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Pay Modernisation: NHS Consultant Contract

Cardiff and Vale University Health Board

We found that the UHB is not yet realising the intended benefits of the consultant contract, mainly as a result of ineffective job planning, though the new framework being introduced should result in the necessary improvements, if implemented successfully.

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Summary

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

6. In 2008 we undertook a medical staffing review, producing a report and recommendations to the predecessor Cardiff and Vale NHS Trust (the Trust). The report found that the Trust needed to undertake further work in key areas to improve value for money from the substantially increased investment in medical staffing. Recommendations included making improvements to clinical leadership, developing clinical indicators and improving medical staffing planning. In addition, recommendations were made to improve job planning arrangements at the Trust. Action was taken in response to the recommendations in this report and Cardiff and Vale University Health Board (UHB)'s progress on job planning will be considered as part of the current audit.

7. This audit seeks to answer the question: 'Are the intended benefits of the new consultant contract being delivered?' In particular, we focused on the extent to which job planning was embedded in the Health Board as an annual process and how effective it was in facilitating service improvement. We also considered the working environment of consultants, which was part of the contract's wider aim for the NHS to provide ongoing improvements to the quality of consultants' working lives. The intention of these benefits was to aid recruitment and retention of consultants although we did not consider this directly as part of the audit.

8. We carried out our fieldwork in a sample of directorates suggested by UHB chosen because they would provide a good range of experiences of job planning. Appendix 3 provides further details of our audit methodology. This included an online survey for all consultants at the UHB. We received responses from 150 consultants, a response rate of 28 per cent.

9. We found that the UHB is not yet realising the intended benefits of the consultant contract, mainly as a result of ineffective job planning, though the new framework being introduced should result in the necessary improvements, if implemented successfully. We have come to this conclusion because:

   - in the past, the approach to job planning was not sufficiently robust which has meant many issues have not been addressed;
   - the UHB has taken action to strengthen its job planning arrangements; and
   - barriers still exist which may prevent the UHB from realising the full potential of the consultant contract.

Recommendations

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

R1	Through strengthening its approach to job planning through the introduction of the new framework the UHB must ensure: • the job planning process takes account of clinical demand and activity; • job plans accurately reflect a consultant's workload and DCC and SPA commitments reflect consultant contract guidance; • activity and outcomes indicators are developed and agreed for the different specialties to inform job planning and performance review; • SPA commitments are clearly defined with clear outcomes that are aligned with service improvement objectives and a consultants development needs; • documentation is standardised which clearly and accurately identifies the job content and expected SMART outcomes; and • on-call commitments are equitable and meet the consultant contract guidance.
R2	Where directorates have developed sound approaches to job planning, learning from this should be shared across the UHB.
R3	Job planning should support equitable sharing of work within consultant teams and the UHB needs to develop strategies and action plans to reduce excessive workload and ensure work loads are balanced.
R4	The UHB needs to ensure its business planning processes are integrated with job planning to ensure the opportunities to more fully involve consultants in modernising and developing services are taken.

In the past, the approach to job planning was not sufficiently robust which has meant many issues have not been addressed

The UHB has not delivered all the job planning recommendations in our 2008 medical staffing review

11. In October 2008, we undertook a medical staffing review, producing a report and recommendations to the predecessor Trust. The report found that the Trust needed to undertake further work in key areas to improve value for money from the substantially increased investment in medical staffing. Recommendations included improvements to clinical leadership, developing clinical indicators and improving medical staffing planning.

12. A key set of recommendations related to job planning. Specifically, clinical directors should ensure job planning and appraisal takes place on an annual basis and that the medical director should regularly update guidance and ensure that it is applied consistently throughout the Trust. The action plan for the recommendations stated that regular reminders are sent to clinical directors on the importance of job planning and appraisal. The methodology adopted in the former Trust to manage job plan reviews, and hence the reporting of this data centrally, required clinical directors to respond to the medical director's office only if there were any changes to the job plans logged centrally when the consultant contract was introduced in 2003. The Trust reported to the Assembly Government in 2008-09 that 75 per cent of all consultants had had a formal job plan review.

The approach to job planning has been inconsistent

13. Training and guidance was provided to relevant managers and consultants when the new contract was introduced in 2004. This facilitated consultants to diarise their sessional and additional activities, and provided the basics of uniform job plan outputs from clinical directorates and specialties.

14. We found that in some clinical directorates, clinical leads and directorate managers have met annually since 2004 with each consultant to review their job plan, for example in Biochemistry and Clinical Genetics. In other directorates, such as Radiology, regular job planning has not taken place for all consultants. Fifty-eight per cent of consultants responding to our survey have had a job plan review in the last year, 28 per cent more than a year ago and 14 per cent reported that they have never had a job plan review.

