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Pay Modernisation: NHS Consultant Contract

Hywel Dda Health Board

The Health Board recognises that its current approach to job plan reviews is not yet sufficiently robust, and while progress is being made some of the consultant contract benefits have not been fully realised.

Contents

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Summary

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

6. The Wales Audit Office has therefore undertaken work at each health board and NHS trust that employs significant numbers of consultants which seeks to answer the question: 'Are the intended benefits of the new consultant contract being delivered?' The audit has had a particular focus on the extent to which job planning was embedded in the health board as an annual process and how effective it was in facilitating service improvement. We also considered the extent to which the new contract was contributing to a more positive and equitable working environment of consultants, and the extent to which it has assisted recruitment and retention.

7. We undertook fieldwork at Hywel Dda Health Board (the Health Board) during October 2010. We interviewed key staff including the medical director, divisional directors, clinical directors, and key staff from HR, finance and data management plus a sample of consultants selected by the Health Board. We also ran an online survey of all consultants which received responses from 41 of the Health Board's 214 consultants – a response rate of 19 per cent. We also reviewed a sample of 60 consultant job plans.

8. Our fieldwork followed a period of unprecedented and protracted organisational change. We are aware of the considerable agenda that the Health Board has been addressing in order to develop a single set of corporate arrangements. Work is currently underway at the Health Board to develop a clinical strategy, which should significantly influence future job planning. It is in this context that we report our findings.

9. Our overall conclusion is that the Health Board recognises that its current approach to job plan reviews is not yet sufficiently robust, and while progress is being made some of the consultant contract benefits have not been fully realised. We came to this conclusion because:

   - the approach to reviewing job plans is not robust and many consultants have not had an annual review;
   - the Health Board has delivered few of the benefits expected from the consultant contract; and
   - for many consultants the working environment has improved following the introduction of the consultant contract.

Recommendations

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

R1	The Health Board needs to take action to successfully embed the new medical leadership model and through this ensure that all its consultants understand the value of job planning and how it is to be used to support the delivery of the Health Board, strategic objectives and operational targets.
R2	Business processes should be reviewed to ensure that all consultants have an up-to-date job plan that accurately reflects the work that they do, and which is reviewed on an annual basis. Appropriate monitoring and reporting arrangements should be developed to provide Board members with the appropriate assurances that this is happening.
R3	The job planning process needs to be strengthened by the quick introduction of the new framework: • ensuring the job planning process takes account of clinical demand and activity; • developing and agreeing the necessary activity and outcomes indicators for different specialties to inform job planning and performance review; • defining what constitutes an SPA, and how the value from SPAs may be measured; • promoting job planning on a team basis, where this is seen to add value; • standardising documentation which clearly identifies the job content and expected outcomes; and • undertaking compliance and quality audits.
R4	The Health Board needs to ensure that staff undertaking job plan reviews have the necessary support in terms of: • supporting corporate guidance; • training; and • creation of a Clinical Directors Forum or similar to share learning and experiences.
R5	Where directorates have developed more robust approaches to job planning, learning from this should be shared across the Health Board.
R6	The Health Board needs to develop a strategy that will strengthen the working relationship between managers and consultants to facilitate service development and modernisation.

The approach to reviewing job plans has not been robust, although the Health Board is now introducing a new planning framework

A large number of consultants have not had a job plan review in the last year

11. All of the Health Board's consultants have a job plan but not all have had a review in the last year which has meant some job plans are not current and are outdated, undated or not agreed. Managers have attributed this to reorganisation which has disrupted previously existing arrangements. However, interviews and consultant survey results suggest predecessor arrangements were not robust and many consultants have not had their job plans reviewed for several years.
12. The Health Board's new structure is settling down, and the Medical Director informed us that good progress is now being made with job plan reviews. A number of consultants, such as some at the Prince Philip Hospital (PPH), had job plan reviews in 2010. The mental health service is currently reviewing its job plans.
13. More typically, consultants have job plans dated 2009; these include trauma and orthopaedics, obstetrics and gynaecology at Withybush General Hospital (WGH) and pathologists at West Wales General Hospital (WWGH).
14. Our review of 60 job plans from across the Health Board found:
    - 15 were undated;
    - two were last reviewed in 2006;
    - six were last reviewed in 2007;
    - 12 had been reviewed in 2009 but longer than 12 months ago; and
    - 25 had been completed in the last year.
15. A large number of undated job plans related to Bronglais General Hospital (BGH) and on further examination were found to have been last done in 2006-07.
16. A minority of consultants have not signed their most recent job plan because either the paperwork is incomplete, or they have not reached agreement with the Health Board.
17. Some consultants, such as the anaesthetists in BGH recognise a rota rather than a job plan as their agreed timetable with the Health Board. Whilst this may be pragmatic but it does not fulfil the requirements of the consultant contract.
18. Not all specialties have been affected and paediatric consultants have continued to have regular annual job plan review meetings. This is good practice and should become the norm for all specialties in the Health Board.

19. The poor approach to annual job planning review was confirmed in our consultant survey with respondents saying:
    - 70 per cent had not had the job plan reviewed in the last year;
    - 41 per cent had not had a review in the last 18 months; and
    - seven per cent had never had a job plan review.
20. Without current agreed job plans the Health Board cannot be assured consultants are working to agreed timetables, resources are being used effectively, activity is maximised and that consultants are paid correctly for the work they do.

