robust processes in place to discuss and agree objectives and outcomes for consultants as part of the job planning process. It will be important to ensure that clinicians and managers involved in setting these objectives and outcomes receive the appropriate training and support to undertake effective job planning with consultants. (Auditor General for Wales National Report, Rec 4) |
| R10 The Health Board should encourage all clinical directors and consultants to develop meaningful outcome measures for all job plans. (Abertawe Bro Morgannwg UHB Local Report, 2011, Rec 6) |

| National and local recommendations still to be achieved at January 2016 | |
|---|---|
| **Appraisal** | |
| R11 | NHS bodies should ensure that while job planning and appraisal are separate processes, there is a clear linkage between appraisal outcome and job planning when meeting the development needs of a consultant. NHS organisations will need to ensure the two separate processes are appropriately aligned and integrated to support the requirements for the new General Medical Council (GMC) revalidation requirements that will be introduced in 2013. (Auditor General for Wales National Report, Rec 1e) |
| R12 | The Health Board should encourage all directorates to undertake an annual appraisal for all consultants, and they should take place before the annual job planning review. (Abertawe Bro Morgannwg UHB Local Report, 2011, Rec 2) |
| **Monitoring arrangements** | |
| R13 | NHS bodies should ensure that they have monitoring processes in place to check that all consultants have an up-to-date job plan, and that job planning is being undertaken in accordance with guidance that has been issued; monitoring processes should include an update report to the Board, at least annually, that demonstrates the extent to which consultant job planning is embedded across the organisation as a routine management practice. (Auditor General for Wales National Report, Rec 1g) |
| **Service improvement** | |
| R14 | NHS bodies should ensure that where changes to NHS services are occurring following public consultation, consultant job plans should be updated and agreed to reflect new service models. This should happen as an integral part of the process to redesign services, rather than a retrospective activity that occurs after the new services are in place. (Auditor General for Wales National Report, Rec 1b) |
| R15 | NHS bodies should demonstrate more explicitly how consultant job planning is being used to support the delivery of service improvement and modernisation, and the achievement of organisational priorities and performance targets. (Auditor General for Wales National Report, Rec 8) |
| R16 | The Health Board's strategic objectives should be embedded more effectively in the job planning process. (Abertawe Bro Morgannwg UHB Local Report, 2011, Rec 4) |

| National and local recommendations still to be achieved at January 2016 |
|---|
| **Supporting professional activities** |
| R17 NHS bodies should ensure their job planning process includes a clear and informed discussion on the SPA needs of individual consultants, recognising that these will not be the same at different stages in a consultant's career. The job planning discussion should specify the SPA activities to be included in the job plan, and identify the outputs and outcomes that should be achieved, and the location where these activities will be carried out. (Auditor General for Wales National Report, Rec 5) |
| R18 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 job plan review. (Abertawe Bro Morgannwg Local Report, 2011, Rec 5) |
| **Wider benefits realisation** |
| R19 NHS bodies should look to adopt a team-based approach to job planning where it can be shown that this would be beneficial. Consultants would need to be persuaded to participate rather than coerced, based on a clear explanation of the benefits associated with a team-based approach, and should still retain the right to agree an individual job plan with their employing organisation. (Auditor General for Wales National Report, Rec 6) |

17 The Health Board's management response setting out how the Health Board intends responding to the issues identified in this report will be included in Appendix 3 once complete and considered by the relevant Board committee.

# Detailed report

## National guidance on the job planning process is inconsistently applied, although changes in organisational roles and the introduction of electronic job planning may help to strengthen arrangements

### A minority of consultants have a job plan, and there is no corporate information to determine which job plans have been reviewed in the last 12 months, although the introduction of electronic job planning has been approved to help address this situation

18 The amended NHS Wales Consultants' Contract (the contract), which came into effect on 1 December 2003 makes it clear that effective job planning underpins the majority of the amendments. The process allows the employer and consultant to agree the composition and scheduling of activities in the working week, what they seek to achieve, and to discuss and agree changes on a regular basis.

19 The contract states that a consultant's job plan should be reviewed at least annually to ensure that job plans take account of changing patterns of service delivery, evolving organisational and personal objectives and advances in technology and medical practice. Interim job plan reviews can also be undertaken if consultants or their clinical managers think one is needed.

20 The national guidance (the guidance), issued in 2014, states that employers should agree an explicit job planning approach with the Local Negotiating Committee based on this guidance. The approach should make the 'sign-off' process for finalising job plans clear. A job plan should be a prospective agreement that sets out a medical and dental practitioner's duties, responsibilities, and outcomes for the coming year.

21 A job plan review will cover the job content, outcomes, time and service commitments, and the adequacy of resources. Local guidance should set out the outline process for appeals and the timeline for aiding resolution of areas of disagreement where these exist.

22 Our 2010 work identified that many consultants across Wales did not have an annual job plan review. At the time, 85% of consultants working at the Health Board said their job plan was reviewed annually, compared with 61% across Wales.

23 Consultants we spoke to during this follow-up audit said that while job planning is done frequently and well in some specialties, others are much less effective at completing the process. The intention is that it should be carried out on an annual basis, although, the scheduling of the process is, on the whole, currently failing to achieve that aim. In addition, there is scope to achieve closer co-ordination of consultant job planning where there are inter-dependencies between specialties such as anaesthetics and surgery.