15. Over time, the job planning process in each clinical directorate and specialty has developed its own approach. Examples of existing arrangements include:
    - Most clinical directorates have relied on the diary approach to underpin job planning. A few, such as in Pathology, have based their job plans on the activity required to meet service targets and objectives. Pathology's approach is transparent and equitable and can be more readily used to show value for money is being delivered.
    - Some clinical directorates have undertaken a team approach to planning to even out workloads within specialities. Our survey found that just 13 per cent of consultants had their job plan undertaken as part of a team and 68 per cent of these respondents said that they were able to agree individual commitments at a subsequent meeting.
    - Some clinical directorates have agreed, or have applied, their own internal definitions of the types of activity which might be described as DCC or SPA. This has contributed to inequitable consultant job plans and workloads within and between specialties, clinical directorates and across the UHB.
    - Many consultants do not think that the job plan reflects their true levels of activity. Our survey found that only one-third (36 per cent) of respondents felt that their current job plans accurately reflect their working hours and commitments and 43 per cent felt that their job plans reflect the specific demands of their specialty.
16. Within the annual job planning meetings, individual clinical directors have adopted different approaches. Some have taken a fairly prescriptive approach to the job planning review, 'telling' the consultant the requirements of the input required. Other clinical directors have adopted a more two-way process which seeks proactively to align consultant sessional work plans in a mutually acceptable way with:
    - clinical care demands;
    - individual consultant preferences and objectives;
    - the outcomes of appraisal and consultants' clinical and personal development needs; and
    - the service's delivery and improvement objectives, often related to UHB-wide Annual Operating Framework and other objectives.
17. Most clinical directorates have not made full use of the information coming from appraisal to inform job planning, covering service and personal development. As with job planning, the approach to appraisal varies widely across the UHB. In some specialties, all consultants have had an appraisal on an annual basis, whilst in others consultants have only had an appraisal if they ask for one and, in some instances, not at all. Four directorates are currently participating in the enhanced appraisal pilot with the Wales Deanery which will provide an improved mechanism for delivering structured annual appraisal and assist consultants in meeting future revalidation requirements.

Many job plans are poorly documented so the UHB is unable to be sure that all consultants are correctly remunerated

18. The sample of job plans we reviewed showed a range of issues which potentially raise questions about elements of corporate, clinical or financial governance:

- The format of job plans varies between specialties as well as within a specialty. Few job plans are clear, transparent and easy to understand. Several lacked clarity about sessional inputs, activities and locations. Some used the standard template from the contract although it was often incomplete. Some were undated, did not specify the period for which they applied, or had not been signed off.
- Some of the job plans appear to have arithmetic and other errors in the way sessions are calculated and worked out and because of their general poor quality made it difficult to verify. Specific examples we found included a lack of clarity on how many hours were allocated to particular activities that did not take place weekly, including time allocated outside the NHS for private practice. This could make it difficult to fully account for the hours worked and leave the job plan open to interpretation.
- Some part-academic job plans lacked sign off from the University partners. Only thirty-five per cent of respondents with academic contracts reported that the University had been involved in agreeing job plans. This lack of University involvement means both partners may not be getting the full value from some sessions or could be putting unrealistic expectations on the individual consultant.
- On-call commitments are expressed in different ways across the directorates reviewed. Some consultants were allocated a session for an unspecified commitment of 'unpredictable on call' while others were on a rota, for example 1:7 which was expressed as six hours resulting in one DCC session. Others said that their on call was remunerated via intensity payments. Our survey found that only 31 per cent of consultants thought that their emergency workload was fairly recognised but 45 per cent did not think their emergency workload was fairly recognised. This highlights the need for the UHB to undertake further work in this area;
- None of the reviewed job plans contained robust SMART[1]-based outcome targets or measures. Only a small proportion identified any outcomes although this generally related to the activity to be undertaken, for example that a consultant will undertake an additional session to cover a colleague's long term sick leave, and not what the consultant was expected to achieve in their DCC and SPA in the coming year.

19. We did find examples where directorates had overcome some of these difficulties. The Integrated Medicine directorate has taken an effective approach using an Excel spreadsheet with sessions accurately calculated in a transparent, consistent and easy-to-understand way.

[1] SMART – objectives, outcomes and performance targets should be Specific, Measurable, Achievable, Realistic and Timely.

