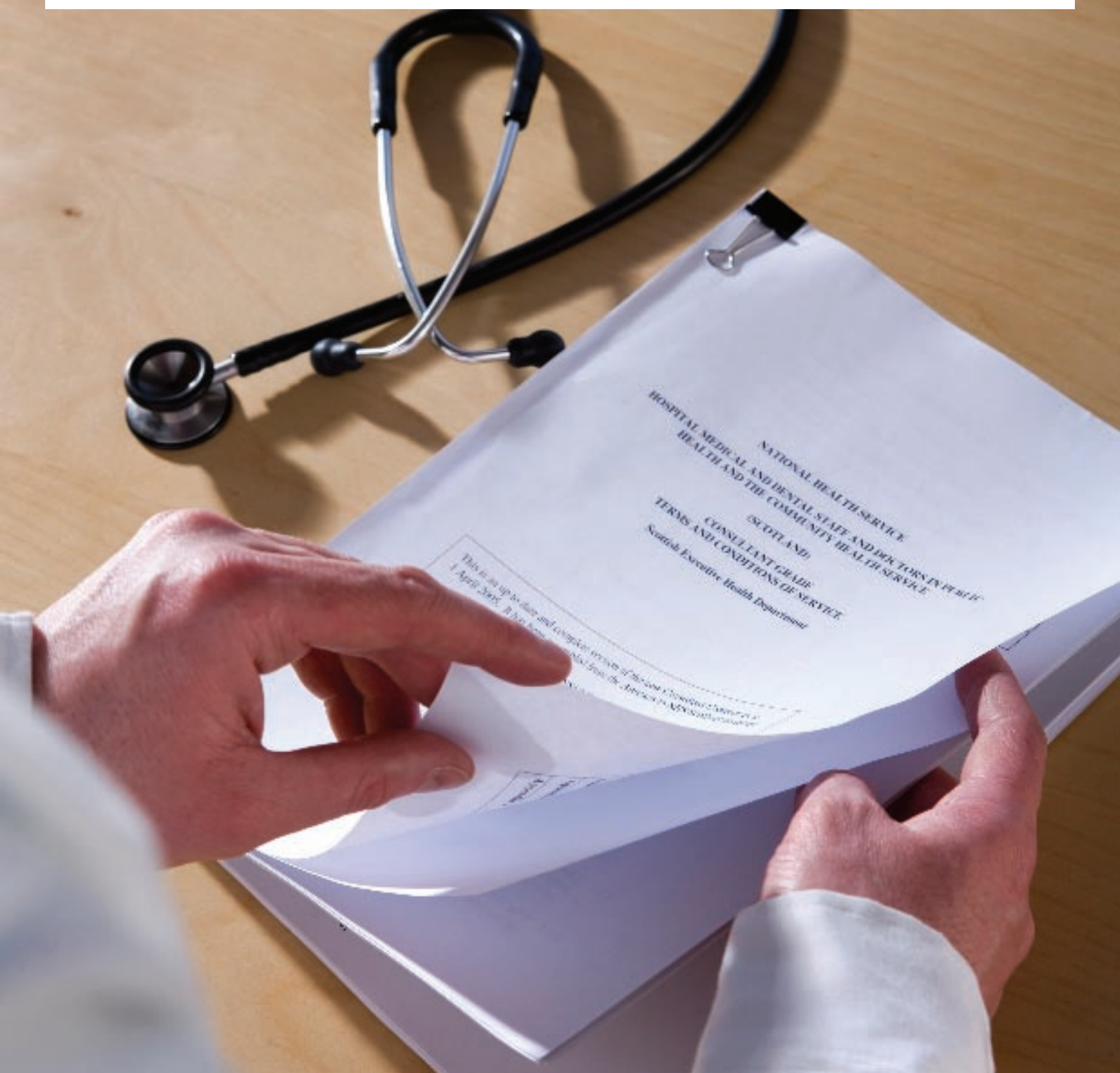


Implementing the NHS consultant contract in Scotland

Prepared for the Auditor General for Scotland

March 2006



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Summary



To date, the consultant contract has cost £235 million. It has the potential to improve patient care, but there is not yet clear evidence of benefits.

1. In April 2004, a new contract was implemented for the 3,513 consultants employed in Scotland as part of a UK-wide move to reform pay across the NHS.¹ This contract is the first major change to consultants' terms and conditions since the 1948 agreement. It provides a framework for managers and consultants to plan work and link it to improving patient care. The aims of the contract are to:

- allow boards to plan consultants' work around the needs of patients and the service
- limit consultants' working hours in line with the European Working Time Directive (EWTD)²
- ensure the NHS has first call on consultants' work and reduce conflicts around private practice
- make it easier for the NHS to recruit and retain consultants
- increase earnings for consultants.

2. Key findings:

- The new contract represents a change in the way that NHS managers and consultants work together. It offers an opportunity to focus the work of consultants on priority areas, and improve patient care. But, it is not yet being used to its full potential and there is limited evidence of benefits to date.
- Prior to the introduction of the new contract, the Scottish Executive Health Department (SEHD) set out a number of anticipated benefits

for the NHS in Scotland. However, it has not provided timely guidance to ensure these benefits were planned for from the outset.

- Although some initial changes to services are evident, at this stage it is difficult to identify the overall impact of the contract on patient care, or on consultants. The SEHD and boards are just beginning to assess the impact of the contract.
- Prior to the new contract the annual pay bill for consultants was £257 million. This had risen to £335 million by 2004/05 and is projected to rise to £354 million in 2005/06 which represents a 38 per cent rise over the three years to 2005/06.³ This increases to approximately 44 per cent if we include on-costs and inflation.⁴
- The cumulative additional cost over these three years is £235 million.⁵ This increases to £273 million when inflation and on-costs are included.
- Planning for the contract should have been more robust and the uncertainty has contributed to cost pressures for boards. The initial national costing model used by the SEHD was inaccurate due to a lack of information on consultant working patterns. This model underestimated the overall financial impact by about £171 million for the first three years.

3. In this report we reviewed:

- the background to the new consultant contract
- how the new contract was planned and implemented (excluding the negotiation process)
- the cost of the new contract and how boards are monitoring costs
- the impact of the contract on patient care and on consultants.

About the study

4. In this study we:

- interviewed medical directors at most NHS boards and the two special health boards that employ consultants (jointly referred to as boards throughout the report) to consider local implementation and any local issues
- interviewed a number of managers at a sample of boards ([Appendix 2, page 37](#))
- reviewed a selection of job plans and documents at a sample of boards
- collected and analysed data on activity and cost from all boards and the SEHD
- conducted a national survey of all consultants in Scotland seeking views on the impact of the new contract, which had a 52 per cent response rate.⁷

1 NHS Workforce Statistics, Information and Statistics Division, as at September 2003.

2 EWTD is a directive from the Council of the European Union to protect the health and safety of workers. It lays down minimum requirements in relation to working hours, rest periods, annual leave and working arrangements for night workers. The directive was enacted in UK law as the Working Time Regulations, which took effect from 1 October 1998.

3 This excludes the cost of superannuation, inflation, employers' National Insurance (NI), clinical academics and locums. If we include inflation and on-costs, these figures rise to £292 million for 2002/03, £419 million for 2004/05 and a projected £441 million for 2005/06.

4 This 44 per cent includes only a proportion of superannuation. Employers' superannuation contribution increased from 5.5 to 14 per cent from April 2004 onwards. Some of this increase is not due to the new contract and is excluded from the 44 per cent.

5 Consultant contract data collection, Audit Scotland, September 2005.

6 This is the cumulative additional cost of the contract on the basic pay bill each year from 2002/03.

7 Of the consultants who replied, 95 per cent had transferred to the new contract.

Part 1. Setting the scene



Key findings

The contract represents a major cultural change within the NHS and has the potential to improve delivery of services through more structured discussions about workload and activity between consultants and managers.

The SEHD, boards and the British Medical Association (BMA) developed the contract in partnership.

In Scotland, 98.5 per cent of consultants have opted to transfer to the new contract.

The new consultant contract is part of a wider process of modernising contracts for almost all NHS staff

New contracts are being negotiated for almost all NHS staff

5. In July 2000, the English Department of Health's (DoH) *NHS Plan* announced UK-wide pay modernisation schemes affecting most NHS staff and with a significant cost to the NHS.⁸ This was reaffirmed in Scotland in *Our National Health*, in December 2000, which stated that NHS staff in Scotland should be rewarded fairly for the contribution they make to patient care.⁹ In addition a new contract for consultants, the two other major contracts are the new General Medical Services contract for GPs and primary care services, and Agenda for Change which affects nurses, allied health professionals and other staff. There are differences between the contracts, for example, in relation to holidays and enhancements paid to different groups of staff.