There is no standard plan documentation and the quality of the job plan and review meetings vary considerably

21. The three predecessor trusts developed their own approaches to the implementation of the new consultant contract and job planning. Each had a steering group, which supported the introduction of the consultant contract. Following implementation of the contract, these groups were disbanded.
22. Neither the merged Hywel Dda NHS Trust, nor the Hywel Dda Health Board, has established any similar forum to promote a consistent approach to the consultant contract. Given this history, it is not surprising there is variation in how job planning is done across the Health Board.
23. Our job plan review found that different forms are in use across the Health Board to record job plans with the British Medical Association pro forma being the most common. Some job plans are fully completed showing sessions and hours, location and type of work and provide a breakdown of duties and hours for DCC and SPA sessions. They also detail other responsibilities and include a completed outcomes page, although the impact of private practice commitments and fee-paying work are rarely discussed or recorded as part of the job plan review.
24. Other job plans are sparsely populated with some showing sessions and little else. The job plan for one consultant simply listed activity and did not show hours, sessions or locations. This is very poor practice and needs to be addressed quickly.
25. Good preparation can improve the effectiveness of review meetings. We found there was no consistent approach to allowing consultants to prepare for the meeting. In our survey, 24 per cent of respondents felt they were not given sufficient notice of the meeting and only 18 per cent were able to see and comment on the information that was being used by managers.
26. Whilst 97 per cent of those who responded to the survey said they were able to consider their current pattern of work and activities in advance of the meeting, only 53 per cent said they were able to consider the impact of initiatives such as NHS reform and changes in the health needs of the community.
27. The robustness of the job plan review meeting is variable. Some consultants reported that the job plan meeting is an in-depth discussion covering all aspects of a consultant's work. Where the job plan meeting has been a difficult negotiation, more evidence is sought and the outcomes of the job plan meeting are formally documented as a post-meeting letter.

28. A handful of consultants interviewed reported that the job plan meeting was a 'dismal experience'. Results from the survey show only 26 per cent found job planning either useful or very useful, which is disappointing low.

29. Typically, clinical directors and general managers meet with consultants at the job plan meeting. Eighty one per cent of those who responded to the survey said they thought the right managers were involved in their last job plan review. Although 24 per cent of consultants thought the meeting was too short to fully discuss the issues.

30. Although the Health Board has provided training for those running job plan reviews some consultants when interviewed were concerned with the reviewer's ability to undertake the review, whilst reviewers had been concerned with how some recipients had taken the review. This suggests that training needs to be ongoing to build confidence with consultants undertaking and receiving job plan reviews.

31. The ability of the Health Board to use the consultant contract to plan services is in part dependent on the quality of the documentation and most importantly the discussion at the job plan review meeting. The Health Board's current arrangements are not supporting this process.

Data is not routinely used as part of the job plan review meeting

32. Consistent and rigorous use of data to inform the job plan meeting can help consultants and the Health Board to get the best from the job plan review. The availability of useful data to support the job plan review varies across specialties. Consultant orthopaedic surgeons tend to be more satisfied with the availability of data to support their service than specialties such as mental health. Generally, consultants do not find COMPASS data useful and have concerns about its accuracy.

33. The use of data at the job plan meeting varies across the Health Board. At best, consultants bring their current job plan, completed diaries, activity data and evidence of their SPA activity to the meeting. Managers bring service plans, activity and performance information to the meeting.

34. Most consultants interviewed said the use of information was very poor and disconnected from performance management. A few consultants were able to identify where it had worked well, and there had been a positive dialogue focused on the data.

35. However, in most instances, the Health Board and its managers were unable to provide information and many consultants said the only information they bring to the meeting is their current job plan. They reported the job plan meeting mainly focuses on the timetable and often only a cursory discussion about performance data.

36. In some instances where there are small close-knit specialty teams, the consultants involved were less concerned with data as they felt they understood performance and how the team was working. Whilst this is understandable, hard data can still help to inform the discussion.

37. For individual consultants, the use of data in job plan meetings varies between these two extremes. Generally, consultants only keep diaries where job plans are likely to change. Some consultants report managers do not share activity data with them regularly. Eighty seven per cent of those who responded to the survey say they use their own information in preparing for their job plan review.

38. Sometimes, the appraisal rather than the job plan meeting is the forum where activity data and performance is discussed. Specialty meetings are also forums where activity and performance data are scrutinised.

Job planning and appraisal have historically been linked but this link is less clear for 2010-11

39. The contract says that job planning should be linked closely with the agreed appraisal scheme for consultants. In the past, the job plan review and appraisal have been linked at the Health Board. The two meetings would sometimes take place within the same day. Typically, the same senior consultant would undertake both meetings and the same evidence was used at both meetings.

40. For 2010-11, the two meetings will not be so closely linked. The Health Board is clear the two processes should be linked but has prioritised the appraisal. The Medical Director has directed that appraisals should be completed by March 2011 and all consultants are aware that appraisals are imminent. The Health Board is involved in a pilot of a new appraisal system and this has also raised the profile of the current round of appraisals.

41. The Medical Director has also directed that job plans be completed as soon as possible. Not all consultants we spoke to were aware of this and some had no expectation of a job plan review in the immediate future.

42. Senior clinicians are now gearing up to begin the next round of job planning. It is not imperative that the meetings take place at the same time. However, it is important the links are made and that the Health Board plans to do this.

