

Assessing the New NHS Consultant Contract

A SOMETHING FOR SOMETHING DEAL?

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A something for something deal?

Sally Williams
James Buchan

King's **Fund**

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First published 2006 by the King's Fund

Charity registration number: 207401

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ISBN-10: 1 85717 547 6

ISBN-13: 978 1 85717 547 9

A catalogue record for this publication is available from the British Library.

Available from:

King's Fund
11–13 Cavendish Square
London W1G 0AN
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www.kingsfund.org.uk/publications

Edited by Final Draft Consultancy Ltd
Typeset by Andrew Haig & Associates
Printed in the UK by the King's Fund

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Acknowledgements

Sincere gratitude goes to all those who generously gave up their time to reflect on the new arrangements. Particular thanks are due to the senior managers at the five London trusts that participated in the project, and to key national informants.

Glossary

Agenda for Change

Agenda for Change is a system of pay, terms and conditions for the NHS put in place in 2004. Applying to all directly employed staff, except very senior managers and those covered by the Review Body on Doctors' and Dentists' Remuneration, the new arrangements cover more than 1 million workers and represent the biggest ever overhaul of NHS pay, terms and conditions.

Clinical Excellence Awards

Clinical Excellence Awards are given to recognise and reward the exceptional contribution of NHS consultants, over and above that normally expected in a job, to the values and goals of the NHS and to patient care. The Clinical Excellence Awards Scheme comprises both local and national elements and replaces the discretionary points and distinction awards.

Consultant Contract Implementation Team

The Consultant Contract Implementation Team was set up by the NHS Modernisation Agency to support trusts with implementation of the new contract. In April 2005, the team was split in two: some staff moved to NHS Employers and were tasked with maintaining, amending and refining the 2003 contract. A Consultant Contract Benefits Realisation Team was created and given a year's funding to support trusts in deriving benefits from the contract.

General Medical Services contract

In 2003, GPs accepted a new General Medical Services contract. The terms of this contract mean that payments to GPs are more closely related to the quantity and quality of the services they provide.

Payment by Results

Payment by Results is a new funding system for care provided to NHS patients, which pays health care providers on the basis of the work they do adjusted for case-mix. It does this by paying a nationally set price or tariff for similar groups of patients, known as health care resource groups (HRGs), based on the historic national average cost of providing services to those HRGs. The fixed tariffs for specified HRGs are set by the Department of Health and are intended to avoid price differentials across providers that could otherwise distort patient choice. Payment is on a per spell basis, where a spell is defined as a continuous period of time spent as a patient within a trust, and may include more than one episode.

Programmed activities (PAs)

The new consultant contract organises a consultant's working week into programmed activities (PAs). The basic contract for a full-time consultant is ten four-hour PAs per week. There are four types of PAs: direct clinical care, supporting professional activities, additional NHS activities, and external duties (for more details, see *The new deal*, pp 7–8). Trusts can contract separately for additional PAs where a consultant has regular, additional duties that cannot be contained within a standard ten PA contract.

Supporting professional activities (SPAs)

Supporting professional activities (SPAs) are a type of programmed activity. SPAs include training, continuing professional development, teaching, audit, job planning and appraisal. Typically, one-quarter of a consultant's working week will be given to SPAs.

Review Body on Doctors' and Dentists' Remuneration

The role of the Review Body on Doctors' and Dentists' Remuneration (also referred to as the Review Body) is to make recommendations to the Prime Minister, the Secretary of State for Health, the Secretary of State for Scotland and the Secretary of State for Wales on the remuneration of doctors and dentists taking any part in the NHS. The Review Body must give regard to: the need to recruit, retain and motivate doctors and dentists; the effects of regional/local variations in labour markets on recruitment and retention; the UK health departments' output targets for the delivery of services and the funds available; the government's inflation target; and evidence submitted by the government, staff, professional representatives and others.

Summary

The programme of NHS workforce reform and pay modernisation includes a new contract for general practitioners (GPs), a new pay system for nurses and other NHS staff (through Agenda for Change) and a new contract for NHS hospital consultants. These reforms are designed not just to pay staff more, but to secure changes in working patterns and productivity that translate into benefits for patients – what has been termed ‘benefits realisation’.

This paper provides an independent assessment of the impact of the new (2003) consultant contract in England (for details of arrangements in other parts of the UK see Annexe 1). Its findings are based on information provided by key national level informants and case study analysis of the experiences of five acute NHS trusts in London.

The paper reports that implementation of the new contract has not been straightforward for two main reasons. First, the scale of the task was underestimated. Second, the contract was complex to implement and national level guidance was absent, unclear or delayed. This has had repercussions for how the contract has been implemented locally. There has been considerable variation in approach and outcome between and within trusts. Job planning for consultants has been process-driven, with cost pressures driving negotiations in some trusts. As a consequence, many job plans are not a true reflection of workload. The link between job planning and appraisal of consultants is also often blurred or unclear, compounded by the fact that objective setting has so far often been weak.

More than two years on, the new consultant contract has had an impact, but there is little reported evidence, as yet, that it has led to any widespread changes in consultant working patterns or influence on patient care, as originally envisaged. There has been a tendency by managers in some trusts to regard the contract as a compliance issue – a box to be ticked – rather than a mechanism for change.

Positive impact

The most positive contribution has been in terms of providing for greater transparency around consultant work through the use of job planning. The contract has also introduced some new levers for management control (particularly the ability to defer pay progression), although these have not as yet been used in any significant or measurable way. Some slack has been removed from the system in relation to external activities by individual consultants that held little direct value for the health service, and greater attention is now being paid to assessing the outcomes of activities such as research, audit and teaching.

Negative impact

Consultant earnings have increased significantly, but the cost of implementation has been greater than anticipated or budgeted. This is because the funding formula was based on flawed financial and workload assumptions. Full implementation of the contract has therefore contributed to the deficits faced by some trusts.

Unintended consequences

Some unintended consequences are emerging in relation to ‘professionalism’ of consultants and incentives towards patterns of retirement. Implementation of the contract appears to have had little significant direct impact on patterns of consultant private practice, in London at least, which is ironic given its dominance in the original contract negotiations.

Outlook

There is little sign as yet that the patient care benefits envisaged are being realised, and some concern that not all the building blocks required to facilitate benefits realisation are in place. There is considerable uncertainty at trust level over benefits realisation. The time-based nature of the contract diverts the attention of both management and consultants away from the needs of the service. The potential to achieve benefits realisation has also been undermined by an inadequate national framework for monitoring and oversight. Consequently, national strategy has not translated into benefits realisation at a local level.

A lack of strategic planning by some trusts in relation to the contract has made it difficult for clinical directors – the linchpin to the new arrangements – to use the contract to best effect. Medical management capacity and competency issues, the level of support at an executive board level and access to information to support job planning have heavily influenced local experiences.

Full and effective implementation of the contract is constrained by the absence of levers to encourage performance and address the wide variations in activity that exist among consultants. The changing health care environment, particularly the advancement of independent sector treatment centres (ISTCs) and Payment by Results, is likely to increase pressure for incentives to drive consultant performance. Unless the contract can adapt to these and other external pressures it is unlikely to be sustainable in its current form in the longer term.

Recommendations

The report makes the following recommendations, which have implications at national and operational levels.

- The Department of Health and NHS Employers must provide a consistent and clear national steer on how the contract is expected to deliver improvements for health services and patients. Nationally, specific measurable outcomes should be developed.
- Clearer national guidance is needed on the interplay between appraisal and job planning, and the responsibilities of the parties involved, to help trusts develop service objectives that are both challenging and achievable.
- NHS Employers and the Department of Health should give consideration to how managers can best be equipped with incentives for consultants to work ‘smarter’. Tying

pay progression to objective setting alone is unlikely to deliver the productivity required of a modern consultant-led service. Stronger linkages of pay to performance and clearer incentives for consultants to respond to local priorities are needed.

- Trusts need to develop detailed strategic plans for benefits realisation, which includes linking job plans with strategic goals such as reducing waiting times and emergency bed days used.
- Clinical management needs to be strengthened, including a clearer career path, sound support structures and greater collaborative working between clinical and non-clinical managers.

The report's findings offer lessons for the implementation of other pay reforms, including Agenda for Change and the new deal for staff and associate specialist grade doctors, as well as salaried dentists.

Introduction

No new pay system for NHS staff is developed in isolation. It has to build on, or replace, that which already exists. In order to understand the complex dynamics that have led to the new contract for NHS consultants, it is important to understand the drivers for change and the legacy of past pay negotiations.

The NHS in England and its 30,000 consultants (Department of Health 2005c) have long colluded in a relationship that has held benefits for both parties. The NHS has relied heavily on the goodwill of consultants, many of whom have worked hours well in excess of their contracts. In return, consultants have been able to operate with minimum accountability. Compared with many other NHS staff, they have been able to pursue other interests alongside their NHS commitments. This relationship has had its limitations. NHS employers were hampered by the lack of accountability, and consultants resented working excessive hours. Recent changes in NHS policy have increasingly exposed this arrangement as outmoded and unfit for purpose. Momentum built for changes in working practices, in return for ‘better’ rewards for those who made the biggest contribution to improving patient services (Department of Health 2002c).

Reforming the consultant contract

Dissatisfaction with the existing NHS consultant contract, largely untouched since 1948, had been evident for some time. The government acknowledged that the existing contract had not kept pace with medical advances or with changes in the NHS (Department of Health 1998).

Alongside a commitment to expand consultant numbers and introduce compulsory appraisal, *The NHS Plan* promised a consultant-delivered hospital service, underpinned by a new contract that would harness consultants’ commitment to the NHS (Department of Health 2000). Therefore, the new contract was to be a core building block of the new ‘modernised’ NHS. It was to be accompanied by a single, more graduated award scheme to replace the distinction awards and discretionary points schemes, which would reward those who did most for the NHS.

The old contract for consultants was based on a system of fixed commitments (for example, running clinics) and flexible sessions (such as ward rounds, research and time spent on call). There were three contractual options: whole-time, maximum part-time and part-time. Both whole-time and maximum part-time contracts required consultants to devote substantially the whole of their professional time to their duties in the NHS. The key difference between these two contracts was the amount consultants could earn from private practice. Consultants on the whole-time contract were limited by the 10 per cent rule (restricting their earnings from private practice to a tenth of their NHS salary), while

the maximum part-time contract allowed consultants to earn as much as they wanted from private work in return for giving up an eleventh of their NHS salary.