24 In 2014, the Medical Director established the Effective Job Planning project, which was to deliver a more flexible approach to job planning, to ensure that effective capacity planning underpinned job planning, and also that leave arrangements were fair and consistent. The project was to include a range of tasks, including:

- customising national job planning guidance;
- developing and commencing a job planning training package;
- developing an approach to team job planning;
- developing an SPA tariff;
- developing service-sensitive outcomes;
- developing a framework to ensure the review of job plans;
- monitoring job planning and reporting on an annual basis to the Health Board;
- working with academic partners to develop a more robust process for clinical academics; and
- reviewing study leave and professional leave policies to ensure a fit with job planning processes.

25 We understand that, while some of this work was carried out at the time, the momentum behind this project was lost. The Health Board told us that the introduction of revalidation and appraisal, strategic medical workforce issues, and patient safety concerns arising from the Francis and Trusted to Care reports, directed the organisation's focus away from consultant job planning. The Health Board would benefit from reinvigorating this project to provide a focus for the improvement work that is still needed.

26 Approval was given in late 2015 for the introduction of electronic job planning. The expectation is that this will provide the Health Board with the basis for a consistent approach to job planning across specialties. It should enable monitoring of the extent to which job plans have been completed, as well as the comprehensiveness of job plan content.

27 The Health Board recorded that at 31 March 2015, 33% of consultants had an agreed job plan. The finance team receives job plans for inclusion on the Electronic Staff Record (ESR) system, although it was acknowledged that not all job plans are sent to them. This may partly explain why 96% (147) of consultants responding to our recent staff survey[4] said that they had a job plan, although it should be noted that this figure represents 29% of consultants at the Health Board.

28 We reviewed a sample of 20 consultant job plans, which we used together with other evidence to help draw our conclusions. The majority of those we reviewed had not been signed off. However, in our survey, 70% (99) of consultants said that they had formally agreed their job plan. This may be due to a lack of understanding amongst consultants of what constitutes a formally agreed job plan. The Health Board recognises that existing arrangements to check on the implementation of job plans in line with guidance, is insufficient. Senior staff told us that it is difficult to ensure a physical signing off for each job plan, and that alternative arrangements are needed to recognise an agreed job plan.

29 The ESR system, which is in place across NHS Wales, provides functionality to record job plan sessions. Job planning data can be stored, reviewed, analysed, and reported on both a local and national level. However, the Health Board finds that the ESR system does not contain sufficient detail to enable effective monitoring of job plans. While job plans will continue to be logged on the ESR system, the introduction of electronic job planning will provide the primary means for ensuring that the job planning process is being carried out effectively.

## While the Health Board is updating corporate guidance, there is no training programme for job planning

### Corporate guidance is being updated in light of strategic and organisational changes

30 Our 2010 work identified that when the contract was first introduced, health bodies developed their own guidance based on the Welsh Government and British Medical Association (BMA) guidance produced in 2004. We found the extent to which updated local guidance had been introduced varied across Wales.
The Health Board developed its own guidance based on the BMA's standards, to support its 2010-11 job planning process. At a corporate level, the process was led by the Assistant Medical Director of Secondary and Specialist Services.

[4] We received 147 responses from consultants which was a response rate of 29%. Whilst unlikely to be representative of the views of all consultants working for the Health Board, we have used the responses with other sources of evidence in our report. Details of our staff survey are included in Appendix 1.

31 In April 2014, further all-Wales guidance on job planning for health boards and NHS trusts in Wales was produced. The Health Board has adopted this national guidance, and customised it in order to update its local guidance. However, awareness of guidance on job planning within the Health Board is mixed, with, only 48% (67) of consultants responding to our most recent survey indicating that there was clear guidance in place.

32 Work is underway to update local guidance, which will include taking account of issues and developments such as Trusted to Care, multidisciplinary working, and new accountability arrangements. The expectation was that significant progress would be made on that work by May 2016.

33 The Medical Director told us that the new guidance will set out clear expectations with regard to SPA time. This will help to support a quality improvement outcome in that it will be linked to the Health Board's Quality Assurance Strategy and to the annual Quality Assurance Plan, which is in turn linked to the Integrated Medium Term Plan. The intention is to provide greater clarity about how time should be allocated for research and teaching.

### There is no current programme of job planning training

34 In 2010, local audits found the extent to which training had been provided (for consultants in general and for those tasked with reviewing the job plans of others) varied between and within organisations. At the time of that audit, we reported that the Health Board was not providing specific training to clinical directors, lead clinicians or managers responsible for delivering job plans as most had some experience. Consultants and managers new to the process were supported by more experienced staff.

35 In our most recent survey as part of the current audit, only 32% (45) of consultants responding to our survey said that they had received sufficient training on job planning. There is no current programme of job planning training. We recognise that the provision of such a programme for the Health Board's medical workforce would be a considerable logistical exercise. Nonetheless, staff who are new to the organisation or to delivering the job planning process, need timely training in order to understand the purpose of the process and to carry it out effectively. For the same reason, existing staff need to be trained and to have the opportunity to refresh their training over time.

## A significant minority of job planning meetings take place without the presence of both clinical and service managers, and there is little participation from academic institutions and other employers

36 The national guidance (2014) states that job plan reviews should be carried out by the clinical manager (that is, any appropriate medical manager or leader such as the Clinical Director or Medical Director) accompanied and assisted by the nominated service manager.

37 Our 2010 work across Wales highlighted a variable approach to the involvement of general managers in job planning meetings. Our audit work at the Health Board at that time found that job planning meetings were typically attended by the relevant clinical director or specialty lead consultant and the appropriate general manager.

38 Our current audit found that the involvement of clinical and general managers in job planning review meetings varied significantly. Our survey of Health Board consultant staff showed that a quarter of these meetings took place with either a general manager or a clinical manager, but not both (Exhibit 2). National guidance (2014) prescribes that both should be present.