20. Job plans also showed some positive areas of practice that have resulted from the job plan review meeting. In Trauma and Orthopaedics and General Surgery, they evidenced reductions in numbers of sessions, and more appropriate levels of workload, as a result of job planning. In Histopathology, job plans clearly demonstrated team planning of short-term sessions to cover a long-term vacancy.

There has been little change in sessional commitments of consultants in recent years

21. As shown in Exhibit 1, in 2009-10 the UHB reported to the Assembly Government that it had a total of 532 medical consultants, of which more than one in five were on less than full time contracts. Many of these apparently part-time contracts are full time academic consultants with honorary contracts in the UHB, often with six sessions or fewer for their NHS commitment. This represented a growth in total numbers of consultants of more than 10 per cent in the preceding two years, with a steadily increasing proportion of less than full time consultants.

22. The consultant body in Cardiff is somewhat different from the rest of Wales. Our survey found that 85 per cent, compared to an all-Wales 94 per cent, of consultants have the NHS as their main employer, and 21 per cent (compared to 11 per cent) have an academic contract. As reported in the medical staffing review, the level of academic appointments at the UHB for 2006-07 was high compared to other university teaching hospitals in the UK although the reasons why are unclear.

Exhibit 1: Cardiff and Vale University Health Board consultant numbers 2007-08 to 2009-10

Health Board/Trust	2007-08	2008-09	2009-10
Total number of consultants	**482**	**515**	**532**
Growth year on year		+ 6.8%	+ 3.3%
Less than full time (9.5 sessions or fewer)	93	106	113
Less than full time as % of total	19.2%	20.6%	21.2%
Full time (more than 9.5 sessions)	389	409	419

Source: Cardiff and Vale UHB and Welsh Assembly Government

23. Exhibit 2 shows that in 2009-10, the average job plan was 11.34 sessions, slightly above the all Wales level. Compared to other Health Boards, there was also a high proportion of consultants working fewer than 10 sessions per week.

Exhibit 2: Health Board/Trust average sessions and levels of part-time consultants 2009-10

Health Board/Trust	DCC	SPA	Other	Management	Total	% of consultants who are part-time
ABM	8.49	2.41	0.26	0.04	11.20	9.3%
Aneurin Bevan	8.20	2.83	0.01	0.22	11.26	10.1%
BCU West	8.65	2.28	0.37	0.09	11.38	5.0%
BCU Central and East	8.48	2.72	0.08	0.16	11.44	
Cardiff and Vale	**8.23**	**2.84**	**0.15**	**0.13**	**11.34**	**21.2%**
Cwm Taf	8.26	2.32	0.15	0.14	10.87	13.6%
Hywel Dda	8.49	2.37	0.01	0.00	10.87	8.9%
Powys	7.87	1.67	1.26	0.36	11.16	20.0%
Public Health Wales	7.65	2.86	0.03	0.00	10.55	27.6%
Velindre	7.84	2.85	0.00	1.15	11.84	11.8%
Wales Average	**8.34**	**2.60**	**0.14**	**0.13**	**11.21**	**13.0%**

Source: Cardiff and Vale UHB and Welsh Assembly Government

24. Exhibit 3 shows that there has been a small reduction in average sessions over the last three years. New consultants are recruited on a standard 10-session contract. However, Exhibit 4 shows that more than one in five consultants is working more than 12 sessions per week. The former Trust reported in the medical staffing review that they had provided consultants with a choice as to whether they wanted to continue to work 12 sessions or reduce to 10 sessions. The Trust considered that consultants working 12 sessions would be better for continuity of care and value for money than recruiting additional consultants on 10 sessions. Although average sessions are falling, the UHB will need to develop an action plan to reduce excessive workloads for those consultants working above 12 sessions a week.

Exhibit 3: Change in average sessions 2007-08 to 2009-10 for Cardiff and Vale NHS Trust/ Health Board

	DCC	SPA	Other	Management	Total	No of Consultants
2009-10						
Cardiff and Vale	8.23	2.84	0.15	0.13	11.34	532
2008-09						
Cardiff and Vale	8.29	2.85	0.22	0.14	11.50	515
2007-08						
Cardiff and Vale	8.55	2.83	0.24	0.14	11.76	481

Source: Cardiff and Vale UHB and Welsh Assembly Government

Exhibit 4: Health Board/Trust proportions of full-time consultants working more than 12 sessions per week

Health Board/Trust	% of full-time consultants with over 12 sessions
Abertawe Bro Morgannwg University	15.2%
Aneurin Bevan	13.4%
Betsi Cadwaladr University	20.6%
Cardiff and Vale University	**21.0%**
Cwm Taf	8.3%
Hywel Dda	12.3%
Public Health Wales	nil
Velindre Trust (Cancer Centre)	22.7%
Velindre Trust (Welsh Blood Service)	nil
All Wales	**13.9%**

Source: Cardiff and Vale UHB and Welsh Assembly Government

The UHB cannot evidence that it gets value for money from supporting professional activity sessions

25. Whilst most existing job plans identify that a consultant is carrying out SPA sessions in research and development, teaching and training, and clinical audit activities, which might improve services, there is little evidence provided saying what these activities are. In addition, there is no information to determine whether these activities have been aligned to service and corporate improvement objectives such as aspects of the UHB research and development strategy.