6. Implementing the consultant contract has been a challenge for the NHS due to the contract's complexity, cost and changes in the way in which NHS managers and consultants work together. Lessons can be learned for the implementation of other large-scale agreements, such as Agenda for Change.

The consultant contract has introduced new ways of working

7. The new contract represents a change in the way that consultants work within the NHS. The previous contract for NHS consultants remained largely unchanged since it was agreed in 1948. The new contract is based on a job planning process that clearly sets out a consultant's working week and the amount of time spent on different activities, such as direct patient care. The contract provides a framework for managers and consultants to discuss and agree workload and work areas through job planning. It also offers the potential for consultants' activities and pay

⁸ *The NHS Plan: a plan for investment, a plan for reform*, DoH, 2000.

⁹ *Our National Health: A plan for action, a plan for change*, Scottish Executive, 2000.

progression to be closely linked with priorities for service delivery and redesign. The new contract is also designed to ensure that private practice work does not conflict with NHS work.

8. There was scope in the previous contract to plan the work of consultants, and since April 2001, consultants' performance should have been appraised. However, regular detailed job planning for consultants was not common practice in the NHS. Although automatically progressing through the pay scale is currently the norm under the new contract, it does require a regular appraisal process for consultants, focused on an agreed job plan, and progression is expected to be linked to the consultant achieving specified objectives.

The new consultant contract has various components

9. Before the new contract was introduced, consultants received a basic salary for their work and their contract identified nominal working hours. The old contract allowed employers to agree local terms and conditions, such as how much to pay for waiting time activity. The new contract standardises the national approach to most elements of pay, specifying pay for contracted hours and defining clear categories of work.

10. Full-time consultants receive a basic salary for working 40 hours per week during normal working hours (8am to 8pm, Monday to Friday). Boards can contract separately with consultants for work over and above this. However, consultants should no longer be working more than 48 hours per week, in line with the EWTD, unless they sign a

EWTD waiver.¹⁰ Exhibit 1 (overleaf) summarises the main components of the new contract and compares it to the previous contract.

Contract negotiations started six years ago

11. The contract took a long time to agree. Discussions started in 2000, and the four UK health departments produced a draft framework in June 2002. Later that year, consultants and specialist registrars voted in favour of the new contract in Scotland but not in England, Wales or Northern Ireland. An amended contract was then agreed by the DoH and the SEHD in 2003 (Exhibit 2, page 8).

12. Because of the UK-wide basis to the contract, there were certain aspects which, once agreed by England, had to be agreed in Scotland to ensure similar terms and conditions for all consultants. An increase in the pay bill for consultants in Scotland was inevitable, even before any discussions about local implementation began, because pay scales were increased, more hours were paid for and new payments were introduced, such as recognition of out-of-hours work.

13. In June 2003, the four UK departments of health were finally in a position to negotiate individual national contracts, although most aspects of the contract were agreed across the UK, based on the revised framework agreed in England.

14. Four UK contracts are now in place, each with common underlying principles: the focus on how time is spent; clear payments for different types of activity; and structures to agree and review objectives. There are minor differences between the four contracts, for example, Scotland has defined core hours as 8am to 8pm Monday to Friday, while England has 7am to 7pm Monday to Friday.

15. The SEHD, BMA and boards carried out Scotland-wide negotiations in partnership, and developed the detail of the contract.¹¹ Boards negotiated some elements of the contract locally. The contract was implemented in 2004 but pay was backdated to the original agreement date of April 2003. As at 31 March 2005, 98.5 per cent of consultants in Scotland had signed up to the new contract.¹²

10 Council Directive 93/104/EC, 23 November 1993, concerning certain aspects of the organisation of working time, Official Journal L 307, 13/12/1993 P. 0018 - 0024.

11 The BMA is an independent trade union and voluntary professional association for doctors and represents doctors from all branches of medicine throughout the UK.

12 Pay modernisation team letter (2005) 24, Evaluation of the consultant contract, 20 September 2005.

Exhibit 1

The main components of the new consultant contract and comparison with the previous contract

There are differences in the way consultants' work is categorised under the new contract.

Component	Explanation	Comparison to old contract
Job planning	Accurate and detailed job planning is central to the new contract. Job plans should be negotiated at least annually. The job plan includes service and personal objectives and defines all NHS work undertaken by the consultant.	Job planning was a contractual requirement for consultants from 1990 but there was no robust process to ensure this was carried out effectively.
Programmed activity (PA)	Working time in the contract is defined in terms of PAs. A PA is equivalent to four hours work, unless delivered out of hours. Each week, a full-time consultant will normally have: <ul style="list-style-type: none"> • 7.5 PAs allocated to provide direct clinical care, which may include on-call work (30 hours) • 2.5 PAs for supporting professional activities (SPAs), such as continuing professional development, teaching and audit (ten hours). PAs may also be allocated to cover additional responsibilities, or a separate payment can be made to cover these. This includes roles such as Clinical Governance Lead, or other external duties, such as work for the Royal Colleges.	A nominal 38.5 hours per week was specified in the consultant contract.
Extra programmed activity (EPA)	Boards can contract separately with consultants for work they want them to do in addition to the standard 40-hour week through agreeing EPAs. These are also equivalent to four hours of work. They are paid at the standard PA rate or premium rate if outside normal working hours. It was agreed nationally by NHS employers that EPAs should only be contracted to provide direct clinical care. It was also agreed that there should be a maximum of two EPAs per consultant to meet EWTD regulations, although more can be contracted in exceptional circumstances.	There was no provision to pay consultants working above the minimum commitment.
Pay progression	Pay progression means that the consultant moves up to the next point on the salary scale. At the end of the financial year, the consultant's progress in achieving the objectives in the job plan is reviewed. Pay progression is the norm under the new contract if the consultant takes part in the appraisal process and complies with the Code of Conduct for Private Practice. ¹³ However, if objectives are not achieved, the board can defer pay progression.	Consultants automatically progressed through the pay scale annually.
On-call work	The number of hours worked while on-call is assessed and recognised in the consultant's weekly direct clinical care PAs. If on-call work takes place outwith standard working hours, three hours of work will count as one PA.	Two payments were available: a daytime intensity supplement payable after three years in post, and an out-of-hours intensity supplement of up to £2,505 per annum paid according to how onerous the out-of-hours and on-call commitment was.

13 Code of Conduct for Private Practice, DoH, January 2004.

Component	Explanation	Comparison to old contract
On-call availability supplement	The level of supplement paid reflects the frequency of availability and also recognises two levels of on-call availability. Level one applies to a consultant who needs to attend a place of work immediately when called, or provide complex telephone consultations. Level two applies to a consultant who can attend a place of work later or respond by non-complex telephone consultations later.	
Resident on-call payment	The contract states that it will be unusual for consultants to undertake resident on-call duties and they will only be resident on-call by mutual agreement. Local arrangements apply to payment.	Resident on-call payments were locally negotiated.
Fee-paying work	<p>Consultants can still carry out fee-paying work. The new contract does not allow double payment for work. The work is defined in two ways - either part of the consultants' contract and relevant to NHS work or not part of the consultants' contract and not reasonably incidental to the core contract, such as work for the courts.</p> <p>Work which is not part of the consultants' contract and not reasonably incidental to it must be done in the consultant's own time or cause minimal disruption to core work, as agreed locally. If fee-paying work is included in the consultants' core contract, then a fee is not paid.</p>	The old contract specified the types of work that consultants were not expected to carry out as part of their contractual obligation and for which extra fees were paid.
Waiting time initiative payment	Consultants can agree to take on extra activity separate to EPAs, helping to meet waiting times targets. This work is paid at three times the hourly rate at the top of the pay scale, or at a lower rate with time off in lieu.	Consultants could agree to undertake extra NHS work under a separate contract with their employer, at a locally agreed rate.
Discretionary points and distinction awards	<i>Our National Health</i> states that there will be reforms to the current distinction awards scheme and discretionary points system 'to ensure that the bulk of any new awards go to those consultants who make the biggest contribution to delivering and improving health and healthcare locally'. The SEHD has advised us that it is considering a review of these payments.	Employers award consultants discretionary points under nationally agreed criteria. A central national committee makes distinction awards. These processes are still in place at present.
Recruitment and retention premium payment	The contract includes the potential for boards to make a payment, for up to four years, to attract new consultants. NHS employers in Scotland have agreed not to use the recruitment and retention premium at present.	NHS boards were able to offer additional incentives to consultants to encourage them to take up posts in their area.
Private work	Consultants must be open and explicit about any private work. They must not do private work during NHS time, unless agreed with the employer. Consultants must abide by the code of conduct for private practice to be eligible for pay progression. The consultant must offer one EPA to the NHS first before taking on any private work.	All whole-time and maximum part-time consultants were expected to spend most of their professional time carrying out NHS work but there was little monitoring of private work.