The Health Board cannot evidence that it gets value for money from SPA sessions

43. Scrutiny of SPA activity is limited. The Health Board accepts this is an area for improvement. Some job plans clearly show how SPA time is spent; others have no record of this activity. The extent to which SPA is discussed in the job plan meeting varies similarly. This discussion sometimes takes place in the appraisal meeting. Only 10 per cent of those that responded to the survey said their job plan clearly identifies the outcomes from their SPA. Some of the Royal Colleges require consultants to provide robust evidence of their continuing medical education and development. This can be a useful source of evidence for SPA.

44. Supporting Professional Activities is an essential part of a consultant's work and is an investment by the Health Board. West Wales General Hospital has estimated this SPA investment costs £1.7 million.

45. We found little evidence of SPA being directed to support the Health Board's broader strategy. For example, the Health Board does not focus SPA audit topics to further its priorities. Internal Audit planned, but did not undertake, a review of SPAs in 2009. Unless the Health Board can direct SPA more strongly, there is a risk that the expected benefits from this investment will not be fully realised.

46. It is not clear the variations in SPA sessions between contracts reflect need or work done. While 53 consultants have three or more SPA sessions, more than 130 full-time consultants have fewer than three SPAs.

47. Compared with other health boards, consultants at the Health Board have proportionately less SPA (see Exhibit 2 later on in this report). Some consultants say they struggle to deliver SPA sessions because clinical pressures squeeze them but because of the general weaknesses in the job planning process this is not evidenced.

48. All consultants indicate they manage to achieve their continuing medical education even if this is sometimes done in their own time. Without an objective assessment of what is achieved through SPA, it is difficult to judge if individual consultants have enough SPA time. The Health Board will need to ensure SPA outcomes are clearly identified in its job planning documentation.

Only 25 per cent of job plans had identifiable outcomes

49. The job plan should include expected outcomes which set out a mutual understanding of what the consultant and Health Board want to achieve over the following 12 months. Outcomes need to be appropriate, identified and agreed. We reviewed 60 job plans and only 15 had a completed outcomes section.

50. The 2009-10 job plans of pathologists and haematologists at WWGH were well completed including the outcomes section.

51. We found three good examples in setting expected outcomes. These consultants' 2009-10 objectives included SMART[1] targets for new to follow-up ratio and waiting times and for team working.

52. Only 29 per cent of those who responded to the survey agreed that they now have clear personal objectives linked to service improvement. Objective setting can be a key mechanism for aligning consultant's activity to the Health Board and service priorities.

[1] SMART – specific, measureable, achievable, realistic and timed

The Health Board now has a draft planning framework which could address the current weaknesses

53. Many of the issues identified in the previous section have been recognised by the Health Board and in the last few months it has drafted a job planning framework. The proposed framework:
    - provides clarity about the purpose of job plan review meetings;
    - has guidance on how to prepare the meeting itself and the expected outcomes from job planning;
    - is clear that job planning should be linked to appraisal;
    - supports delivery of the Health Board's strategy, local delivery plans and targets of the annual operating plan and modernising services; and
    - addresses outcome setting and SPA.
54. In addition, the proposed framework has a clear intention to support consultants in achieving a work-life balance and supporting their future career development.
55. The framework intends to standardise documentation and data that might be included in the review process.
56. This framework and guidance has been welcomed by most consultants and if applied as described, the job planning framework should deliver a robust process that benefits both consultants and the Health Board. However, given that an implementation plan has yet to be developed and agreed, it is unlikely the Health Board will see any benefits before 2011-12.
57. The Health Board should progress the implementation as a matter of urgency to ensure the next job plan review cycle addresses the issues identified in this report.

The Health Board has yet to deliver some of the benefits expected from the consultant contract

The Health Board is not yet using job planning to support delivery of its strategic and financial objectives

58. Currently, links between consultants' job plans and the Health Board's priorities are weak and they do not clearly support delivery of the Health Board's strategy. The Health Board does not have a clear approach to managing the costs of the consultant contract beyond standard budgetary controls. Job plans rarely refer to targets such as those of the annual operating framework and to the need to reduce costs. A number of consultants and team leaders told us that the achievement of referral to treatment targets is the responsibility of managers.

59. Consultants are willing to do additional sessions to reduce waiting times. However, we found little evidence of consultants and managers working in partnership to find cost-effective alternative solutions to tackle waiting lists. Barriers to full productivity include perceived bed shortages – one orthopaedic surgeon and team leader said there are occasions when surgeons have no work to do in their theatre sessions because of perceived bed shortages.

60. Some consultants differentiate between managing waiting times based on clinical need and the need to meet targets, with a worryingly large number stating meeting targets and RTT was a manager's problem.

61. Waiting lists and times are now growing and some consultants think that this is inevitable unless the Health Board funds additional sessions. There appears to have been little dialogue between managers and clinicians about this perception and how best to manage the problem.

62. In understanding the impact of job planning on delivering commitments, our survey found only:

- 23 per cent of respondents felt it helped them prioritise work;
- 31 per cent said it provided a stimulus to discussing improving clinical practice; and
- 46 per cent felt it allowed them to discuss constraints and workload pressures.

The Health Board is not routinely using job planning to modernise services

63. The service changes achieved within the Health Board varies between hospitals and specialties. Generally, departmental meetings are the main forum for discussing and introducing service change. However, the job planning review should be seen as an integral part of this process providing an opportunity for an individual consultant to discuss issues and ideas. Our review found where job planning reviews had been undertaken that this opportunity had generally been missed. There were one or two examples where the appointment of a new consultant had prompted a review of service delivery and team job plans.

