National Audit Office

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

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Department of Health

Managing NHS hospital consultants

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National Audit Office

Department of Health

Managing NHS hospital consultants

Report by the Comptroller and Auditor General

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Comptroller and Auditor General
National Audit Office

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This report examines the extent to which the expected benefits of the 2003 consultants' contract have been realised and whether consultants are managed effectively and consistently across NHS trusts.

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Contents

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This report can be found on the National Audit Office website at www.nao.org.uk/consultants-budget-2013

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Glossary

Clinical Excellence Awards	Rewards NHS consultants who go above and beyond the norm, through pensionable salary increments. There are employer-based and national awards (see Figure 12).
Clinical managers	Clinicians with management responsibility (for example medical directors, clinical directors and divisional directors).
Direct clinical care	Work to directly prevent, diagnose or treat illness.
Full-time equivalent (FTE)	A unit used to compare workloads. An FTE of one is equivalent to one full-time worker. Two people working half-time (FTE of 0.5) would equal one FTE. One FTE is equal to ten 'programmed activities'.
Headcount	Headcount is the total number of staff in either part-time or full-time employment.
Job plans	Job plans list all the consultant's NHS duties, the number of 'programmed activities' for which the consultant is contracted and paid, the consultant's objectives and agreed supporting resources.
Locally agreed rates or payments	The 2003 contract had provision for trusts to negotiate local rates of pay with consultants for additional work.
NHS Employers	Represent and act on behalf of health service employers in England in negotiations, workforce planning and employment policy and practice.
NHS trusts	NHS trusts have either foundation or non-foundation status. Foundation trusts have significant managerial and financial freedom compared to other NHS hospital trusts.
NHS hospital and community health service	Comprises staff in: strategic health authorities; NHS trusts; primary care trusts; social care trusts; a small number of special health authorities; and other statutory authorities. It does not include GPs or their practice staff.
Programmed activity	A scheduled period defined in the 2003 contract. Four hours between 7am and 7pm on weekdays. Three hours outside these times and at weekends.

Service-line reporting	Measures a trust's profitability, activity and use of resources by each of its service-lines.
Service-line management	Manages specialist clinical areas as distinct operational units, often led by clinicians. These structures allow clinicians and managers to plan service activities, set objectives, monitor financial and activity levels, and manage performance.
Supporting professional activities	Activities that underpin direct clinical care. These include: training; medical education; continuing professional development; formal teaching; job planning and appraisal; research; and local clinical governance activities.
Total employment cost	Includes earnings (basic salary plus any additional payments), employer pension and National Insurance contributions.

Key facts

40,394
NHS consultants as at September 2012

£5.6bn
employment cost of NHS consultants in 2011-12

12%
real-terms increase in full-time equivalent consultant earnings, 2002-03 to 2003-04

1.6 percentage points	improvement in consultant productivity against a declining trend. Consultant productivity fell by an average of 1.8 per cent a year between 1995 to 2003. This decline slowed to an average of 0.2 per cent a year between 2003 to 2010
1.3 per cent	annual average real terms growth in full-time equivalent consultant earnings 2003-04 to 2006-07, compared to 4.9 per cent between 1999-00 and 2002-03.
5.1 per cent	annual average growth in number of full-time equivalent consultants, 2003 to 2006 compared to 5.9 per cent prior to the contracts introduction (2000 to 2003)
97 per cent	of consultants on the 2003 contract
£109,000	average (median) annual total earnings of consultants between October 2011 and September 2012
£500 million	approximate value of Clinical Excellence Awards in 2011-12. The total annual value of national awards was £192 million and employer-based awards between £310 million and £315 million. These figures include employer pension and National Insurance contributions. Sixty-one per cent of consultants hold an award
£48 to £200 per hour	average local rates trusts pay consultants to secure extra work outside agreed job plans
90 per cent	Consultants work hard. Ninety per cent of trusts state that consultants work beyond what they are contracted to do

Summary

1 NHS consultants (consultants), the majority of which work in hospitals: treat NHS patients; manage clinical work in hospitals; and undertake work that benefits the NHS (for example, training future doctors). At September 2012, the NHS employed 40,394 consultants (38,197 on a full-time equivalent basis) across a range of specialty areas. The total employment cost of consultants was £5.6 billion in 2011-12, of which 81 per cent was consultants' earnings, with employer pension and employer National Insurance contributions each accounting for 9.5 per cent. In 2011-12, consultants made up 4 per cent of all NHS hospital and community health service full-time equivalent staff, accounting for 13 per cent of related employment costs.

2 In October 2003, the Department of Health (the Department) introduced a new consultant contract (the contract). By 2012, an estimated 97 per cent of consultants were on the contract. The contract was designed to provide:

- a career structure and remuneration package that rewards and incentivises consultants who make the biggest contribution;
- a stronger contract framework so managers can better plan consultants' work; and
- better arrangements for consultants' professional development.

3 The General Medical Council will introduce 'revalidation' in December 2012, to regulate licensed doctors and ensure they are fit to practise. The Council will revalidate doctors every five years through regular appraisals, and aims to revalidate the majority of licensed doctors for the first time by March 2016.

4 The Department has estimated that, to keep pace with demand and live within its tighter means, the NHS must make recurrent efficiency savings of up to £20 billion between 2011-12 and 2014-15. Consultants play a vital role within the NHS, and managing consultants effectively will help to make some of these savings.

5 In August 2010, the Secretary of State of Health commissioned the Review Body on Doctors' and Dentists' Remuneration to review compensation levels and incentive schemes for consultants. On 17 December 2012 the Government published the report, as a basis for discussion with the medical profession and NHS Employers. Recommendations include:

- Rewards for clinical excellence should be linked to performance including patient feedback.
- Rewards for clinical excellence should be capped nationally at £40,000 and locally at £35,000.

- Rewards should reward current excellence, not past performance – awards should be awarded for no more than five years nationally and normally one year locally.
- A new 'principal consultant' grade should be introduced, to reward very senior and outstanding doctors (capped at 10 per cent of consultants across the country).
- Progression through the current consultant grade should be based on performance rather than time served.
- Awards should also continue to recognise excellence in medical education, teaching and research – including work to support the Royal Colleges and NHS system improvement.

The scope of this study

6 This report examines: how far the expected benefits of the contract have been realised (Part One); whether consultants are managed effectively and consistently across NHS trusts (Part Two); and how far the Committee of Public Accounts' recommendations of 2007, designed to improve the management of consultants, have been implemented (Part Three). Our methods are set out in Appendices One and Two. Central to our findings are a census of all acute trusts and a survey of consultants in acute trusts. The trust census achieved an 85 per cent response rate. We requested a response agreed by senior management including, for example, the Chief Executive, Medical Director, Director of Human Resources and Finance Director. Our survey of consultants in acute trusts achieved a response rate of 28 per cent (8,808 responses).

Key findings

On managing consultants under the 2003 contract

7 The contract is one of a range of the tools available to get the best out of consultants, for patients and taxpayers. Some trusts have used the contract's provisions alongside other good management practices to, for example: engage consultants to improve performance; achieve trust objectives; and provide services within activity, financial and quality boundaries (paragraphs 1.6 and 1.11).

On realising the contract's expected benefits

8 **The contract increased the cost of employing consultants.** An explicit objective of the contract was to invest additional resources into consultant pay at a time of real-terms growth in funding for the NHS. Between 2002-03 and 2003-04, the bottom of the consultants pay band increased by 24 per cent and the top by 28 per cent. This meant that the NHS invested up front for the expected benefits it hoped to achieve in the future. In addition, trusts stated that they now pay for work which was previously not paid for under the old contract. As a result, between 2002-03 and 2003-04, total earnings per full-time equivalent consultant increased by 12 per cent in real terms. Between 2003-04 and 2005-06, the Department gave the NHS £715 million (£839 million in 2011-12 prices) of funding to cover the additional cost of the contract. In 2005-06, the recurring additional funding to the NHS was in the region of £400 million a year, which covered the increased cost of the contract and the increased number of consultants. Although largely unrelated to the introduction of the contract, average (mean) pay in real terms has fallen over the past five years (paragraph 1.8).

9 **The contract has had a number of positive impacts.** Ninety-seven per cent of consultants now have a job plan (see Glossary) and 58 per cent of trusts stated that the contract had helped them to better manage consultants' time. Productivity is difficult to measure. However, while indicators show that consultant productivity has continued to fall after the new contract, the rate of decline has slowed significantly compared to before 2003. Consultants' private practice work has not increased. Most trusts stated that consultants, working ten programmed activities or less a week, work an additional programmed activity (see Glossary) at standard rates for the NHS, where required, before undertaking private practice work. The contract also reduced the speed of consultant pay progression and has, to some degree, helped to extend patient services. Furthermore, an explicit objective of the contract was to increase consultant participation rates. The consultant participation rate (the ratio of full-time equivalent consultants to headcount) has increased in line with the projections included in the business case, although it remains unclear as to what extent this has resulted in consultants doing more work for the NHS (paragraphs 1.12 to 1.25).

10 **More could be done to achieve better value for money in fully realising the benefits set out in the Department's business case.** The contract, for example, states that work agreed as part of a consultant's job plan, including the first additional programmed activity above ten where a consultant wishes to conduct private practice work, should be paid at contractual rates. However, the average paid programmed activities across trusts is over 11 with most trusts using locally agreed rates of pay for additional work outside that agreed in job plans. Average rates over the last 12 months range from £48 to £200 per hour with a mean of £119 and median of £114. Based on the top and the bottom of the consultant pay scale, contractual rates range between £36 and £64 per hour. In addition, pay progression is not linked to consultant performance in most trusts (paragraphs 1.23 and 1.25).

On responsibility for achieving the contract's expected benefits

11 Realising most of the contract's expected benefits depends on how well individual NHS trusts manage consultants. NHS non-foundation and foundation trusts are responsible for managing their consultants. The Department has no power to direct NHS foundation trusts. It can direct NHS non-foundation trusts, but the Department does not intervene in day-to-day operational management, which includes managing consultants. For example, managing consultants' time better depends on how far NHS trusts implement effective job planning. Academic literature also links trust performance and clinical outcomes to a range of management practices. These include: how well trusts engage consultants to meet trust objectives; the quality of clinical management within trusts; and using performance management processes, such as annual appraisals, effectively (paragraphs 2.1 and 2.2).

12 The Department established a partial baseline for 2002 from which to assess progress in realising the contract's expected benefits. The lack of a comprehensive baseline made it difficult to assess the overall impact of the contract. While the Department held data in areas such as the number of consultants, participation rates and contract costs, it did not hold data on the number of consultants with job plans, the extent of consultant private practice work and the amount of direct clinical care (paragraphs 1.9 and 1.10).

On how trusts can further improve the utilisation of the contract and better manage consultants

13 The Department and NHS Employers issued guidance to help implement the contract, but some was not timely and some has been discontinued. NHS Employers issued a range of guidance after the contract was introduced. For example, job planning guidance was introduced in 2005 and updated in 2011. In addition, although the Department published a toolkit to compare individual consultant activity levels for 2005-06 and 2006-07, this was then discontinued. While 66 per cent of trusts stated that there was effective national guidance on job planning, only 8 per cent of trusts stated that there was effective national guidance on measuring consultant productivity (paragraphs 1.20 and 2.23).

14 While most of the expected benefits of the contract have been either fully or partially realised, there remains significant room for improvement in the management of consultants. While our case studies highlighted areas of good practice and our survey results showed that many trusts had implemented some aspects of good practice, there are still significant gaps with many trusts not managing consultants effectively.

Consultant engagement:

- We found some differences in opinion between consultants and trusts' senior management over the level of consultant engagement. Most trusts stated there was a shared sense of purpose and a high level of collaboration between management (both clinical and non-clinical) and consultants. Consultants supported this view in relation to clinical managers, but less than half thought there was a shared sense of purpose and a high level of collaboration between consultants and non-clinical managers. Only 41 per cent of consultants stated that their trust motivates them to achieve the trusts' objectives (paragraph 2.4).

Clinical management:

- Most consultants are managed by fellow consultants, usually clinical directors. Our survey results and case study focus groups with clinical directors showed that many clinical directors have insufficient time, training and administrative support to do this effectively (paragraphs 2.6 to 2.8).