39 However, as part of the Health Board's restructure during 2015, new clinical lead roles have been established. Job descriptions have been developed, and designated time is included in job plans, to help ensure that there is greater accountability for issues such as the job planning process. Therefore, the Health Board has actively invested in ensuring improvement in this area. The introduction of directly managed units across the Health Board should also help to make the job planning process more manageable, although it will need to guard against inconsistencies of approach developing across sites. Large specialties, such as anaesthetics, have been re-organised into smaller sub-groups. While these changes should support better job planning over time, there is no clear evidence of improvement yet.

Exhibit 2: Manager representation at job planning meetings

| Job plan review meeting attended by: | Number | Percent |
|---|---|---|
| Clinical manager and general manager | 78 | 53% |
| Clinical manager only | 20 | 14% |
| General manager only | 17 | 12% |
| Other arrangement | 26 | 18% |
| No meeting | 6 | 4% |
| **Total** | **147** | **100%** |

Note: 'Other arrangement' includes job plan reviews carried out by a clinical manager or general manager plus 'other' unspecified manager.
Source: Wales Audit Office survey of consultants

40 Some consultants who work for the Health Board have academic contracts and can undertake sessions teaching or researching at local universities. The national guidance (2014) states that the job plan should include the work clinical academic consultants do for the health body and the work they do for the university. It also states that university representatives need to be engaged in the job planning process for clinical academics. Such engagement aims to ensure there is clarity about SPA and university commitments and that there is no conflict between university and NHS requirements.

41 Senior staff acknowledged that, despite efforts on the part of the Health Board since the introduction of the contract in 2003, it has been difficult to ensure joint involvement of academic institutions, or other NHS employers, in job planning arrangements.

42 Of the consultants who responded to our most recent survey, 23 said that they held an academic contract. Only three said that the university had been involved in their job planning process. Of the 20 consultant job plans we reviewed, one held an academic contract and this commitment was reflected in the job plan. There has been some discussion about using service level agreements with academic institutions to try to ensure engagement on this issue. However, it should be noted that such agreements are not binding on either party.

43 The guidance for visiting consultants is clear that where the health body is the lead employer for medical and dental staff who undertake sessions in other health bodies, they must invite representatives from the other organisations to participate in the process. This will include sharing copies of the documentation when agreed. Where the health body has visiting medical and dental staff who are employed by other health bodies, they should contact the other organisation to request that they are included in the process. If timescales are not compatible, the two organisations will need to agree what will work best for all parties.

44 The Health Board has consultants who work for other NHS bodies. Of the consultants who responded to our survey, seven held a contract with another NHS organisation. Most of these said that either they had seen involvement of their other employer in their job planning process, or that their job plan reflected the work in both organisations.

45 The contract sets out the principles by which the consultant can engage in private practice. It states that the job planning process should be used to ensure there are no conflicts between the consultant's NHS commitments and their private work. The guidance goes on to state that the job plan should capture any fee paying work carried out.

46 Of the 20 job plans we reviewed, only three indicated an element of private practice. Two of these clearly set out a separate private practice commitment, while one did not clearly define private practice as being separate to NHS work commitments.

## Information is not being used consistently to help set and monitor outcomes from DCCs, and many job planning meetings take place on the basis of limited supporting information

47 The contract is clear that consultants should agree an appropriate set of outcomes, relevant to the speciality, that are challenging, holistic, transparent, and innovative. Outcomes could be stated in quantitative terms or, for example, described in terms of the local application of modernisation initiatives. The job plan review should compare outcomes and activities with appropriate benchmarks, taking account of service delivery priorities, best clinical practices, and performance indicators. t should review whether the consultant met the agreed outcomes in their job plan, or has made every reasonable effort to do so. Agreed outcomes at individual consultant level, although an integral part of the job plan, should not be contractually binding.

48 The national guidance (2014) provides detailed information on how to set and monitor outcomes as part of the job planning process. The outcomes will set out a mutual understanding of what the consultant will be seeking to achieve over the annual period that they cover and how this will contribute to the objectives of the employing organisation. The achievement of outcomes should be a key factor in the clinical manager's judgement that the job plan review is satisfactory, or unsatisfactory. This judgement will inform decisions on pay progression.

49 To support the setting and reviewing of outcomes, in late 2005 the Welsh Government established an all-Wales consultant outcomes indicators project (known as Compass). The aim was to develop a suite of outcome indicators for individual consultants which could inform job planning discussions and appraisals. However, Compass did not deliver a national solution to generating accurate, consultant level data and the project was discontinued in December 2009. In the absence of a recognised national system, individual health bodies have developed their own approaches to consultant outcome indicators.

50 In 2010 our local audit work at the Health Board found that job planning reviews should include any outcome measures agreed at the previous round. However, many job plans made no reference to outcome measures at all. It was also expected that consultants and clinical directors would access and download real-time performance information throughout the year for use as part of consultant appraisal. Many of the consultants, clinical directors and managers we interviewed at the time confirmed that they had made use of performance information from Hypercube[5], CHKS (who ran the Compass Project for consultant outcome indicators) 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 Welsh Government's NHS performance management targets that were in force at that point in time. Whilst these targets were relevant to the majority of specialties, for others such as Radiology and Pathology, they had limited relevance.

51 As part of our current review, we asked the Health Board to indicate what information they used to set and monitor consultant outcomes for DCCs. Exhibit 3 shows that while some specialties are using different sources of information, there is still some way to go before this information is used consistently across the organisation.

[5] The Health Board has 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.