Exhibit 2

Timeframe for developing the consultant contract in Scotland

Date	Development	
June 2002	Framework agreed by UK health departments, BMA and NHS Confederation based on two years of negotiation.	
October 2002	Consultants in Scotland voted for the new consultant contract, but consultants in other areas of the UK voted against.	
	Results of ballot of all UK consultants and specialist registrars:	
	Area of UK	Percentage in favour of new contract
	Scotland	54%
	England	30%
	Wales	30%
	Northern Ireland	49.7%
Overall	34%	
January - July 2003	Ongoing talks between the SEHD and the BMA in Scotland.	
June - July 2003	Talks on the consultant contract reconvened at UK level, with the four UK health departments negotiating slightly different contracts.	
October 2003	Ballot of all consultants and specialist registrars employed in England and Scotland:	
	Area of UK	Percentage in favour of new contract
	Scotland	78.7%
England	60%	
March 2004	Agreed contract document released to the NHS in Scotland.	
1 April 2004	The new contract became available to all consultants.	
April 2004 onwards	Local negotiations at boards on some elements of the contract and issues not explicitly covered within the contract, such as resident on-call payments. National groups continue to meet to discuss emerging issues.	

Source: SEHD, BMA, Audit Scotland fieldwork, 2005

Part 2. Planning for the new contract

Key findings

The SEHD, boards, and the BMA have worked in partnership to implement the contract. But the SEHD should have taken a more active role in providing timely guidance and direction to help boards plan for and implement the contract.

The initial SEHD national costing model was inaccurate and underestimated the overall financial impact by about £171 million for the first three years.

National guidance issued up to July 2005, focused on advising boards on how to transfer consultants to the new contract rather than on how to achieve benefits. Most boards did not plan how they would achieve benefits through the contract until after implementation.

In most boards, planning for the contract before implementation was minimal. However, some developed more accurate initial cost estimates than others.

Financial planning for the contract could have been better

16. The SEHD, boards and the BMA have worked in partnership to develop and implement the contract in Scotland. This has included issuing joint guidance to boards on some parts of the contract and helping boards to implement it. However, some aspects of planning for the contract could have been improved; there is evidence that the cost of the contract was not properly estimated or planned for.

17. Although the SEHD carried out preliminary work before March 2003 on the cost of the contract, three main cost estimates have been produced in Scotland, and boards have also been working on costs at a local level:

- The first cost estimate, in March 2003, was a Scotland-wide estimate, not at board level, and covered three years from 2003/04 to 2005/06.
 - The second cost estimate, in March 2004, was at board level, and covered two years from 2003/04 to 2004/05.
 - The third cost estimate and statement of costs incurred, in November 2004, was at board level and covered two years from 2003/04 to 2004/05.
- 18.** These estimates did not include inflation or on-costs, such as National Insurance (NI) contributions. Therefore we have excluded these costs from the cumulative additional costs set out in this part of this report.¹⁴
- 19.** In this section, we discuss each of these estimates and show how they compare to the reported cumulative additional cost of the contract.

¹⁴ Cumulative costs are built up over more than one year.

The SEHD originally underestimated the cost of the contract for the first three years by £171 million

20. The SEHD developed an initial national cost estimate for the contract in March 2003, for three years up to 2005/06, showing the additional cost over the previous contract costs. It was based on the DoH's UK-wide costing model, adjusted to reflect the limited known differences in Scotland, such as 13 per cent fewer consultants on maximum part-time contracts.¹⁵ ¹⁶ The costing model did not take account of all differences in Scottish consultant working patterns, as there were no Scotland-wide consultant activity data before the new contract. The new contract started a process of recording what work is done by consultants. The SEHD did not produce board level estimates at this stage.

21. At this time, the SEHD estimated that, in 2003/04, the additional cost of the contract would be £15 million (8.6 per cent increase on the previous years' pay bill), a further £6 million in 2004/05 (5.3 per cent increase) and a further £7 million in 2005/06 (5.4 per cent increase). [Exhibit 3](#) outlines the SEHD initial estimate of the additional cost for each of the three years. The cumulative additional cost for the first three years was estimated as £64 million.

22. Our fieldwork during 2005 shows the cumulative additional cost of the contract to be an estimated £235 million for the first three years, so the SEHD initially underestimated the additional cost by £171 million for this period (see [Part 3, page 18](#)).

23. Boards that had more detailed consultant activity data then tested the model and found the SEHD cost estimates were inaccurate.¹⁷ They reported that consultant activity was higher and more frequent on-call work would be required. At this time it became clear that the initial national cost estimate was likely to be significantly understated. In November 2003, the SEHD made a costing toolkit available to boards to help them cost the contract.

The second cost estimate for the initial two years underestimated the cost by almost £32 million

24. In March 2004, the SEHD asked boards to produce local estimates of the additional cost of the contract, this time for the initial two years up to 2004/05 rather than for three years as with the previous estimate. [Appendix 3 \(page 38\)](#) shows this second additional cost estimate by board compared with the reported additional cost and variances between the two.¹⁸

25. The second cost estimate showed the additional cost of the contract for two years as £103 million, although the reported additional cost for these two years was £135 million. This shows that the cost was underestimated by approximately £32 million (24 per cent of the reported cost) just before the contract was about to be implemented. This March 2004 estimate was not based on complete data as four boards did not provide estimates at this time; for comparison, we therefore excluded their reported costs.

26. Some boards had more accurate financial plans before the contract was in place, in particular, NHS Fife and NHS Forth Valley. Others were less accurate with their estimates, particularly NHS Greater Glasgow, NHS Highland and NHS Lothian, which underestimated the cost of the contract. These differences are due to a number of reasons, including how much information boards had on consultant working levels and the percentage of consultants who had transferred to the new contract. Five boards overestimated the cost of the contract for the initial two years.¹⁹ Reasons for these overestimates varied, but as an example, managers at NHS Borders were aware that their consultants were working on average, 55 to 60 hours, and based their cost assumptions on this. When extra programmed activities (EPAs) were capped at two nationally, it led to an overestimate of costs.

The third estimate underestimated the additional cost for the first two years by almost £11 million

27. In November 2004, after the contract was implemented, the SEHD asked all boards to return a monitoring form. This collected up-to-date figures on costs incurred for the first year (2003/04) and a forecast of costs for the second year for consultants who had already signed up. Boards were also asked to include an estimate of costs for the initial two years for those consultants who had still not signed up to the new contract.

¹⁵ The DoH's cost assumptions derived from the results of a survey they carried out of consultants in England to understand their working patterns eg, levels of out-of-hours work, frequency of on-call, etc.

¹⁶ A consultant's contract of employment, attracting 10/11ths of the consultant's salary scale, but essentially classed as whole-time. This allows the consultant to engage in unlimited private practice, provided the consultant devotes, substantially, the whole of their professional time to NHS duties. This contract is not offered as part of the new contract arrangements, and procedures for transferring consultants on maximum part-time contracts to full-time contracts are specified in the contract documentation.

¹⁷ Including NHS Ayrshire & Arran, NHS Greater Glasgow and NHS Borders.

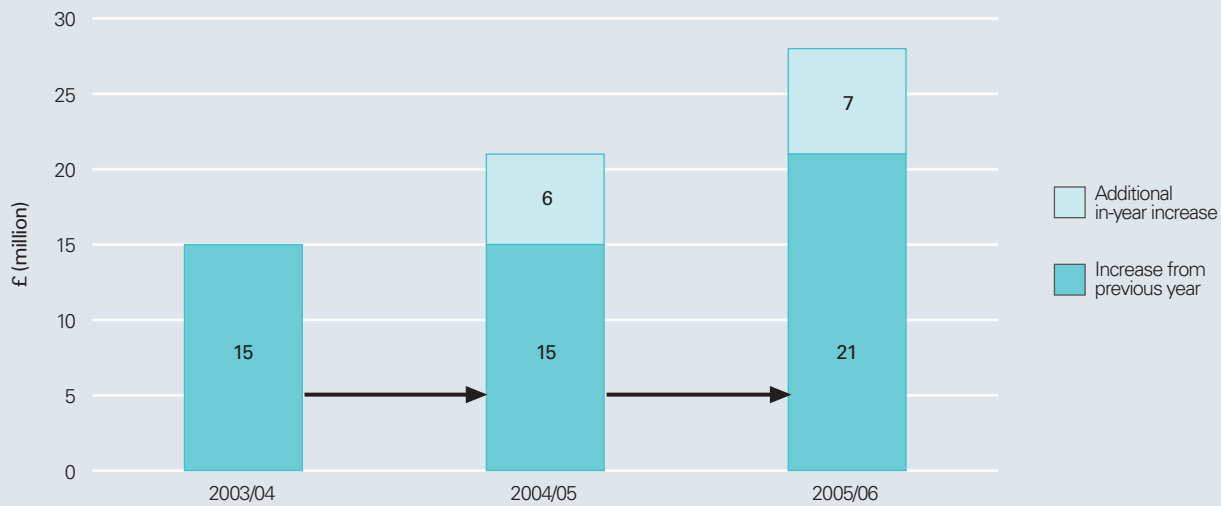
¹⁸ Reported to us by boards as part of this audit as at September 2005.