Performance management:

- Seventy-nine per cent of trusts reported monitoring direct clinical care activity levels of consultants across all or most specialty areas, with 82 per cent monitoring clinical outcomes. However, it is often difficult to assess individual consultant performance due to consultants working in integrated specialty teams (paragraphs 2.9 to 2.10).

- Despite 66 per cent of consultants stating that comparing their performance against their peers motivated them, around a fifth of trusts either do not benchmark clinical outcomes for consultants in the same specialty area or do so less than once a year (paragraph 2.11 and Figure 11).

- Pay progression is the norm. Less than a third of trusts stated that pay progression for all or most consultants either depended on achieving objectives set out in job plans or achieving objectives from appraisals (paragraphs 1.23 and 2.18).

- Clinical Excellence Awards reward performance above and beyond the norm. While most trusts thought awards reflected exceptional performance, less than half of consultants agreed. The Prime Minister and Secretary of State for Health, informed by recommendations from the Review Body on Doctors' and Dentists' Remuneration, determine the value of employer-based awards that trusts must fund and distribute. While there is no obligation on trusts to distribute the full amount, the Advisory Committee on Clinical Excellence Awards takes the view that trusts should spend the minimum investment each year. There is no limit to the maximum number of employer-based awards that a trust can allocate. Currently 61 per cent of consultants hold an award (47 per cent hold an employer-based award with 14 per cent holding a national award). While the Advisory Committee on Clinical Excellence Awards reviews national awards every five years, employer-based awards are not reviewed to ensure that they continue to reflect performance above the norm with the exception of Level Nine awards which are reviewed every five years (paragraphs 2.18 and 2.19).

Job planning:

- Ninety-seven per cent of consultants now have a job plan, although 16 per cent of these have not been reviewed in the last 12 months. Many trusts are not implementing the good practice guidance published jointly by NHS Employers and the British Medical Association in 2011. For example, only 18 per cent of trusts stated that all or most job plans contain SMART (specific, measurable, achievable and agreed, realistic, timed and tracked) objectives. Only 56 per cent of trusts confirmed that individual and trust objectives are aligned in all or most job plans. Around two-fifths of trusts do not set objectives for supporting professional activities for all or most consultants, with only 23 per cent monitoring their completion for all or most consultants (paragraphs 2.21 to 2.24 and 2.28).

On implementing the Committee of Public Accounts' recommendations

15 There has been limited progress in implementing the Committee of Public Accounts' recommendations, designed to better manage consultants. There were 12 recommendations in the Committee's 2007 report on the contract:

- One was addressed solely to the Department and has been implemented.
- One was addressed to the Department and NHS Employers and has been partly implemented.
- Three were for NHS Employers with one fully, one partly and one not implemented.
- Six were for NHS trusts. One of which was not accepted by the Department. Of the remaining five, one was partly implemented and four not implemented.
- One was directed at consultants and has been partly achieved (paragraph 3.3).

Conclusion on value for money

16 NHS consultants play a key role in treating patients. Under the 2003 consultant contract, the NHS increased consultants' pay, investing up front for future benefits it hoped to achieve. Most of the expected benefits of the contract have been either fully or partly realised which has improved the value for money of consultants to the NHS.

17 Despite some good practice, it is reasonable to expect that more progress would have been made in improving trusts' management of consultants and realising the full benefits of the contract. We cannot, therefore, conclude that value for money has been fully achieved. There are still, for example, a number of trusts who have not fully implemented key elements of the contract and good practice management. Less than a third of trusts stated that pay progression for all or most consultants either depended on achieving objectives set out in job plans or achieving objectives from appraisals. Trusts reported that 19 per cent of consultants have not had an appraisal in the last 12 months. In addition, most trusts continue to use locally agreed rates of pay well above defined contractual rates to secure extra work from consultants.

Recommendations

18 The Department, NHS Employers and trusts must review and implement the Committee of Public Accounts' recommendations made in 2007. We make a number of further recommendations to improve the management of consultants and, therefore, value for money.

a **Trusts should ensure that consultants are engaged in meeting trusts' objectives and held to account for their performance.** Given the key role played by consultants across the NHS, trusts and consultants need to work together if the NHS is to achieve the Department's significant efficiency savings over the next four years. In particular, trusts should:

- devolve responsibility and accountability to consultants for designing and providing services, for example through service-line reporting and management;
- ensure the trust's objectives and consultants' individual objectives are clearly aligned;
- ensure good communication between senior management and consultants; and
- hold consultants to account for meeting the objectives and activity levels agreed in job plans through the appraisal process and pay progression.

b **Trusts should ensure that clinical managers have the right skills and support to get the best out of consultants.** Giving clinical managers more time, training and support should ensure that consultants are better managed. This should improve patient care and help to meet trust objectives. In particular, trusts should:

- ensure clinical managers have sufficient time to undertake their role;
- give appropriate financial and administrative support to help clinical managers better plan and allocate consultant time, within activity and financial boundaries; and
- give clinical managers formal financial, administrative and management training, as well as on-the-job training and coaching.

c **Trusts should implement the joint NHS Employers and British Medical Association guidance on job planning.** Job planning is the key way to manage consultants' time. Implementing the latest guidance, including SMART (specific, measurable, achievable and agreed, realistic, timed and tracked) objectives, should ensure job planning is collaborative and trust and consultant objectives are aligned to make service and productivity improvements.

d **The Department and NHS Commissioning Board should work with trusts to improve the quality and use of information to better understand and improve consultant performance.** Robust information will improve transparency and improve how well trusts assess consultant's performance, for example, through benchmarking performance within specialty areas.

e **The Department and trusts should ensure that consultant's financial rewards reflect performance.** Pay progression in most trusts is not linked to performance. With the annual national and employer-based Clinical Excellence Awards costing £500 million in 2011-12, it is important that awards accurately reflect exceptional performance. In particular:

- trusts should ensure that pay progression is linked to consultant performance; and
- the Department should instruct the Advisory Committee on Clinical Excellence Awards to review national awards more often than every five years and trusts to begin to regularly review Level One to Level Eight employer-based awards.

Part One

The 2003 consultant contract

1.1 This part of the report gives an overview of the role and cost of consultants. We review progress made in achieving the expected benefits of the 2003 consultant contract.

The role and cost of NHS hospital consultants

1.2 NHS consultants (consultants) are highly trained, senior doctors who lead on the majority of care delivered in hospitals. Recent evidence shows the benefits of consultant-delivered services.[1] All trusts in our census stated that consultants play a key role in achieving good clinical outcomes. Ninety per cent of trusts agreed that consultants work beyond what they are contracted to do. In addition to direct patient care, consultants have a crucial role in leading clinical teams, managing other consultants and in work that benefits the NHS more widely, such as teaching.

1.3 At September 2012, the NHS employed 40,394 consultants (38,197 on a full-time equivalent basis), primarily within acute hospitals, across a range of specialties (**Figure 1** overleaf).

1.4 Consultants represent a significant cost to the NHS. For example, in 2011-12:

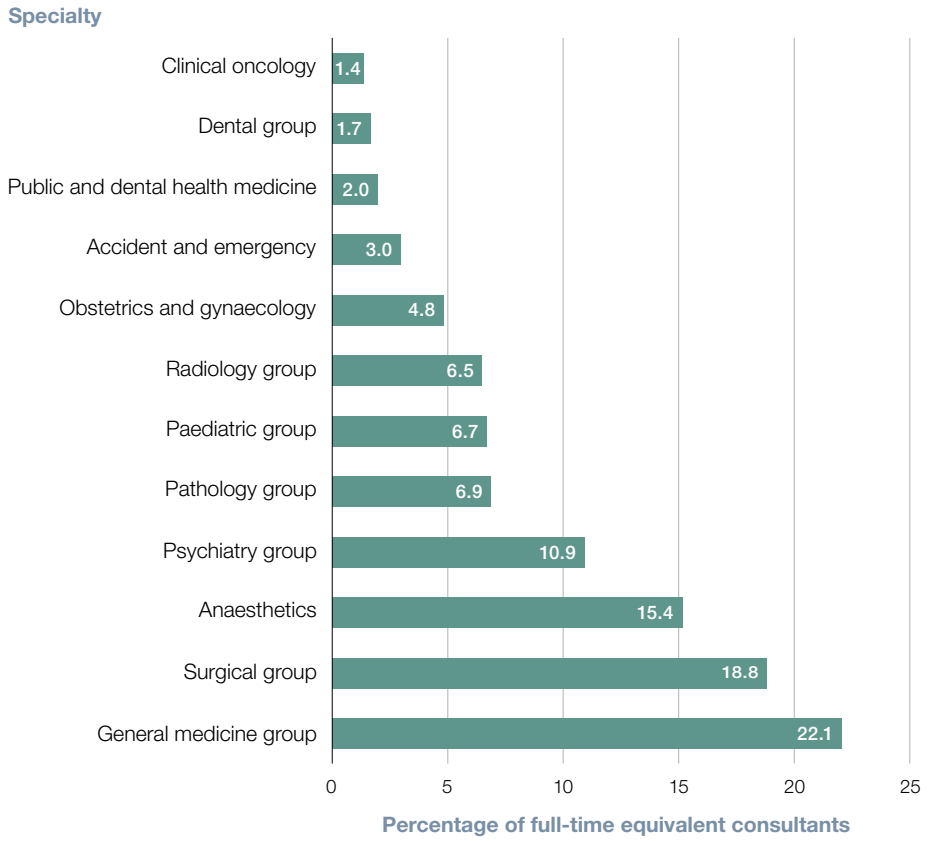
- The total employment cost of consultants was £5.6 billion, of which 81 per cent was consultants' earnings, with employer pension and employer National Insurance contributions each accounting for 9.5 per cent.
- In 2011-12, consultants made up 4 per cent of all NHS hospital and community health service full-time equivalent staff, accounting for 13 per cent of related employment costs.[2]
- Basic salary accounted for 75 per cent of consultant's total earnings of £4.5 billion in 2011-12, with the remainder made up of other payments, including Clinical Excellence Awards, programmed activities not included in job plans and payments for being on call.[3]

1 Centre for Workforce Intelligence, *Shape of the Medical Workforce,* February 2012.
2 Department of Health, analysis of internal pay bill data, 2012.
3 NAO analysis of data from the NHS Electronic Staff Record Data Warehouse. The Electronic Staff Record collates national workforce data from several payroll systems into a single database.

Figure 1

Consultant numbers by specialty for full-time equivalent staff in 2011

Consultants work across a range of specialties, with the majority working in general medicine, surgery and anaesthetics



NOTE

1 The data covers consultants working in the NHS Hospital and Community Health Service in England.

Source: Health and Social Care Information Centre, Workforce statistics, March 2012. Available at: www.ic.nhs.uk/searchcatalogue?productid=4876&topics=1%2fWorkforce%2fStaff+numbers&sort=Relevance&size=10&page=2#top

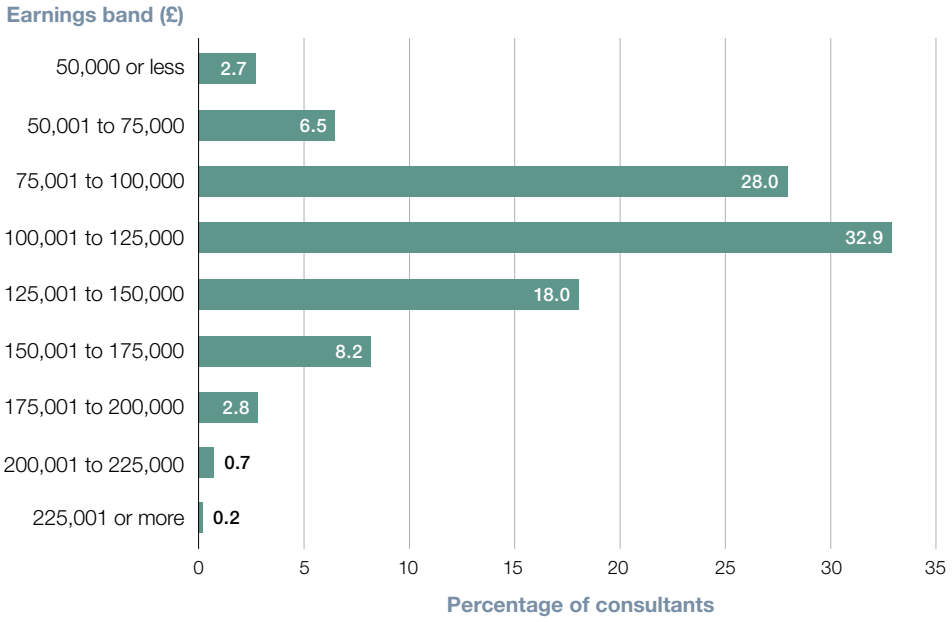
1.5 Between October 2011 and September 2012, the average annual (median) basic salary of consultants was £84,000 with median total earnings of £109,000.[4] **Figure 2** shows the number of consultants across earnings bands, with a wide variation in total earnings.