Exhibit 3 – Information sources used to set and monitor outcomes

| | Yes, across all speciality areas | Yes, across most speciality areas | Yes, across some speciality areas | Don't know |
|---|---|---|---|---|
| Activity and safe practice | | | | Yes |
| Clinical outcomes | | | Yes | |
| Clinical standards | | | Yes | |
| Local service requirements | | Yes | | |
| Management of resources, including efficient use of NHS resources | | | Yes | |
| Quality of care | | | Yes | |

Source: Wales Audit Office Information and Data Collection Form completed by the Health Board

52 Our consultant survey found a mixed picture in terms of access to information to support their job plan review (Exhibit 4). The Health Board uses a system called Albatross, which consultants have access to their personal performance including metrics such as cost and length of stay, drug costs, support service costs, and overall treatment costs. Despite this, a significant proportion of the respondents indicated that they did not have access to either local clinical information or information on the Health Board's objectives. It is concerning to note that two thirds of respondents indicated that performance information was not of sufficient quality to accurately assess their performance.

Exhibit 4 –Consultants' views on the information provided for their job planning meeting

| | Yes | No | Not sure |
|---|---|---|---|
| Access to information from local clinical/management information systems to support discussions about your existing work? | 56 (40%) | 77 (55%) | 7 (5%) |
| Information on the Health Board's objectives? | 58 (41%) | 66 (47%) | 17 (12%) |
| Performance information of sufficient quality to accurately assess your performance? | 35 (25%) | 96 (68%) | 10 (7%) |

Source: Wales Audit Office survey of Health Board consultants

53 Fifty-six per cent (79) of consultants responding to our survey said that they had set objectives in their job plan. Of those, 41% (57) said that they had discussed the relationship between their personal outcomes and those of the organisation, and only 30% (42) said that the relationship between personal and organisational outcomes was clearly set out.

54 Our survey of consultants also indicates that the setting of outcomes is not fully embedded across the Health Board. Fifty-seven per cent (80) of consultants said that their job plan clearly stated outcomes and outputs for their DCC commitments, 48% (67) for their SPA activity, and only 39% (53) for other activities (Exhibit 5).

Exhibit 5 – Consultants' views on outcome setting in their job plans

| | Yes | No | Not applicable/ Not sure |
|---|---|---|---|
| Are outputs and outcomes clearly stated in your current job plan for: | | | |
| • DCC commitments? | 80 (57%) | 50 (36%) | 10 (7%) |
| • SPA? | 67 (48%) | 65 (46%) | 8 (6%) |
| • Other programmed activities eg, management role? | 53 (39%) | 70 (52%) | 13 (10%) |
| In your view, does your current job plan:<br>• Clearly set out the relationship between your personal outcomes and those of the organisation? | 42 (30%) | 83 (60%) | 13 (9%) |

Source: Wales Audit Office survey of Health Board consultants

55 Exhibit 6 sets out how many consultants said that they reviewed outputs and outcomes at their job plan review meetings. Across all session categories, a significant proportion of consultants had not reviewed the relevant outputs or outcomes.

Exhibit 6 – Consultants' views on reviewing outcomes

| | Yes | No | Not applicable/ Not sure |
|---|---|---|---|
| During your most recent job plan meeting did you: | | | |
| • Review the outputs and outcomes of your DCC sessions? | 70 (50%) | 60 (43%) | 9 (7%) |
| • Review the outputs and outcomes of your SPA sessions? | 77 (55%) | 52 (37%) | 10 (7%) |
| • Review the outputs and outcomes of your other activities? | 55 (40%) | 65 (47%) | 18 (13%) |
| • Discuss the relationship between your outcomes and those of the organisation? | 57 (41%) | 75 (54%) | 8 (6%) |
| Were your current job plan outcomes assessed during your most recent annual appraisal? | 79 (56%) | 49 (35%) | 12 (9%) |

Source: Wales Audit Office survey of Health Board consultants

56 Most of the sample of job plans we reviewed did not have consistently SMART (specific, measurable, agreed, realistic and timely) outcomes. At best, while some outcomes were SMART, others in the same job plan were not. They did not cover most of a consultant's activities and did not relate to patient benefits or organisational objectives. While previous objectives may have been discussed during job planning meetings, there was no documented evidence in any of the job plans that made it clear that they had been reviewed.