¹⁹ NHS Borders, NHS Dumfries & Galloway, NHS Grampian, NHS Lanarkshire and NHS Forth Valley.

Exhibit 3

First SEHD estimate of the additional cost of the contract, March 2003

The SEHD first estimated the cumulative additional cost of the contract as £64 million for the first three years.



Source: SEHD first cost estimate, March 2003

28. More boards completed this third return than completed the second return, increasing the costs included, and giving a more complete picture. The estimated additional cost for the two years at this time increased to £125.6 million, but was still less than the reported additional cost of £136.3 million – an underestimation of almost £11 million (eight per cent of the reported cost) after the contract had been introduced.²⁰

29. Appendix 4 (page 39) shows each board's cost estimates, reported costs and variances between the two. There were still differences between the estimated and reported costs for some boards even at this stage, in particular, for NHS Ayrshire & Arran, NHS Highland, NHS Lanarkshire, NHS Lothian, NHS National Services Scotland (NSS) and NHS Orkney.

30. The differences in costs for 2003/04 are largely due to delays in sign-up and some terms of the contract not being finalised at a local level, such as resident on-call payments.²¹ These delays meant that full costs were still uncertain, even for consultants who had signed up to their new contract. The cost of waiting time initiative payments and other ad hoc work was also still unknown and underestimated by most boards at this time.

31. Exhibit 4 (overleaf) shows the three estimates for 2003/04 and 2004/05 together, compared against reported costs. Cost estimates have improved since the introduction of the contract, as boards worked through implementation and had a clearer view of the costs. However, reported costs for the first two years of the contract were almost four times higher than first estimated.

32. The initial national costing model for the contract was inaccurate, but there was information available through the framework document which the SEHD issued to boards in 2002. This gave boards an opportunity to begin costing the contract locally, although there was no central requirement to do so. But the approach of boards to the contract has been largely reactive. Planning should have started earlier.

A lot of detailed guidance has been issued to boards since the contract was implemented

33. The SEHD approach to implementing the contract was to work in partnership with the BMA and employers. The new contract is complicated and a number of groups were set up to help implement it.

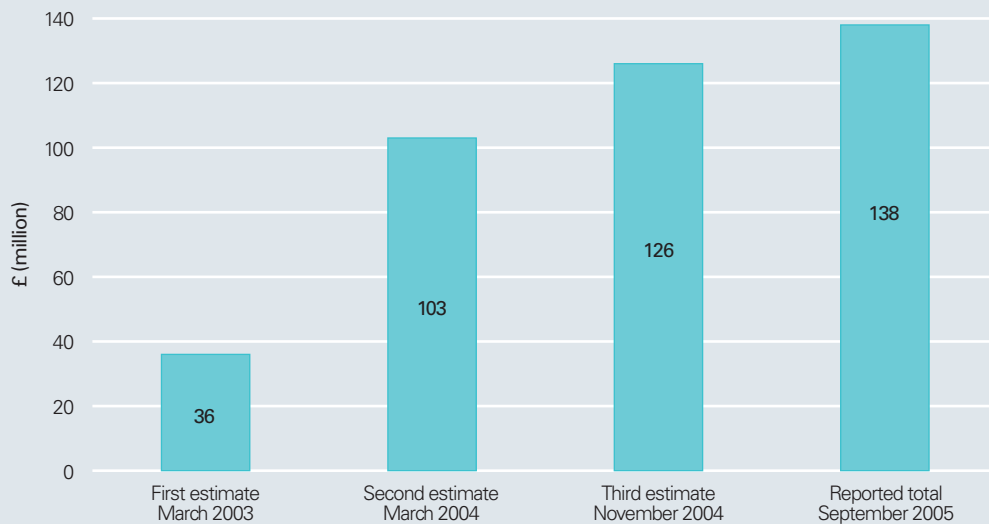
20 The State Hospital and NHS Western Isles did not provide local estimates at this time, therefore we excluded their reported costs.

21 Resident on-call, where the consultant resides in the hospital overnight, is only to be used in exceptional circumstances. Payment is at a locally agreed rate.

Exhibit 4

Comparisons of the estimated and reported cumulative additional cost of the contract for 2003/04 and 2004/05²²

Cost estimates improved over time.



Source: SEHD estimates and Audit Scotland data collection, September 2005

34. In November 2003 the Pan-Scotland NHS Employers' Reference Group (PSERG) was established. The aim of the group was to assist with a coordinated and consistent approach to the implementation of the contract, and to disseminate good practice. PSERG included representatives from boards and the SEHD. The group issued guidance to boards but did not have the power to instruct boards to implement it.²³

35. In January 2004 a National Partnership Steering Group (NPSG) was established. The aim of this group was to oversee delivery of the new contract. This group included representatives from the SEHD, boards, the universities and BMA, and was able to issue instruction to boards.

36. The Consultant Contract Team at the SEHD, part of the overall Pay Modernisation Team, was set up three months before implementation started. Once in place, in January 2004,

the consultant contract team provided advice to boards on implementing the new contract.

37. The SEHD Consultant Contract Team, PSERG and NPSG considered issues of concern raised by boards and issued advice or guidance. The BMA and SEHD issued separate guidance in November 2003, but following this the various groups involved issued joint guidance.

38. While the SEHD provided boards with the contract document and associated guidance on how to implement the contract in advance of the date it came into effect, a lot of guidance on how to deal with specific elements of the contract was issued after implementation. (Exhibit 5 shows a breakdown of some of the letters issued). The contract document did not set out all areas of the contract clearly, for example it did not provide clear definitions on how to handle fee

paying work. This was unhelpful to boards. There have been four updates to the main contract document since the original version in September 2003, and there may be other updates as the contract develops.

39. The SEHD believes that because of the complexities of the contract and lack of information on consultant working patterns, it was not possible to anticipate all issues that boards would face in implementing it. They feel that their approach allowed them to respond to problems as they arose. Our view is that earlier planning would have reduced the volume of guidance required after the contract was implemented and reduced uncertainty for boards. Boards have also reported that they found advice from the Consultant Contract Team of use but that they would have benefited from receiving this help earlier in the process, when they were planning to implement the contract.

²² Reported costs shown in September 2005 are for all 15 NHS boards and two special health boards. However, the second and third estimates are not entirely complete as a small number of boards did not provide estimates at this time. The second estimate was not provided by NHS NSS, NHS Orkney, NHS Shetland or the State Hospital. The third estimate was not provided by the State Hospital and NHS Western Isles.

²³ Terms of reference, PSERG.

Exhibit 5

Timeline of central guidance and support

A lot of guidance was issued after the contract was implemented.

Date	Action by SEHD	Action by PSERG	Action by other groups
Guidance issued prior to implementation			
September 2003	Consultant contract terms and conditions issued to boards (version one).		
November 2003	Ballot results and next steps.		
November 2003	Costings toolkit made available to boards. Guidance issued by SEHD: Transitional and backdating arrangements. Job planning.	PSERG to be established.	NPSG to be established when Director for Pay Modernisation (consultant contract) is appointed. BMA issued separate guidance on initial stages of implementation.
March 2004	Version two of the consultant contract released. First local NHS board estimates of cost. Consultant contract event to discuss costs. Guidance issued by SEHD: How medical directors are dealt with under the new contract.	Guidance issued by PSERG: Deadline for job planning. Handling of fee-paying work.	
	Partnership letter issued by PSERG, NPSG, and BMA, with further guidance on: Job planning. Handling of fee-paying work. Backdated payments.		
April 2004	Contract available to transfer consultants over.		