4 Health and Social Care Information Centre data. Median data is rounded up to the nearest £500. The equivalent mean (average) basic salary was £82,315 and mean total earnings £109,651. Mean data is per person, not per full-time equivalent. 'Mean' is the mathematical average and 'median' or middle is the point at which 50 per cent of salaries fall.

Figure 2

Consultant total earnings by earnings bands for the 12 months to September 2012

There is a wide variation in total consultant earnings, with 62.8 per cent of consultants earning £100,000 or more



Source: Health and Social Care Information Centre. Workforce statistics: NHS staff earnings, September 2012 (provisional data). Available at: www.ic.nhs.uk/searchcatalogue?productid=10239&topics=1%2fWorkforce%2fStaff+earnings&sort=Relevance&size=10&page=1#top

Introducing the 2003 contract

1.6 In October 2003, the Department of Health (the Department), as part of the modernisation of contracts for all NHS employees, introduced a new consultant contract (the contract), which we examined in 2007.[5] The contract is one of several tools available to achieve good value from consultants for patients and taxpayers. The contract changed the terms and conditions of consultants and how their work was managed. It was designed to provide:

- a career structure and remuneration package that rewards and incentivises consultants who make the biggest contribution to delivering services;
- a stronger contract framework so managers can better plan consultants' NHS work;
- increased consultant commitment to the NHS, for example, by preventing an increase in private practice work; and
- better arrangements for supporting consultants' professional development and greater clarity and transparency about their time commitments to the NHS.

5 Comptroller and Auditor General, *Pay Modernisation: A New Contract for NHS Consultants in England*, Session 2006-07, HC 335, National Audit Office, April 2007.

1.7 Our 2007 report showed that, by the summer of 2006, 89 per cent of consultants were on the contract. Department of Health estimates show that this has increased to 97 per cent by 2012.[6] Our case study evidence shows that some consultants remained on the old contract to, for example, maintain a greater degree of control over their working life and their private practice commitments.

The cost of the 2003 contract

1.8 An explicit objective of the contract was to invest additional resources into consultant pay at a time of real terms growth in funding for the NHS. Overall, introducing the contract increased the cost of employing consultants for the NHS:

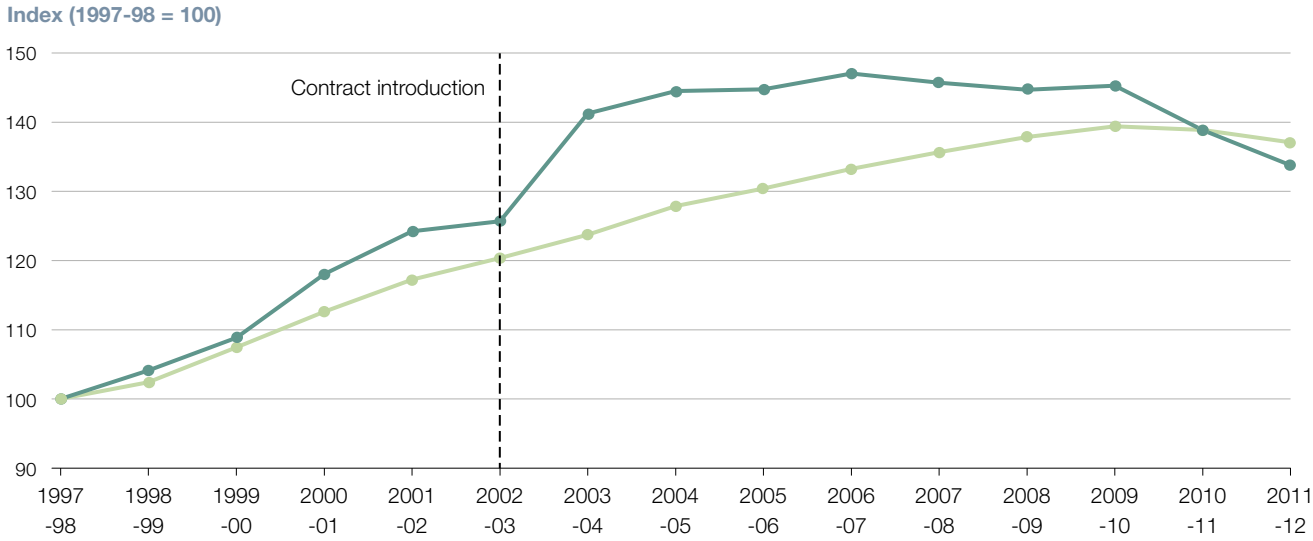
- In 2002-03, the consultants' salary band was £52,640 to £68,505. Under the contract, this increased to £65,035 to £88,010 (2003-04). This equates to a 24 per cent increase in the bottom of the pay band and a 28 per cent increase in the top of the pay band, a recurring cost built into the lifetime of the contract.
- Eighty-one per cent of trusts stated that they now paid for work, which they had not previously paid for under the old contract.
- Between 2003-04 and 2005-06, the Department gave the NHS £715 million (£839 million in 2011-12 prices) of funding to cover the additional cost of the contract. In 2005-06, the recurring additional funding to the NHS was around £400 million a year, covering the additional cost of the contract and the continued growth in consultant numbers. Although not an additional burden to the NHS, it was an additional cost to the taxpayer.
- Between 2002-03 and 2003-04, total earnings per full-time equivalent consultant increased by 12 per cent in real terms with the growth in consultant earnings moving significantly ahead of the growth in overall hospital and community health service average staff earnings (**Figure 3**).
- Between 2003-04 and 2006-07, consultant earning grew by an average of 1.3 per cent compared to 4.9 per cent between 1999-00 and 2002-03.
- Figure 3 shows that between 2006-07 and 2011-12, earnings per full-time equivalent consultant fell by 9 per cent in real terms. This is largely due to the recent pay restraint.

6 Department of Health analysis of data from the NHS Electronic Staff Record Data Warehouse, 2012.

Figure 3

Real-terms growth in earnings per full-time equivalent consultant and per full-time equivalent hospital and community health service staff between 1997-98 and 2011-12

The 2003 contract increased the cost of employing consultants for the NHS



NOTES

1 The data is in 2011-12 prices using the HM Treasury GDP deflator (real terms).

2 The employer pension contribution rate increased from 7 to 14 per cent in 2004-05 increasing total employment costs.

3 There is a break in the time series between 2007-08 and 2008-09 when data collection methods changed. However, analysis of the 2008-09 (the overlapping year) data indicates minimal difference in results.

4 Appendix Three (online only) provides the underlying data behind this chart.

Source: Department of Health, analysis of internal pay bill data

Setting a baseline and monitoring the impact of the contract

1.9 There was some evidence on consultants' working practices before 2003.[7] However, the Department only established a partial baseline against which to monitor the implementation of the contract. While the Department held data in areas such as the number of consultants, participation rates and contract costs, it did not hold data on the number of consultants with job plans, the extent of consultant private practice work and the amount of direct clinical care. This made it difficult to determine the full impact of the new contract – especially given responsibility for implementation was devolved to NHS trusts.

7 MORI, *Survey of hospital consultants: research study conducted for the Office of Manpower Economics*, June 1998; and, Health Select Committee, *Consultants' contract*, Third Report of Session 1999-2000, HC 586, July 2000.

1.10 The Department did, however, conduct two surveys of consultants in 2004 and 2005. The surveys monitored, for example, the number of programmed activities being worked and the number of consultants undertaking private practice. It also commissioned NHS Employers to run the Large Scale Workforce Change Consultants Contract Programme. The programme involved 47 NHS trusts between October 2007 and June 2008, and highlighted how service improvements can be achieved through the contract. However, there has been no recent monitoring of the impact of the contract.

Achieving the expected contract benefits

1.11 The Department's business case to HM Treasury outlined a number of expected benefits of the contract. As outlined in **Figure 4** and discussed further in the following paragraphs, the new contract has had a number of positive impacts. But some of the expected benefits have not been fully realised.

Figure 4
Progress in realising the expected benefits of the 2003 contract

Expected benefit	Progress in realising the benefit
Limit increase in private practice	Realised
Increase consultant participation	Realised
Increase consultant productivity	Realised
Improve management of consultants' time	Partly realised
Slow pay progression	Partly realised
Extend patient services	Partly realised
Secure extra work at standard contractual rates	Partly realised
Reduce waiting times	Waiting times have reduced. However it is not possible to determine the contracts' impact
Increase time spent on direct clinical care to the expected typical level of 75 per cent	Not applicable – individual trusts should decide the level of direct clinical care locally

Source: National Audit Office analysis

Benefits fully realised

Preventing increases in private practice work

1.12 We found that the contract has ensured that consultants' private practice work did not increase. In 2012, 39 per cent of consultants undertook private practice work, a significant fall from the two-thirds reported in the 2000 Health Select Committee's report.[8] However, when applying these percentages to the headcount number of consultants in the same years, we found that the number of consultants undertaking private practice work has remained relatively stable. We estimate that 16,349 consultants undertook private practice work in 2000 (67 per cent of 24,401) compared with 15,754 in 2012 (39 per cent of 40,394).

1.13 We also found that most consultants, in line with the terms of the contract, prioritise NHS work over private practice work. Consultants who work ten programmed activities or fewer must provide one additional programmed activity to the NHS before carrying out any private work. Seventy-two per cent of trusts stated that all or most consultants do so where required.

Increasing consultant participation

1.14 The Department's business case to HM Treasury expected an additional 550 full-time equivalent consultants by 2005-06 due to increased participation of consultants. Since 2003, the participation rate (the ratio of full-time equivalent consultants to headcount) has increased. Between 2003 and 2011, the participation rate moved above the long-term trend growth rate per year of 0.1 per cent from 1992 to 2003 to 0.7 per cent from 2003 to 2006; and to 0.4 per cent from 2006 to 2011.[9] We calculate that the increase in participation between 2003 and 2006 was equivalent to an increase of over 560 full-time equivalent consultants.[10]

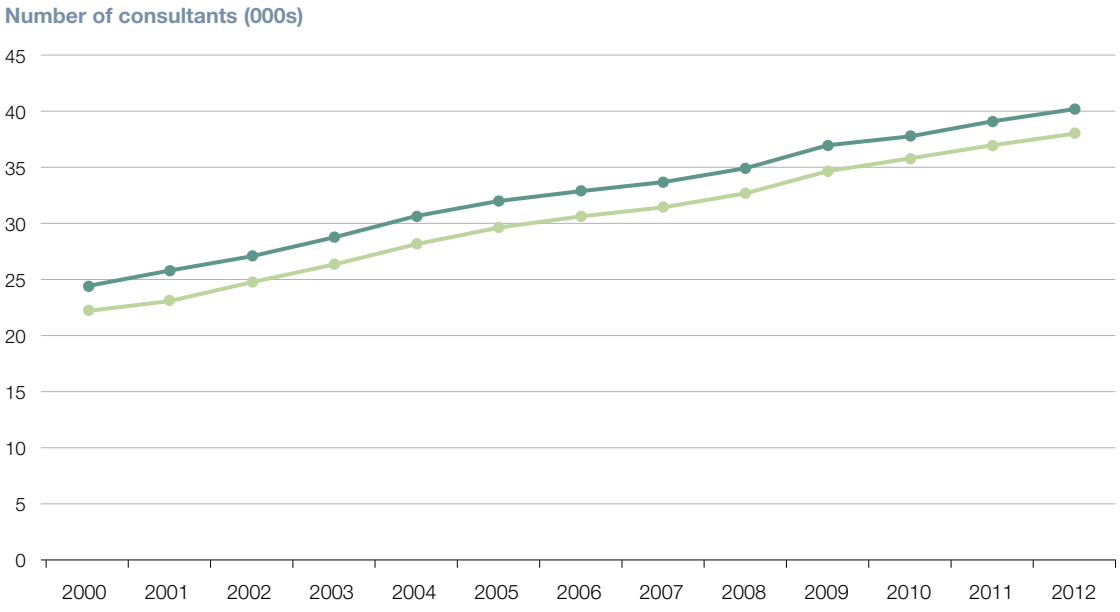
1.15 While the Department states that the increase in participation rates reflects additional time spent by consultants on NHS work, we think other factors will have also played a part. For example, the introduction of the contract resulted in previously unrecorded and unpaid work being paid for and included in job plans under the contract. As trusts record these additional paid hours, consultants will appear to be doing more NHS work. In addition, with the quantity of private practice work relatively stable, the growth in headcount means private practice work is spread more thinly across consultants, resulting in increased participation rates. It is not possible to determine the magnitude of these additional factors on the overall increase in participation.