26. Most of the job plans sampled had two or more SPA sessions although one had no SPA sessions allocated at all and no explanation why this was the case. None of the job plans set out any expected SPA outcomes and there was no evidence that SPA activity has been discussed during the job plan review meeting.

Job planning has not been used systematically to drive development and improvement of service delivery

27. Little evidence emerged from our interviews and other fieldwork that job planning has been used systematically to drive development and improvement of services for patients, or working conditions for consultants. Instead, initiatives such as appointment of nurse practitioners, work to reduce inappropriate referrals and to put on additional clinics appear to have been driven more by meeting waiting list targets.

28. In our interviews, consultants consistently reported that they were finding it difficult to modernise services. This was mainly because planning arrangements were complex and they could not get management support for proposals to introduce innovative practices. This was causing frustration and was not making the best use of the creative solutions that clinicians were putting forward.

29. Even so, there are some examples of good practice where the job planning process had been linked to improving and developing services. Examples included:

- Using benchmarking data to prompt a discussion about underlying performance issues particularly where outliers are identified.
- Using the job planning review as a forum to build on consultant-driven initiatives for service development, or to obtain their support for new initiatives. This has freed up consultant sessions which can be used to support delivery of new, redesigned or more efficient service provision.
- In a few examples, SPA input has been specifically focussed on developing strategic direction and delivery. For example, in the Clinical Genetics directorate, a consultant has been asked to lead the planned web-based enhanced appraisal pilot as part of her SPA commitments.
- One or two examples of (innovative planning) flexible contracts being used to smooth activity over the typical 42-week clinical year.

The UHB has taken action to strengthen its job planning arrangements

A new job planning framework, which appears robust, is now in place

30. In 2010, the UHB produced a new consultant job planning and contract management framework and is starting to implement this in all clinical directorates. A clear set of principles and objectives for consultant job planning has been agreed, both at Board level and with the UHB's Local Negotiating Committee (LNC), together with supporting guidance. The guidance describes a range of objectives for, and principles governing, the job planning and consultant contract management process. There are clear arrangements for leadership and oversight of the framework, and provision for contract and performance management and development.

31. The UHB has defined clear objectives to be delivered by consultant job planning and contract management. These clearly provide a 'golden thread' to, and support delivery of, corporate objectives and priorities. These objectives include delivery of cost savings, financial balance and annual operating framework targets, service development and modernisation, and improved patient outcomes and value for money from the use of health service resources.

32. All clinical directorate managers and consultants received clear guidance about job planning objectives, supported by comprehensive training in summer 2010. Ongoing communication further supports implementation across clinical directorates. The guidance does not state a rigid process to be followed, but allows flexibility for local interpretation and use within overall guidance criteria.

33. The UHB has provided the performance committee with a timetable for completion of the job plan reviews in all directorates by the end of December 2010. This is a challenging timescale but completing job planning with all consultants before the end of 2010-11 will provide the UHB with many benefits.

34. The guidance itself is clear and appears robust, providing a standard approach. It requires job planning to:

- take place annually, on a jointly clear and 'no surprises' basis, by the individual consultant with their clinical director and directorate general manager;
- be informed by the outcomes of professional competency appraisal of the consultant, preferably in advance of the job planning meeting itself, and to include mutually agreed areas of clinical and core professional development;
- be informed by the completed out of hours work intensity questionnaire to establish the on-call element of the job plan; and
- be informed by performance management considerations relating to delivery of agreed objectives and targets, and to inform eligibility for commitment awards.

35. The result of the job plan review should be a job plan using a standard template which clearly states the consultant's DCC, SPA and any management sessional commitments and agreed outcomes to be achieved by the consultant during the year, which support delivery of agreed corporate, service and specialty objectives, including capacity planning. Key requirements of the job plan are:

- Outcome measures which need to be agreed for the year ahead reflecting the UHB's performance targets. The guidance emphasises that these should be SMART and provides a template which should provide a clear basis on which to assess delivery at the next annual job plan review.
- For the first time, all consultants must provide evidence of their SPA activities using the outcome forms in the guidance. The assistant medical director (workforce) will scrutinise these forms for consistency across the UHB and other medical directors will challenge the content of SPAs to ensure that these can be justified, are not excessive and are compatible

with service delivery and corporate strategies. Up to one SPA can be carried out off site but all others should be carried out on UHB premises unless services demand that the consultant provides an additional DCC session in the working week.