There was concern from a number of quarters that, in practice, the 10 per cent rule was not applied consistently, nor monitored by trusts (Health Committee 2000). Furthermore, inadequate use was made of job plans, which are designed to set out the specific details of a consultant's working arrangements with a trust. Consultants had been required to have job plans since 1991 (Department of Health 1990), yet studies found that significant numbers did not have one (Audit Commission 1996, 2002). Where job plans did exist, they were often incomplete or out of date (Audit Commission 1995, 1996).

NHS employers believed that the old contract did not allow for the proper management of consultants' time, work and performance (NHS Confederation 2002). They sought contractual arrangements that would 'enable NHS management to properly manage its staff, including doctors. Recent scandals and reports of failing clinical quality have made this imperative' (NHS Confederation 2001).

From the viewpoint of consultants the old contract provided for no limitation to the quantity of work expected of them and failed to recognise or reward their commitment to the NHS. Dissatisfaction with the balance between career and family life was also an issue (Dumelow *et al* 2000) and, for some, the contract cut to the heart of professionalism (Richards 1998).

Health economists focused on value-for-money aspects of the old contract. 'Why are politicians, managers and surgeons so reluctant to agree clear rules about a consultant's contractual responsibilities to an NHS which is funded out of taxpayers' money?', questioned Dr John Yates (1995a), for example. The need to better manage wide variations in consultants' performance was also highlighted (Maynard and Bloor 2001).

The government made no secret of its desire for a new contract that would strengthen the hand of NHS employers. In return for a phased career structure and pay system that would reward and provide incentives for those consultants who made the biggest contributions to the NHS, the intention was to have 'a stronger, unambiguous framework of contractual obligations, which will provide greater management control over when consultants work for the NHS' (Department of Health 2001, p 3).

Private practice

In 2002, the then Secretary of State for Health highlighted the 'vexed issue' of consultants' private practice (Milburn 2002a), which was a legacy of the 1948 settlement and was at the heart of concerns about the old contract. Misgivings about its potential to create perverse incentives had led the House of Commons Health Committee to call for a study into the influence of private practice on NHS waiting lists (House of Commons 1991). A decade on, the committee again recommended that the Department of Health look at ways 'in which the suspicion of perverse incentives can be removed from the system' (Health Committee 2000, para 56).

Evidence had also emerged from other sources. The Audit Commission reported that only just over half of consultants attended all their NHS commitments, and the quarter of

consultants who did the most private work did less NHS work than the rest (Audit Commission 1995). Specialties with the longest NHS waiting lists were reported to be the main, and most lucrative, areas of private practice (Yates 1995a). Attempts were made to assess the amount of time consultants spent in the private sector (*Health Which?* 1998; Yates 1995a). NHS employers did not appear to have an accurate overview of the extent of private sector activity by their consultants (Pay and Workforce Research 1999).

The government claimed that, while most consultants worked very hard for the NHS, a minority ‘do not properly co-operate in working productively for the health service and put their private practice before their NHS work’ (Department of Health 1998). *The NHS Plan* raised the possibility that newly appointed consultants should be prevented from engaging in similar work outside the NHS, ‘for perhaps the first seven years of their career’ (Department of Health 2000, p 79).

The focus on private practice set the tone for drawn-out negotiations on the new contract between the Department of Health and the British Medical Association (BMA). The proposal to ban private practice for new consultants was vehemently opposed by the consultant body. The underlying problem was that the old contract had never set clear boundaries around what was, and what was not, NHS time. The issue related to accountability, clarity and transparency over consultants’ commitment to the NHS, but this was submerged by ideological clashes over the legitimacy of private practice.

Striking a deal

The UK health departments (the Department of Health, Scottish Executive and National Assembly for Wales), the BMA, and employers’ representatives the NHS Confederation reached an agreement on a new contract in June 2002 (Department of Health 2002a). Alan Milburn, Secretary of State for Health during the initial negotiations, announced, ‘It is a something for something deal, where consultants can earn more, but only if they do more for NHS patients. And it will be for NHS employers to make sure that is what the contract delivers’ (Milburn 2002b).

NHS employers were told that the contract would increase productivity, with more face-to-face sessions with patients and an increase in the time consultants spend on direct clinical care. The 9-to-5 working week would go, and instead employers would be able to schedule consultants’ work, paid for at standard rates, between 8am and 10pm on weekdays, and 9am and 1pm at weekends (Milburn 2002a). These promises sparked fears among consultants of rising workloads and excessive management control over their working hours, pay and career progression (Westlake 2002, Smith S 2002, Gleeson 2002). A lack of arrangements for part-time and flexible working (BMA 2003b), anxiety about the contract’s potential to destroy family life (Smith R 2002) and a belief that professionalism would be undermined by the new deal (Best 2002) were also highlighted as concerns.

The BMA defended the deal it had negotiated, emphasising the pay rise and boost to pensionable salary, the time-limited nature of the contract and its recognition for the various aspects of a consultant’s work (Hawker 2002). Consultants in England and Wales were not convinced; they rejected the deal by two to one (consultants in Scotland and Northern Ireland voted to accept the new package) (BMA 2002).

The Department of Health was adamant that it would not renegotiate, but consultants rejected suggestions of local implementation and backed the BMA's push for further talks on a national contract (BMA 2004a). The main areas for resolution were the potential for management control in job planning and pay progression, recognition of evening and weekend work, the differential treatment of new and established consultants, the appeals mechanism, and the requirement to offer an extra programmed activity (PA) before undertaking private practice.

By the end of June 2003, GPs had voted in favour of their new contract. That same month, John Reid took over as Health Secretary and determined to resolve the dispute over the consultant contract. Agreement was reached on all the BMA's areas of concern, except in relation to the requirement to offer the NHS an additional PA per week before undertaking private practice. Concessions made by the Department of Health in order to achieve agreement included removing any obligation to carry out non-emergency evening and weekend work, reducing the length of an out-of-hours session from four hours to three, and dropping the proposal that newly appointed consultants offer two additional sessions before doing private practice while established consultants offer only one (Department of Health 2003a).

By the end of October 2003, six out of ten consultants in England had voted in favour of the new contract (BMA 2003c). Maynard and Bloor (2003, p 5) observed that, 'The 2003 consultant contract demonstrates that, temporarily at least, the demand for clinical autonomy... has triumphed. At the same time, the personal income of consultants has been substantially enhanced.'

An imposing array of benefits was ascribed to the new contract. For consultants, they included an increase in earnings and pensions, recognition of the various aspects of their NHS work (including on-call duties) and more flexible working patterns. For patients, there was the promise of better use of consultants' time and the provision of services that are more responsive to their needs. For the health service, the contract was intended to formalise and support the provision of services over an extended day, allow for flexible timetabling that could help meet service needs at different times of the year, spread work more evenly throughout the day, promote better use of resources through new ways of working and provide greater clarity over private practice (CCIT 2003).

This study

Against this backdrop of significant change and compromise to achieve a deal in 2003, this report examines three critical questions.

- What has been the experience locally of implementing the new contract, since 2003?
- What evidence exists that the contract is demonstrating benefits for consultants, the service and patients?
- How sustainable are the new arrangements and what challenges lie ahead?

Three methods have been used to gather information.

- **Literature review** This was undertaken by the researchers.
- **Information provided by key national informants** Face-to-face (and some telephone) discussions were conducted between September 2005 and February 2006 with 28 key informants, representing a wide range of stakeholders at national level, including

representatives of hospital consultants, health service employers, clinical academics, the Department of Health, the royal medical colleges and deaneries. Interviews were also conducted with the senior managers at the five London strategic health authorities (SHAs), and with NHS trust chief executives, human resources and medical directors across England and Wales.

- **Detailed case studies and qualitative analysis of data from London NHS trusts** The experiences of five acute NHS trusts in London were examined in depth, with case studies conducted between December 2005 and February 2006. A total of 27 senior staff were interviewed using discussion guides including, at each trust, the human resources director and medical director, and three senior medical managers (clinical directors and equivalent) covering medicine, surgery and either pathology or radiology. One trust was selected for each of the five SHA areas in London. A mixture of teaching and non-teaching trusts participated; they varied according to size and budget, star rating, the population served, the number of consultants employed and the proportion of clinical academics.

The consultant workforce in London exhibits particular characteristics. This includes, in some trusts, relatively high numbers of clinical academics, greater opportunities to engage in private practice and significant participation in external activities such as royal college work. As a consequence, the reported experiences of London trusts may not always reflect experiences outside the capital. However, information from national sources suggests that this report's main findings and recommendations have a resonance and relevance across England.

The report is divided into four sections. The first examines trusts' experiences of implementation. The second section highlights the main ways in which the contract has had an impact two years on. The third considers the future outlook in terms of benefits realisation, and the final section contains the recommendations.

Implementing the new NHS consultant contract

Nearly nine out of ten consultants in England had moved over to the new contract by May 2005 (BMA 2005b). Take-up of the contract at the beginning of 2006 in the London trusts included in this study was slightly lower than the national average at 82 per cent.

THE NEW DEAL

The new (2003) contract became the sole contract for all new consultant appointments in England from 31 October 2003. Existing consultants who indicated a commitment to transfer to the new contract between November 2003 and March 2004 were eligible for backdated pay increases. In addition to hospital consultants holding substantive posts, the contract covers locum consultants, dental consultants, consultant clinical academics, dental clinical academics and senior academic GPs (clinical academics specialising in primary care).

The contractual framework incorporates a new pay structure, including a higher starting salary and extra pay for those with the heaviest on-call duties. Salary increases are no longer automatic, although the majority are expected to progress. Pay progression is linked to a number of factors including satisfactory performance against an agreed job plan.

Mandatory job planning is the bedrock of the contract. A job plan is designed to be a prospective agreement that sets out a consultant's duties, responsibilities and objectives for the coming year. The aims are to enable consultants and employers to prioritise work better, agree how a consultant can most effectively support the objectives of the service and how the employer can support a consultant in this (Department of Health 2003b).

There is a new system for organising a consultant's working week. The basic contract for a full-time consultant is ten four-hour programmed activities (PAs) per week. PAs are separated into four types:

- direct clinical care, including emergency duties and on-call work, operating sessions, ward rounds and outpatient clinics
- supporting professional activities (SPAs), including training, continuing professional development, teaching, audit, job planning and appraisal
- additional NHS responsibilities, such as serving as a Caldicott guardian, clinical governance lead, postgraduate dean, clinical tutor, medical director, clinical director or lead clinician

- external duties, which may include trade union duties and certain work for the General Medical Council, as well as ‘reasonable quantities of work for the royal colleges in the interests of the wider NHS’ (Department of Health 2004b, p vi).