Date	Action by SEHD	Action by PSERG	Action by other groups
Guidance issued after implementation			
May 2004	Partnership letter issued by PSERG, NPSG, and BMA, with further guidance on: <ul style="list-style-type: none"> • External duties. • Handling teaching and research. • Appeals process. • How to handle consultants transferring between employers. 	Guidance issued by PSERG: No agreement reached on on-call arrangements. Request local resolution.	
July 2004	Partnership letter issued by PSERG, NPSG and BMA, with further guidance on: Handling of fee-paying work.		
August 2004	Appeals panels to be available, from now, in all NHS board areas.		
September 2004	Frequently asked questions on website, available to all boards.	Guidance issued by PSERG: Ban on using the recruitment and retention premium in Scotland.	
October 2004	Version three of the consultant contract released. Boards asked to provide data on activity and cost. The SEHD asked all boards to undertake an audit, looking at terms and conditions by March 2005.		
November 2004	Third estimate of costs released.		
December 2004	Boards to submit details of appeals panel list to the SEHD. Training presentation available to boards on appeals panels.		Guidance issued by NPSG: Clinical academics ability to transfer to new contract.

Date	Action by SEHD	Action by PSERG	Action by other groups
January 2005		PSERG changes to Employers Reference Group (ERG).	
March 2005	Training pack on job planning made available to boards.		Guidance issued by NPSG: Back pay for consultants transferring between employers. Recording of EPAs in the contract.
April 2005	Version four of the consultant contract released.		
May 2005			Guidance issued by NPSG: Pay progression. Handling of appeals.
June 2005			Guidance issued by NPSG: Discretionary points. Public holidays.
July 2005	Boards asked to submit pay modernisation benefits delivery plans. The plans should outline how boards are using the new contracts to achieve service change linked to national priorities.		
September 2005	Boards asked to provide data on activity and cost from 2003/04 to 2005/06.		

Source: SEHD pay modernisation website: www.paymodernisation.scot.nhs.uk

Boards agreed some elements of the contract locally

40. Most of the contract terms and conditions were negotiated by the SEHD and the BMA. These were issued to boards in September 2003 for implementation from 1 April 2004. There were some areas of the contract where the SEHD and the BMA were unable to reach agreement, and these were passed on for local negotiation.

41. As a result, boards negotiated separately with local BMA representatives on certain areas. This led to some variations in implementation, such as handling of fee-paying work and the associated differences in cost. Although these areas do not account for major costs under the new contract, they have often been difficult to agree locally, involved a lot of management time and have delayed implementation.

Initially most boards focused on signing up consultants to the contract rather than on the potential to improve services

42. Boards have been successful in getting most consultants wanting to transfer to the new contract moved over to their new terms and conditions. This has been a challenge, given the workload involved in recalculating payments due, managing a new system of job planning and processing payments and paperwork, largely within existing resources. In the first year, this may have limited boards' abilities to plan for the potential benefits of the contract and achieve value for money.

43. Few of the boards we sampled were able to provide evidence of having integrated implementation of the contract with local priorities for services and changing the way services are delivered. Only NHS Borders and NHS Tayside had detailed project plans in place. These were supported by a comprehensive risk assessment, which led to a more thorough process linked to changing the way in which services are delivered.

44. A significant gap at many boards was not including Strategic Planning or Organisational Development departments during the planning and implementing of the contract. As the contract influences all aspects of the delivery of services, planning departments should have been involved as early as possible. However, we found that planning departments were just becoming involved once implementation was complete and boards were starting to look at achieving benefits from the contract. Several directors of planning, or equivalent, said they should have been involved in the process earlier, so that planning for benefits and incorporating changes to the way in which services are provided could have started sooner. NHS Borders was the exception – the Director of Integrated Care led the implementation of the contract, and provided regular reports to the executive team.

Boards took different approaches to implementing the contract, focusing on either maintaining activity levels or minimising costs

45. Boards reported different approaches to agreeing the contract. Boards facing serious financial constraints were more focused on containing the cost of the contract, accepting that there may be risks to activity levels. Boards under less financial pressure were able to accept higher costs to avoid the risk of reducing activity levels.

46. Consultants who responded to our survey raised the issue of inconsistency:

“There has not been applied consistency across Scotland... This reflects differences in management attitude not in what people are doing.”

A consultant response from Audit Scotland national survey of consultants, September 2005

47. This difference in approach affects consultant job plans and risks inequity and inconsistency in how the contract is applied across Scotland. By providing timely guidance, clearer direction and taking a central decision on some areas that were not well defined within the contract documentation, the SEHD could have reduced the potential for differences in approach among boards.

In Scotland, 98.5 per cent of consultants have signed up to the new contract

48. The majority of consultants in each board have signed up to the new contract although some boards still have a number of consultants waiting to transfer on to the new contract.²⁴ In some cases this delay is due to consultants going through mediation or appeals processes. In six of the 17 boards employing consultants, all consultants have opted for the new contract.²⁵ In the other boards, sign-up levels are over 90 per cent.

49. There is a high sign-up rate to the contract across all specialties, with the highest in Accident and Emergency, and in Community Dentistry where all consultants have transferred to the new contract. Community Medical Specialties show the lowest at 71 per cent.

Recommendations

The SEHD should:

- ensure that national cost models are based on accurate data relating to Scotland and work with boards to accurately assess the cost of major developments before implementation
- provide timely and effective guidance when implementing major new schemes, provide national support, identifying actions that boards are required to take and monitoring whether this happens.

Boards should:

- ensure that robust planning and monitoring takes place as early as possible, to allow them to prepare for the impact of new initiatives with significant costs.

²⁴ NHS Fife, NHS Forth Valley, NHS Lanarkshire and NHS Ayrshire & Arran each have over six per cent of consultants who have opted for the new contract but yet to sign up to it.

²⁵ NHS Borders, NHS Dumfries & Galloway, NHS Orkney, NHS Shetland, the State Hospital and NHS Western Isles.

Part 3. Cost and financial management



Key findings

The new consultant contract has cost approximately £235 million over the first three years, and has increased the consultant pay bill by 38 per cent. If inflation and on-costs are included, the costs rise to £273 million, an increase of 44 per cent.

Some boards have found it difficult to provide detailed costings, and are not monitoring all elements of contract costs. This will make it difficult for them to identify areas for improvement or savings.

In 2004/05, the SEHD provided additional non-recurring funding of £70 million, to contribute to cost pressures arising from pay modernisation and other financial pressures, and, in 2003/04 and 2004/05, increased boards' allocations by around seven per cent.

Due to delays in negotiating and implementing the contract, a UK-wide agreement gave consultants a one-off back payment. The total cost of back pay in Scotland was £76 million.

The SEHD expected waiting time payments to consultants to decrease under the new contract, but between 2002/03 and 2004/05, they increased by 34 per cent to £3.4 million.

Some specific contract terms were negotiated locally, which has led to small variation in costs and a risk that consultants may be treated inconsistently across Scotland. Although this does not relate to a lot of money, there have been local difficulties in addressing this work.

Over the initial three years, the estimated additional cost of the contract is £235 million, with the consultant pay bill increasing by almost 38 per cent

50. The new consultant contract was implemented in April 2004 but was effective from April 2003.²⁶ The total additional cost of the contract was £60 million in 2003/04, £78 million in 2004/05 and is estimated to be £97 million in 2005/06. This gives a total additional cost for the new contract of approximately £235 million for the first three years.²⁷

51. This total estimated cost does not include costs for employers' superannuation, National Insurance contributions or inflation to keep it consistent with the initial costing model used by the SEHD. These amount to approximately £38 million from 2003/04 to 2005/06. If we include these costs, the total additional cost of the contract

²⁶ Costs are shown from 2003/04 as boards made provision in their accounts for the costs relating to each year.

²⁷ Consultant contract data collection, Audit Scotland, September 2005 (based on a detailed breakdown of costs from all boards).

increases to £273 million for the initial three years.^{28 29}

52. We collected detailed costings from all boards. But identifying the exact additional cost of the new contract for the three years since implementation is complex. Boards have found it difficult to provide detailed contract costings, and many have identified the complexity of the contract itself as a problem.

53. The contract has increased the salary scale for consultants from a range of £57,370-£74,658 under the old pay scale to a range of £69,298-£93,768.³⁰ Existing consultants were transferred to a point on the new salary scale. This is one component of the total pay of consultants (Exhibit 1, page 6).

54. Many cost elements contribute to the overall pay bill – some are entirely new costs but some would have been at least partly incurred under the old contract, such as basic salary costs, fees and waiting time payments. Some local terms have not been finalised and therefore the actual cost to boards may still be subject to minor changes.

55. Exhibit 6 (overleaf) shows the total increase to the pay bill for each board. The exhibit also shows the total additional cost over the first three years and the percentage increase to the pay bill. Most back pay was accrued in year 2003/04. Some boards had back pay costs in 2004/05 due to late sign-up, and expect further costs in 2005/06. We have excluded costs for superannuation, inflation, clinical academics, locums, agency staff and the increased costs for service level agreements between boards for work provided by consultants.