- For clinical academics, university representatives need to participate in the job planning process and ensure there is no duplication in terms of the university and UHB's requirements. To resolve these issues, a joint job planning process has recently been agreed with the Cardiff University partnership board. It will be published as supplementary guidance to the main UHB job planning guidance following consultation with the LNC.

36. While the UHB will benefit from having a standard job plan template, there is still a need to develop an electronic version to ensure complex job plan arrangements are accurate and are presented in a clear and transparent way, building on the approach developed in the Integrated Medicine directorate.

37. The framework includes clear arrangements for leadership and oversight of implementation, plus contract and performance management and development. Although some of these arrangements had not yet been tested in practice at the time of our audit fieldwork, these include:

- an assigned assistant medical director lead for the consultant contract and job planning, who has a clear vision for the way that the consultant contract can aid the UHB to meet its challenging targets;
- a medical workforce group, which manages and has oversight of the progress to deliver a job planning project plan and timetable;
- formal arrangements to scrutinise business cases for new and replacement consultants and to ensure these help deliver agreed service and corporate objectives; and
- assistant medical director (workforce) 'QA consistency sessions' to scrutinise and challenge all completed plans from job reviews since the introduction of the new procedures, to ensure that these are consistent with the guidance.

The new job planning approach is widely accepted by consultants and clinical directors

38. From our interviews, we found that clinical directors, consultants and the LNC generally accept the provisions of the new consultant job planning procedure. They welcome the clear statement of objectives and expected outcomes, and an intention to work in a clinically-led service where they can influence the shape of service delivery through the job planning process. A standardised process across all clinical directorates is seen as likely to result in job plans which are more equitable than previously and which better reflect the realities of current clinical workloads and needs for service improvement.

39. We also found consultants generally accept the need for job planning and they are committed to discussing their development needs and bringing a range of robust information to job planning meetings to support their scheduled SPA and DCC sessions. Moreover, few consultants appear to have had any problems with having their SPAs scrutinised, and the number of SPA sessions reduced if they agree that this is appropriate.

40. At the time of our fieldwork, most clinical directorates were still at an early stage of rolling out the new job planning process with consultants. Even so, it was clear that clinical directorates had adopted, or were planning to adopt, a number of different job planning processes, reflecting the flexible nature of the guidance. Examples of these varying approaches are detailed below:

- In Clinical Genetics, the long-established approach to job planning and appraisal was well aligned with the new guidance and policy. Annual job plan reviews had been undertaken for each consultant for a number of years. Reviews assessed existing and potential future clinical workload, alongside individual consultant development needs and preferences, and service requirements. This produced a standard job plan of ten sessions, with an appropriate DCC:SPA split.
- In Pathology, the consultant workload typically lends itself to a more mechanistic allocation of activity to each consultant session than in many other clinical directorates. The team had therefore adopted this planning approach and allocated activity to consultants in line with Royal College and other professional standards. Again, this resulted in a standard job plan and DCC:SPA sessional split.
- In Radiology, job planning for all consultants has not been routinely carried out since 2004. The clinical director is not a medical consultant, which some of the consultants stated was a potential cause of dissatisfaction in a new job planning process. To address this, four radiology consultants were recruited and trained as appraisers and they were assigned a number of consultant colleagues to appraise. The clinical director planned to roll out appraisal in October and November 2010 and then job plan on the basis of appraisal outcomes. This has proved successful, so that more consultants have asked to be involved and plans exist to extend this arrangement to spread workload, and the clinical leadership model, further.

Barriers still exist which may prevent the UHB from realising the full potential of the consultant contract

Mechanisms do not always ensure that clinical directorates work together effectively to develop services

41. We have found a few examples where the clinical directorate structure appears to have encouraged a strong internal focus on service development, without assessing the impact of change on other specialties and directorates. Orthopaedics has recently moved towards three-session consultant days, so increasing demand for supporting clinical sessions from Anaesthetics and

Radiology. However, these directorates report that they were not involved in the planning of the orthopaedic service change. This has led to a range of actual and potential issues, including:

- difficulties in resource planning and consultant rostering within the support directorates;
- increased activity and impact of workload on the maintenance of acceptable levels of non-orthopaedic directorate consultant sessions; and
- additional costs of providing the service, arising from clinical sessions required outside tightly specified core hours in non-orthopaedic directorates.