Trusts can contract separately for additional PAs where a consultant has regular, additional duties that cannot be contained within a standard ten PA contract. The NHS also has first call on a consultant’s time. In order to be eligible for pay progression, consultants must offer their trust one extra PA per week before undertaking paid clinical work outside of their NHS contract. The relationship between private practice and NHS work is clarified by *A Code of Conduct for Private Practice*. Adherence to this forms part of the eligibility criteria for a new scheme of Clinical Excellence Awards – which replaces the distinction awards and discretionary points schemes – and should be assessed at the annual job plan review (Department of Health 2004a).

Emergency work is divided into that which is predictable and should be scheduled into the working week as part of a consultant’s PAs, and unpredictable work done while on call (such as being called to the hospital to perform surgery). Work between 7am and 7pm Monday to Friday is paid for at standard rates; work outside of these hours and at weekends or public holidays is during premium time and split into PAs of three hours each. Consultants who participate in on-call rotas are eligible for an availability supplement based on the frequency of their rota commitment and whether or not they typically need to return to hospital immediately or perform complex interventions (category A) or can provide advice by phone (category B).

Problems with implementation

Implementation, however, has not been straightforward, for two main reasons. First, the scale of the task was underestimated, resulting in implementation being rushed. Second, the contract is complex, and management in some trusts has struggled with its implementation.

The scale of the task

Implementation has been a bigger and more time-consuming task than envisaged, and it was hindered from the start by unrealistic deadlines set by a political rather than organisational agenda. Consultants who gave a formal commitment to the new contract by 31 October 2003 were eligible to have pay increases backdated to April 2003, and those who gave a commitment between 31 October 2003 and 31 March 2004 had pay increases backdated by three months from the date they gave the commitment. In each case, backdating was conditional upon a job plan being agreed within three months, except where the deadline was missed for reasons outside of the consultant’s control. Almost eight out of ten consultants had indicated a desire to move to the new contract by January 2004, but by the end of that month there were no reports of any job plans having been signed off (BMA 2004a).

The Department of Health acknowledged that implementation was taking longer than anticipated (Hutton and Miller 2004). A team was set up, consisting of representatives of the British Medical Association (BMA) and the NHS Modernisation Agency’s Consultant

Contract Implementation Team (CCIT), to work with trusts to overcome local difficulties. The aim was to complete the job planning process in all but the most exceptional cases by the end of April 2004.

In early April 2004 there were indications that some trusts would not meet this deadline (*Hospital Doctor* 2004a). At the end of summer 2004, a number of trusts were still trying to agree initial job plans, by which time they should have been moving into the second round of job planning. At the beginning of 2005, there continued to be reports of consultants who wanted to transfer to the new contract but had not yet moved over (BMA and CCIT 2005). In autumn 2005, fieldwork for this report uncovered local accounts of initial job plans that were still to be agreed. Some trusts were preparing for the second round of job planning only in early 2006.

One key constraint on implementation has been local management capacity. Implementation costs in terms of management time have been considerable. The initial round of job planning placed a huge administrative burden on trusts at a time when they were gearing up for other pay modernisation initiatives (such as Agenda for Change). Managers in London trusts in late 2005 and early 2006 reported that implementation was extremely labour intensive. The lack of capacity in medical management has been a particular issue, as medical directors and clinical directors have led on job planning. 'For three months I did hardly anything else,' said one medical director, who had to cancel clinical work because of job planning.

A complex contract

Implementation was hampered by the complexity of the contract. 'It was a horrendous contract to put in place. The whole thing was very complex,' said one human resources director, interviewed in January 2006. Another remarked, 'Overall, I thought the contract was so complicated, it's almost made to trip up managers.'

One of the main sources of confusion with the new contract has been the distinction between the two on-call bands. Managers in one London trust acknowledged that they stalled implementation until they could see how other trusts dealt with this issue. The medical director said, 'We didn't want to jump first on the issue of A and B banding.' Senior trust staff perceived that there had been no consensus on on-call banding between the Department of Health and BMA, making it difficult to settle the issue locally. This has been especially problematic where consultants have been well organised nationally, led by their specialty associations, about their expectations in terms of which on-call band (A or B) they should be entitled to as a specialty.

Other areas of confusion have included costings, whether consultants can reasonably work an SPA from home and what constitutes a 'three-PA' day. Agreeing contracts for clinical academics, of which London has high numbers, has also been a source of complexity. Universities are reported as having implemented the contract more slowly and rigidly.

These complexities have not been helped by absent, delayed or unclear guidance from the centre. The contract terms and conditions came out in January 2004 – after implementation was to have begun. The Consultant Contract Implementation Team launched a job planning toolkit in January 2005 (NHS Modernisation Agency 2005b),

well after the first round of job planning should have been completed. ‘The toolkit was too late and too basic,’ said one human resources manager interviewed in December 2005. Disputes between the Consultant Contract Implementation Team and the BMA (2004b) over aspects of each other’s guidance undermined the value of the materials that existed.

Implications of contract implementation

There have been several consequences of the hurried implementation of a complex contract:

- there has been considerable variation in approach and outcome between trusts
- job planning has been process-driven
- many job plans are not a true reflection of workload
- job planning review has been variable
- overall, objective setting has been weak.

These are examined in more detail below.

Variation in approach and outcome

In the absence of clear national guidance over some issues, local comparisons and communication between trusts have been important. London trusts have relied heavily on local networks of human resources managers or medical directors, for example, to share experiences and resolve issues. This has informed decisions around implementation, but has not translated into uniformity. To the contrary, the approach to implementation has varied considerably between trusts, even within the same locale.

Variations reflect the interplay of a number of factors. These include the starting point for the trust (particularly if there was already a culture of job planning), the level of commitment of senior trust management, the capacity and competence of the clinical directors, local relations between management and the consultant body, and the profile of consultants within the trust. For example, one London trust has made use of annualised contracts as a tool for contracting with clinical academics. Another plans to make greater use of such contracts for certain groups of consultants, while a third has deliberately stayed away from these because of a reported tendency for consultants to double-count some activities. A fourth London trust is undertaking a single pilot, while a lack of information or capacity reportedly prevented their use at a fifth trust.

Such disparity can cause difficulties where consultants work for two trusts or share rotas. For example, consultants at the James Paget Healthcare NHS Trust in Suffolk were reportedly planning an appeal on on-call banding after being told they would be paid at B rates, while colleagues at the Norfolk and Norwich University Hospital NHS Trust, with whom they share on-call rotas, were on the A banding (*Hospital Doctor* 2005).

‘It’s very difficult if you don’t have consistency beyond trust boundaries,’ remarked one London-based senior medical manager in January 2006. Difficulties can arise where organisational change or a merger between trusts results in consultants who have been employed on more than a trust’s defined ceiling (12 PAs, for example) working alongside consultants with PAs set to different rules. Inconsistencies with neighbouring trusts, particularly in London where a number of hospitals are in close proximity to each other, can create discontent. For example, managers at one London trust reported that a decision

had been taken to classify a 7am to 7pm working day as constituting two PAs, while some other London trusts reported that this same level of commitment was recognised as a three-PA day.

The approach to implementation has also varied significantly within NHS trusts, between directorates, and even between departments within directorates. The profile of consultants is the main influence, with the number of clinical academics and the characteristics of the specialty being the key variables. For example, trusts are more likely to have used team job plans to cope with the complexities of the academic contract or for groups of consultants with particularly onerous on-call commitments. Team negotiations are more difficult where there is significant variation in the nature of jobs or age range of consultants, or where the department comprises a mix of consultants on the old and new contract, or where the team is simply not big enough. However, variations at directorate level can also reflect the capacity and capabilities of the senior medical manager, as well as the level of support and guidance they have received from human resources departments and medical directors.

Job planning

Under pressure to implement the contract, trusts were forced to rush through the initial job planning round before having fully considered what it was intended to achieve or how patient care could best benefit from it. As one human resources director put it, 'We were told to implement the contract in a matter of months. There wasn't time to sit back and think "What will we get out of it?".'

Job plans should reflect the level of activity that employers wish consultants to work prospectively, yet experience suggests that the first round of job planning has been largely a retrospective mapping exercise of how consultants were spending their time. 'Job planning is done on the basis of what people say they do,' said one senior medical manager. Prospective job planning was made more difficult in the first year by the arrangements for backdated pay, which were reported to have encouraged trusts to look backwards instead of focusing on the year ahead.

Often the initial round of job planning was kick-started by asking consultants to complete self-reporting diary cards, usually for about six weeks. However, diaries have been shown to be vulnerable to problems of double-counting and imaginative accounting, for example, where consultants count time spent teaching as a direct clinical care PA and also a teaching activity. 'Some would set out a wish list that wasn't realistic, but might represent what they did in their busiest week. Double-counting was a big problem,' reported one senior medical manager. Another observed, 'Diary cards are less useful than anticipated. No one but a lunatic would present a diary card that doesn't support their case.'

Cost has been a key determinant in terms of settling on the number of PAs and has deflected attention away from the clinical aspects of job planning. 'Our main objective was to keep within budget,' said the human resources director of one trust. Many trusts have set a ceiling at 12 PAs, or else this limit was imposed by the local strategic health authority. One London trust reportedly offered all its consultants the same blanket number of PAs, undermining the ethos of having a job plan tailored to the individual. A number of trusts have used benchmarking within a directorate and within departments to ensure parity of PAs among consultants doing broadly similar jobs, and to draw in outliers.

Peer pressure has been a key tool in terms of challenging consultants perceived to be claiming unrealistic numbers of PAs. However, grouping consultants into ‘herds’ – which has tended to happen in relation to on-call banding in particular – weakens the underpinning philosophy that job plan agreements should reflect an individual’s practice.

Relationship with workloads

Informants interviewed for this report generally believe that consultants’ pay is now better related to workload and more consultants are paid more appropriately for what they do compared with the old contract. However, managers at the five London trusts revealed that cost pressures have meant significant numbers of job plans do not accurately reflect real consultant workload. Therefore, a key principle of the new contract is being undermined in practice.

The degree to which job plans reflect workload varies between trusts. Only a minority of senior medical managers interviewed for this report maintained that job plans in their directorates presented a reasonably accurate picture. ‘This trust has committed to the key philosophy of the contract, which is that you get paid for what you do. We’ve tried to do things by the book,’ said one.

Other senior medical managers reported that significant numbers of consultants in their directorate were working beyond the hours agreed in their job plans, largely because the number of PAs in their job plans had been limited, yet their workload had remained unchanged. ‘Many consultants are working beyond their job plans – almost as many as were before,’ indicated one medical manager. Two senior medical managers at one London trust claim that their trust gets, on average, between one and two extra PAs per week from consultants. Some London consultants have a statement in their job plan that acknowledges they are working beyond their contract and are not paid for everything they do. There is evidence to support this; for example, the Royal College of Physicians (2005) reported that the average consultant physician works 14.9 PAs per week, yet the average contract for such consultants was for 11.1 PAs.