56. Some boards had a higher percentage increase due to the contract than others (Exhibit 6, overleaf). Increases to the pay bill are particularly high at NHS Orkney, NHS NSS, and NHS Shetland. Island boards show higher percentage increases to their pay bill, mainly because they have more onerous on-call requirements and higher levels of EPAs, given their lower staff numbers.

The SEHD allocated some funding to meet the cost of the contract

57. The cost of the contract has significantly increased the financial pressure for most boards. In June 2004, the SEHD made a one-off payment of £70 million to the NHS in Scotland to help it meet financial pressures, including pay modernisation.³¹ Boards also received an average increase in their allocations of approximately seven per cent in 2003/04 and 2004/05 to help with cost pressures.³²

Back pay was agreed across the UK, with a cost to Scotland of £76 million

58. The contract was intended to be in place by April 2003, but was delayed until 2004. It was agreed across the UK to provide a backdated payment because of the delay. This payment was the difference between what consultants were actually paid under the old contract in 2003/04 and what they would have received if the new contract had been implemented in April 2003.

59. The approximate total cost of back pay is estimated to be £76 million. The actual cost is not yet known because a small number (3.5 per cent)

of consultants are still in mediation or appeal and the outcome of these could affect the amount they receive, but this will make only a small difference to the overall cost of back pay.

60. Back pay represents 32 per cent of the cumulative cost of the contract over the initial three years. Back pay was a significant one-off cost of the contract. It was part of the overall pay settlement and was not intended to bring immediate benefits in patient care.

Extra programmed activities have cost £129 million in the first three years, and boards face a major challenge in reducing this cost

61. EPAs are contracted for separately and are intended to be used on a temporary basis where it is necessary for consultants to work additional hours to sustain or improve patient care.

62. Exhibit 7 (page 21) shows variation among boards in the average number of EPAs agreed with consultants. Specialties without any EPAs tend to be Community Medical Specialties, Hospital Dental Specialties, and Community Dental Specialties.

63. The SEHD expected the number of EPAs to decrease year-on-year, through a combination of changes in the way services are delivered and an increase in the number of consultants. Data returns from boards show that average EPAs are not yet decreasing in most areas. EPAs cost £42.4 million in both 2003/04 and 2004/05, and are projected to increase to £44.2 million in 2005/06.

28 The £38 million is made up as follows: inflation £7.58 million (3.225%); employers' National Insurance contribution £21.85 million (9%); superannuation costs relating to the contract of £8.83 million. This excludes superannuation changes from 5.5% to 14% from April 2004.

29 There have been small changes to the numbers of consultants employed in each year, but the effect on the overall national costs has been minimal.

30 Review Body on Doctors' and Dentists' Remuneration, 34th Report, 2005 (based on 2005/06 rates).

31 SEHD letter 15 June 2004, Deputy Director of Finance, to all chief executives of NHS boards.

32 Audit Committee 5th Report, 2005. *Overview of financial performance of the NHS in Scotland 2003/04*, Scottish Parliament, June 2005.

Exhibit 6

Cumulative additional costs of the consultants' contract, by board, 2003/04 to 2005/06

Increases to the pay bill are variable but are higher at island boards.

Boards	2003/04 (£)	2004/05 (£)	2005/06 (estimate) (£)	Additional cumulative cost of contract 2003/04 to 2005/06 (£)	Total % increase to the pay bill from 2002/03 to 2005/06
Ayrshire & Arran	2,866,000	3,178,000	3,257,000	9,301,000	23.60
Argyll & Clyde	4,004,146	4,207,652	4,233,070	12,444,869	24.38
Borders	1,223,871	1,135,490	1,405,039	3,764,400	28.51
Dumfries & Galloway	1,049,000	1,545,000	2,122,000	4,716,000	35.17
Fife	1,872,000	2,101,000	3,667,000	7,640,000	32.76
Forth Valley	2,683,491	3,783,985	3,818,021	10,285,497	34.13
Grampian	6,036,000	8,681,000	9,603,000	24,320,000	33.89
Greater Glasgow	16,698,374	22,862,726	28,290,400	67,851,502	43.92
Highland	3,019,724	4,371,409	5,545,127	12,936,260	46.12
Lanarkshire	1,016,819	1,505,935	6,235,756	8,758,510	27.13
Lothian	11,295,827	15,579,817	18,431,293	45,306,937	47.00
NSS	385,008	1,224,961	1,327,780	2,937,749	68.49
Orkney	240,349	202,089	272,963	715,401	90.95
Shetland	12,468	423,340	499,480	935,289	65.19
State Hospital	110,681	325,902	328,088	764,673	44.36
Tayside	6,438,701	6,655,193	8,023,088	21,116,982	39.77
Western Isles ³³	704,789	490,893	172,759	1,368,441	13.04
Total	59,657,249	78,274,395	97,231,866	235,163,511	37.87

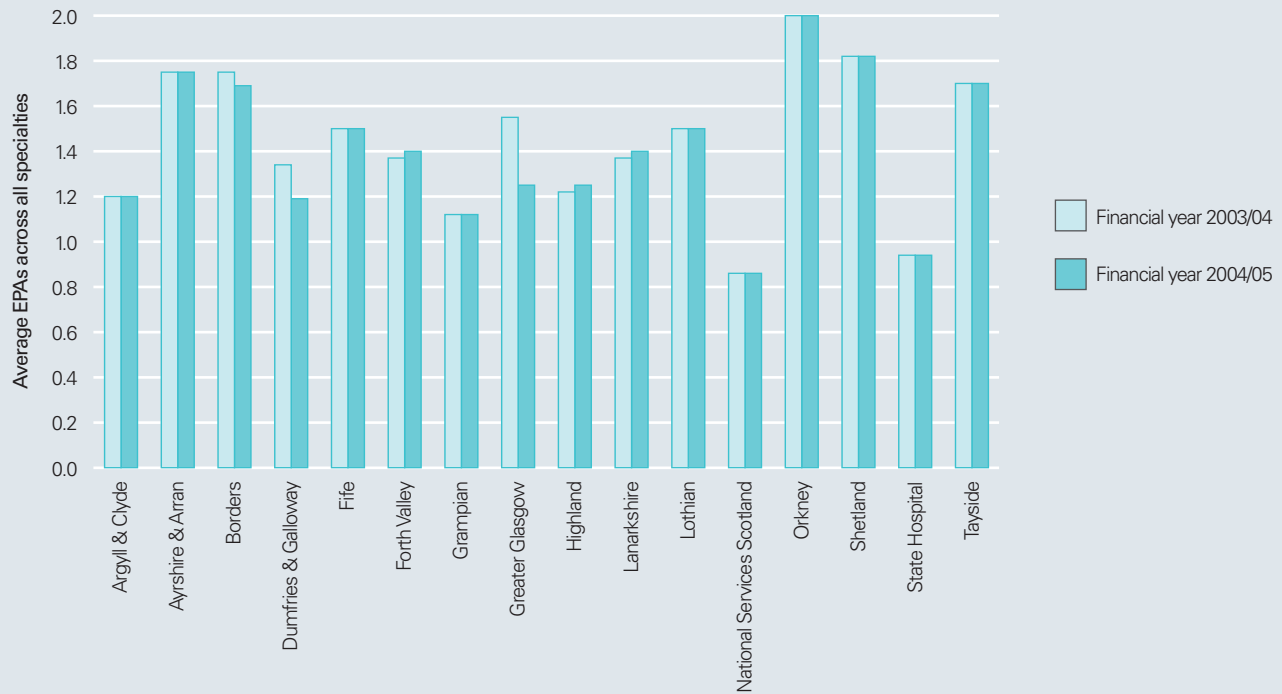
Source: Consultant data collection, Audit Scotland, September 2005

³³ The number of consultants employed at Western Isles reduced by almost 40 per cent from 13 consultants in 2002/03 to eight in 2003/04 and then increased to nine in 2004/05. Its pay bill would have increased by an estimated 90 per cent if the 13 consultants had been employed throughout the initial three years of the new contract. This is then comparable with the picture at other island boards.

Exhibit 7

Average EPAs by board³⁴

The number of EPAs allocated to consultants varies by board.



Source: Audit Scotland data, September 2005

³⁴ No information on EPAs was provided by NHS Western Isles.

Exhibit 8

Extract from a board's pay modernisation benefits delivery plan and progress report

An example of using EPAs to contribute to reduction in waiting times.