64. In some areas, the job plans of consultants have not changed since the new contract was introduced. A number of consultants confirm there has been little change in their service during this time. Only 34 per cent of those who responded to the survey said the job plan review provides an opportunity to discuss modernising services and introducing innovative and new ways of working. Some consultants told us that service change is the responsibility of managers. This suggests consultants are not always sufficiently engaged in the process of planning and modernising services.

65. One area where the consultant contract has supported significant service change is dividing elective surgery between PPH and WWGH. Job plans were amended to bring about this service change. In addition, several specialties have introduced new roles as part of modernising their services. Examples include anaesthetic practitioners, specialist cardiac services and in radiology.

66. Some consultants clearly take a lead in modernising their service but for most this does not happen. This contrasts with the approach taken in mental health services where recently job planning is being used to achieve change in the way the service is organised. Through job planning, the service is taking a strategic approach to recruitment and deployment of its current consultant workforce to achieve a more sustainable service. However, the approach being undertaken in this service has not been shared more widely across the Health Board, so any learning from this experience is being lost.

The Health Board continues to experience difficulties with consultant recruitment in some specialties

67. As elsewhere in Wales, the consultant contract has reduced but not resolved recruitment and retention difficulties at the Health Board. Managers and consultants have found factors such as the European Working Time Directive and changes to immigration policy have had an impact.

68. Consultant turnover in 2009-10 was 12.27 per cent (headcount) which is high. At October 2010, the Health Board had 27 consultant vacancies. Vacancies have been at this level at least since March 2010.

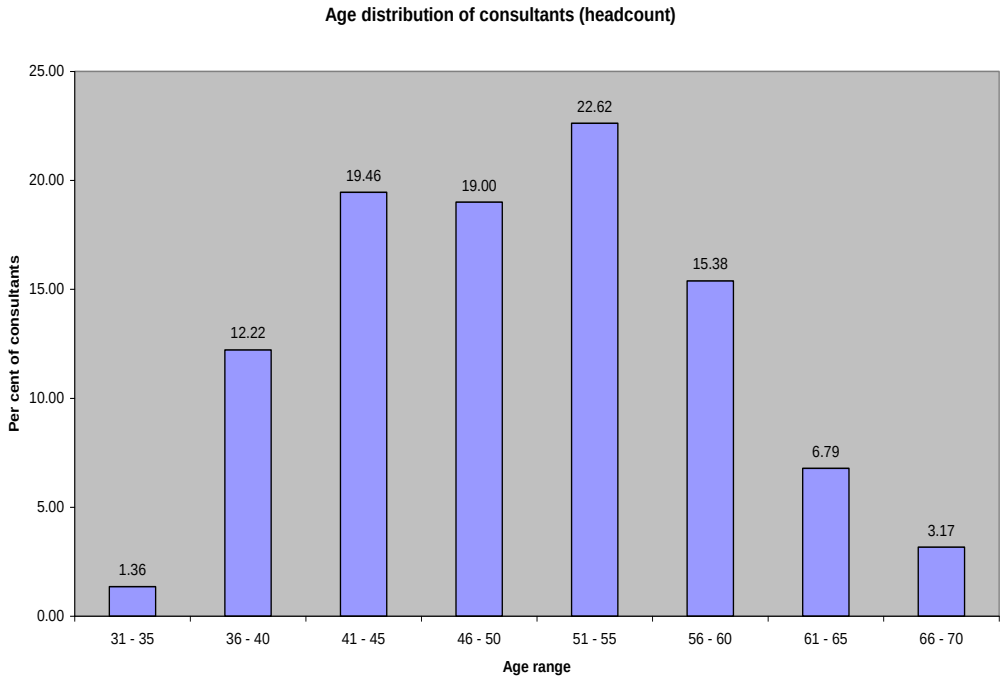
69. The Health Board monitors its medical vacancies weekly and is actively trying to fill vacant posts. Hot spots remain, for example, the Health Board has struggled to recruit histopathologists.

70. The Health Board attributes some recruitment difficulties to being a rural area and being distant from many teaching and research centres, and consequently it faces special difficulties in recruiting new consultants.

71. There are potential solutions to this problem and we found an example of where one service in the Health Board was using the consultant contract arrangements to improve recruitment. Mental health is concentrating on improving trainees' experiences and adapting job plans to attract new consultants.

72. Of particular concern at the Health Board is the age profile of the consultant workforce. Forty-eight per cent of consultants are over 50 years old and many will be nearing retirement in the next few years (Exhibit 1). The Health Board recognises the need for a succession plan to sustain services.

Exhibit 1: Age profile of the consultant workforce



Source: Hywel Dda Health Board

The new medical leadership arrangements are now in place but are not yet mature in several areas

73. The Health Board only confirmed its new medical leadership structure in August 2010. This follows the Health Board's county structure. The medical leadership structure comprises two Medical Directors with supporting Associate Medical Directors and Clinical Directors. There are seven Clinical Programme Directors with cross-cutting portfolios. The three Hospital Directors of Clinical Care and Clinical Director of Diagnostic Services are responsible for most consultants in the Health Board. Mental health services are organised separately.

74. Consultants are organised into teams headed by team leaders. The Health Board advertised all these leadership posts with job descriptions. Although many team leaders were generally slotted into roles without competition. Some team leaders at BGH were concerned about the absence of job descriptions and consequently what was expected from them.