42. Planning for service change should involve staff from all affected directorates to ensure that new ways of working are supported by all staff and can be implemented effectively.

The potential of job planning to develop better team working between consultants and managers is being hindered by an overreliance on using diaries and rushing some review meetings

43. There has been some upheaval in the UHB's directorate structure following NHS reorganisation in 2009. A number of clinical directors and general managers interviewed had changed posts recently and were in the process of forging new relationships. This is a good opportunity for relationships between management and clinicians to improve where these had been difficult in the past and to provide good quality job planning meetings.

44. Despite the emerging work to embed a robust job planning framework across the UHB, we have noted some aspects which potentially hinder the use of job planning to develop team working and more effective joint working relationships between managers and consultants.

45. While the survey results show that job planning meetings were overwhelmingly held in an appropriate location (95 per cent) and with adequate notice (90 per cent), our fieldwork found that job planning meetings do not always take place at a time and place conducive to full, frank and non-threatening exchange of views, issues and solutions between consultant and managers. In one clinical directorate, as part of the new initiative, we were told that job plan reviews had been done hurriedly, in corridors and offices, in an ad-hoc fashion 'because the auditors were coming'. It is unlikely that such an approach would achieve the required outcomes as set out in the recent job planning guidance.

46. The new guidance states that a consultant can keep and discuss a workload diary but that this is not mandatory. Furthermore, the clinical director is expected to challenge any activities that are not required by the directorate. However, we found that the routine use of diaries continues to be widespread, but its continued use may not always be appropriate:

- Consultants report that a diary is often used, for example, to support a claim for more sessional payments or an additional SPA. Whilst this in itself is not an issue, diaries measure consultant input only loosely related to patient care outcomes. If used indiscriminately, or without challenge, there is risk of

incurring increased pay costs and failing to achieve delivery of improved patient care outcomes and value for money from the use of UHB resources.

- Use of diaries is seen by many consultants as being a de-professionalising and administrative task, and as encouraging an inappropriate clock-watching culture which is at variance with many doctors' view of their own patient care responsibilities.
- Measuring inputs through diaries is perceived by some consultants as getting in the way of developing professional joint working relationships between consultants and managers about improving the outcomes of health care for patients.

Many directorates are using information on activity to support job planning although accessing data via the UHB's intranet is problematic

47. Most clinical directors told us that there are adequate information systems and available data for them independently to record and verify consultants' DCC working patterns and to inform the job planning, performance management and appraisal processes. One clinical directorate has developed its own information systems to support its particular job planning and performance management needs.

48. Data available from corporate systems includes that on individual consultant activity, clinics and operating theatre throughput. Consultant response to the survey, however, shows that just under half of consultants (47 per cent) use this data to inform the job planning review discussion. Most consultants state that they use their own information (85 per cent), including detail of DCC and SPA activities, clinical audit and clinical governance issues. All data used in the job planning meeting is usually shared in advance of meetings.

49. Consultants told us that their ability to get access to internet and intranet-based data from UHB sites was problematic as the result of slow local networks. In particular, the UHB had difficulty emailing the link to our survey to all consultants via one distribution list. This had implications from several perspectives, including patient, service development, co-ordination and efficient delivery of clinical care, CPD, teaching and training.

Session benchmarking

Health Board specialty analysis 2009-10

	DCC	SPA	Other	Management	Total
Accident & Emergency	7.13	3.10	0.00	0.20	10.43
Anaesthetics	7.99	2.75	0.00	0.05	10.79
Audiological Medicine	6.80	3.00	0.00	0.00	9.80
Cardiology	8.89	2.90	0.00	0.18	11.96
Cardiothoracic Surgery	11.55	3.01	0.00	0.00	14.56
Chemical Pathology	7.76	2.96	0.00	0.59	11.31
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 Pharmacology & therapeutics	9.33	3.33	0.69	0.38	13.74
Dental Medicine Specialties	7.62	2.94	0.00	0.25	10.81
Dermatology	7.57	2.43	0.10	0.18	10.28
Endocrinology	7.50	3.13	0.00	0.00	10.63
ENT	9.28	3.27	0.70	0.00	13.26
Forensic Psychiatry	7.87	2.14	0.17	0.00	10.18
Gastroenterology	7.77	2.96	0.24	0.00	10.97
General Medicine	7.59	3.52	0.06	0.00	11.17
General Surgery	8.89	2.41	0.34	0.13	11.77
Genito Urinary Medicine	7.65	2.35	0.00	0.00	10.00
Geriatric Medicine	8.49	3.22	0.04	0.07	11.82
Gynaecology	8.39	2.62	0.08	0.14	11.22
Haematology (Clinical)	8.20	2.92	0.17	0.18	11.47
Histopathology	8.29	3.30	0.88	0.00	12.48
Infectious Diseases	10.17	3.63	1.00	1.33	16.13
Mental Illness	7.14	2.74	0.23	0.22	10.33
Nephrology	8.93	3.46	0.00	0.12	12.51
Neurology	7.77	3.27	0.23	0.00	11.27
Neurosurgery	9.16	2.47	0.33	0.00	11.96
Occupational Medicine	6.37	3.67	0.00	0.00	10.04
Old Age Psychiatry	6.57	3.29	0.70	0.00	10.56
Ophthalmology	8.07	2.78	0.10	0.08	11.03
Oral Surgery	8.44	3.02	0.00	0.00	11.46
Orthodontics	7.98	2.96	0.00	0.59	11.53
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	7.99	2.84	0.27	0.42	11.53