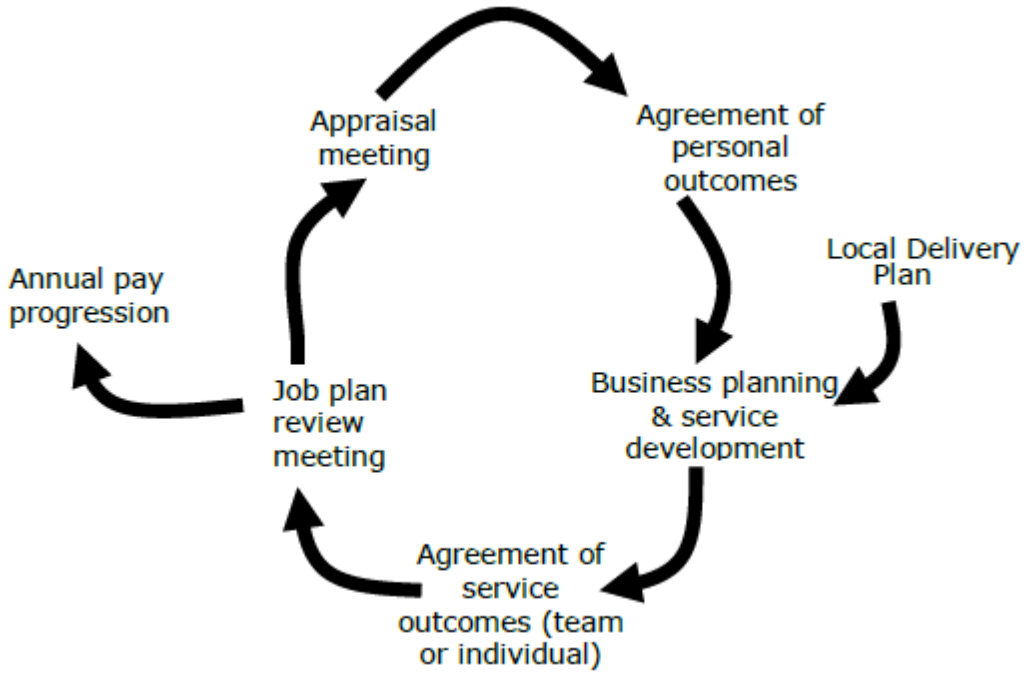
57 Moreover, there was very limited evidence from our review of job plans to suggest that discussions about productivity and delivery expectations had taken place during job planning meetings. The Medical Director identified that while systems to help identify productivity are not yet available in Wales, the experience with such systems in England has been helpful in driving improvement.

## The Health Board has set out a clear linkage between job planning, appraisal, and revalidation in principle, although this is not consistently achieved in practice

58 Revalidation is the process by which licensed doctors are required to demonstrate to the GMC that they are fit to practise. Revalidation has been dependent on the doctor participating in annual appraisals since December 2012.

59 The guidance says that the job plan review should be supported by the same information that feeds into appraisal, and by the outcome of the appraisal discussion. Personal development plans will usually be formulated during the appraisal discussion. This discussion will inform the job plan review meeting and provide links to service and corporate outcomes. Exhibit 7 illustrates how job planning and appraisal should interlink.

Exhibit 7: The job planning and appraisal cycle




Source: **The National Health Service in Wales Effective Job Planning for Consultant Medical and Dental Staff**, the Welsh Government, NHS Wales Employers, BMA Cymru Wales, April 2014.

60 Our 2010 work found that the strength of links between the job plan review meeting and appraisal varied across Wales and there was no standard approach to appraisal. While some consultants had annual appraisals, others said that they only had an appraisal when they asked for one, or had never had an appraisal. In some areas, we found that appraisal had a higher priority than job planning. In some areas the job plan review meeting and appraisal meeting were held back to back while in others they were kept separate.

61 In 2010, the Health Board's directorates had adopted their own approach to linking appraisals with job planning, although some were not providing appraisals annually to all consultants. The Health Board's annual appraisal rates had been falling, and some consultants reported that appraisals were not taking place at an appropriate time to feed into job planning.

62 Since April 2014, the Medical Appraisal and Revalidation System (MARS) is the agreed system for medical appraisal in Wales for all doctors, except GPs, in Wales. Appraisers are not usually line managers.

63 As part of the current audit, the Health Board told us that 68% of consultants had completed a formal appraisal in the 12 months to 31 March 2015. The Health Board actively manages doctors who do not engage with appraisal. There is a robust process in place which ultimately can remove a doctor's license to practice. Senior staff recognise the potential for further work to ensure the linkage between appraisal and job planning. Their priority was to embed revalidation first to allow the Health Board's priorities and consultant personal development plans to be reflected within the job plan.

64 The Medical Director is confident that, with new managerial resources available from March 2016, the Health Board will be able to further improve on the quantity and quality of its appraisals. The increased focus and momentum from this increase in resources are also intended to drive improvement in the job planning process, and to help ensure the linkage between job planning and appraisal. In addition, there are plans to introduce a Doctor Dashboard which will provide information to support the job planning, appraisal, outcome reporting, and revalidation processes.

## Corporate monitoring of the job planning process is not robust, although the introduction of electronic job planning should help to strengthen arrangements

65 The Auditor General's national report in 2013 recommended that all health bodies should ensure they have job planning monitoring processes to check that consultants have an up-to-date job plan, and that job planning is undertaken in accordance with guidance. It recommended that an update should be provided to the Board at least annually, on the extent to which consultant job planning is embedded as a routine management practice.

66 Embedding the job planning process has been part of the Medical Workforce Board's agenda since December 2009. A new Medical Workforce Board (MWB) has recently been constituted as a sub-committee of the Workforce and Organisational Development Committee (WODC). Work is underway to establish the MWB's reporting responsibilities to the WODC and to the Board, including those for job planning.

67 In recent years there has been consistent and clear reporting and discussion regarding appraisal and medical revalidation to various committees including the Quality and Safety Committee, as well as to the Board. However, reporting and discussion in relation to job planning are much less apparent.

# While some of the intended benefits from the contract were seen initially, they have been eroded over time

## It is unclear whether job planning is supporting better dialogue between managers and clinicians to clarify expectations and support service modernisation

68 A key aim of the contract is to facilitate closer working between health managers and consultants to enhance the quality of service and benefit patients.

69 The national guidance (2014) says that the job planning process has a key role to play in creating a more flexible organisation. It presents the job planning process as an essential mechanism for enhancing patient care and driving service developments. Where changes to NHS services have occurred following public consultation, the guidance indicates that consultant job plans should be updated and agreed to reflect new service models.

70 The Auditor General's national report in 2013 indicated that, broadly speaking, the contract had not been a significant driver for service modernisation. Our previous local audit work identified variations in the extent to which clinicians and managers had worked together to provide better services. There were plenty of examples of this happening across Wales. But, there were also examples of consultants finding it difficult to engage with managers in developing new services or ways of working.