75. Changes in structure have disrupted regular meetings such as directorate and specialty meetings and the new forums, the clinical programme boards and specialty teams have not yet bedded down. Some consultants remain unclear about how the new structures and networks operate. They are unsure of meeting structures where consultants and managers in their own specialty can discuss local service issues. In the absence of these meetings, it will take some time for managers and consultants to establish strong and effective working relationships.

76. There are examples of where the new meeting structures have achieved positive change through breaking through traditional silos. For example, mental health cover at night has traditionally been difficult and through the new unscheduled care network, mental health practitioners now provide cover through hospital at night.

77. The reorganisations have left some consultants feeling disconnected from the executive which is not unique to this Health Board. Relationships between radiologists and the Health Board for example are strained because radiologists do not feel the Health Board recognises their workload.

78. The Health Board has recognised this perception and in WGH senior managers have met every consultant to discuss topics such as the job plan, service responsibilities, concerns and ambitions, and medical team management structures. This is a positive and proactive approach to supporting consultants through the latest organisational changes and needs to be adopted across the whole Health Board.

The absence of a clinical service strategy is acting as a barrier to more effective job planning in the short term

79. Consultants see the absence of clinical service strategy as a barrier to service modernisation. In some quarters there is an appetite to revise job plans to reflect new service models. However, without a clinical service strategy the future shape of services is unclear, which makes it more difficult to discuss these issues in the job plan review meetings and an opportunity to engage with consultants is being lost.

80. We understand the ‘think tanks’ will inform the clinical service strategy but the earliest this will be in place is mid 2011. Meanwhile, this round of job plan reviews is likely to map existing arrangements rather than drive change or make a major contribution to savings plans.

81. The Medical Director accepts the absence of a service strategy limits the ability to change job plans.

82. We did find clinical managers at WGH plan to use the next round of job plan reviews to focus on productivity and flexibility in advance of the service strategy. This is a good use of job planning in the absence of the strategy.

For many consultants the working environment has improved following the introduction of the consultant contract

The average number of sessions has reduced closer to 10 over the last three years

83. The number of sessions individual consultants were contracted to work reduced when the consultant contract was introduced and consultant numbers expanded. Exhibit 2 shows the number of sessions has steadily fallen over the last couple of years. This means consultants are contracted to work fewer hours.

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

	DCC	SPA	Other	Management	Total
2009-10					
Hywel Dda Health Board	8.49	2.37	0.01	0.00	10.87
Wales average	*8.34*	*2.60*	*0.14*	*0.13*	*11.21*
2008-09					
Hywel Dda Health Board	8.56	2.31	0.04	0.05	10.96
Wales average	*8.36*	*2.57*	*0.22*	*0.14*	*11.29*
2007-08					
Carmarthenshire NHS Trust	8.93	2.16	0.05	0	11.15
Ceredigion NHS Trust	9.43	2.12	0.03	0.33	11.91
Pembrokeshire and Derwen NHS Trust	7.9	2.5	0.03	0.28	10.71
Wales average	*8.45*	*2.61*	*0.26*	*0.14*	*11.46*

Source: Hywel Dda Health Board and Assembly Government

84. On average, consultants at the Health Board have 10.89 session contracts compared with 11.21 across Wales (see Exhibit 3). A 10-session contract generally equates to a 37.5 hour working week and about half of consultants at the Health Board still have 10 (or fewer) session job plans. Many of these consultants report they work over their contracted hours but consider this is reasonable. They are also content to work an extra session when needed.

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

Health Board/Trust	DCC	SPA	Other	Management	Total
Abertawe Bro Morgannwg	8.49	2.41	0.26	0.04	11.20
Aneurin Bevan	8.20	2.83	0.01	0.22	11.26
Betsi Cadwaladr Central and East	8.48	2.72	0.08	0.16	11.44
Betsi Cadwaladr West	8.65	2.28	0.37	0.09	11.38
Cardiff and Vale	8.23	2.84	0.15	0.13	11.34
Cwm Taf	8.26	2.32	0.15	0.14	10.87
Hywel Dda	**8.49**	**2.37**	**0.01**	**0.00**	**10.87**
Public Health Wales	7.65	2.86	0.03	0.00	10.55
Powys	7.87	1.67	1.26	0.36	11.16
Velindre	7.84	2.85	0.00	1.15	11.84
Wales Average	**8.34**	**2.60**	**0.14**	**0.13**	**11.21**

Source: Hywel Dda Health Board and Assembly Government

There is no action plan to reduce the excessive workload of some consultants

85. Published data shows 46 consultants still have contracts of 12 or more sessions and although no concerns have been raised the Health Board needs to establish an action plan to reduce excessive workloads. Thirty five per cent think their job plan accurately reflects their working hours and commitments. These are disappointing results, given this was one of the aims of the consultant contract.

86. Some specialties including obstetrics and gynaecology and paediatrics consider job plans are inequitable with what can be seen as differing job plans for the same or similar workloads. Exhibit 4 summarises the job plan outcomes for this specialty by each consultant.