One trust reported that it had approached implementation of the contract knowing that consultants would end up doing more than they would be paid for. ‘We’ve been pretty rough on consultants, but the quid pro quo is that we’re flexible about how they pursue their other interests during the week, because we tend to benefit from it,’ explained the medical director. A deal was brokered with some consultants, with the aim that most accepted ten PAs or fewer, even though their diary may reflect 11 or 12 PAs. One senior medical manager said, ‘In return, I said I wouldn’t hound people about private practice and encourage them to do what private practice they do on site at the trust.’ He added, ‘The statement that the new contract would pay consultants for the work they do was fallacious.’

Three particular groups of consultants appear to be more likely to be working beyond their contracted hours. The first is clinical academics, who are a significant element of the consultant workforce in many London trusts. The second is clinical directors and their equivalent, many of whom feel that clinical management work isn’t sufficiently recognised under the new contract. The third group is consultants with a particularly onerous on-call commitment. Some trusts try to compensate by giving flexitime to consultants with a

workload in excess of their contract or paying for extra sessions on a temporary basis; some will be recognised through Clinical Excellence Awards, but most extra work is reportedly done on a goodwill basis.

‘Most consultants work more hours than they’re paid for; it’s about professionalism and commitment to the job,’ remarked one human resources director in January 2006. The challenge is in deciding what should and should not be paid for, which determines the extent to which there is a service gap. Unless trusts or universities are able to negotiate away the hours they are not prepared to pay for it is likely to breed resentment among those consultants working longer than they are contracted for. One trust said this was already happening, with clinical academics working way above the five PAs that they were contracted to do for the medical school.

Job planning reviews

The job plan review, which should take place annually, offers the opportunity to evaluate, and if necessary revise, consultant working patterns and workloads set against the needs of the service. However, aligning job planning with appraisal has not been straightforward.

National guidance indicates that job planning should be informed by, but separate from, appraisal. Appraisal should happen in advance of the job plan meeting, although confusingly the two processes can sometimes be carried out at the same time (NHS Modernisation Agency 2005c). The approach taken has varied enormously across and within London trusts, including undertaking appraisal first, doing job plan review first, always offering a separate appraisal and job plan review, tagging job planning on to the end of appraisal, and signing off the previous year’s job plan without any formal review at all. The second round of job planning at one trust, scheduled for autumn 2005, was so delayed that job plan reviews had to use the previous year’s personal development plans and some were still taking place as the annual appraisal round was beginning in January 2006. At another trust, one senior medical manager noted in February 2006 that he did not have the capacity to start the second round of job planning until he had completed appraisals at the end of March. ‘The mixing of job planning and appraisal is a mess,’ summed up another medical manager.

Ultimately, the ordering of job planning and appraisal should not matter as long as there is a robust mechanism for ensuring that information from one process feeds into the other (British Association of Medical Managers 2004). However, there are inherent weaknesses in the interplay between job planning and appraisal. Job planning is likely to be more robust and better informed when it is carried out by the same person who undertakes appraisal, but time constraints often make this impractical. It often falls to clinical directors and their equivalent to undertake job planning reviews. However, they tend not to appraise all the consultants in their directorate, instead delegating at least some appraisals to clinical leads. The formative and confidential nature of appraisal means that very limited information is shared outside of the appraisal meeting, with clinical directors receiving only the personal development plan.

The issue is not only one of information sharing. Some human resources and medical directors cast doubt on the capability of medical managers to handle the job planning and appraisal process, as well as questioning their appetite to challenge consultant

colleagues. All the senior medical managers interviewed for this study felt confident in their ability to challenge colleagues if support was available from the human resources function and the trust executive. But there was a perception that clinical leads may be less able to challenge.

Part of the problem is uncertainty over where performance assessment should rightly sit and trust expectations of appraisal as a tool for performance management. 'Appraisal is weak – a polite conversation you have with a colleague rather than a review of performance,' claimed one human resources director. Some advocate using job planning rather than appraisal as the mechanism for performance review (British Association of Medical Managers 2003). In practice, in the five trusts, non-clinical managers were more likely to look to appraisal to raise performance issues, while medical managers tended to be reluctant to use appraisal in this way.

Aligning job planning with the trust business planning process is also an issue. Trusts have limited ability to plan their activity levels. They know what activity is required of consultants only when they have signed contracts with commissioners. Job plans should reflect the level of activity that commissioners wish to commission. But Payment by Results and the choice initiatives will lead to some flexing during the year because of changing patient flows. This creates difficulties for job planning where, for example, surgeons have been told not to do any routine surgery for three months. One senior medical manager, interviewed in January 2006, explained that, 'The contract assumes the business of the NHS is planned and predictable, which of course it isn't. So we'll agree job plans in April in the knowledge that they can only be an overview and that things may change.'

Objective setting

Pressure to get the contract in place and the enormity of the first round of job planning have resulted in few trusts paying much attention to objective setting in the first year. Managers at the five London trusts acknowledged that objective setting had not yet happened in any robust or meaningful way. 'Last year was about getting the timetable done and getting what consultants do down on paper. This year the objective is to set objectives and get people used to the idea of them,' explained one senior medical manager. Selling the idea of objective setting was a recurring theme. One medical director highlighted the scale of the task ahead by saying that, 'There is still no culture of doctors accepting that the setting of corporate objectives is legitimate'.

Management at all the London trusts reported that they planned to give greater attention to objective setting during 2006 and specifically to link personal objectives – which tend to be self-determined and may not be congruent with a trust's objectives – with service ones. In this respect trusts are just beginning to enter phase two of implementation. 'Objectives were thrown together pretty hastily first time round. This year we want to make them more rigorous, so that next year we can properly assess them,' said another senior medical manager.

Where service objectives exist, they are sometimes too vague to measure an individual's achievement against, or to secure their buy-in. The environment for objective setting can be overwhelming, such as the broad generic aims one trust has developed for its consultants around service delivery, governance and personal development to provide a

framework for objective setting. The five core generic objectives adopted by one trust in the Midlands around infection control, clinical coding, outpatient utilisation and productivity, correspondence with GPs, and clinical governance and audit are likely to have a greater impact (personal communication).

In terms of clinical care, developing objectives as part of a team, such as reducing the ratio of follow-up patients to new patients in clinics, appears to hold the greatest potential. There is also evidence that team objectives, properly monitored, can result in productivity gains (Craig and Thomas 2001). Indeed, a greater emphasis on the clinical team and less on the individual should help to bring consultants closer to the needs and objectives of the organisations they work for.

Impact of the contract

More than two years on from reaching agreement on the new contract, what has been the impact of implementation so far? There have been considerable variations between, and sometimes within, trusts in terms of the impact of the contract. This section outlines the key findings of our research:

- consultant earnings have increased significantly
- the cost of implementation has been much greater than anticipated
- there is greater transparency around consultant work
- new management tools have yet to be fully utilised
- some slack has been removed from the system
- changes to working patterns have so far been limited
- the contract has had little impact on patterns of private practice
- unintended consequences are emerging.

These are examined in more detail below.

Consultant earnings

Increased earnings are widely perceived as being the main reason why most consultants have moved to the new contract. Estimates of the actual pay rise for individual consultants, and the actual paybill increase, vary depending on factors such as the start date used, the circumstances of the individual consultant, and what is (or is not) included in the estimate. One recent estimate provided by the UK health departments (Department of Health, Scottish Executive, National Assembly for Wales) reported that consultants on the new deal had seen their basic salary increase by almost 50 per cent between 2001 and 2005, including 17 per cent in 2003 (see Table 1 overleaf) (Department of Health, Scottish Executive, National Assembly for Wales 2005). This reflects the combined effect of switching to the new contract, the incremental rises and the Review Body on Doctors' and Dentists' Remuneration awards, and includes a three-year pay uplift of 3.225 per cent per year from 2003. In a separate study, with a different focus and methods, Audit Scotland (2006) reported that the paybill for consultants in the NHS in Scotland had increased by 38 per cent, or approximately 44 per cent when inflation and costs such as National Insurance contributions are included, over the first three years.

Overall, the departments' claim that the contract promises to deliver a 15 per cent average increase in a consultant's earnings over the lifetime of their work for the NHS, and a 24 per cent increase in the maximum basic salary (Department of Health, Scottish Executive, National Assembly for Wales 2005). Additionally, there is extra pay for those with the heaviest on-call duties, backpay for those who transferred to the new deal within the early months and annual payments for any additional weekly programmed activities (PAs) over the basic number of ten.

TABLE 1: IMPACT OF INCREMENTAL RISES ON PAY FOR CONSULTANTS (WITH TRANSFER TO NEW CONTRACT)

Year	Actual basic salary (£)	Annual percentage increase (of which Review Body headline award)	Cumulative percentage increase
2001 (minimum)	50,810		
2002 (point 1)	56,470	11.1 (3.6)	11.1
2003 (new contract)	66,065	17.0 (3.225)	30.0
2004	70,328	6.5 (3.225)	38.4
2005	75,899	7.9 (3.225)	49.4

Source: Department of Health, Scottish Executive, National Assembly for Wales (2005).

The actual increase in pay experienced by individual consultants has varied depending on their starting point and their pattern of working. There is no doubt that many consultants have seen a significant growth in earnings. A survey of over 400 consultants in 2004 by *Hospital Doctor* and Medix UK found that the reported average annual pay increase that year for those who had transferred to the new contract had been £12,454. The report highlighted that consultants most commonly received over £5,000 in backpay, although 16 per cent received between £10,000 and £15,000 (*Hospital Doctor* 2004b). Research for this study found that a consultant at one London trust reportedly received £60,000 in backpay, although this was unusual.

Doctors' leaders have supported the initial growth in earnings. As Paul Miller, Chairman of the Central Consultants and Specialists Committee of the BMA said, 'There is no more appropriate way of spending the extra money going into the NHS than on the consultants who work long, hard hours to maintain patient services' (BMA 2004a).

Pay increases could bring benefits in terms of the recruitment and retention of consultants, but sit uncomfortably next to recent reports of funding shortfalls and threatened service cuts (BMA 2005c, Hawkes 2005), and freezes on consultant recruitment (BMA 2005a). The projected year-end NHS deficit for 2005/6 will be the largest since 1997/8. And the biggest share – nearly 40 per cent – of the £4.5 billion cash increase for health and community health services in England for 2006/7 will be absorbed by pay rises for all staff groups, according to analysis by the King's Fund (2006). The growth in earnings for consultants is likely to continue to be strong in 2006/7 as some reach the new maximum pay threshold for the first time (Department of Health, Scottish Executive, National Assembly for Wales 2005).