8 Health Select Committee, *Consultants' contracts*, Third Report of Session 1999-2000, HC 586-I, July 2000.
9 Figures are based on Department of Health unpublished analysis of workforce statistics data from the Health and Social Care Information Centre.
10 The calculation involves applying age and gender participation rates for 2003 to the 2006 headcount age and gender cohorts.

1.16 While the number of full-time equivalent consultants has increased since 2000 (**Figure 5**), the rate of growth was faster before the 2003 contract (5.9 per cent a year between 2000 and 2003) than in the three years immediately after (5.1 per cent a year between 2003 and 2006). Growth slowed further between 2006 and 2012 (3.8 per cent a year). The overall growth in full-time equivalent consultants is affected, primarily, by the headcount number. This is related to, for example, the number of medical places at university; and the supply of overseas consultants. The 2000 NHS Plan set a target to increase the number of consultants by 7,500 by 2004, which is likely to have been a key driver behind the strong growth rate before 2003.

Figure 5
Growth in consultant numbers between 2000 and 2012

The overall number of full-time equivalent consultants has increased since 2000, but numbers grew faster before the 2003 contract



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Headcount	24,401	25,782	27,070	28,750	30,650	31,993	32,874	33,674	34,910	36,950	37,752	39,088	40,394
Full-time equivalent	22,186	23,064	24,756	26,341	28,141	29,613	30,619	31,430	32,679	34,654	35,781	36,965	38,197

NOTE

1 Data for 2000–2012 is for September of each year.

Source: Health and Social Care Information Centre, Workforce statistics. Available at: www.ic.nhs.uk/searchcatalogue?productid=4876&topics=1%2fWorkforce%2fStaff+numbers&sort=Relevance&size=10&page=2#top

Increasing consultant productivity

1.17 The Department achieved the expected benefit. The Department's business case expected consultant productivity to improve by two percentage points a year against a declining trend. Of this, 1.5 percentage points was expected from efficiency improvement with a 0.5 percentage point from quality improvements. Consultant productivity is difficult to measure. There is no baseline against which to measure quality improvements. Therefore, we assess performance against the 1.5 percentage point efficiency improvement element. The Department's measure divides the Office of National Statistics Hospital and Community Health Services outputs (not quality adjusted) by the number of consultants. Although this measure is crude, it shows that consultant productivity continued to fall after 2003, although with the decline slowing by, on average, 1.6 percentage points a year (**Figure 6**).

Figure 6
Annual average change in consultant productivity

The fall in consultant productivity slowed significantly following the introduction of the contract in 2003

	Hospital and Community Health Services output (annual average change) (%)	Consultant numbers (annual average change) (%)	Consultant productivity (average annual change) (%)
Before the contract (1995–2003)	3.0	4.9	-1.8
After the contract (2003–2010)	4.3	4.5	-0.2
Change in productivity due to efficiency improvements (target 1.5 per cent)			**1.6**

NOTES
1 Office of National Statistics Hospital and Community Health Services (HCHS) data are not adjusted for quality.
2 Output data and consultant numbers are for England only.
3 Some elements of HCHS output are not consultant-led. However, this only makes up around 2 per cent of the total HCHS output figure. Therefore, we have not excluded this data.
4 Total may not sum exactly due to rounding.

Source: Department of Health analysis of Office of National Statistics data and consultant numbers

1.18 Using a different measure of productivity, recent work by York University shows a downwards trend in finished episodes per consultant (the time a patient spends under the care of a particular consultant) per month between 1999 and 2009. They concluded that the contract had no or a negative impact on the declining trend in the ten specialty areas analysed.[11]

1.19 The above work does not consider changes in the quality of consultant's work or changes to other staff groups. Adjusting for quality has, on average, had a positive impact on Hospital and Community Health Service outputs since 2001-02. However, sufficient quality adjusted output data is not available prior to the introduction of the contract to compare quality adjusted consultant productivity measures before and after the contract was introduced. The hours worked by junior doctors have reduced since the European Working Time Directive was phased in. From 2004, junior doctors worked a 58-hour maximum average working week and then a 56-hour average from 2007. The 48-hour working week was fully implemented from August 2009. This may have adversely affected productivity as junior doctors are core members of the consultant-led teams. However, the increased use of specialist nurses may have contributed to improvements in productivity by generating efficiencies through, for example, nurses: conducting some surgical procedures; enhancing post-surgery symptom control; reducing the length of stay; and freeing up of consultant appointments for other patients.

1.20 Difficulties for trusts in measuring consultant productivity are compounded by the lack of current national guidance on this. The Department published a toolkit to compare individual consultant activity levels for 2005-06 and 2006-07 but this was discontinued. Only 8 per cent of trusts stated that there was effective national guidance on measuring consultant productivity.

Benefits partly realised

Managing consultants' time better

1.21 The contract has improved how consultants' time is managed, with more emphasis on job planning. Consultants' duties are based on three- or four-hour blocks of activities known as programmed activities:

- Ninety-seven per cent of consultants stated that they have a job plan, compared with 96 per cent in 2006 and 79 per cent in 1998.[12]
- Fifty-eight per cent of trusts said that the contract helped to better manage consultants' time, with our case study trusts agreeing that it had increased the transparency of consultant's work.
- However, 16 per cent of consultants with a job plan had not had it reviewed in the last 12 months.

11 Bloor K, Freemantle N, Maynard A. 'Consultant contracts and the effect on clinical activity in the NHS: retrospective analysis of secondary data', *Journal of the Royal Society of Medicine*, vol. 105 issue 11, November 2012.

12 MORI, *Survey of hospital consultants: research study conducted for the Office of Manpower Economics*, June 1998.

Slowing pay progression

1.22 The contract introduced a longer time period for consultants to progress up the pay scale. Under the contract it takes 19 years for a consultant to achieve a 30 per cent basic pay progression, compared with only four years under the old contract. However, only 10 per cent of trusts reported that the contract had reduced the cost of consultants moving up the pay scale. Evidence from our case studies suggests that this low percentage reflects the 24 and 28 per cent increase in the bottom and top of the pay bands, introduced in 2003. This increase has driven up the pay bill for consultants over and above any savings arising from the slowdown in pay progression.

1.23 We also found that pay progression is currently the norm. Less than a third of trusts stated that pay progression for all or most consultants either depended on achieving objectives set out in job plans (29 per cent) or achieving objectives from appraisals (30 per cent). This is despite the contract and the Department's business case to HM Treasury explicitly linking pay progression with performance.

Extending patient services

1.24 Overall, the contract has to some degree helped to extend patient services, such as evening and weekend work. Recent evidence shows the benefit of extending consultant-delivered services during evenings and weekends, where mortality rates are generally higher and patient care can be compromised.[13] Case study participants stated that the contract can facilitate weekend and evening work. This is especially where consultants believe that clinical outcomes for patients can be improved. However, the contract does give consultants the right to refuse work outside 7am to 7pm Monday to Friday. Thirty-four per cent of trusts stated that the contract helped them increase the provision of services for patients.

13 Royal College of Physicians; *An evaluation of consultant input into acute medical admissions management in England*. England, 2012; N Freemantle et al., 'Weekend hospitalisation and additional risk of death: an analysis of inpatient data', *Journal of the Royal Society of Medicine*, vol. 105 issue 2, 2012, pp. 74–84.

Securing extra work at standard contractual rates

1.25 Most consultants, who are working ten programmed activities a week, work an additional programmed activity at defined contractual rates before undertaking private practice work. Our surveys show that, on average, consultants are contracted for more than 11 programmed activities a week. In addition, some trusts secure further extra work at defined contractual rates. However, despite the contract providing a clear structure for paying for additional work at defined contractual rates, most trusts continue to use locally agreed rates of pay for additional work outside that agreed in job plans, as allowed for under the contract, for example to help reduce waiting times. This is likely to be linked to the fact that the contract allows consultants to refuse to work outside 7am to 7pm Monday to Friday. For example:

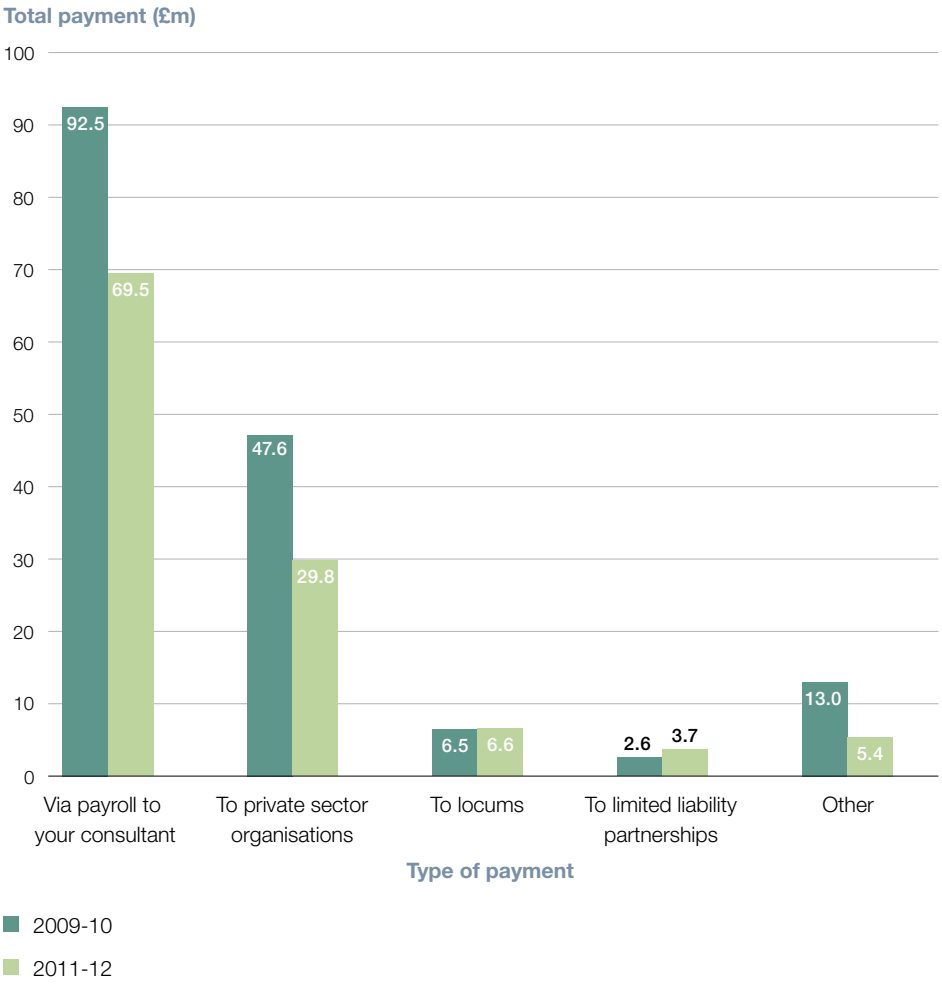
- Ninety-one per cent of trusts (of the 97 trusts who responded) stated that they pay for additional work using locally agreed rates. Fifty-four per cent do so for at least 90 per cent of extra work. On average, 71 per cent of extra work is secured using locally agreed rates.
- The average rate reported by trusts for the last 12 months was between £48 and £200 per hour with a mean of £119 and median of £114. Based on the top and bottom of the consultant pay scale, contractual rates range between £36 and £64 per hour.[14]
- Trusts often pay consultants locally agreed rates to reduce waiting lists. Only 84 trusts could provide either full or partial data on payments to reduce waiting lists for 2011-12 (**Figure 7**). These trusts spent an estimated £115 million in 2011-12.