71 In our most recent survey of consultants, 61% (85) of those who responded to our survey said that job planning was used to discuss service modernisation and 54% (73) agreed they could discuss steps that could be taken to improve clinical practice. However, there were also a significant number of consultants that indicated they did not discuss modernising services or improving clinical practice.

72 However, the Health Board lacks a consistent and robust framework of information to assist in the dialogue between managers and consultants, in order to clarify expectations and support service modernisation. The Medical Director is very keen to ensure that information systems are developed to support job planning and is actively involved in working to ensure that this happens. There was no evidence in the job plans that we reviewed to suggest that consultants have become more involved in service planning.

## There is limited evidence to suggest that the number and type of SPAs are being managed and monitored effectively

73 SPA covers a number of activities which underpin DCC. SPA activities include training and teaching the next generation of doctors, carrying out research and clinical audits, clinical management roles, and clinical governance activities. SPA time should also be used by the consultant to support their own continuing professional development, appraisal and revalidation, and time for job planning. The contract states that for a full-time consultant, there will typically be seven DCC sessions and three SPA sessions. It also states that variations should be agreed by the employer and the consultant at the job planning review.

74 The Auditor General's national report in 2013 identified that there was too much focus on the number of SPAs rather than the quality and outcome of this investment. Few health boards required consultants to evidence their SPA time or monitor outcomes. In February 2011, the Chief Medical Officer wrote to all medical directors confirming job plans 'should include reasonable SPA time for the consultant to be able to undertake their agreed and evidenced SPA activity, recognising that these will vary from person to person and, potentially, year to year'. The number and content of SPA sessions should change throughout a consultant's career, and be agreed each year in the annual job plan review.

75 The national guidance states that each directorate (or equivalent) should annually review the SPA sessions in consultants' job plans. Where there is a discrepancy between evidence of participation in SPA and the time allocated, this should be addressed through the job planning process. The national guidance does not mention setting a 'tariff' for particular activities, which would be an agreed amount of time that a particular activity would be allocated across the organisation. However, some SPA tariffs have been set, for example, the Wales Deanery requires that job plans for delivery of the Educational Supervisor role should typically include the equivalent to a minimum of 0.25 SPA per week per trainee supervised.

76 Of the consultants who responded to our survey, 61% (86) of those with a job plan said that it provides an appropriate balance between their DCC and SPA activities. Also, 55% (77) said that they do review the outputs and outcomes from their SPA sessions as part of their job planning process, although there was no written information to support this in the job plan documentation we reviewed.

77 In our review of a sample of 20 job plans, only one had clear outputs and outcomes. In the other 19, they were either partially defined or not defined at all. The majority of the job plans we reviewed did not indicate the locations for SPA sessions. Moreover, there has been no consistent monitoring of the outputs and outcomes for SPAs in the past, either at directorate or corporate level.

78 The Medical Director intends that the forthcoming revision of job planning guidance will have a particular focus on defining the nature and extent of SPA time. Since early 2015, the Health Board has advertised consultant posts on the basis of seven DCCs and three SPAs, with an indication that the number of SPAs will be reviewed after a three month-period to see whether they can continue to be justified after the induction period. If three SPAs can no longer be justified, one of the SPA sessions becomes a DCC session. At the time of our work, the Medical Director intended to carry out a review to see whether this arrangement was being implemented effectively.

## The percentage of Health Board consultants working 12 or more sessions has increased since 2010, although flexible working opportunities are regarded positively

79 The contract's intention was for all full-time consultants to have a 37.5-hour working week, in line with other NHS staff. The contract states that a working week for a full-time consultant will comprise 10 sessions with a timetabled value of three to four hours each. Through the job planning process, these sessions will be programmed in appropriate blocks of time to average a 37.5-hour week. Full-time consultant jobs are advertised as 10 sessions.

80 Our 2010 work found that only a third of consultants in Wales had 10-session contracts and that the average number of weekly sessions in a consultant's contract was 11.21. At that time, the average weekly sessions in the Health Board were 11.19. By 2015 this had decreased slightly to 10.37% (Exhibit 8).

Exhibit 8: Average weekly sessions between 2010, 2012 and 2015

| | 2010 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|
| DCC | 8.49 | Not available | Not available | Not available | 7.83 |
| SPA | 2.41 | Not available | Not available | Not available | 2.28 |
| Management | 0.26 | Not available | Not available | Not available | 0.02 |
| Other | 0.04 | Not available | Not available | Not available | 0.24 |
| **Total** | **11.19** | **Not available** | **Not available** | **Not available** | **10.37** |

Source: Wales Audit Office survey of Health Board consultants

81 Our 2010 work identified that some consultants across Wales were working excessively long hours. A detailed analysis of job plans found that around one in six consultants were working 46.5 hours or more with the vast majority in this group working in excess of the 48-hour European Working Time Directive (EWTD) limit. At the time, our review found wide variation in the numbers of consultants with more than 12 sessions in job plans at different health bodies.

82 At the time, 14% of the Health Board's consultants were identified as working 12 or more sessions. Our recent review found that at 31 March 2015, of the 591 consultants directly employed by the Health Board, 20% (120) were identified as working 12 or more sessions.

83 Of the consultants responding to our survey, 54% (76) identified that their job plan clearly schedules all their commitments including management or other roles, while 42% (59) did not think so.