Specific area	Supporting data to measure baseline and demonstrate progress	Actions to be taken	Anticipated results (quantifiable and with dates)
Orthopaedics	Waiting times information.	Job plan reviews for all orthopaedic consultants with EPAs allocated to support waiting time reductions.	Additional two clinics per week.

Source: Benefits delivery plan extract, SEHD, January 2006

This gives a total cost of £129 million for the first three years of the contract.³⁵ In addition, many consultants who responded to our survey report working in excess of their contract, which will limit the scope for boards to reduce EPAs.³⁶

64. Only 25 per cent of survey respondents who had transferred to the new contract reported that they were keen to reduce their EPAs. There are some examples, however, where boards have renegotiated job plans to reduce EPAs and recruit additional staff.

65. In the short term, it is more expensive for boards to recruit new consultants than to add to the work of existing consultants through EPAs.³⁷ As consultants progress through the pay scale, however, it could be more cost-effective to review work patterns and identify different approaches. For example, there is scope to review

some consultant workload. In our survey we asked consultants if they currently undertake work that could be delegated to more junior staff – 55 per cent said they did.

The SEHD expected waiting time initiative payments to decrease, but instead, they are rising

66. Boards receive additional funding from the SEHD to deliver against national targets. Based on their initial estimates of cost, the SEHD anticipated savings from waiting time initiative payments to consultants of around £2 million annually. These were expected as a result of the new contract through:

- an extended working day
- scope for additional EPAs
- the ability to change the way in which services are delivered.³⁸

67. There are examples of EPAs being used for waiting times activity (Exhibit 8).

68. But, overall, the cost of waiting time initiative payments to consultants has risen since the contract was implemented. In 2002/03, £2.24 million was paid to consultants for waiting time work under the old contract. This has risen to £2.95 million in 2003/04 and £3.41 million in 2004/05 under the new contract.

69. Under the old contract, boards were able to set a locally agreed fee for waiting time work that could be more than three times a consultant's hourly rate. However, only one board reported making use of this option.³⁹ Some boards were paying consultants at a lower rate before the new contract came into effect.⁴⁰

³⁵ The cost of EPAs in 2003/04 was paid as part of back pay, and is therefore not an additional cost.

³⁶ Survey of consultants, Audit Scotland, September 2005.

³⁷ When employing a new consultant, 25 per cent of their time is non-clinical, whereas purely clinical time can be contracted from an existing consultant through EPAs.

³⁸ SEHD costing paper October 2003 and DoH costing model, June 2002.

³⁹ NHS Ayrshire & Arran.

⁴⁰ NHS Forth Valley, NHS Lothian, NHS Greater Glasgow, NHS Lanarkshire (except for anaesthetists who were paid at three times the hourly rate).

70. Under the new contract, payments for waiting time activity were agreed nationally. Waiting time initiative payments to consultants are paid at three times the hourly rate, or at one or two times the hourly rate with corresponding time off in lieu. The overall costs of these payments are increasing.

71. All boards are now using only the higher payments, except NHS Lothian which is continuing to use a mix of the lower and higher payments and time off in lieu. Using the higher rates has contributed to increased costs within the overall pay bill for consultants, and is an expensive way to deliver consultant waiting times activity.

Out-of-hours work is now recognised and paid for under the new contract

72. Under the previous contract, out-of-hours (OOH) work by consultants – work done outside of core working hours – was not usually recognised.⁴¹ This is now included in the new contract, and consultants are paid for OOH work.

73. Boards have three options available to recognise and pay for the OOH work by consultants. Boards can either: make a premium payment for hours worked; include OOH work in EPAs; or treat three hours of OOH work as four hours, equivalent to one PA. Although it is more cost-effective to include the work within the main contract as PAs, consultants may not have sufficient available hours, and an additional payment is incurred.

These arrangements must be agreed locally and NHS boards are taking different approaches.

74. The approximate total cost of OOH payments to consultants was £1.18 million in 2002/03 under the old contract, increasing to £1.67 million in 2003/04 and £1.77 million in 2004/05 under the new contract.⁴²

Progression through the salary scales cost over £12 million in 2004/05, which was more than expected by boards

75. Pay progression – moving up the salary scale – has cost approximately £12.7 million since the contract began.^{43 44} Only 11 boards were able to provide details of pay progression costs so the total cost shown is likely to be understated.

76. Under the new contract, consultants should only move up the salary scale if they take part in an appraisal process, meet their agreed objectives and comply with the Code of Conduct for Private Practice. Almost all boards in our sample told us they had underestimated the cost of pay progression, partly due to complexities in how consultants who have transferred to the new contract move up the pay scale and poor information systems to manage this.⁴⁵ This adds to the financial pressures of the larger boards, such as NHS Lothian and NHS Greater Glasgow, where pay progression cost £4.6 million and £6.4 million respectively in 2004/05.

77. In 2004/05, pay progression payments were made automatically because boards had not completed

job plan reviews on time. Boards have told us that they plan to have systems in place to award pay progression in future only where the consultant meets their agreed objectives.

Most boards are starting to make savings on fees but there are still problems

78. Although costs to the NHS for fee-paying work are small in comparison to the cost of the contract, there have been significant difficulties for boards in addressing such work. Examples of fee-paying work are family planning work, undertaking domiciliary visits, or non-NHS work such as court work. The new contract offers an opportunity to include NHS-related, fee-paying work under core duties, making management of this work clearer, preventing double payments to consultants and reducing costs. Some boards have made savings where they have included some or all work they had previously paid for by fees in consultants' job plans. These boards include NHS Ayrshire & Arran, NHS Argyll & Clyde, NHS Borders, NHS Fife, NHS Tayside and NHS Forth Valley. In December 2005 the contract was amended to include all family planning work within the core contract.

79. Central guidance on handling fees as part of back pay was issued to boards. However, boards interpreted this guidance differently – for NHS-related work some reclaimed fees paid from the consultant but others did not. This has led to mediation at some boards and an appeal by consultants at one board.

41 NHS Greater Glasgow, NHS Highland and NHS Orkney made OOH payments before the new contract.

42 Consultant contract data collection, Audit Scotland, September 2005.

43 Five NHS Boards (NHS Argyll & Clyde, NHS Ayrshire & Arran, NHS Grampian, NHS Highland and NHS Orkney) were unable to provide information on the cost of pay progression for 2002/03, the year before the contract was implemented. However, for those boards that are able to provide this information, it is evident that pay progression under the new contract is costing more.

44 NHS Lanarkshire, NHS Grampian, NHS Shetland, NHS Western Isles, the State Hospital and NHS NSS did not provide pay progression costs for 2004/05. Therefore the £12.67 million represents costs for the remaining 11 boards.

45 Transitional arrangements for consultants moving up the pay scale exist under the new contract.

80. Some fees can be paid for by boards and some by other agencies such as the courts. During our fieldwork, we reviewed the cost of NHS fee-paying work to boards, but were unable to establish accurate costs. This is because there has been limited monitoring of fees work and costs at boards, both before and since the new contract was introduced.

81. In addition, there is no central monitoring data shared among the Scottish Executive departments and agencies involved, such as between the Scottish Courts Service and the SEHD. This means it is difficult to monitor what work is being done by whom. A lack of data at national and local level makes it difficult for boards to ensure that consultants are not being paid twice for the same work. We understand that work is now being taken forward by the SEHD and boards with other Scottish Executive departments to explore more effective ways of paying for such work.

82. We estimate that fee payments cost approximately £1.9 million in 2002/03, £3.4 million in 2003/04 and £0.9 million in 2004/05. Costs for fees appear low in 2002/03 as many boards were unable to provide figures for these payments.⁴⁶ Although it appears that fee payments initially increased, they decreased between 2003/04 and 2004/05 as these payments became part of core contracts or were included within EPAs. This has made activity more transparent.

Boards are not monitoring the various individual cost elements of the consultant pay bill

83. In [Part 2 \(page 9\)](#) we looked at estimates and reported costs of the contract. Here we quantify the various categories of consultant pay, including some areas which are not affected by the new contract, such as discretionary points and distinction awards.

84. Some cost elements within the consultants' pay bill are set, such as the basic salary. Boards agree other costs, such as EPAs, fees and waiting time payments, separately with consultants for a specific period, or as they arise, to allow flexibility for boards to deliver the services they need in the short term.

85. [Exhibit 9](#) shows an estimate of the costs for all the individual categories of consultants' pay in 2004/05. Adding these elements together gives a total cost of £338 million. This rises to £419 million when we include inflation and on-costs.

86. In addition to asking boards to provide costs for these individual payment categories ([Exhibit 9](#)), we asked them for their total pay bill costs for consultants in 2004/05. The total pay bill was £335 million, a difference of just over £3 million. This difference is relatively small and is due to a combination of factors, not least that boards are not routinely monitoring all elements of consultant cost and had to provide estimates for some of the categories of payment in [Exhibit 9](#).