14 The range of locally agreed rates is based on data from 46 trusts. Bottom of the pay scale: (£74,504/52 weeks a year/40 hours a week) = £36 per hour. Top of the pay scale: (£100,446/52 weeks a year/40 hours a week) = £48 x 1.33 = £64 per hour. We have multiplied the top of the pay scale by 1.33 to reflect that programmed activities are three, rather than four, hours during premium times.

Figure 7

Payments trusts made to reduce waiting lists between 2009-10 and 2011-12

Trusts paid £115 million to consultants in 2011-12 to reduce waiting lists, often at locally agreed rates



NOTES

1 Data has been converted to 2011-12 prices using HM Treasury GDP deflator to adjust for inflation.

2 Only 77 of 137 trusts could provide data for 2009-10. Only 84 of 137 trusts could provide data for 2011-12. Of trusts providing data, some could not do so for all expenditure categories.

Source: National Audit Office 2012 trust census

Other expected contract benefits

Reducing waiting times

1.26 Waiting times have reduced significantly over the past ten years, with average (median)[15] inpatient waiting times falling from 13 weeks in 2001-02 to just over four weeks in March 2010. It is not possible to separate the impact of the contract on waiting times, including better management of consultant time, from a range of other government policies designed to reduce waiting times such as: the 2000 NHS Plan to reduce waiting times by 2005; 2004 NHS Improvement Plan which promised that, by 2008 no one will have to wait longer than a maximum of 18 weeks; and increased funding in baselines to sustain low waiting times. Nineteen per cent of trusts stated, however, that the contract had helped to reduce waiting times.

Increasing direct clinical care

1.27 Total direct clinical care paid (time spent providing care to patients) as a percentage of total paid time has not, on average, reached the indicative 75 per cent suggested in the contract based on a number of recent surveys of consultants. However, we have not assessed progress against this benefit as it is for managers and clinicians to determine the appropriate level of direct clinical care. In addition, there is also no data available for 2002 to use as a baseline comparison for before the contract was introduced.

1.28 Even so, comparing the level of 'direct clinical care paid' against 'total time paid' across three recent surveys shows a range of 69.2 to 73.1 per cent. This compares to 74 per cent (2004) and 72.6 per cent (2005) based on the Department's surveys. Our trust survey did indicate that on average across trusts the ratio was 75 per cent, although only 72 of 137 trusts could provide data. In addition, there is no comparable trust level data for earlier years. Consultants do, on average, undertake some unpaid direct clinical care work. As a measure of value for money, we compared the level of direct clinical care worked (both paid and unpaid) against total time paid. This shows a range of 77 to 82 per cent (**Figure 8**), above the indicative level of 75 per cent.

1.29 In 1998, MORI conducted a survey of consultants for the Review Body on Doctors' and Dentists' Remuneration. This showed the ratio of direct clinical care to total hours (paid and unpaid) in the range of 64 to 67 per cent. The Department consider this evidence to show that direct clinical care as a percentage of total time did increase after the introduction of the contract. However, we do not consider this an adequate baseline to judge the impact of the contract as the MORI survey was conducted five years before the contract was introduced. A direct comparison with our consultant survey shows that the amount of direct clinical care (paid and unpaid) in 2012 is 64 per cent.[16]

15 Median or middle point up to which 50 per cent of patients wait.
16 MORI Social Research, *Survey of hospital consultants: research study conducted for the Office of Manpower Economics*, May to June 1998.

Figure 8

Direct clinical care as a percentage of total time worked, from recent consultant surveys

The amount of direct clinical care has remained relatively stable

Survey source	Direct clinical care	Total time	Direct clinical care as percentage of total time (%)	Direct clinical care worked (paid and unpaid) as percentage of total time paid/ contracted (%)
British Medical Association (2010 survey)				
Contracted (paid)	31.5 hours	43.1 hours	73.1	81.2
Worked (paid plus unpaid)	35.0 hours	47.9 hours	73.1	
Royal College of Physicians (2010 survey)				
Contracted (paid)	7.4 programmed activities	10.6 programmed activities	69.5	77.3
Worked (paid plus unpaid)	8.2 programmed activities	11.9 programmed activities	68.9	
National Audit Office (2012 consultant survey)				
Paid	8.2 programmed activities	11.9 programmed activities	69.2	81.5
Worked (paid plus unpaid)	9.7 programmed activities	15.2 programmed activities	63.8	

NOTES

1 Numbers shown are mean (mathematical average) values across the survey population.

2 Averages include those for both full-time and part-time consultants.

3 The 69.5 per cent figure is taken directly from the Royal College of Physicians publication and due to rounding cannot be directly calculated from the numbers in the table.

4 Royal College of Physicians data are for the UK. British Medical Association data are also for the UK with the survey results weighted (adjusted) to take account of sample bias.

5 Our report shows a figure of 11.2 programmed activities on average across trusts at paragraph 2.25 which is taken from our census of trusts, rather than survey of consultants.

Source: British Medical Association, BMA survey of the consultant contract in a changing NHS, August 2010; Federation of the Royal Colleges of Physicians of the UK, Census of consultant physicians and medical registrars in the UK, 2011; and NAO 2012 consultant survey

Part Two

The management of hospital consultants

2.1 NHS trusts manage consultants directly. The Department of Health (the Department) is responsible for all trusts as their expenditure counts against, and must be contained within, the Department's budget. The Department has no power to direct NHS foundation trusts. It can direct NHS non-foundation trusts, but does not intervene in day-to-day operational management, which includes managing consultants. The Department's policy is that all trusts should become NHS foundation trusts by 2014, or as soon as possible afterwards.

2.2 Trusts need to manage consultants effectively. Academic literature links hospital performance and their clinical outcomes with a number of management practices. These include, the degree of consultant engagement in improving performance; the quality of clinical management; and how well human resource practices, such as performance management and appraisals, are used.[17] Effective management will enable value for money to be improved and the expected benefits of the contract to be fully realised.

2.3 This part of the report reviews how well trusts apply good practice in the above areas. Our case studies highlighted areas of good practice. Our survey results showed that while many trusts had implemented some aspects of good practice, there are still significant gaps with many trusts not managing consultants effectively.

17 On clinical engagement, see: J Clark, *Medical engagement: too important to be left to chance*, The Kings Fund, 2012; P Spurgeon et al., *Engaging doctors: can doctors influence organisational performance?*, NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges, July 2008. On medical leadership, see: C Ham and H Dickinson, *Engaging doctors in leadership: what can we learn from international experience and research evidence?*, NHS Institute for Innovation and Improvement, Academy of Medical Royal Colleges and University of Birmingham, March 2008. On human resource management practices, see: A Topakas et al., *NHS staff survey scores as predictors of trust outcomes*, Aston Business School, 2011; M A West et al., The link between the management of employees and patient mortality in acute hospitals, *International Journal of Human Resource Management*, vol. 133 Issue 8, pp. 1299–1310.

Consultant engagement

2.4 Trusts and consultants in our surveys stated that there is a shared sense of purpose and high levels of collaboration between consultants and clinical managers. However, the relationship with non-clinical managers was less positive. Furthermore, consultants stated that their trust was not motivating them to achieve trust objectives. Our results show some differences in opinion between consultants and trusts' senior management in these areas:

- Eighty-two per cent of trusts, stated that all or most clinical managers and consultants have a shared sense of purpose with 75 per cent of consultants agreeing.
- While 66 per cent of trusts stated there was a shared sense of purpose between all or most consultants and non-clinical managers, only 47 per cent of consultants agreed.
- Ninety-three per cent of trusts, and 70 per cent of consultants, stated that there was a high level of collaboration between clinical managers and consultants. However, while 87 per cent of trusts stated there was a high level of collaboration between non-clinical managers and consultants, only 43 per cent of consultants agreed.
- Only 41 per cent of consultants stated that their trust motivates them to achieve trust objectives.

2.5 Although some trusts were more advanced than others, all our case study executive teams were working to build constructive relationships with consultants, to engage them to meet the trust's objectives (**Figure 9** overleaf).

Clinical management of consultants

2.6 Our consultant survey showed that clinical directors in specialty areas typically manage consultants. Clinical directors are overseen by a medical director on the board. In our case studies, some clinical directors had clear sole responsibility and accountability for budgets and services, while others shared the role with non-clinical managers. Clinical directors at our case studies continued to undertake clinical work.

2.7 Both trusts (80 per cent) and consultants (61 per cent) agreed that clinical managers have the right skills to get the best out of consultants. Despite the importance of clinical management, we found a number of issues in recruiting, supporting and training clinical managers across our case studies. Clinical directors were usually recruited for a fixed two- or three-year period through open competition, although some were directly appointed without open competition. While many saw benefits in rotating the role to avoid becoming 'stale', others said they only became effective towards the end of their term. Most clinical directors in our focus groups stated that their primary career focus was their clinical work rather than management. A consistent theme across our case studies was that consultants lacked enthusiasm for applying for clinical director roles.

Figure 9

Examples of engaging consultants – actions by case study trusts

Key feature	Case study example
Trust objectives are clinically focused	**University College London Hospital NHS Foundation Trust's** top three objectives are: patient safety, patient outcomes and patient experience.
Clear alignment between trust and individual objectives	**University College London Hospital NHS Foundation Trust** and **Salford Royal NHS Foundation Trust** annually realign trust, divisional and individual objectives.
Clinical managers are responsible and accountable for providing and improving services	**Salford Royal NHS Foundation Trust** developed a clinical management structure with clinical divisional chairs and clinical directors accountable for providing services.
Empower consultants in redesigning services	**Surrey and Sussex Healthcare NHS Trust** significantly improved ear, nose and throat theatre utilisation, through increased consultant engagement.
High degree of board-level engagement with clinical staff	**Surrey and Sussex Healthcare NHS Trust** recently appointed four clinical chiefs to the board. **University College London Hospital NHS Foundation Trust** board annually negotiates trust objectives with the clinical management team.
Good communications or visible senior management team, or both	**Salford Royal NHS Foundation Trust** ensure: trusts objectives are regularly shared with consultants; there is genuine two-way communication between senior management and consultants; and, the Chief Executive and senior managers regularly attend consultant forums and ward rounds.
Stable senior management teams	Across our case studies, trusts with the strongest relationships with consultants had the longest serving and stable senior management teams.
Building a team-working culture	**Hillingdon Hospitals NHS Foundation Trust** recruits consultants on the basis of good team-working skills and values, as well as clinical ability.

NOTE

1 See Appendices One and Two for details of case study selection.

Source: National Audit Office case studies

2.8 Our case studies and surveys highlighted a lack of support and training for clinical managers:

- Only 42 per cent of trusts thought that all or most clinical managers had enough time to manage consultants effectively. Our clinical director focus groups also raised a lack of administrative support as a key issue. The Royal College of Surgeon's submission noted that clinical director roles are often under-resourced and poorly supported.[18]
- Seventy-eight per cent of trusts had a formal programme for developing clinical leaders and 61 per cent provided specific job planning training for all, or most, clinical managers. However, only 42 per cent provided training to all, or most, clinical managers on how to manage consultants. **Figure 10** summarises case study examples of training and development programmes for clinical managers.

Figure 10
Examples of clinical director training and development programmes

Trust	Programme
University College London Hospital NHS Foundation Trust	**Staff college senior leadership course** A two-day overview followed by four modules covering: self-awareness; self-management; leading teams; and 'big leadership' focused on the interdependency of the preceding three modules.
Salford Royal NHS Foundation Trust	**Clinical leaders' development programme** In 2010, the trust assessed and enrolled existing and aspiring clinical directors on a programme comprising: six master classes (patient first, team approach, inspiring and engaging, change leadership, drive and accountability, strategic problem solving); 360 degree feedback; one-to-one coaching; psychometric tools; action learning; and a work-based change project.
Hillingdon Hospitals NHS Foundation Trust	**Associate clinical director role** Associate clinical directors are appointed to gain on-the-job training for future clinical director roles.