Exhibit 4: Obstetrics and gynaecology job plan outcomes 2010

Consultant	Total DCC sessions	Total SPA sessions	Total overall sessions
1	8.0	3.0	11.0
2	8.0	3.0	11.0
3	8.0	3.0	11.0
4	9.0	3.0	12.0
5	9.0	3.0	12.0
6	10.3	1.2	11.5
7	9.2	2.4	11.6
8	10.3	2.1	12.5
9	11.0	2.0	13.0
10	8.0	2.0	10.0
11	10.0	2.0	12.0
12	7.0	3.0	10.0

Source: Hywel Dda Health Board and Assembly Government

87. As well as improving consultants' work/life balance, the employer was expected to make ongoing improvements to ensure consultants have good facilities. Consultants recognise that secretarial support and office space are under pressure particularly when consultant numbers are expanded. Most feel they have adequate resources with their own office and IT equipment.

88. Some consultants do share resources, for example anaesthetists at BGH share a common room and bank of computers which most feel is acceptable.

Session benchmarking

Health Board specialty analysis 2009-10

Specialty	DCC	SPA	Other	Management	Total
Hywel Dda					
Accident & Emergency	8.24	2.47	0.00	0.00	10.71
Anaesthetics	9.51	2.23	0.00	0.00	11.74
Audiological Medicine	8.33	1.67	0.00	0.00	10.00
Cardiology	7.65	2.80	0.00	0.00	10.45
Chemical Pathology	10.80	1.33	0.00	0.00	12.13
Child & Adolescent Psychiatry	7.00	3.00	0.00	0.00	10.00
Clinical Oncology	10.00	1.87	0.00	0.00	11.87
Dermatology	7.00	3.00	0.00	0.00	10.00
Endocrinology	7.03	3.00	0.00	0.00	10.03
ENT	8.62	1.38	0.00	0.00	10.00
Gastroenterology	7.96	2.59	0.00	0.00	10.55
General Medicine	7.87	2.45	0.13	0.13	10.58
General Surgery	9.33	2.05	0.00	0.00	11.38
Genito Urinary Medicine	7.47	2.62	0.00	0.00	10.09
Geriatric Medicine	8.10	2.78	0.17	0.00	11.05
Gynaecology	8.99	2.48	0.00	0.00	11.47
Haematology (Clinical)	9.09	2.58	0.00	0.00	11.67
Histopathology	9.54	1.87	0.00	0.00	11.41
Medical Microbiology	9.60	3.00	0.00	0.00	12.60
Medical Oncology	7.00	3.00	0.00	0.00	10.00
Mental Handicap	7.78	2.59	0.37	0.00	10.74
Mental Illness	8.57	1.98	0.00	0.00	10.55
Occupational Medicine	7.50	2.50	0.00	0.00	10.00
Old Age Psychiatry	7.17	2.83	0.00	0.00	10.00
Ophthalmology	8.07	2.30	0.00	0.00	10.37
Orthodontics	9.20	1.20	0.00	0.00	10.40
Paediatrics	7.37	2.71	0.00	0.00	10.08
Palliative Medicine	6.73	3.29	0.00	0.00	10.02
Psychotherapy	8.75	1.88	0.00	0.00	10.63
Radiology	8.88	2.11	0.00	0.00	10.99

Specialty	DCC	SPA	Other	Management	Total
Rehabilitation	10.00	2.00	0.00	0.00	12.00
Rheumatology	6.67	3.33	0.00	0.00	10.00
Thoracic Medicine	6.52	3.78	0.00	0.00	10.30
Trauma & Orthopaedic	8.17	2.25	0.00	0.00	10.42
Urology	8.64	1.97	0.00	0.00	10.61
LHB average	**8.49**	**2.37**	**0.01**	**0.00**	**10.89**

Welsh averages

Specialty	DCC	SPA	Other	Management	Total
Accident & Emergency	8.07	2.58	0.18	0.12	10.95
Anaesthetics	8.27	2.64	0.04	0.08	11.03
Audiological Medicine	7.62	2.69	0.00	0.00	10.31
Cardiology	8.79	2.58	0.06	0.15	11.58
Cardiothoracic Surgery	9.76	2.70	0.00	0.00	12.46
Cellular Pathology	8.86	2.86	0.00	0.00	11.71
Chemical Pathology	7.91	2.89	0.02	0.27	11.08
Child & Adolescent Psychiatry	7.94	2.47	0.24	0.14	10.80
Clinical Biochemist	9.00	3.00	0.00	0.00	12.00
Clinical Genetics	7.75	3.33	0.31	0.10	11.48
Clinical Immunology & Allergy	9.00	3.00	0.00	0.00	12.00
Clinical Neuro-physiology	7.00	3.00	0.00	0.00	10.00
Clinical Oncology	8.16	2.61	0.13	0.90	11.81
Clinical Pharmacology & Therapeutics	9.33	3.33	0.69	0.38	13.74
Community Medicine	7.08	2.69	0.00	0.38	10.15
Dental Medicine Specialties	7.82	2.97	0.00	0.18	10.96
Dermatology	7.62	2.66	0.09	0.13	10.49
Endocrinology	7.50	2.62	0.39	0.12	10.63
ENT	8.78	2.55	0.17	0.05	11.55
Forensic Psychiatry	7.95	2.75	0.24	0.55	11.49
Gastroenterology	8.10	2.57	0.16	0.05	10.87
General Medicine	8.35	2.61	0.05	0.11	11.12
General Surgery	9.38	2.29	0.19	0.14	12.00
Genito Urinary Medicine	7.70	2.69	0.27	0.00	10.66
Geriatric Medicine	8.48	2.72	0.19	0.09	11.47
GP Other	7.00	3.00	0.00	0.00	10.00
Gynaecology	8.47	2.56	0.13	0.10	11.27
Haematology (Clinical)	8.61	2.45	0.31	0.11	11.48