84 One of the intentions of the contract was to improve arrangements for recognising on-call commitments for unpredictable emergency work. The contract provides for intensity banding payments (paid annually) reflecting the 'disturbance factor' for a consultant having to be available for work when on-call. Actual work done for regular on-call commitments is included within DCCs in the job plan.

85 At the time of our work in 2010, most consultants thought that any early benefits from the contract in reducing working hours had been lost when the impact of the EWTD and changes to junior doctors' working hours were introduced. Amongst the consequences, consultants said that in some specialties, such as Paediatrics, they were spending more time covering on-call gaps in the rota as a result of the need to keep junior doctor hours within EWTD limits.

86 Of the consultants who responded to our current survey question, 68% (92) said that their job plan covered their on-call and out-of-hours commitments, while 27% (37) said that it did not. Some consultants commented that the clinical hours required to complete their duties, including for on-call, were more than those set out in their job plan.

87 The contract states that job planning can be undertaken on a team basis, where this is likely to be more effective. Where job planning takes place on a team basis, each individual team member should still agree a schedule of individual commitments. The national guidance states that a job plan is an agreement between an individual consultant and his/her employer. Some groups of consultants have found that there is benefit in developing job plans as a team which then inform the job planning process for the individual consultants. A team agreement is not contractually binding but helps set out how the team intends to translate its shared outcomes into individually agreed job plans. The guidance sets out a number of approaches to team job planning.

88 Despite the potential benefits, our 2010 work identified that team-based job planning was not frequently employed. In the Health Board at that time, the majority of job planning interviews were conducted on an individual basis, although a small number of specialties took a team-based approach. About a quarter of consultants who responded to our survey in 2010 told us that they had a team-based job plan. However, over a third of that group were not given the opportunity to agree individual commitments at a subsequent meeting.

89 In our most recent work, senior staff told us that team job planning was happening in some areas, such as anaesthetics, where the specialty lends itself to team job planning. However, we also heard that there has been no clear management of outcomes for teams. Of the sample of job plans we reviewed, none appeared to be linked to a team job planning approach, and there were only basic references to teams. Our survey of consultants found that 11% (15) of respondents said that their most recent job planning meeting was as part of a team.

90 One of the contract's aims was to improve flexible working. The contract allows, with agreement between consultants and employers, for flexible timetabling of commitments over a period. Flexible work patterns can help meet service needs that fluctuate during the year. Examples of flexibility include term-time working; alternating clinical and teaching duties across the year; and 'consultant of the week' arrangements.

91 The national guidance has a section on arranging flexible timetables. The contract as a whole should be expressed in terms of the annual equivalent of the working week. The job plan will specify agreed variations in the level and distribution of sessions within the overall annual total. A consultant could thus work more or less than the standard number of sessions in particular weeks.

92 In 2010, the Health Board had been encouraging flexible working to some extent, with 29% of consultants agreeing that the contract allowed them to work more flexibly, for example, by varying the clinical commitment, allowing for part-time, and term-time working. At that time, we also 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.

93 In 2016, we heard that this type of approach continued in some areas, including the use of annualised hours group job plans. This was recognised as being a transparent, fair and flexible approach. It was also helping to enable recognition, in more pressured roles, of out-of-hours work.

## The contract and job planning are not perceived to have made any difference to the recruitment and retention of staff

94 The amendments to the contract in Wales were intended to improve consultant recruitment and retention. The Auditor General's national report highlighted a steady year-on-year increase in the number of consultants working in Wales since the contract was implemented. There was a 37% increase in the total number of full-time equivalent consultants employed in Wales between 2004 and 2011.

95 Since 2011, there has been continued growth in the number of consultants working in the NHS in Wales, although the rate of increase has slowed significantly. The Welsh Government statistics show that the number of consultants employed by the Health Board increased by 7.8% between 2011 and 2015, which is above that in Wales as a whole. However, the local trend slowed over that period to the point where the number of consultants employed actually fell slightly between 2014 and 2015 (Exhibit 9).

Exhibit 9: Number (WTE) of consultants employed in the NHS 2011 to 2015

| | 2011 | 2012 | 2013 | 2014 | 2015 | Change in number 2011 to 2015 | Percentage change 2011 to 2015 |
|---|---|---|---|---|---|---|---|
| ABMUHB | 474 | 486 | 490 | 498 | 495.6 | 38.8 | 7.8% |
| All Wales | 2,217.5 | 2,273.9 | 2,323.8 | 2,316.1 | 2,344.6 | 128.1 | 5.4% |

Source: The Welsh Government, StatsWales based on NHS electronic staff record annual returns as at 30 September each year[6]

96 We did not find any evidence of particular recruitment and retention problems with consultant posts at the Health Board. Senior staff told us that the contract in Wales does not make a difference either way in this respect. The perception is that potential applicants do not really appreciate that the contract is different to the one in England, and that any initial benefits from the contract have been eroded over time.