NOTE

1 See Appendices One and Two for details of case study selection.

Source: National Audit Office case studies

18 There are several medical royal colleges across a range of medical specialties with the primary aim of improving patient care. As well as supervising the training of doctors, they also, for example, provide education, training and guidance.

Performance management

Performance information

2.9 Most trusts monitor consultant performance. Seventy-nine per cent of trusts reported monitoring direct clinical care activity levels, with 82 per cent monitoring clinical outcomes for consultants across all or most specialty areas. Trusts used a range of information to monitor performance including: complaints; mortality and readmission rates; finished consultant episodes;[19] and national and local clinical audits.

2.10 Our case study evidence indicated that specialty team level data were regularly monitored, but it was difficult to assess an individual's performance when teams of consultants, registrars and junior doctors are not integrated. This was supported by the submission from the Royal College of Physicians. Furthermore, only 43 per cent of trusts (27 per cent of consultants) thought that information was good enough to accurately assess individual consultant performance.

2.11 Some trusts do not benchmark consultant performance (**Figure 11**), despite consultants stating that comparing their performance against their peers motivated them. Most clinical directors in our focus groups noted that when presented with comparable and transparent data, consultants were keen to improve their performance relative to their peers. Sixty-six per cent of consultants in our survey agreed that improving their performance relative to their peers motivated them.

2.12 Monitoring and benchmarking information needs to be used carefully due to differences in patient case mix and consultant capability. Patient safety could, for example, be compromised if surgeons are required to 'speed up' beyond their capability.

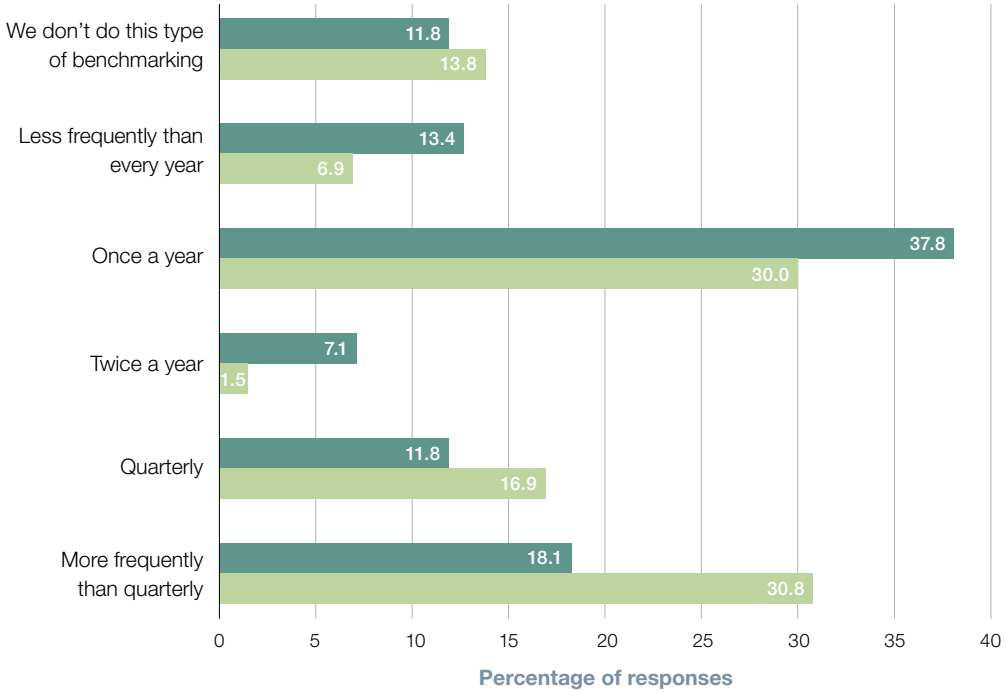
2.13 Monitor, the regulator of foundation trusts, promotes service-line reporting and management to improve trust performance, but many trusts have not yet implemented it. Under service-line reporting and management, trusts use performance information to monitor and manage medical and surgical specialties as distinct operational units. This leads them to better understand performance, organise services and enable clinicians, including consultants, to lead service improvements. Although 62 per cent of trusts surveyed used service-line reporting to monitor performance for all or most specialty areas, only 34 per cent were using service-line management for all or most specialty areas.

19 Refers to the time a patient spends under the care of a particular consultant.

Figure 11

Benchmarking of consultant activity and clinical outcomes across the same specialty areas

Some trusts do not benchmark consultant activity or clinical outcomes, or do so less frequently than once a year



NOTE

1 Of 137 trusts, ten did not answer question (a), with seven not answering question (b), and are excluded from the analysis.

Source: National Audit Office 2012 trust census

Performance assessment

2.14 Managers often find it difficult to challenge consultant performance. Sixty-eight per cent of trusts surveyed stated that non-clinical managers found it difficult to challenge consultant's performance, with 43 per cent reporting that clinical managers also found it difficult to do so. Indeed, only 67 per cent of consultants agreed that their trust held them to account for their performance. Our case studies highlighted a number of reasons for this including: reluctance to risk disrupting services where a consultant is critical to delivery; and junior non-clinical managers finding it difficult to challenge senior consultants.

2.15 Annual appraisals should be a key mechanism for reviewing performance. However, our trust survey showed that only 52 per cent of trusts assess the achievement of individual job plan objectives for all, or most consultants during annual appraisals. Across our case study focus groups with clinical directors and consultants a recurring theme was that appraisals are discussions about personal development rather than formal performance assessments.

2.16 On average across trusts, 17 per cent of consultants did not have an appraisal in the last 12 months,[20] although a higher number of consultants (92 per cent) said that they had done so. Similarly, the NHS Revalidation Support Team's recent report[21] found that only 73 per cent of hospital consultants had completed an appraisal between April 2011 and March 2012.

2.17 In addition to some consultants not having an appraisal, the Royal College of Surgeons' submission and our case studies show that the quality of appraisals varies across trusts. This situation should improve when the General Medical Council introduces revalidation in December 2012 to regulate licensed doctors and ensure they are fit to practise. Consultants will be revalidated every five years through regular appraisals based on the General Medical Council's core guidance for doctors. The Council aims to revalidate the majority of licensed doctors for the first time by March 2016.

Linking performance to financial rewards

2.18 Consultants pay progression is regarded as the norm and does not generally depend on performance. The key way of rewarding consultants' performance is through employer-based and national Clinical Excellence Awards (**Figure 12**). A total of 61 per cent of consultants held a Clinical Excellence Award at the end of 2011 (47 per cent hold an employer-based award with 14 per cent[22] holding a national award). The total cost of employer-based awards in 2011-12 was estimated to be between £310 million and £315 million. The total cost of national awards was £192 million. These costs include employer pensions and National Insurance contributions.[23]

20 Of the 137 trust respondents, 12 could not answer this question.
21 NHS Revalidation Support Team, *Organisational Readiness Self-Assessment (ORSA) Report 2011-12*, August 2012. Available at: www.revalidationsupport.nhs.uk/about_the_rst/rst_projects/Implementation-Support/ORSA/ORSA-report-2011-12.php
22 As defined by the Advisory Committee on Clinical Excellence Awards (ACCEA), national awards include Level 9 Employer-based awards and Distinction Awards B, A and A+.
23 Department of Health estimates.

Figure 12
Types of Clinical Excellence Awards

Clinical Excellence Awards, managed by the Advisory Committee on Clinical Excellence Awards, recognise NHS consultants, clinical academics and senior academic GPs performing above expected standards through pensionable increments to their annual salary.

Employer-based Clinical Excellence Awards: funded by individual trusts, reward consultants for local achievements. There are nine levels from £2,957 to £35,484. Employer-based awards committees recommend individuals for awards. Level One to Eight awards are not reviewed while Level Nine awards are reviewed every five years.

National Clinical Excellence Awards: funded centrally by the Department through the Advisory Committee on Clinical Excellence Awards, reward consultants for national achievements. There are four levels: bronze (£35,484), silver (£46,644), gold (£58,305), platinum (£75,796). The Committee, and its regional subcommittees, recommend individuals for awards, which are reviewed every five years.

Source: Department of Health, Advisory Committee on Clinical Excellence Awards, 2012. Available at: www.dh.gov.uk/health/category/accea

2.19 While most trusts thought Clinical Excellence Awards reflected exceptional performance, less than half of consultants agreed (**Figure 13** overleaf). Sixty-six per cent of trusts thought that (national) awards should be reviewed more often than every five years to better reflect the current performance of consultants. The Prime Minister and Secretary of State for Health, informed by recommendations from the Review Body on Doctors' and Dentists' Remuneration, determine the value of employer-based awards that trusts must fund and distribute. There has been no recent uplift to the number and value of awards in recent years because of the public sector pay freeze. While there is no obligation on trusts to distribute the full amount, the Advisory Committee on Clinical Excellence Awards takes the view that trusts should spend the minimum investment each year. There is no limit to the maximum number of employer-based awards that a trust can allocate.

2.20 Separate submissions from the Royal Colleges of Anaesthetists, Surgeons and Physicians stated the importance of Clinical Excellence Awards in motivating consultants to undertake work over and above what is normally expected.

Job planning

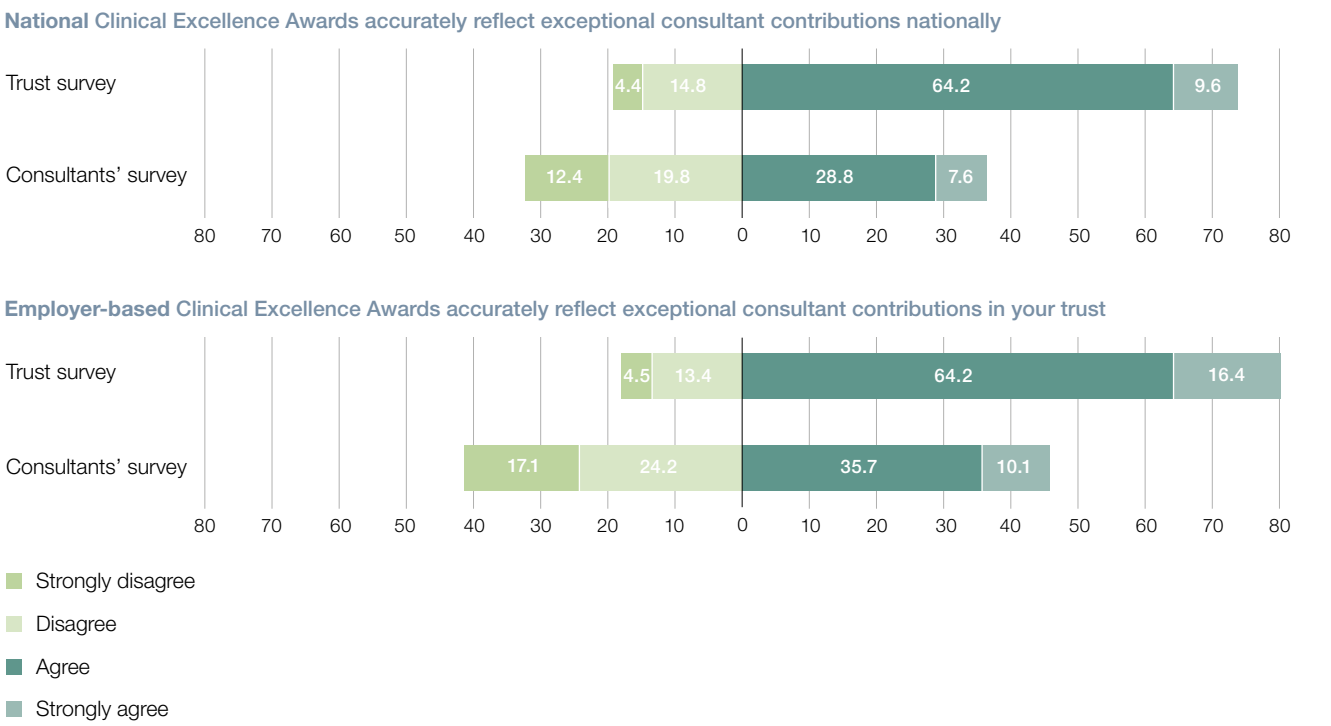
2.21 The Department introduced job planning in 1991 to better manage consultant's time. A job plan outlines a consultant's duties based on three or four hour blocks of activities known as programmed activities. However, many trusts are still not following best practice. The contract increased the focus on job planning. In 2012, 97 per cent of consultants had a job plan, although 16 per cent of these had not had their job plan formally reviewed in the last 12 months. Further, 43 per cent of trusts stated that some of their job plans were rolled over without review.[24] On average across these trusts, 36 per cent of consultant's job plans were rolled over without review in the last 12 months.