	DCC	SPA	Other	Management	Total
Radiology	8.46	2.50	0.20	0.15	11.31
Rehabilitation	7.00	3.00	0.00	1.07	11.07
Restorative Dentistry	6.83	3.17	0.00	0.00	10.00
Rheumatology	7.55	3.01	0.00	0.46	11.03
Thoracic Medicine	7.66	3.06	0.00	0.00	10.71
Trauma & Orthopaedic	9.11	2.67	0.01	0.04	11.83
Urology	9.04	2.54	0.00	0.14	11.72
All Specialties average	**8.23**	**2.84**	**0.15**	**0.13**	**11.34**

Welsh Averages

	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
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 Handicap	7.87	3.41	0.07	0.06	11.41

	DCC	SPA	Other	Management	Total
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**

Consultant survey[2]

No.	Question	Answer	Cardiff and Vale number giving answer	Cardiff and Vale % giving answer	All Wales % giving answer
1	Total number of responses		150	28.2%	580
4	Percentage of consultants received adequate notice of the date of their last job plan review meeting	Yes	124	89.9%	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	63	47.0%	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	47	31.3%	26.2%
		Your own information	128	85.3%	67.2%
		None	8	5.3%	5.7%
		Other *	14	9.3%	8.4%

[2] Highlighted in orange are those figures where Cardiff compares significantly below the all Wales figure and in purple are those figures where Cardiff compares above the Wales figure

No.	Question	Answer	Cardiff and Vale number giving answer	Cardiff and Vale % giving answer	All Wales % giving answer
7a	Percentage of consultants that prior to the job planning meeting were able to consider last year's work	Yes	119	91.5%	89.6%
7b	Percentage of consultants that prior to the job planning meeting were able to consider their current pattern of work and activities	Yes	132	94.3%	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	120	89.6%	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	113	90.4%	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	91	70.0%	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	104	78.8%	80.1%

No.	Question	Answer	Cardiff and Vale number giving answer	Cardiff and Vale % giving answer	All Wales % giving answer
7g	Percentage of consultants that prior to the job planning meeting were able to consider their own personal development plan from their appraisal	Yes	108	83.7%	81.7%
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)	61	42.7%	44.1%
9	Percentage of consultants where the NHS is their primary employer	Yes	126	85.1%	93.6%
10	Percentage of consultants that hold an academic contract	Yes	31	20.8%	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	10	34.5%	21.6%
12	Percentage of consultants that have their job plan reviewed annually	Yes	85	60.7%	61.5%
13	Percentage of consultants that whose last job plan review was:	Within the last 3 months	28	18.9%	14.4%
		Between 3 months and 6 months ago	10	6.8%	14.7%
		Between 6 months and 12 months ago	48	32.4%	26.3%
		Between 12 months and 18 months ago	25	16.9%	17.2%
		More than 18 months ago	17	11.5%	19.1%
		I've never had a job plan review	20	13.5%	8.3%

No.	Question	Answer	Cardiff and Vale number giving answer	Cardiff and Vale % giving answer	All Wales % giving answer
14	Percentage of consultants whose last job plan review lasted:	Less than one hour	80	62.0%	60.7%
		One to two hours	43	33.3%	35.7%
		More than two hours	6	4.7%	3.6%
15	Percentage of consultants that said that their last job plan review was	About right?	103	80.5%	78.6%
16	Percentage of consultants that said that the right managers involved in the job plan review	Yes	112	88.9%	87.3%
17	Percentage of consultants whose last job plan review was undertaken as part of a team	Yes	16	12.6%	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	11	52.4%	52.8%
19a	Percentage of consultants that felt their job plan review was conducted in a constructive and positive tone	Yes	104	81.9%	85.4%
19b	Percentage of consultants that felt their job plan review was conducted was held in an appropriate location	Yes	121	94.5%	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	45	36.3%	36.1%