Aware of the number of NHS organisations facing deficit by the year end, the Secretary of State, in late 2005, revised the Department of Health's original submission to the Review Body, and called for a pay increase of just 1 per cent for hospital doctors (with the exception of staff and associate specialist doctors) .

The Review Body report, when published at the end of March 2006, noted that 'the pay position of our remit groups has been helped considerably by the new contracts for consultants and general medical practitioners' (Review Body 2006, p vi) and recommended a pay uplift of 2.2 per cent from April 2006. The government accepted the recommendations but stated that it would delay implementation of the award for consultants, prompting the British Medical Association (BMA) to issue a press release

stating it was ‘astonished at the vindictive and petty treatment of consultants by awarding them a phased below-inflation pay rise’ (BMA 2006).

The Review Body also highlighted differing evidence from the health departments and from the BMA relating to the actual cost of the new contract, and noted that ‘it is still too early to reach a fully informed view about the true impact of the new consultant contract’. (Review Body 2006, p 102). Its report also acknowledged that financial pressures were becoming much more pronounced in parts of the NHS, but that there was a lack of data available on which to base judgements about workload and productivity of consultants.

It is clear that there is an imperative to demonstrate that the increased costs of the NHS consultant contract in England are having an impact beyond merely paying consultants more.

Cost of implementation

It is difficult to identify the actual cost of implementing the new contract. The first Department of Health implementation survey failed to produce a reliable picture of the actual cost. The overall cost to individual trusts is hard to estimate – managers in some of the trusts involved in this study found it difficult to provide an accurate estimate of the total additional paybill costs incurred by the new contract.

The Department of Health had originally estimated that the cumulative total additional cost would be £250 million between 2003 and 2006. A later official estimate suggested that the contract would have cost about £340 million by the financial year 2005/6 (House of Commons 2005a). This followed an acknowledgement by the Department of Health that its own forecasts were an underestimate by about £90 million (House of Commons 2005b). The underestimate at national level has caused considerable cost pressures at local level. The Review Body (2005) heard from the NHS Confederation how insufficient funding had left trusts ‘to make difficult choices between jeopardising relations with their consultant workforce or overspending to a significant degree’ (p 82).

The funding formula used to cost the new contract relied on a number of financial and workload assumptions that have proven unreliable. The main source of funding in the first year was the £133 million set aside in primary care trust allocations. Trusts with large numbers of consultants but relatively small patient populations are likely to have lost out. Consultant length of service was not considered as part of the funding formula, yet the contract is likely to have been expensive for trusts where proportionally there are more consultants at the top end of the pay scale. Conversely, a young consultant workforce can also represent cost pressures because new consultants are eligible, for the first time, for intensity supplements and Clinical Excellence Awards.

On-call supplements have contributed significantly to the financial pressures facing some of the London trusts studied for this report. Total expenditure on on-call availability supplements was intended to represent around 3.5 per cent of the total consultant paybill (CCIT 2004). But here too the assumptions on which the funding formula was based have been proved to be flawed. The implementation survey carried out towards the end of 2004 found that 68 per cent of consultants were in band A and just under a quarter in band B (Department of Health 2005b). There are anecdotal reports that the percentage of consultants in band A was much higher than had been anticipated.

Other sources of funding for the contract include intensity supplements and payments for additional notional half days (each of these account for about an additional £55 million in spending) (CCIT 2004), and premium payments, such as waiting list initiatives. The initial thinking was that trusts could save £20 million by using additional PAs rather than premium payments to secure extra activity (CCIT 2004), but late implementation of the contract meant trusts were unlikely to realise such savings in 2003/4, which left them with little money against which to offset backdated pay – a considerable pressure in the first year. Moreover, it has been argued that consultants who most benefit from the waiting list initiatives are least likely to transfer to the new contract (Bold 2004). In Scotland, waiting time payments to consultants are reported to have increased by a third between 2002/3 and 2004/5 under the new contract, instead of decreasing as expected (Audit Scotland 2006).

Ultimately, the actual costs of the contract have depended on how trusts approached job planning. NHS employers were told to assume that whole-time equivalent consultants would receive around 11 PAs on average. However, the Consultant Contract Implementation Team (2004, p 4) acknowledged that this rule would not hold true for the first two years, and that in 2003/4 alone an average of 11 PAs for whole-time consultants would ‘result in a pressure of around £20 million nationally’. It was unclear where the funding would come from to fill this gap. If an 11 PA average was going to cause a shortfall locally, it could only be worse for trusts with a higher average than this.

A recurring message is that consultant workload had been underestimated in the funding formula; the focus on average PAs failed to consider trusts with consultants in particular specialties or with commitments who were working in excess of the average. The national implementation survey carried out in October 2004 showed that the average number of weekly PAs in job plans was 11.17 (Department of Health 2005b).

Management in London trusts reported that the new contract had contributed to considerable shortfalls – they reported deficits of £1 million or more that were attributable to the additional costs of the contract. These additional costs hit particularly hard because they coincided with other cost pressures, including compliance with the European Working Time Directive and the increase in employers’ pension contributions to 14 per cent on higher consultant salaries.

Transparency

A reported positive impact of the contract is that it has provided greater clarity and transparency to the relationship between employers and consultants. Trust managers can see more clearly what they are getting for what they pay. ‘For the trust there is greater clarity around what consultants do and when. We can set objectives against a very clear picture rather than a fuzzy one,’ said one medical director.

Transparency around out-of-hours work is reported to be a key benefit. Employers now have a clearer idea about the contributions consultants make at evenings and weekends. In one London trust the development of an understanding of the high level of out-of-hours workload of one specialty has led to a significant increase in their number. In another, the contract is attributed to helping to establish emergency weekend ward rounds and weekend shifts for some consultants. The medical director of this trust explained, ‘The new contract made negotiations easier. We probably could have had some negotiations under

the old contract, but it would have been difficult to get consultants to commit to evening and weekend work because they wouldn't have been recompensed so clearly.'

Even where no changes had yet been made, the contract makes clear what work has to be given up if a consultant wants to go part-time, or how a consultant should be recompensed for doing a ward round on Saturdays, for example. 'It's much easier to plan and construct new jobs – the building blocks are more obvious,' said one senior medical manager. For consultants, the contract is providing much-needed clarity in terms of setting boundaries around when they are not expected to work. This is particularly important for those on a part-time contract or with childcare commitments.

Utilising management tools

Fears among some consultants that the contract would result in excessive management control over consultants do not appear to have materialised, so far at least. Consultants may be more constrained contractually and their commitment to the service is clearer, but any changes have relied on their buy-in. 'There's a perception by consultants that the contract is softer than they thought it would be,' reported one senior medical manager. The price they must pay for greater accountability to their employer appears to be a small one. Managers at the five London trusts indicated that this is contributing to a trickle of consultants on the old contract gradually transferring to the new.

That said, the contract has brought with it some new managerial levers. In theory it is easier to make sure that consultants turn up for clinics, and there is a sense that consultants are more conscious that management could check that they are where they should be. Where there are problems, the job plan provides a document, signed by the consultant, which managers can refer back to. One medical director summed up: 'It has allowed us to reference and restate a set of rules that were never explicit under the old contract.' The contract allows managers to challenge the status quo every year, which is particularly important in the current financial climate.

One of the key management tools under the new contract is the ability to defer pay progression to consultants who fail to meet objectives, other job plan commitments or the new rules around private practice. But there appears to be some reluctance among trusts to link objectives to pay progression. There is considerable cautiousness about how managers would go about trying to withhold pay progression. 'You can't do it as a first line thing; people have to know there is a problem and get help in trying to address it,' said one medical director. Management at one trust believed it would be a minefield to stop pay progression and would instead use disciplinary mechanisms to handle performance issues. This trust had not stopped pay progression for a consultant about whose performance there were concerns, and it was not alone in taking this line.

The contract appears to have had some impact in terms of encouraging consultants to think of themselves as employees and affirming the relationship they have with their employers. The detailed discussions involved in job planning are helping to bring consultants closer to the needs and objectives of the service. 'The contract has cemented the concept that a consultant is not a self-employed anarchist but an employee with obligations to their employer,' said one senior medical manager. This increased accountability reflects a cultural change that was already under way, but which the new contract is helping to make more defined.

A recurring theme reported by trust managers was that any continued difficulties between consultants and management relate mainly to consultants on the old contract. One senior medical manager remarked, 'There are different attitudes among those on the new contract from those on the old'. Reportedly, some consultants on the old contract have not yet appreciated that they should also be doing job planning. Yet there is also evidence to indicate that the new contract is having an impact on consultants on the old contract in terms of management control. There are reports that job planning for consultants on the old contract is now more rigorous than before and that some management controls have been tightened. For example, consultants on the old contract now have to comply with a notice period for requesting leave. As part of this change, consultants on the old contract are willing to declare what they do in non-fixed sessions, even though they do not have to do this.

Creating efficiencies

Cost pressures have forced trusts to look carefully at PAs that are not for direct clinical care. Supporting professional activities (SPAs), additional NHS activities and external activities have come under closer scrutiny, and the contract has created an opportunity for trust management to reflect on the type of activities that they are willing to recognise and reward, and to have structured dialogue with consultants about these activities. This has led to some 'flushing out' of activities that are perceived not to hold direct value for the service. For example, some trusts have been far more questioning about some royal college related activities, based on a belief that some such roles are principally about individual aspirations or where the benefit to the wider NHS is marginal or simply not clear.

Some trusts are taking the view that they will not pay consultants for any external activities, but will release them to participate in such activities. Others are reportedly reluctant to do this. Double-counting around external activities, where consultants expect to see such activities rewarded through job planning and also as part of Clinical Excellence Awards, is reported to be a problem.

It will be critical that the NHS does not lose out by denying legitimate activities to consultants. Reluctance by some trusts to release consultants for external activities is reported to be making it more difficult for them to participate in postgraduate training activity, such as Postgraduate Medical Education and Training Board Article 14 assessments for doctors seeking a certificate of equivalent entry to the specialist register. Those involved in deanery activity similarly insist that the contract's focus on delivering direct clinical care is causing some managers to refuse to release consultants to participate in deanery postgraduate training committees (personal communication). Another concern is that consultants will have less enthusiasm to participate as college tutors. The Department of Health has asked chief executives to respond positively to requests from the Postgraduate Medical Education and Training Board, through the royal colleges, for consultants to help assess applicants (Department of Health 2005b), but there is no sense of coherence in terms of the approach trusts take, or the extent to which they are expected to recognise and reward other external activities.