Specialty	DCC	SPA	Other	Management	Total
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
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

	Survey question	Response	Hywel Dda HB %	Wales %	Hywel Dda HB Number
1	Total number of responses for the HB		…	….	41
4	Percentage of consultants received adequate notice of the date of their last job plan review meeting	Yes	75.7%	87.7%	28
5	Percentage of consultants that had access to information from local clinical/management information systems to support discussions about their existing work	Yes	48.6%	53.1%	18
6	Percentage of consultants that use each of the following categories of information to help prepare for their job plan review meetings:	Health Board or Trust information	0.0%	25.5%	0
		Your own information	87.8%	67.0%	36
		None	7.3%	5.6%	3
		Other*	17.1%	8.3%	7
7a	Percentage of consultants that prior to the job planning meeting were able to consider last year's work	Yes	91.4%	89.8%	32
7b	Percentage of consultants that prior to the job planning meeting were able to consider their current pattern of work and activities	Yes	97.2%	95.9%	35
7c	Percentage of consultants that prior to the job planning meeting were able to consider pressures and constraints that were causing them difficulties	Yes	77.1%	88.2%	27
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	75.0%	84.8%	24

	Survey question	Response	Hywel Dda HB %	Wales %	Hywel Dda HB Number
7e	**Percentage of consultants that prior to the job planning meeting were able to consider the impact of internal and external initiatives (eg, NHS reform, changes in health needs of the community and junior doctor training requirements)**	**Yes**	52.9%	68.6%	18
7f	**Percentage of consultants that prior to the job planning meeting were able to consider any ideas they had for improving the service**	**Yes**	69.4%	79.8%	25
7g	**Percentage of consultants that prior to the job planning meeting were able to consider their own personal development plan from their appraisal**	**Yes**	68.6%	81.2%	24
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)**	39.5%	44.1%	15
9	**Percentage of consultants where the NHS is their primary employer**	**Yes**	100.0%	93.7%	41
10	**Percentage of consultants that hold an academic contract**	**Yes**	2.4%	11.4%	1
11	**Percentage of consultants holding an academic contract, where the University was involved in the process to agree a single overall job plan**	**Yes**	0.0%	20.3%	0
12	**Percentage of consultants that have their job plan reviewed annually**	**Yes**	32.5%	61.9%	13
13	**Percentage of consultants whose last job plan review was:**	**Within the last 3 months**	7.3%	14.8%	3
		Between 3mths and 6mths ago	0.0%	14.4%	0
		Between 6mths and 12mths ago	22.0%	26.5%	9
		Between 12mths and 18mths ago	22.0%	17.1%	9

	Survey question	Response	Hywel Dda HB %	Wales %	Hywel Dda HB Number
		More than 18mths ago	41.5%	19.0%	17
		I've never had a job plan review	7.3%	8.1%	3
14	**Percentage of consultants whose last job plan review lasted:**	**Less than one hour**	71.1%	61.1%	27
		One to two hours	26.3%	35.2%	10
		More than two hours	2.6%	3.7%	1
15	**Percentage of consultants that said that their last job plan review was**	**About right?**	67.6%	78.5%	25
16	**Percentage of consultants that said that the right managers involved in the job plan review**	**Yes**	78.9%	87.3%	30
17	**Percentage of consultants whose last job plan review was undertaken as part of a team**	**Yes**	17.1%	17.4%	6
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**	44.4%	53.4%	4
19a	**Percentage of consultants that felt their job plan review was conducted in a constructive and positive tone**	**Yes**	83.8%	84.9%	31
19b	**Percentage of consultants that felt their job plan review was conducted was held in an appropriate location**	**Yes**	91.7%	93.7%	33
19c	**Percentage of consultants that felt their job plan review was conducted helped to prioritise work better and reduce an excessive workload**	**Yes**	22.9%	36.1%	8
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**	30.6%	46.7%	11

	Survey question	Response	Hywel Dda HB %	Wales %	Hywel Dda HB Number
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**	35.3%	47.4%	12
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**	45.9%	61.9%	17
19g	**Percentage of consultants that felt their job plan review identified issues relevant to other staff groups, clinical teams or service providers**	**Yes**	47.1%	53.1%	16
19h	**Percentage of consultants that felt their job plan review helped in delivering their personal development plan from their appraisal**	**Yes**	37.1%	54.1%	13
20	**Percentage of consultants that said a set of outcome indicators been agreed for their job plan**	**Yes**	14.3%	34.3%	5
21	**Percentage of consultants that felt they have confidence with the accuracy of the outcome indicator information**	**Yes**	27.3%	26.9%	6
22	**Percentage of consultants that felt that the outcomes indicators used are appropriate and provide a true reflection of the work**	**Yes**	14.3%	23.9%	3
23	**Percentage of consultants that were involved in any discussion about the type and relevance of the indicators**	**Yes**	15.0%	31.6%	3
24	**Percentage that take part in the CHKS Compass Clinical Outcomes Indicator (COI) programme?**	**Yes**	82.4%	76.2%	28
25	**Percentage that have confidence in the accuracy of the CHKS Compass COI reports?**	**Yes**	14.3%	8.4%	5