24 Seventy-two trusts could not answer this question, left it blank, or provided invalid responses and are not included in the analysis.

Figure 13

Trusts' and consultants' views on Clinical Excellence Awards

While most trusts thought Clinical Excellence Awards reflected exceptional performance, less than half of consultants agreed



NOTES

1 Sixty-two per cent of consultants in our survey stated they had a Clinical Excellence Award, either employer-based or national. Overall, consultants with awards were more likely to agree that they reflected exceptional performance than those without them.

2 For employer-based awards 1.5 per cent of trusts and 13 per cent of consultants selected 'don't know'. For national awards 7 per cent of trusts and 32 per cent of consultants selected 'don't know'.

Source: National Audit Office 2012 trust census and consultant survey

2.22 Despite 83 per cent of trusts stating that they had a central system to collect job planning information from across the trust, many could not provide basic job planning information for our survey. For example:

- twenty per cent could not provide the percentage of consultants who had a job plan agreed in the last 12 months;
- forty-seven per cent could not provide the average number of programmed activities paid for across the trust by activity type;[25] and
- eighty-four per cent could not provide the percentage of consultant's direct clinical care programmed activities worked at weekdays, evenings and weekends.

25 The 47 per cent includes trusts who: provided a partial breakdown with at least one category unknown; provided incorrect data; or provided data which appeared to be an outlier.

The job planning process

2.23 NHS Employers, established in November 2004, provided a range of guidance to support the increased focus on job planning, after the contract was introduced. However, some guidance was published over a year after the contract was introduced.[26] NHS Employers and the British Medical Association issued updated guidance on job planning in 2011 initially issued in 2005,[27] with a particular focus on job planning objectives. Sixty-six per cent of trusts surveyed stated that there was effective national guidance on job planning.

2.24 Many trusts are not yet implementing key aspects of the NHS Employers and British Medical Association's good practice job planning guidance. For example, few trusts stated that job plans contain SMART (specific, measurable, achievable and agreed, realistic, timed and tracked) objectives. Furthermore, job plans are rarely used to redesign services or improve the patient experience (**Figure 14** overleaf).

Programmed activities

2.25 The contract states that a standard full-time job plan will contain ten programmed activities. It also provides an indicative split between direct clinical care (75 per cent) and supporting professional activities (25 per cent) although this is to be determined by individual trusts. Our trust census showed that, on average, trusts paid for 11.2 programmed activities a week[28] the same as we reported in 2006. In 2012, half of trusts reported no change in the number of paid programmed activities over the last 12 months, 34 per cent reported an increase and 11 per cent a reduction.

2.26 Our survey results showed that many consultants do not think their job plans reflect the time they need to do their job effectively (**Figure 15** on page 41). As highlighted in Figure 8 in Part One, many do significant amounts of unpaid overtime.

2.27 Separate submissions from the Royal Colleges of Anaesthetists, Surgeons and Physicians stated the importance of providing adequate time for professional development and how reducing supporting professional activities might affect clinical outcomes. This was supported by our consultant survey with 89 per cent of consultants agreeing that supporting professional activities contributed to improved clinical outcomes. The royal colleges also highlighted increasing reports of trusts not releasing consultants to undertake external duties which benefit the NHS more widely.

26 For example, NHS Employers, *Job planning toolkit*, January 2005.
27 NHS Employers and the British Medical Association, *A guide to consultant job planning*, July 2011.
28 Sixty-five trusts could not provide data across some or all categories of programmed activities.

Figure 14
Trust's compliance with key elements of good practice job planning

Survey question	Percentage of trusts				
	All managers	Most managers	Some managers	No managers	Don't know
Does your trust give clinical managers training on job planning?	27	34	18	20	2
	All job plans	**Most job plans**	**Some job plans**	**No job plans**	**Don't know**
Job plans contain SMART objectives	6	13	53	27	2
Individual job plan and trust objectives are linked	14	42	36	7	2
Achieving job plan objectives is assessed during annual appraisal	23	29	28	18	2
Job plans are used to improve the patient experience	7	16	47	23	7
Job plans are used to redesign services	8	12	62	15	4

NOTE

1 Numbers in the table may not add to 100 due to rounding.

Source: National Audit Office 2012 trust census

2.28 Managing supporting professional activities was a recurring theme across our case studies. Using our survey results, we estimate that consultants were paid around £870 million in 2011-12 for supporting professional activities work.[29] While some case study trusts were looking to manage these activities more closely by requiring consultants to provide proof of completing work, our survey results showed that many trusts are not managing these activities effectively:

- Seventy-two per cent of trusts stated they clearly understood what all or most consultants did during their supporting professional activities.
- Sixty-one per cent of trusts reported that all or most consultants had clear objectives for their supporting professional activity work. Only 51 per cent of consultants stated that they had clear objectives.
- Only 23 per cent of trusts stated that managers monitor completion of supporting professional activity work for all or most consultants.

29 According to our 2012 consultant survey, supporting professional activities make up 19.3 per cent of the total activities paid for by trusts. Multiplying the £4.5 billion paid to consultants in 2011-12 by 0.193 gives a figure of £870 million.

Figure 15

Consultant views on whether their job plan reflects the time they need to do various aspects of their jobs

Area of work	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
Provide good quality patient care	6	54	29	10	1
Update my professional knowledge (supporting professional activities)	4	44	34	16	1
Undertake additional NHS responsibilities	3	33	43	19	2
Undertake external duties	2	31	41	19	7

NOTES

1 Additional NHS responsibilities include, for example: medical director, director of public health, clinical director roles.

2 External duties include, for example: trade union duties; acting as an external member of an advisory appointments committee; and work for the royal colleges in the interests of the wider NHS.

3 Consultants responding 'does not apply to me' are excluded from the analysis.

4 Figures do not always sum to 100 due to rounding.

Source: National Audit Office 2012 consultant survey

Part Three

Progress in implementing the 2007 Committee of Public Accounts' recommendations

3.1 This part reviews the progress made in implementing the recommendations made by the Committee of Public Accounts, in its November 2007 report.[30] While several of these recommendations relate to the areas discussed in Part One and Part Two of the report, they are reviewed here to provide an overview of progress.

3.2 The Committee of Public Accounts made 12 recommendations for the Department of Health (the Department), NHS Employers, trusts and consultants to help realise the benefits of the contract. Overall two have been implemented, four partly implemented and five not implemented, while the Department did not accept one.

3.3 **Figure 16** outlines the individual recommendations, details the actions taken and rates the progress made.

Figure 16
Progress in implementing the Committee of Public Accounts' recommendations

Recommendation	Action taken	Progress
The Department should use sufficient, relevant and reliable data to cost new policies more accurately.	In 2008, the Department implemented a new contract for specialty and associate specialist (SAS) doctors drawing on data from its Electronic Staff Record database and expertise from its Revenue Investment Branch to improve its forecasting.	Implemented
Major new Human Resource policies should be fully piloted within the NHS before implementation to test any assumptions and effects.	Although trusts were able to implement the SAS doctors contract at their own pace it was not piloted prior to implementation. The Department reported that, in 2004, responsibility for negotiating and implementing new arrangements transferred to NHS Employers. In agreeing the details and implementation of new arrangements for SAS doctors in 2008, neither NHS Employers nor the British Medical Association considered piloting was needed. Although not piloted, NHS Employers stated that the longer time frame for implementing the SAS doctors contract afforded opportunities for reflection.	Not implemented
NHS trusts should set boundaries within which managers should negotiate individual contracts based on a clear understanding of what work the trust needs and can afford.	In 2012, only 38 per cent of trusts set financial boundaries within which managers negotiated job plans. Only 71 per cent kept within these boundaries.	Not implemented

30 HC Committee of Public Accounts, *Pay Modernisation: A New Contract for NHS Consultants in England*, Fifty-ninth Report of Session 2006-07, HC 506, November 2007.

Figure 16 *continued*
Progress in implementing the Committee of Public Accounts' recommendations

Recommendation	Action taken	Progress
NHS Employers should help NHS trusts identify appropriate ways of measuring and comparing productivity of consultants locally.	Although discontinued, the Department published a toolkit for 2005-06 and 2006-07 *Delivering Quality and Value: Consultant Clinical Activity* allowing trusts to compare individual consultant and national activity levels. The NHS Institute for Innovation and Improvement (e.g. the Productive Series) and NHS Employers (Large Scale Workforce Change Programme) undertook further productivity improvement work. However, in 2012, only 8 per cent of trusts agreed there was effective national guidance on measuring consultant productivity.	Partly implemented
The Department and NHS Employers should develop training aids and tools, such as electronic job plan software, to help managers improve their capability and capacity to carry out effective job planning.	In 2011, NHS Employers and the British Medical Association issued joint job planning guidance, this updated NHS Employers' guidance published in 2005. No specific tools or software have been developed by the Department or NHS Employers. The Department report that there is no appetite from employers to use/fund centrally developed tools. In 2012, 43 per cent of trusts used electronic job planning software.	Partly implemented
NHS trusts should allocate enough time to medical managers for job planning.	In 2012, only 42 per cent of trusts stated that all/most clinical managers had enough time to manage consultants effectively.	Not implemented
NHS trusts should agree job plans, in partnership with consultants or teams of consultants, which are consistent with organisational objectives and reflect feedback from patients.	In 2012, only 56 per cent of trusts stated that all or most job plans align individual and trust objectives, with only 12 per cent reporting that all or most job plans reflected patient feedback.	Partly implemented
While job plans should be renegotiated annually, managers and consultants should assess individual job plans more frequently and agree to modifications, where appropriate, if they fail to meet patient needs.	In 2012, 82 per cent of trusts formally reviewed job plans once a year with 11 per cent doing so less frequently. Only 2 per cent of trusts stated that they formally review job plans more frequently than annually.	Not implemented
NHS trusts should negotiate job plans for consultants based on the Department's objective that at least 75 per cent of their time should be spent on direct clinical care.	The Department disagreed with this recommendation believing that individuals should determine appropriate direct clinical care levels.	N/A
NHS Trusts should use the job planning process, in partnership with consultants, to redesign services and improve the patient experience.	In 2012, only 20 per cent of trusts used all, or most job plans to redesign services, with only 24 per cent using all, or most job plans to improve patient experience.	Not implemented

Figure 16 *continued*
Progress in implementing the Committee of Public Accounts' recommendations

Recommendation	Action taken	Progress
NHS Employers should identify and share good practice in using job planning to extend patient services and tailor them to patient need.	NHS Employers, through the Large Scale Workforce Change Programme, highlighted good practice job planning. This was incorporated into the joint 2011 NHS Employers and British Medical Association job planning guidance. In 2012, 66 per cent of trusts said national job planning guidance was effective.	Implemented
In return for their increased pay, consultants should increase their support for service redesign with the aim that productivity gains will be achieved by working differently.	In 2012, most trusts reported very/quite high levels of collaboration between non-clinical managers and consultants and between clinical managers and consultants. Respective figures from our consultant survey were 43 and 70 per cent.	Partly implemented

NOTE

1 Recommendations scoring rule: 0 to 49 per cent of trusts = not implemented, 50 to 74 per cent = partly implemented, 75 per cent or greater = implemented. Where other additional actions have been taken assessments may differ.