The contract is also having an impact in terms of encouraging greater scrutiny of SPAs, with managers demonstrating a desire to pin down the outputs of these activities. There are examples of consultants being asked to provide evidence for time spent undertaking research, audit or reading journals. Pinpointing deliverables in terms of teaching is another

example where managers are keen to develop clear outcome measures. The appropriateness of doing SPAs at home has also been an issue. 'It [the contract] has allowed us to say that SPAs must be done on site or somewhere else where there is a measurable outcome that we can understand,' explained one medical director. This is encouraging consultants to reflect on how they use this time. 'For consultants it's clearer what good practice is in terms of governance – some have realised how little they were doing of continuing professional development or audit previously,' said one senior medical manager. It has also brought advantages in terms of enabling consultants to negotiate time and recognition for different things, such as participating in committees and working groups or getting heavily involved in developing hospital guidelines or audit.

There is a danger, however, that SPAs become a soft target under the contract's emphasis on direct clinical care. Where trusts will not pay for external activities but recognise them in terms of time, consultants end up dovetailing external work into their SPAs, which are pushed into their own time. The risk is that activities such as audit and continuing professional development could get squeezed out.

The pressure on SPAs is sometimes more obvious. For example, one London human resources director wants to ask surgeons to do extra clinical work in their SPA time on a temporary basis. At one southern trust a small number of consultants have converted a maximum of four hours of SPA time to direct clinical care time either because they felt they did not require ten hours per week for SPAs, or because they had agreed to do extra clinical sessions as an interim arrangement to reduce a gap in capacity (personal communication).

Such arrangements demonstrate the flexibility to alter the 3:1 typical ratio of direct clinical care to SPAs in order to meet local health needs. However, the degree to which flexibility exists varies between trusts. Senior medical managers at one London trust claim it has been difficult to sell the idea that for some consultants – such as clinical pharmacologists who tend to undertake a lot of research – more SPAs may be appropriate, or that newly appointed consultants should not need the same number as their more established colleagues.

Working patterns

The Department of Health claims that the contract is enabling consultants to better manage a growing workload (Department of Health, Scottish Executive, National Assembly for Wales 2005). There is little evidence to support this claim, in London at least. Rather, it appears that London trusts have made scant use of the information that now exists about consultant working patterns to assess whether best use is being made of their time. Management in one London trust made it clear that it did not want to make any major changes to working patterns for the first three years of the new contract. Another said it was not the time to review working practices when the contract was being implemented. 'It was more about translating existing arrangements into a new parlance, rather than a radical overhaul,' explained a senior medical manager at this trust. Others were similarly dismissive of the contract's impact in terms of measurable change to working patterns.

A number of changes to consultant working practices were already well underway before the contract was introduced; where the contract appears to have had value is in being able to draw in outliers and ensure greater parity. While there are isolated reported examples of

changes to working patterns – being more explicit about the time consultants should set aside for ward rounds, and introducing three-PA days for certain groups of consultants, for example – there is little evidence that such change is widespread, and even where changes exist it is sometimes difficult to pin down the impact. One senior medical manager claimed that, ‘For most consultants the contract isn’t changing the pattern of work they did before – it just means they are more likely to call a long day a three-session day.’

The average number of PAs reported by management in the five London trusts ranged from 10.1 to 11.2. For three of the trusts, the PA average had dropped slightly in the second year compared to the first. One London trust has set a very clear objective to reduce the PAs per consultant as part of its financial recovery plan. Yet generally there appears to be little concerted effort to reduce the number of PAs, unless they represent an onerous burden on the consultant. Some managers highlighted an objective to get down to ten PAs, but others viewed this as impossible, at least in the short term. One medical director remarked, ‘The work of an institution like this doesn’t fit into ten PAs for everybody, it just can’t be done’.

Escalator payments in Wales (see Annexe 1), which increase the rate paid to consultants for work in excess of the basic commitment at two-year intervals, create a financial incentive for trusts to bring down PAs to ten. But one trust in Wales reported that delays to implementation meant it had lost a year in terms of being able to plan out the extra sessions, and it had told consultants that it could not afford the escalator payments for December 2005 (personal communication).

Getting PAs down to what consultants actually work is a more immediate challenge for many. Around 11 PAs has emerged as ‘the going rate’ and having most consultants at this level is seen as a good position to be in. As one senior human resources manager said, ‘We’ve maintained a relatively low number of PAs, so it’s not a big issue for us to claw back PAs or seek benefits realisation’. Consequently, when an opportunity presents to reduce PAs, such as the creation of a new consultant post, it does not necessarily lead to a fall in the PAs of existing consultants. One senior medical manager said he would prefer to share out additional PAs between existing consultants than create a new post.

Updating job plans to reflect changes in circumstances, outside of the annual job plan review, is another challenge. There are examples of consultants dropping clinical management responsibilities but keeping hold of the PA given in recognition of that activity, or of on-call rotas changing but a consultant’s banding remaining the same.

London managers report that there is pressure on trusts to increase PAs, particularly for teaching and education following the implementation of Modernising Medical Careers and the consequent demand involved in regularly assessing trainees. Limitations on the hours juniors can work are also blamed for creating extra pressure on consultants. ‘The trust would like to reduce costs, but the progressive withdrawal of activity by junior doctors means it is unrealistic to change consultant workloads,’ said one medical director. And while new consultants may be appointed at ten PAs, discussions with London trust managers suggest that they often do not stay at this level for long. One senior medical manager remarked, ‘New consultants are on ten PAs for about a week’. Efforts to keep new consultants on ten PAs can cause tensions where they perceive themselves to be undertaking the same workload as established colleagues with higher numbers of PAs.

Impact on private practice

Private practice income for those consultants who do private work was, on average, approximately 50 per cent of their NHS income in 2004 (BMA 2004d). Derek Machin, Chairman of the BMA's Private Practice Committee, reports that over a quarter of those who undertake some private practice earn less than £10,000, but 14 per cent earn in excess of £100,000 (personal communication). Therefore, the incentives to do private practice can be considerable.

A perception that the new contract will make private practice work more difficult is one of the main reasons why a minority of consultants have chosen to remain on the old contract. London managers indicated that take-up of the new contract has been considerably lower among consultants in specialties traditionally associated with lucrative private practice, such as orthopaedic surgery. The requirement that consultants offer their trust one PA per week before undertaking any paid clinical work outside of their NHS contract in order to be eligible for pay progression does not apply to consultants already working 11 or more PAs. The fact that the average consultant is already working 11 PAs means this aspect of the contract is irrelevant. One medical director said his trust was 'too hard up' even to offer consultants an extra session.

If the 'eleventh PA' provision has not had the impact envisaged, the contract has at least enabled senior trust management to have a clear picture of consultants' private practice. 'One of the best bits of the new contract is that it says this is legitimate NHS time and you can't do private practice during this time,' said one senior medical manager.

However, one of the five London trusts was not able to even quantify how many of its consultants undertake private practice.

Ensuring that consultants put their NHS commitments before their private work is one of the key drivers behind the contract. However, there would appear to be significant variation in the way trusts interpret this. One senior medical manager discovered through job planning that some consultants were doing private work while on call for the trust and put a stop to this. Another London trust has decided that its consultants can do private outpatient work when on call as long as they return to hospital promptly if needed. One trust has used private practice as a bargaining tool to get consultants to accept a lower number of PAs than they actually work. The medical director explained, 'There has to be a balance of benefit for consultants and the service. We are happy for consultants to do their private work on the premises. In return they realise that it has to work for the service.'

Unintended consequences

As well as the impacts described above, there have also been unintended consequences resulting from the implementation of the contract.

The contract is having an unintended impact on the culture of the profession. Superficially, consultants appear to have done well out of the new deal. 'As soon as people got their pay packets they wondered what they'd been arguing about,' claimed one medical director. Low take-up nationally of mediation and appeals has been reported; within the London trusts examined for this report there had been just four appeals in total. Yet some medical managers report that consultants continue to feel aggrieved.

Part of the problem is that the contract has raised expectations by allowing consultants to record what they really do, only in many cases not to pay them for this. There is a new disgruntlement if work done is not paid for, which is fuelling concerns that professionalism is being undermined by having a time-sensitive contract. One London medical director summed up, 'We now have very well remunerated doctors and greater clarity about work. The cost has been a loss of sense of vocation and what it means to be a professional and self-directing.'

Views are mixed on the extent to which the contract has led to a loss of goodwill on the part of consultants. There is a sense that generally consultants will do the occasional extra clinic or stay late, yet are more assertive in negotiating rewards or time off where they are expected to work beyond their contractual hours on a regular basis. Newly appointed consultants are felt to be more likely to ask for something in return, according to some senior managers. A greater tendency towards 'clock-watching' among some consultants has been observed by senior medical managers at one London trust.

The fact that managers at other trusts were less likely to have witnessed this may reflect a greater degree of flexibility in working practices (for example, allowing a consultant to leave early to make up for a clinic that over-ran the previous day), which appears to be key to ensuring that an hours-led focus does not undermine professionalism.

There is widespread agreement that time sensitivity or consciousness will be an issue for future consultants. 'Junior doctors are more militant about not working beyond their contractual hours. There's no sense of team responsibility for filling gaps. I expect in time it will hit consultants too,' said one senior medical manager. Clock-watching among junior doctors is reportedly already an issue, reflecting their own contractual arrangements, European Working Time Directive limitations on their hours, and different attitudes to work/life balance. 'We're training juniors to be clock-watchers; they're becoming blue collar workers,' remarked one medical director.

Another unintended consequence of the new contract is that it creates incentives for early retirement. The BMA (2004c) asserts that there are likely to be two waves of consultant retirements in 2006 and 2007, when a significant number of doctors will be able to retire with pension benefits based on the top point of the new scale. The capping of pension contributions at £1.5 million compounds this. 'Colleagues are more driven by their accountants saying that they've hit their max so there is no point continuing. They might as well retire and come back to work, which they usually don't do full-time,' remarked one London medical director. A survey of 5,000 consultant physicians by the Royal College of Physicians (2005) revealed that 78 per cent planned to retire before they reached 65 years of age. At one London trust slightly more than one in ten consultants was within five years of retirement.

The outlook for benefits realisation

The government has been explicit that the new deal for consultants has to secure benefits not just for the profession, but for the service and patients as well – ‘something for something’. So far this report has examined the national backdrop, and local experiences in London of implementing the new consultant contract and early assessment of its impact. This section looks in more detail at ‘benefits realisation’, and examines whether the necessary building blocks are in place to enable the contract to deliver what is expected of it.

Key findings

The research has identified the following key findings.

- The time-based nature of the contract diverts attention away from benefits realisation.
- An opportunity has been missed to tie pay increases to performance incentives.
- Benefits realisation has been undermined by an inadequate national framework for monitoring and oversight.
- The focus and experiences at local level have been mainly about implementation, not benefits realisation.
- The effectiveness of clinical directors will continue to be critical to success.
- In its current form the contract is unlikely to be effective and sustainable in the long term.