[6] Medical and dental staff by hospital and year, StatsWales

# Appendix 1

## Audit approach

We carried out a number of audit activities between January 2016 and March 2016. Details of these are set out below.

| Method | Detail |
|---|---|
| Information and Data Collection Form | The form was the main source of corporate-level information and data that we requested from the Health Board. |
| Document request | We requested and reviewed documents from the Health Board including:<br>• minutes, papers and reports where issues around consultant job planning and appraisal have been subject to internal discussion in the last 12 months;<br>• job planning guidance and training materials;<br>• performance reports on job planning, appraisal and revalidation that have been reported to senior management forums, such as senior management team or board committees; and<br>• information on new projects/models of undertaking job planning and appraisals including any evaluation reports. |
| Interviews | We interviewed a small number of staff including:<br>• Mr Hamish Laing, Medical Director<br>• Dr Push Mangat, Assistant Medical Director<br>• Sharon Vickery, Head of HR Delivery Units and Medical Staffing<br>• Beverley Edgar, Director of Workforce and Organisation Development<br>• Samantha Lewis, Assistant Director of Finance<br>• Dr Sharon Blackford, Joint Chair of the Local Negotiating Committee<br>• Dr Simon Poulter, Joint Chair of the Local Negotiating Committee |
| Surveys of consultants | We carried out an online survey of all consultants to ask their views on the effectiveness of job planning arrangements.<br>We received 147 responses from consultants, which was a response rate of 29%. |
| Review of job plans | We carried out a review of a sample of 20 job plans which included the following specialities:<br>• ACT (Anaesthetics Critical Care and Theatres)<br>• General Surgery, Trauma and Orthopaedics and Urology<br>• Medicine<br>• Radiology |

# Appendix 2

## National and local recommendations

Table 1 sets out the eight local recommendations set out in the Health Board's report from 2011.

Table 2 sets out the 12 national recommendations from 2013, which relate to health bodies only.

The status of each recommendation is reported at the Health Board as follows:

- (A) indicates that the recommendation has been achieved;
- (O) indicates that work to implement the recommendation is ongoing but is not yet completed; and
- (N) indicates that insufficient or no progress has been made.

Table 1 – 2011 local recommendations

| Number | Local recommendations | Status at January 2016 |
|---|---|---|
| R1 | All consultants who are managing the job planning process should have access to appropriate training that supports the delivery of effective job plans. | N |
| 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. | O |
| 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. | O |
| R4 | The Health Board's strategic objectives should be embedded more effectively in the job planning process. | O |
| 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. | O |
| R6 | The Health Board should encourage clinical directors and consultants to develop meaningful outcome measures for all job plans. | O |
| R7 | The Health Board should establish a consistent approach to managing leave arrangements for consultants with annualised hour contracts. | A |
| R8 | The Health Board should approach the university to establish better engagement in job planning and appraisal for consultants on academic contracts. | N |

Table 2 – 2013 national recommendations

| Number | National recommendations | Status at January 2016 |
|---|---|---|
| **Strengthening job planning processes within NHS bodies** | | |
| R1a | NHS bodies should ensure that all consultants have a job plan that is reviewed annually to ensure that it reflects the business needs of the NHS organisation and the continuous professional development of the consultant. | O |
| R1b | NHS bodies should ensure that where changes to NHS services are occurring following public consultation, consultant job plans should be updated and agreed to reflect new service models. This should happen as an integral part of the process to redesign services, rather than a retrospective activity that occurs after the new services are in place. | O |
| R1c | NHS bodies should ensure that job planning is supported by up-to-date local guidance material and regular training for all staff who participate in the process. | O |
| R1d | NHS bodies should ensure that there is involvement in consultant job planning from general managers to ensure that wider organisational objectives, service improvements and financial issues are considered when agreeing consultants' job plans, and to help managers understand what resources and support consultants need to deliver their job plan commitments. | O |
| R1e | NHS bodies should ensure that while job planning and appraisals are separate processes, there is a clear linkage between appraisal outcome and job planning when meeting the development needs of a consultant. NHS organisations will need to ensure the two separate processes are appropriately aligned and integrated to support the requirements for the new GMC revalidation requirements that will be introduced in 2013. | O |
| R1f | NHS bodies should ensure that they work jointly with universities in agreeing job plans for consultants that have academic contracts, such that the expectations and requirements of both organisations are properly and fairly considered; similar arrangements should be in place for consultants working for two or more NHS organisations. | N |
| R1g | NHS bodies should ensure that they have monitoring processes in place to check that all consultants have an up-to-date job plan, and that job planning is being undertaken in accordance with guidance that has been issued; monitoring processes should include an update report to the Board, at least annually, that demonstrates the extent to which consultant job planning is embedded across the organisation as a routine management practice. | O |

| Number | National recommendations | Status at January 2016 |
|---|---|---|
| **Using the right information to inform job planning** | | |
| R3 | NHS bodies develop an information 'framework' to support job planning, on a speciality-by-speciality basis. Clinicians and managers will need to work together to identify the components that need to be included in such a framework for each speciality, but it would be expected to include:<br>• information on activity;<br>• cost;<br>• performance against local and national targets;<br>• quality and safety issues;<br>• workforce measures; and<br>• plans and initiatives for service modernisation and reconfiguration. | O |
| **Developing a clearer focus on benefit realisation** | | |
| R4 | NHS bodies should ensure that they have clear and robust processes in place to discuss and agree objectives and outcomes for consultants as part of the job planning process. It will be important to ensure that clinicians and managers involved in setting these objectives and outcomes receive the appropriate training and support to undertake effective job planning with consultants. | N |
| R5a | NHS bodies should ensure their job planning process includes a clear and informed discussion on the SPA needs of individual consultants, recognising that these will not be the same at different stages in a consultant's career. The job planning discussion should specify the SPA activities to be included in the job plan, and identify the outputs and outcomes that should be achieved, and the location where these activities will be carried out. | N |
| R6 | NHS bodies should look to adopt a team-based approach to job planning where it can be shown that this would be beneficial. Consultants would need to be persuaded to participate rather than coerced, based on a clear explanation of the benefits associated with a team-based approach, and should still retain the right to agree an individual job plan with their employing organisation. | O |
| R8 | NHS bodies should demonstrate more explicitly how consultant job planning is being used to support the delivery of service improvement and modernisation, and the achievement of organisational priorities and performance targets. | N |

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