No.	Question	Answer	Cardiff and Vale number giving answer	Cardiff and Vale % giving answer	All Wales % giving answer
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	63	50.0%	46.3%
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	56	44.8%	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	79	61.7%	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	69	54.8%	53.0%
19h	Percentage of consultants that felt their job plan review helped in delivering their personal development plan from their appraisal	Yes	72	57.1%	54.6%
20	Percentage of consultants that said a set of outcome indicators been agreed for their job plan	Yes	57	43.5%	34.3%
21	Percentage of consultants that felt they have confidence with the accuracy of the outcome indicator information	Yes	31	31.3%	26.8%

No.	Question	Answer	Cardiff and Vale number giving answer	Cardiff and Vale % giving answer	All Wales % giving answer
22	Percentage of consultants that felt that the outcomes indicators used are appropriate and provide a true reflection of the work	Yes	27	27.6%	23.4%
23	Percentage of consultants that were involved in any discussion about the type and relevance of the indicators	Yes	29	27.1%	31.8%
24	Percentage that take part in the CHKS Compass Clinical Outcomes Indicator (COI) programme?	Yes	100	76.3%	77.0%
25	Percentage that have confidence in the accuracy of the CHKS Compass COI reports?	Yes	8	6.8%	8.5%
26	Percentage of consultants that felt their job plan:		**Answered yes**	**Answered yes**	**Answered yes**
		Clarifies the commitments expected of them	100	66.7%	65.0%
		Clearly schedules their commitments	85	56.7%	60.2%
		Helps to tackle excessive workloads	28	18.7%	18.6%
		Identifies the resources and support needed to deliver their job plan	27	18.0%	19.7%
		Provides an appropriate balance between the sessions Direct Clinical Care (DCC) and Supporting Professional Activity (SPA) commitments	75	50.0%	54.7%

No.	Question	Answer	Cardiff and Vale number giving answer	Cardiff and Vale % giving answer	All Wales % giving answer
		Clearly identifies the outcomes from their SPAs	50	33.3%	27.1%
		Allows them to work more flexibly, for example, by varying the clinical commitment, allowing for part time, term time working, and “chunking” time	34	22.7%	24.7%
27	Percentage of consultants that in overall terms have found job planning to be:	Either useful or very useful	51	38.6%	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	77	57.0%	53.7%
28b	In relation to the consultant contract and job planning, percentage that agreed: Patient care has improved	Either strongly agree or agree	34	25.2%	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	32	23.7%	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	30	22.6%	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	47	34.3%	32.4%

No.	Question	Answer	Cardiff and Vale number giving answer	Cardiff and Vale % giving answer	All Wales % giving answer
28f	In relation to the consultant contract and job planning, percentage that agreed: My working week is more transparent	Either strongly agree or agree	77	55.8%	55.0%
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	30	22.4%	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	39	29.3%	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	33	24.1%	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	59	43.4%	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	48	35.6%	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	14	10.6%	15.0%

No.	Question	Answer	Cardiff and Vale number giving answer	Cardiff and Vale % giving answer	All Wales % giving answer
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	37	31.1%	32.7%
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	16	12.3%	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	103	73.6%	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	57	41.6%	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	45	33.3%	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	22	15.9%	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	82	58.2%	55.3%

No.	Question	Answer	Cardiff and Vale number giving answer	Cardiff and Vale % giving answer	All Wales % giving answer
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	13	9.4%	17.2%
28u	In relation to the consultant contract and job planning, percentage that agreed: Medical workforce planning has improve	Either strongly agree or agree	15	10.9%	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	39	28.7%	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	36	26.5%	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	52	40.0%	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	22	17.1%	20.4%

Appendix 3

Methodology

We interviewed over 30 staff from across the UHB in October 2010. Those interviewed included the assistant medical director (workforce), clinical directors, general managers, and staff from HR and data management who were involved in job planning. We also interviewed a sample of consultants selected by the UHB and the Local Negotiating Committee.

We reviewed a sample of job plans from these directorates and reviewed relevant documentation provided by the UHB.

During September and October 2010, we asked consultants in the UHB to complete an electronic survey. We designed this primarily to establish their views of the consultant contract. Exactly 150 consultants responded to the survey which is a response rate of 28.2 per cent.

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