The implications of each of these findings for policy is explored below.

Time versus benefits realisation

It is unclear quite how the contract will deliver some of the benefits expected of it. Interviews with senior medical managers and other informants revealed considerable uncertainty and scepticism around benefits realisation. ‘It’s a big disappointment for the NHS. Personally, I love it, I’ve done very well out of it. But it hasn’t been value for money for the service,’ said one senior medical manager. Another remarked, ‘I’m not sure how well we’ve done as a trust at really understanding the benefits. I’m not sure we’ve used the contract in the way it was intended.’

A perception that the contract was designed to generate additional capacity – and a belief that it will not deliver this – was a particular issue for some trust staff. Perhaps the biggest problem, however, is the time-based nature of the contract. This represents a built-in limitation, which constrains the ability of health service managers and consultants to focus on benefits realisation. As one human resources director pointed out, ‘It’s a shame that it is hours-based; the default is that we look at hours rather than the needs of the service.’

Performance incentives

The contract provides opportunities to facilitate change in the way consultants deliver services. Depending on the robustness of job planning and its links with appraisal, there is the potential for consultants' time to be better prioritised. But a key question hangs over whether it will improve the performance of services. 'Performance and productivity are not part of what the contract is about and that's a weakness,' remarked one senior medical manager in February 2006.

Patients have been promised that the contract will increase the time consultants spend on direct clinical care (CCIT 2003), which in turn is expected to contribute to improvements in NHS productivity and quality of care (Department of Health 2002b). There is extensive evidence of wide variations in consultant activity (see, for example, Bloor *et al* 2004), but the contract provides no guarantees that such variations will be any better managed. To the contrary, the contract lacks any incentives to encourage productivity. 'The biggest problem with the contract is that it isn't based on productivity. You only have to be at the place you're required to be. There's an incentive to do the minimum and clock-off at 5pm,' said one London medical director. Job plans have some potential to drive productivity by setting out the level of activity trusts are commissioned to provide. But changing patient flows and moves by commissioners at certain times of the year to halt elective surgery, for example, undermine the ability of job plans to encourage efficient working.

Interviewees reported no evidence that the contract had as yet changed consultant output or influenced activity, and there is concern among some senior trust staff, as well as consultants themselves (*Hospital Doctor* 2004b), that the contract could actually result in a fall in productivity. One senior medical manager remarked, 'In terms of the public purse it has been a complete disaster; the public is paying more but getting less.' There is evidence that the contract has helped to pull in outliers in terms of the number of programmed activities (PAs) that are worked. But whether it will put pressure on outliers to become more productive depends on the quality of management information about activity rates and the drive to use it.

Many managers do not have sufficient information about consultant activity to be able to inform job planning. Interviewed in February 2006, one senior medical manager summed up the difficulty by saying, 'We can't say even how many outpatients a consultant has seen in a year'. Some are beginning to collect relevant data, but others lack the detail they need. What information that does exist is sometimes under-utilised because of time constraints. 'Just being able to log whether consultants turn up for their sessions would be a start,' said one senior medical manager; one trust was embarking on an audit to see whether consultants are where they should be. One southern trust has developed electronic software to manage the contract. It has an online diary system that in time will link PAs to consultant activity. 'We're trying to build frameworks and structures to prove that we're getting something out of it. It's very time-consuming and whether the costs involved are justified isn't clear,' said the trust's medical director (personal communication).

Monitoring and oversight

One of the main obstacles to benefits realisation is that there are no specific indicators against which to measure whether the contract is delivering the benefits envisaged. The Department of Health is instead relying on the Integrated Service Improvement Programme

to demonstrate that quality and value is extracted from a range of initiatives that have been introduced into the health service in recent years. The Integrated Service Improvement Programme aims to deliver a single, consistent approach to help organisations identify and share evidence-based practice, have processes for effective change and decision-making, and maximise benefits from investments in people, processes and technology. The risk with this approach is that, by failing to isolate the impact of the contract from the impact of other initiatives, it could become a smokescreen for inaction on the contract.

Elsewhere in the United Kingdom, greater attention has been given to demonstrating benefits. The Scottish Executive Health Department has placed a stronger emphasis on consultant productivity. It has established a Workforce Performance and Effectiveness Group to assess the impact of pay modernisation on productivity, create productivity measures and provide new models of organising skills and resources. Health boards are expected to demonstrate an increase in consultant productivity by 1 per cent per year over the next three years, and it is anticipated that this will have a positive impact on waiting times (Department of Health, Scottish Executive, National Assembly for Wales 2005). Yet an external review of the impact of the Scottish contract concluded that it was not clear how this will be achieved, given that consultants report working over their contracted hours (Audit Scotland 2006).

The National Assembly for Wales has commissioned a benchmarking provider to develop a standards framework for employers to ensure that benefits are realised. It also commissioned the Audit Wales Office to carry out a comprehensive audit on all trusts to ensure that the initial round of job planning was rigorous and produced value for money and service benefits (Department of Health, Scottish Executive, National Assembly for Wales 2005).

In England, strategic health authorities (SHAs) and the NHS Modernisation Agency were tasked with supporting trusts during implementation. The NHS Modernisation Agency's Consultant Contract Implementation Team did this, for example, by organising events and briefing sessions, and providing direct support to trusts (CCIT 2003). In April 2005, the team was split in two: some staff moved to NHS Employers and were tasked with maintaining, amending and refining the 2003 contract. A Consultant Contract Benefits Realisation Team was also created and given a year's funding to support trusts, through their SHAs, to derive benefits from the contract primarily through the use of the job planning toolkit and by disseminating examples of good practice (NHS Modernisation Agency 2005a). However, the team was housed within one SHA and it has only a limited lifespan; it will be wound up at the end of May 2006 when funding runs out.

In London at least, SHAs appear to have defined their role in relation to implementation of the contract largely in terms of facilitating access to training and information for workforce leads within trusts. Four of the five London SHAs imposed some boundaries around implementation by requiring trusts to seek approval before agreeing job plans of more than 11 or 12 PAs. But overall, SHA engagement has been arms-length and, once the initial round of job planning was completed, tended to fall away considerably. SHAs have had no clear remit in relation to realising the benefits of the contract. As a result, their input has not always been welcome and some SHAs' workforce leads report difficulties engaging with trusts in benefits realisation. Current restructuring and staffing reductions mean that SHA staff have also been distracted by uncertainty over their own futures.

Overall, there is a sense that many in the NHS have ‘ticked the box’ in relation to the new contract and moved on to other priorities, particularly Agenda for Change. ‘It all seems like a long time ago,’ was how one human resources director reflected on the contract. Arguably it is in many people’s interest to push the consultant contract down the agenda. Consultants are better paid and have not yet witnessed substantial change to their working practices or the excessive management control they feared. Trusts are relieved to have got through implementation relatively unscathed in terms of consultant–management relations and with few appeals. The Department of Health meanwhile has sheltered benefits realisation for the contract under the broader Integrated Service Improvement Programme umbrella.

A focus on implementation

The absence of clear outcome measures for the new contract together with little formal oversight have contributed to a lack of action in terms of translating national strategy and direction into local change. ‘We missed an opportunity to start off on the right foot, so we’ve picked up bad habits and made the task much bigger,’ observed one medical director, interviewed in February 2006.

Benefits realisation was never going to be a quick win. The rapid pace of implementation, coupled with the complexity of the contract, meant that simply getting the new deal in place was a challenge. As one human resources director remarked, ‘It was a ludicrous timetable; no one could do anything about benefits realisation’. Similarly, the medical director at another trust said, ‘Because it was such a complicated task we never got to saying to people this is quid pro quo, we’ll pay you this and in return we expect such and such’. It is only now, more than two years after the new contract was introduced, that trusts feel able to consider how to make best use of the contract. ‘The first year was sorting it all out, the second year we could say “phew we’ve sorted it”, this year is the first year we can think about the benefits,’ explained one human resources director.

Seeking benefits through workforce redesign is complex and could have implications for non-medical as well as medical staff and for the organisation of services. However, the reported experience of London trusts suggests that few have developed strategic plans on how they might harness the potential of the new contract over the coming years. The absence of detailed strategic planning here is a concern, as it is likely to constrain any real attempts to achieve full realisation of potential benefits.

There are isolated examples where the contract is being used as a catalyst for change, but little has happened yet, or is planned, at a strategic level to deliver benefits. As a consequence the contract is unlikely to deliver fully on benefits realisation in the near future. ‘The new contract is a tool that needs to mature. You’ll have to wait five or ten years to see the benefits,’ said one senior medical manager. But the longer trusts leave it, the more resistant consultants are likely to be to giving up any extra PAs – and the money that goes with them. If trusts show little concerted effort to drive down PAs, this could undermine the message that extra PAs are not permanent.

A senior medical manager at one trust summed up the view when he said, ‘Consultants haven’t got their heads round the fact that any PAs over ten aren’t guaranteed’. This could spell difficulties for the future as consultants have little incentive to give up their extra PAs.

Some consultants reportedly do not want PAs to go down and would rather have the money than the extra free time. One group of London consultants, for example, on 12 PAs each reportedly did not want to lose a PA in order to employ an additional colleague despite claiming to feel overworked. A survey of consultants in Scotland revealed that only 25 per cent of respondents on the new contract were keen to reduce extra PAs (Audit Scotland 2006).

The lack of strategic direction partly reflects a primary focus on the operational and bureaucratic aspects of the contract, but it also reveals a tendency by managers, in some trusts at least, to regard the contract as a compliance issue rather than a mechanism for change. There is also a belief that it is difficult to attribute benefits to the contract alone. For example, one senior medical manager remarked, 'It's a long-term game and part of a bigger package of cultural change. In isolation the contract won't achieve anything.' Certainly the achievement of the numerous benefits originally envisaged (see *Striking a deal*, p 3) will rely on a variety of factors. For example, one aim is for the contract to formalise and support the provision of services over an extended day, but this will depend on the infrastructure for out-of-hours working as well as the timetabling of consultant commitments.

Only one of the five London trusts examined for this report had set up a programme to specifically develop a benefits realisation plan for the contract over the next two years. Three other trusts were setting up projects to examine working practices either across the medical workforce or the workforce as a whole as part of Agenda for Change. Overall, there is a sense that Agenda for Change is now the more pressing priority for NHS management and has greater potential in terms of workforce redesign. This reflects both that it covers more staff groups and that it has a more explicit link to individual development through the NHS Knowledge and Skills Framework.