	Survey question	Response	Hywel Dda HB %	Wales %	Hywel Dda HB Number
26	**Percentage of consultants that felt their job plan:**		**Answered yes**	**Answered yes**	**Answered yes**
		Clarifies the commitments expected of them	53.7%	65.4%	22
		Clearly schedules their commitments	43.9%	60.3%	18
		Helps to tackle excessive workloads	9.8%	18.5%	4
		Identifies the resources and support needed to deliver their job plan	7.3%	19.4%	3
		Provides an appropriate balance between the sessions Direct Clinical Care (DCC) and Supporting Professional Activity (SPA) commitments	34.1%	55.1%	14
		Clearly identifies the outcomes from their SPAs	9.8%	26.9%	4
		Allows them to work more flexibly, for example, by varying the clinical commitment, allowing for part-time, term-time working, and 'chunking' time	14.6%	24.8%	6
27	**Percentage of consultants that in overall terms have found job planning to be:**	**Either useful or very useful**	27.0%	37.1%	10

	Survey question	Response	Hywel Dda HB %	Wales %	Hywel Dda HB Number
28a	**Percentage of consultants that felt following the introduction of the new contract in 2003, the time they spend on clinical care has increased**	**Either strongly agree or agree**	50.0%	53.4%	19
28b	**Percentage that felt following the introduction of the new contract in 2003, that patient care has improved**	**Either strongly agree or agree**	31.6%	27.2%	12
28c	**Percentage that felt following the introduction of the new contract in 2003, that they now have clear personal objectives linked to service improvements**	**Either strongly agree or agree**	27.0%	25.9%	10
28d	**Percentage that felt following the introduction of the new contract in 2003, that the Health Board/Trust is better able to plan clinical activity**	**Either strongly agree or agree**	10.5%	23.5%	4
28e	**Percentage that felt following the introduction of the new contract in 2003, that their work is better planned**	**Either strongly agree or agree**	23.7%	32.6%	9
28f	**Percentage that felt following the introduction of the new contract in 2003, that their working week is more transparent**	**Either strongly agree or agree**	47.4%	55.4%	18
28g	**Percentage that felt following the introduction of the new contract in 2003, that they are able to work more flexibly**	**Either strongly agree or agree**	25.0%	27.0%	9
28h	**Percentage that felt following the introduction of the new contract in 2003, that team working has improved in their speciality**	**Either strongly agree or agree**	33.3%	29.4%	12
28i	**Percentage that felt following the introduction of the new contract in 2003, that the Health Board/Trust is able to measure their performance and contribution to service delivery**	**Either strongly agree or agree**	13.9%	24.9%	5
28j	**Percentage that felt following the introduction of the new contract in 2003, that their job plan now reflects the specific demands of their specialty**	**Either strongly agree or agree**	24.3%	41.7%	9

	Survey question	Response	Hywel Dda HB %	Wales %	Hywel Dda HB Number
28k	**Percentage that felt following the introduction of the new contract in 2003, that their job plan accurately reflects their working hours and commitments**	**Either strongly agree or agree**	33.3%	40.9%	12
28l	**Percentage that felt following the introduction of the new contract in 2003, that the support and resources identified in their job plan to help deliver their objectives have been provided**	**Either strongly agree or agree**	18.9%	14.8%	7
28m	**Percentage that felt following the introduction of the new contract in 2003, that their emergency workload is more fairly recognised**	**Either strongly agree or agree**	32.4%	32.5%	12
28n	**Percentage that felt following the introduction of the new contract in 2003, that they have been able reduce their working hours**	**Either strongly agree or agree**	10.8%	13.8%	4
28o	**Percentage that felt following the introduction of the new contract in 2003, that they are able to take most or all of their annual leave**	**Either strongly agree or agree**	73.0%	75.9%	27
28p	**Percentage that felt following the introduction of the new contract in 2003, that their SPA commitments are fairly recognised**	**Either strongly agree or agree**	41.7%	27.2%	15
28q	**Percentage that felt following the introduction of the new contract in 2003, that their SPA outcomes are clearly identified**	**Either strongly agree or agree**	19.4%	27.2%	7
28r	**Percentage that felt following the introduction of the new contract in 2003, that the relationship between clinicians and managers has improved**	**Either strongly agree or agree**	27.0%	17.5%	10
28s	**Percentage that felt following the introduction of the new contract in 2003, that they have a positive relationship with management**	**Either strongly agree or agree**	40.5%	55.6%	15

	Survey question	Response	Hywel Dda HB %	Wales %	Hywel Dda HB Number
28t	**Percentage that felt following the introduction of the new contract in 2003, that the working environment has improved for the better**	**Either strongly agree or agree**	18.4%	16.5%	7
28u	**Percentage that felt following the introduction of the new contract in 2003, that medical workforce planning has improved**	**Either strongly agree or agree**	5.3%	13.4%	2
28v	**Percentage that felt following the introduction of the new contract in 2003, that some of work they do now can be done by other staff groups or more junior doctors**	**Either strongly agree or agree**	36.8%	32.3%	14
28w	**Percentage that felt following the introduction of the new contract in 2003, that their salary better reflects their workload**	**Either strongly agree or agree**	18.9%	31.5%	7
28x	**Percentage that felt following the introduction of the new contract in 2003, that the balance between their NHS commitments and other commitments is clear**	**Either strongly agree or agree**	36.4%	43.5%	12
28y	**Percentage that felt following the introduction of the new contract in 2003, that the Contract has changed the way they work for the better**	**Either strongly agree or agree**	16.2%	20.4%	6

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