Source: Department of Health evidence; National Audit Office 2012 trust census and consultant survey

Appendix One

Our audit approach

1 This study examined whether NHS acute foundation and non-foundation hospital trusts manage NHS hospital consultants effectively and consistently. We reviewed:

- whether the Department monitored progress against the expected benefits set out in the original business case for the 2003 consultant contract, and if these expected benefits have been realised;
- how far NHS acute trusts manage consultants effectively and consistently; and
- whether the Committee of Public Accounts' recommendations from their 2007 report had been implemented.

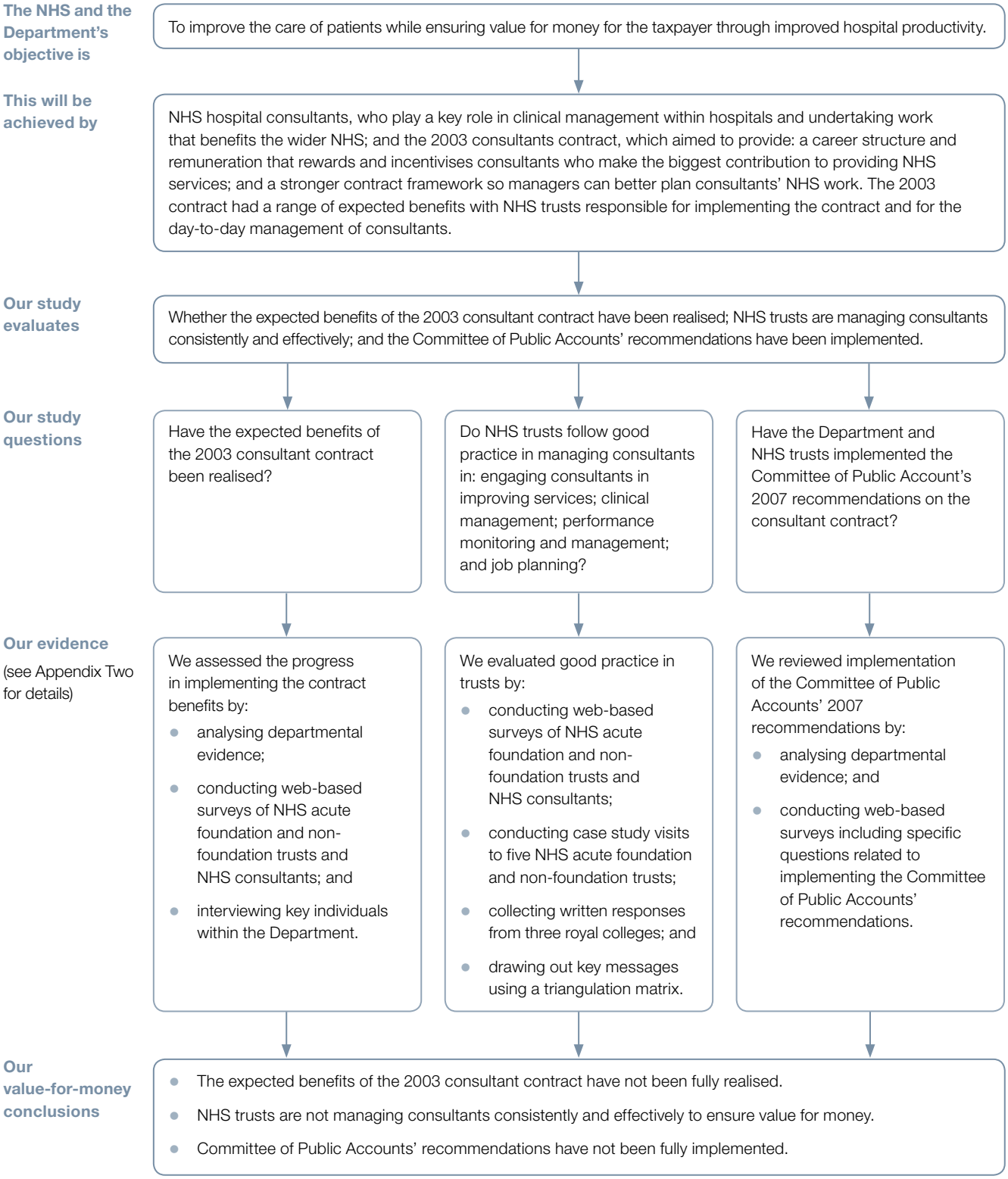
2 In making our assessment we used a combination of different evaluation criteria:

- We assessed the progress made since 2003 against each of the expected benefits of the consultant contract as set out in the Department's business case to HM Treasury.
- We developed a good practice framework to manage consultants drawing on key literature, existing guidance and evidence from our case study visits. The framework covers four keys areas of management: consultant engagement; clinical management; performance management; and job planning.
- We assessed the progress made in implementing each of the Committee of Public Accounts' 12 recommendations.

3 Our value-for-money judgement is based on assessing whether the additional cost of introducing the 2003 consultant contract has resulted in realising the expected benefits. It then draws conclusions about the reasons for not fully achieving all of the benefits.

4 Our audit approach is summarised in **Figure 17** overleaf. Our evidence base is described in Appendix Two.

Figure 17
Our audit approach



Appendix Two

Our evidence base

1 We collected the evidence discussed below between April and October 2012 to independently conclude whether how consultants are managed has realised the expected benefits of the contract and been value for money.

2 To inform the scope and design of our fieldwork, we conducted semi-structured interviews with individuals from a range of stakeholder groups: the Department of Health, NHS Employers; Wrightington, Wigan and Leigh NHS Foundation Trust; the British Medical Association; the Royal College of Physicians; the Royal College of Surgeons; the Royal College of Anaesthetists; University of York; Faculty of Medical Leadership and Management; and a number of medical and clinical directors.

We assessed whether the expected benefits of the 2003 consultant contract had been realised (Part One)

3 We analysed **departmental evidence** on realising the expected contract benefits and held meetings with the Department to discuss the evidence. The evidence included data from the NHS Electronic Staff Records Data Warehouse and Office of National Statistics data on hospital output.

4 We conducted a **web-based census of all NHS acute foundation and non-foundation trusts**, which is where most consultants work:

- Each trust was asked to give a collective response which the trust's Chief Executive signed off as accurate. Of the 162 trusts that we sent a questionnaire to, we received responses from 137; a response rate of 85 per cent.
- A number of closed questions asked for the level of agreement relating specifically to realising the expected benefits of the contract.
- The questionnaire was tested with a number of stakeholders, including the Department of Health and NHS Employers, to ensure the questions were valid and reliable. The design was also informed by a scoping visit to Wrightington, Wigan and Leigh NHS Foundation Trust.
- For the quantitative data that trusts provided (percentage of consultants having an appraisal, percentage of job plans rolled over without review, average weekly programmed activities), the average across trusts is not weighted by the number of consultants in each trust. The weighted and unweighted averages are very similar with differences ranging between zero and three percentage points.

5 We conducted a **web-based survey of NHS hospital consultants**:

- We asked the medical directors across the 162 NHS acute foundation and non-foundation trusts to circulate the questionnaire to their consultants, which employed approximately 33,500 consultants as at September 2012. This was done so all consultants in these trusts could respond to the survey. We did not receive responses from consultants in 12 of the 162 trusts. As at September 2012, the 150 trusts that we received responses from employed approximately 31,700 consultants. We received responses from 8,808 consultants, providing a response rate of 28 per cent among the participating trusts, or 26 per cent of trusts overall.
- The survey design was informed by discussions with the Royal College of Physicians and the British Medical Association together with a number of consultants. It also drew on our previous surveys of consultants, and studies by the Royal College of Physicians and the British Medical Association.
- A number of questions related specifically to realising the benefits of the contract. Responses were anonymous to avoid potential social desirability response bias.
- As part of our routine data checks, we compared the background information for responding consultants with that of the population of consultants using data from the Department (**Figure 18**):
    - The comparison showed that consultants who responded to our survey were broadly similar to the population of consultants, in terms of specialty and gender. Psychiatric consultants were under-represented as our survey sample excluded mental health trusts. There was also some variation across full- and part-time consultants and the number of consultants appointed between 1998 and 2002. However, we did not think this was likely to bias the results significantly, as their experiences of being managed were less likely to differ.
    - However, the under-representation of recently appointed consultants (2009–2011) and over-representation of consultants on the 'old' versus 'new' contract indicated that the survey may over-represent longer serving consultants. We felt this may have the potential to bias the results, as this group is more likely to have a different experience of being managed than newer consultants.
    - We calculated a weight for our sample which adjusted the profile for these two characteristics, so that they were in line with the population statistics. We found little difference between weighted and unweighted survey findings. We therefore used unweighted survey results throughout the NAO report. This gave us reassurance that our analysis included a range of consultants, whose experience of consultant management might differ.

Figure 18

Demographics of consultant population and survey sample

Characteristic		Proportion of population (%)	Proportion in survey (%)	Percentage point difference (%)
Consultant specialty	Surgery	18.4	17.3	-1.1
	Medicine	22.3	27.9	5.6
	Anaesthetics	14.9	17.5	2.6
	Accident and emergency	2.9	4.0	1.1
	Paediatrics	6.7	8.6	1.9
	Pathology	6.8	5.3	-1.5
	Psychiatry	11.2	0.5	-10.7
	Obstetrics and gynaecology	4.7	5.6	0.9
	Occupational medicine	0.2	0.3	0.1
	Ophthalmology	0.0	2.1	2.1
	Other	5.3	7.3	2.0
Year appointed	1975 to 1992	10.0	15.6	5.6
	1993 to 1997	12.7	16.7	4.0
	1998 to 2002	28.7	21.1	-7.6
	2003 to 2007	21.3	23.6	2.3
	2008	5.9	6.3	0.4
	2009	8.4	6.7	-1.7
	2010	5.7	5.4	-0.3
	2011	7.4	3.1	-4.3
	2012	no data	1.0	–
Employment basis	Full-time	80.5	86.6	6.1
	Part-time	19.5	13.4	-6.1
Contract type	'Old' contract	3.3	8.6	5.3
	'New' (2003) contract	96.7	91.4	-5.3
Gender	Male	68.4	68.8	0.4
	Female	31.6	31.2	-0.4

NOTES

1 For specialty, our survey sample contained a much lower number of consultants in psychiatry when compared to the population. This is because our survey sample did not include mental health trusts, where the majority of psychiatry consultants are based.

2 We have excluded locum and honorary consultants from the employment basis, as these figures are very low.

Sources: Department of Health analysis of data from the NHS Electronic Staff Record Data Warehouse, 2012; and National Audit Office consultant survey, 2012

6 The full top-line results of our census and survey can be found in two separate reports published on our website.

We assessed NHS trusts' consultant management against a good practice framework covering: consultant engagement; clinical management; performance management; and job planning (Part Two)

7 We undertook a focused **literature review** of peer-reviewed literature to investigate the links between human resource management practices and hospital performance and clinical outcomes.

8 Our web-based **census of trusts** and **survey of consultants** asked a range of questions on consultant management including: consultant engagement; clinical management; performance management; and job planning.

9 We conducted five **case study visits** to NHS acute foundation and non-foundation trusts:

- We selected five trusts to identify key factors and good practice in managing consultants. We selected these by ranking all acute trusts based on six human resource management indicators: sickness absence; staff satisfaction; team working; percentage of staff without a personal development plan; percentage of staff without an annual appraisal; and staff turnover. The choice of these indicators was informed by our review of peer-reviewed literature. We then selected three trusts from the top 10 per cent and two from the bottom 10 per cent.
- The case study visits consisted of a range of interviews and focus groups with senior management staff, clinical directors and consultants. Interviews and focus groups covered key areas of consultant management including: how to engage consultants; clinical management; performance management; and job planning. We followed up interviews with requests for supporting evidence where required.

10 We received **written submissions** from three royal colleges – The Royal College of Physicians, the Royal College of Surgeons and the Royal College of Anaesthetists. These colleges represent the three largest consultant groups. We gave each college our detailed study questions and each college gave a written submission.

11 We used a **triangulation matrix** to summarise, cross reference and challenge our evidence and draw out key messages relating to our study questions.

We assessed how far the Committee of Public Accounts' recommendations from their 2007 report had been implemented (Part Three)

12 We analysed **evidence provided by the Department** on how the recommendations had been implemented.

13 We used our **web census of trusts** and **survey of consultants** to give further evidence on specific recommendations for NHS trusts and consultants.

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