The drivers that will influence workforce redesign are factors beyond the contract, such as changing demand from the public to 'choose and book', a focus on outcomes and infrastructure change. The biggest driver tends to be funding availability, and there is now some evidence that deficits are beginning to focus the minds of trust management on the opportunities offered by the contract. 'For all the deficit, the knock-on effect is that the management structure is stronger, more performance focused and likely to be more challenging on PAs,' said one senior medical manager. 'We can't sack secretaries so that we can overpay doctors,' remarked the medical director of another London trust. Others are not seeking to use the contract to reap efficiency savings, even though they face a shortfall. This could be because levers other than the contract have a better chance of achieving the desired results.

The importance of clinical directors

Management, particularly medical management, is the cornerstone to local achievement of benefits realisation. However, limited medical management capacity in some trusts and lack of strategic direction have hindered the ability of managers to make best use of the contract. As one senior medical manager admitted, 'Managers, both clinical and non-clinical, haven't been as inventive in using the contract as perhaps we should have been'.

Clinical directors have had to undertake job planning negotiations on top of their usual clinical and managerial workload. Negotiations with consultant colleagues have been time-

consuming, particularly for medical managers overseeing large numbers of consultants across a variety of specialties. One senior medical manager, responsible for more than 100 consultants, described how job planning ‘required a lot of brain space’: ‘I receive three PAs for clinical director work; this works out at about four hours per year per consultant. Time has therefore been a limiter on negotiations.’ This manager handled much of the negotiations with consultant colleagues via email because of time constraints. There was concern among some clinical managers about job planning encroaching on other management or clinical activities or eating into their personal time. One senior medical manager told how his own continuing professional development has suffered and, as a consequence, he has decided not to renew his management contract.

A lack of clear strategic direction from the top has made it difficult for frontline managers, particularly clinical directors. ‘There’s a lack of clear definition of what we want to do,’ reported one senior medical manager. ‘I feel I understand the system; what I find difficult is about how to use it to bring about change.’ In the absence of clear strategic objectives, the role of clinical director has become even more crucial to the success of the contract. Their approach and attitudes towards the contract are variable (frontline medical managers interviewed for this study were more likely than trust board executive staff to be cynical) and this seems to be reflected in how the contract is being used locally. Clinical management tends to be stronger where medical managers are engaged directly in strategic objective setting. Benefits are unlikely to be realised where frontline clinical managers have not bought in to corporate objectives. One senior medical manager described his trust’s objective to reduce PAs as unrealistic and in conflict with his own objective to pay consultants for what they do.

There is evidence that clinical directors move into management roles for positive reasons, mainly because they feel that they can add value to their organisation (Cavenagh and Dewberry 2000). However, they face rejoining the ranks after a few years and there is still an element of expectation that clinical directors are there to represent consultants. Frontline managers therefore need reliable support structures that extend to the top of the organisation and strong leadership from the executive team. Some senior medical managers said they did not receive support during difficult negotiations with colleagues or were undermined by consultants going over their heads to agree job plans. Sometimes key decisions were made about the contract without their involvement. Some senior medical managers criticised staff at executive level for treading too softly, which hindered the ability of the trust to realise benefits.

It was clear from interviews that some human resources directors and medical directors were out of touch with the detailed experience of implementation on the frontline within their own trust, and therefore unaware that the building blocks for benefits realisation were either not fully shaped or not in the right place. One human resources director had left the task of implementing the contract entirely in the hands of clinical managers.

As trusts begin to think about benefits realisation, a number are including non-clinical managers in job planning review and discussions around objectives. This should help clinical managers focus on corporate objectives and is likely to generate discussions with consultants that are more challenging than those led solely by clinicians.

Sustaining the contract

The likelihood that this contract lasts for as long as the previous one depends on the extent to which it proves to be robust yet flexible. If it is too rigid it will fail to be effective.

There is a view among a number of senior managers that the changes to working patterns sought under the new contract could have been achieved under the old contract. The difference is that the new contract appears to have changed the mindset. It provides some new levers and clarity that was previously lacking. It has set the NHS and its consultants on a new path, but is probably a stepping stone to something else rather than an endpoint. A number of factors are likely to put pressure on the way the health service contracts with consultants. For example, different expectations and attitudes of current junior doctors towards work–life balance will, over time, show through in consultants' behaviour as these junior doctors are promoted. The number of consultants working above the European Working Time Directive is large and if the personal waiver arrangement disappears in 2009, it will have serious capacity implications.

One of the biggest influences is likely to be independent sector treatment centres, which are becoming more prominent in the NHS in England and will be driven by productivity-based systems and are likely to want to employ consultants on contracts that reward them for service. This could increase incentives for consultants to set up chambers and contract their services on a fee-for-service basis to independent sector treatment centres, alongside or instead of existing NHS commitments.

Payment by Results could make this model of contracting attractive to NHS trusts, focusing activity in areas and specialties that generate more income. This could have a knock-on effect on job plans and working practices.

An increase in the number of foundation trusts is likely to increase the emphasis on the financial regime and could signal a move away from the current reliance on national terms and conditions to local systems that are more output-oriented. Trusts are likely to be attracted to arrangements that offer greater flexibility to contract with consultants in certain disciplines to buy their time for sessional work for some parts of the week and focus on productivity for the rest of the week.

Recommendations

This report has shown that, more than two years on, the consultant contract in the NHS in England has had an impact in a number of ways. Some of the benefits originally envisaged for consultants – an increase in earnings and pensions and better recognition of the different aspects of their work – have materialised. So far, it is less clear what the service and patients have got out of the deal beyond greater transparency of consultant workloads.

In many ways it is not surprising that there is little evidence of widespread benefits realisation, given the tasks, time and resources required in transferring consultants from the old contract to the new. However, it appears that some NHS organisations seem not to have clear plans for how benefits can be attained in the medium to longer term, and that a coherent framework to support this goal appears to be lacking.

A number of actions need to be taken at national and operational level if the contract is to help deliver more effective use of consultants' time, more responsive services over an extended day and the other benefits originally envisaged. These have implications for the pay reforms for NHS doctors in staff and associate specialist grades (to be introduced in 2006) and for salaried dentists, as well as for the broader pay modernisation agenda in the public sector, including the implementation of Agenda for Change.

National level

There are signs that the consultant contract has dropped down, or fallen off, the management agenda in some trusts. Supportive action is required at a national level to ensure that the contract remains on the agenda so that benefits can be more fully realised.

- **Framework for benefits realisation** There is a need for a clearer and more detailed framework for benefits realisation. NHS Employers and the Department of Health must provide a consistent and clear national steer on how the contract is expected to deliver improvements for health services and patients. Nationally, specific measurable outcomes should be developed.
- **Local processes** Clearer national guidance is needed on the interplay between appraisal and job planning, and the responsibilities of the parties involved, to help trusts develop service objectives that are both challenging and achievable.
- **Performance incentives** NHS Employers and the Department of Health should give consideration to how managers can best be equipped with incentives for consultants to work 'smarter'. Tying pay progression to objective setting alone is unlikely to deliver the productivity required of a modern consultant-led service. Stronger links between pay and performance, and clearer incentives for consultants to respond to local priorities, perhaps through the Clinical Excellence Awards scheme, are needed. Any incentives need to be firmly tied to outcomes focused on quality, not patient throughput.

Local level

At operational level, a number of steps are needed to ensure that trusts get greater return from their investment into the contract.

- **Strategic planning** Trusts need to develop detailed strategic plans for benefits realisation, which includes linking job plans with strategic goals such as reducing waiting times and emergency bed days used.
- **Management** Clinical management needs to be strengthened, including a clearer career path backed up by sound support structures. Greater collaborative working between clinical and non-clinical managers in activities such as job planning and objective setting should support this.

Annexe 1: Contract arrangements across the UK

The original proposals for a new consultant contract represented a common UK position. However, different responses to the national framework from consultants within the four countries have led to variations.

Scotland

Consultants in Scotland voted to accept the framework negotiated in 2002 that was rejected by consultants in England and Wales. Almost eight out of ten voted in favour of the new contract when a second ballot was held in October 2003 (BMA 2003a). The contract is similar to that adopted in England, except the new Clinical Excellence Awards scheme does not apply. Job planning was to have been completed by the end of May 2004, but slow progress resulted in this target being revised to having 95 per cent of job plans either signed off or undergoing mediation or appeal by the end of September 2004 (BMA Scotland 2005). By June 2005, 96 per cent of Scottish consultants were on the new contract (Department of Health, Scottish Executive, National Assembly for Wales 2005).

The estimated cost of implementation was £63 million in 2003/4 (including £53 million for backdated pay), £85 million in 2004/5, and £100 million in 2005/6 (Audit Scotland 2004). An investigation by Audit Scotland (2006) found that the costs were underestimated and the NHS in Scotland has spent an additional £235 million on the contract over the three years to 2005/06.

Wales

Consultants in Wales rejected the 2002 framework, but more than nine out of ten accepted a deal in 2003 based on changes to the terms and conditions of their existing contract, which became mandatory for all consultants. One key difference is the provision for escalator payments – a consultant's work in excess of the basic commitment is recognised at plain time sessional rates for the first two years of the work and then at a rate of 1.25 and 1.5 at two-year intervals. In addition to funding of £17 million already issued, a further £23 million has been distributed to meet the costs of these additional consultant sessions. This has resulted in some consultants benefiting from a pay increase of 35 per cent since April 2003 (Department of Health, Scottish Executive, National Assembly for Wales 2005).

It was originally anticipated that the changes to the contract in Wales would be implemented from 1 December 2003 (Welsh Assembly 2003b). However, implementation was delayed by the Welsh Assembly Government's decision to conduct an audit of consultants' hours across Wales. Early last year the British Medical Association's Welsh Council passed a vote of no confidence in the Welsh Assembly Government's ability to manage the implementation of the contract (BMA Wales 2005).

Northern Ireland

In January 2004, over 80 per cent of consultants and specialist registrars voted in favour of a new consultant contract based on that accepted by the profession in England, with the exception of the arrangements for Clinical Excellence Awards and with different backdating arrangements (BMA 2004a). It was originally the intention that consultants in Northern Ireland would be offered job plans for 2004/5 by October 2004. The British Medical Association Northern Ireland (2005) reported in May 2005 that most employers had not achieved this.

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The government's reforms of contracts and pay for NHS staff are designed not just to pay staff more but also to secure changes in working patterns and productivity that translate into benefits for patients. This paper assesses the impact of the new consultant contract in England. Its findings are based on a literature review, discussion with key informants and case studies of five acute NHS trusts. The report shows that there is little evidence, as yet, of benefits having been realised: the scale of the task was underestimated and national guidance not sufficiently clear, leading to considerable variation in approach and outcome between trusts.

ISBN 1-85717-547-6



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