87. During our interviews, we were only able to identify one board (NHS Borders) that initially estimated and monitored individual cost elements before and during the first year of implementation, while the total cost was still uncertain. It feels that the costs have stabilised, and there is no need to continue to monitor individual cost elements.

Recommendations

The SEHD should:

- ensure that future national contracts are clearly defined from the outset, with guidance issued in a timely manner, to avoid the risk of inconsistencies in local agreements
- work with other agencies to develop and share data about fee-paying work by consultants, including payments and activity.

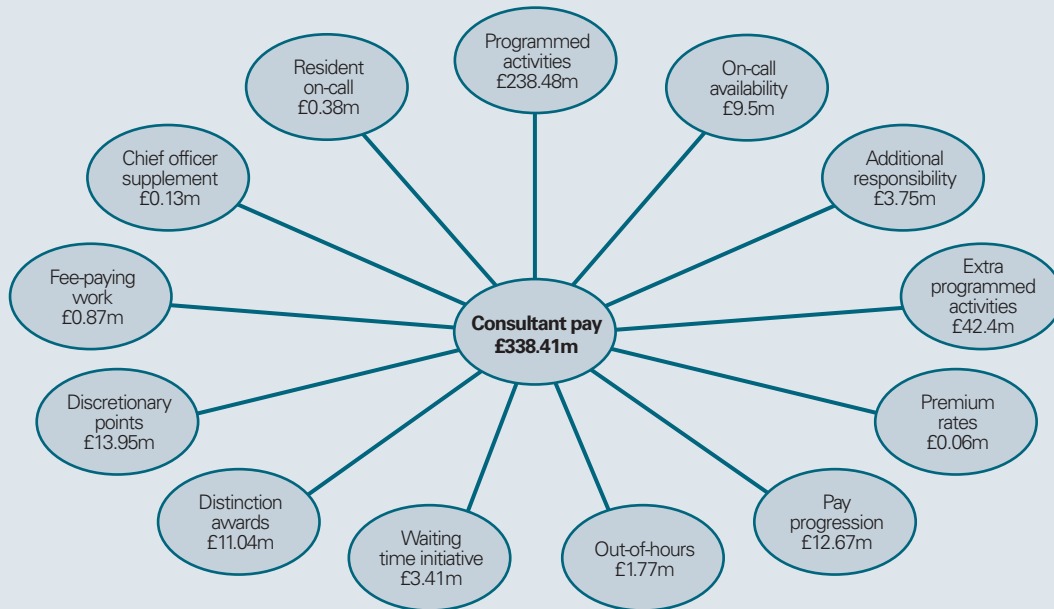
Boards should:

- develop systems for monitoring the individual cost elements of the contract, to enable them to manage and reduce costs over time
- aim to reduce waiting time payments through more effective service and job planning
- ensure that pay progression is linked to achieving objectives.

Exhibit 9

Total costs of the consultants' pay bill for 2004/05 by payment categories

A number of payment categories make up the total consultant pay bill.



Source: Consultant contract data collection, Audit Scotland, September 2005

Part 4. Impact of the contract



Key findings

The new contract offers the opportunity to improve services, but it is not yet being used to its full potential. Well-defined and robust job plans are needed to ensure the contract delivers improvements in patient care.

There is little evidence to assess whether the contract has improved patient care. However, only seven per cent of consultants who responded to our survey agreed that patient care had improved since the new contract was implemented.

The contract aimed to tackle excessive working hours by consultants. The effect of the contract on the work of consultants is not clear, but many consultants report working over their contracted hours.

This part of the report examines:

- the expected benefits of the new contract, for both patients and consultants
- whether these benefits are being achieved
- the extent to which job planning is being used to improve services.

The contract gives the opportunity to improve patient care, but it is not yet being used to its full potential

88. One of the main potential benefits offered by the new contract is the ability to plan and manage the workload of consultants in line with local NHS priorities. But boards are at the early stages of using the consultant contract in this way.

89. The negotiation of the contract took a considerable time ([Part 1, page 4](#)). The NHS then had to negotiate job plans with each consultant and attempt to tie consultant work

into service priorities. Some boards did not have sufficiently detailed plans outlining the priorities for different services, so these had to be drawn up and agreed first between the specialty and the board.

90. The NHS has focused on the practical task of implementing the contract, and is only now beginning to explore its potential for improving services. The impact on the NHS of pay modernisation will only be fully realised if job planning and monitoring are thorough and linked to service improvement. It will take time for the job planning process to develop and bed in with other major developments such as changes in training doctors.⁴⁷

The aims of the new contract have not yet been achieved but some initial benefits are evident

91. In July 2002, the SEHD issued a letter setting out the anticipated benefits of the new consultant contract for patients, the NHS and consultants. These are summarised in [Exhibit 10](#), together with our

⁴⁷ Modernising Medical Careers (MMC) initiative to restructure the training of junior doctors.

Exhibit 10

Summary of the SEHD guidance on the expected impact of the new contract and progress so far

The impact of the new contract is not yet clear.

Expected benefit	Impact on patients to date	Impact on consultants to date
Clear objectives for consultants and systems to manage consultants' time, linked to local service needs and priorities.	Links to service priorities are not well developed at board level and the contract is not yet being used systematically to improve patient care.	Job plans are not sufficiently detailed and many consultants report working above their contracted hours.
Support to enable consultants to meet their objectives.		Most job plans we reviewed did not specify the resources that consultants need to meet their objectives. Where resources are specified, our survey shows that these are not always provided.
More time spent on clinical care and more flexibility.	It is not clear whether the contract has resulted in consultants spending more time on clinical care because there is a lack of monitoring data.	Our survey findings suggest that consultants are not working more flexibly under the new contract.
Easier to recruit and retain consultants.		It is too early to say whether the contract has had a positive impact on recruitment and retention.
Incentives for high-quality performance.		Progression through the salary scale should be linked to consultants meeting agreed objectives. This is not yet working as an incentive and pay progression was automatically paid in year one.
Significant increase in average career earnings		The contract has increased the basic salary scale for consultants from £57,370-£74,658 to a new scale ranging from £69,298-£93,768. Consultants can expect to reach the highest point of the scale if they adhere to the Code of Conduct for Private Practice and take part in the appraisal process.
Preventing any conflicts of interest, or perceived conflicts of interest, between private practice and NHS commitments.		Most boards do not routinely monitor private practice commitments.

Source: Extract and summary of letter from SEHD Director of Human Resources, 1/7/2002, and Audit Scotland fieldwork

Case study 1

Planned reduction in waiting times in dental services at NHS Greater Glasgow

NHS Greater Glasgow has used the new contract to help address waiting times in dental services. Extra programmed activities have been allocated to three of the dental consultants. The board reports that this will remove 30 new referrals per week from the dental waiting list, within normal hours, helping improve patient access to care.

Source: SEHD examples of good practice issued to Parliamentary Audit Committee, 2005

assessment of achievement. [Appendix 5 \(page 40\)](#) sets out the full SEHD statement of intended benefits. This initial SEHD letter did not set out specific performance indicators or monitoring systems to help boards plan for the benefits.

92. The SEHD issued a further letter in July 2005 asking boards to show how they are using pay modernisation schemes to deliver national priorities and improvements in patient care.⁴⁸ The SEHD asked boards to submit action plans based on NHS priorities by September 2005 and provide progress reports by 31 March 2006.

93. We reviewed these plans and although they give an indication of service initiatives and some changes linked to workforce, they are not comparable across board areas and most do not demonstrate proactive developments based on the consultant contract. These plans do not yet provide evidence

of clear benefits to the NHS and to patients as a result of the new contract, and they do not act as a coherent monitoring tool to establish benchmarks. The SEHD and boards will need to identify and collect monitoring data that underpin the action plans. The SEHD is continuing to work with each board individually to develop these. Revised plans are expected in spring 2006.

94. In 2005, the Scottish Association of Medical Directors (SAMd) set up a service-led, short-term working group to consider how to monitor the impact of the contract. In September 2005, the group issued a report which recommended collection of data on:

- productivity and efficiency
- patient experience
- quality of care
- workforce planning.⁴⁹

95. Boards need to ensure they monitor the effect of the contract on services. This will take time, given the pace of change across the NHS. The Modernising Medical Careers (MMC) initiative to restructure junior doctors' training will have an impact on consultants' work. This will add further pressure on more senior doctors, as they will be required to provide more training and supervision of junior doctors, and junior doctors will be spending less time on clinical care. MMC came into effect in August 2005, and the SEHD is currently developing a model to help boards plan for its impact.

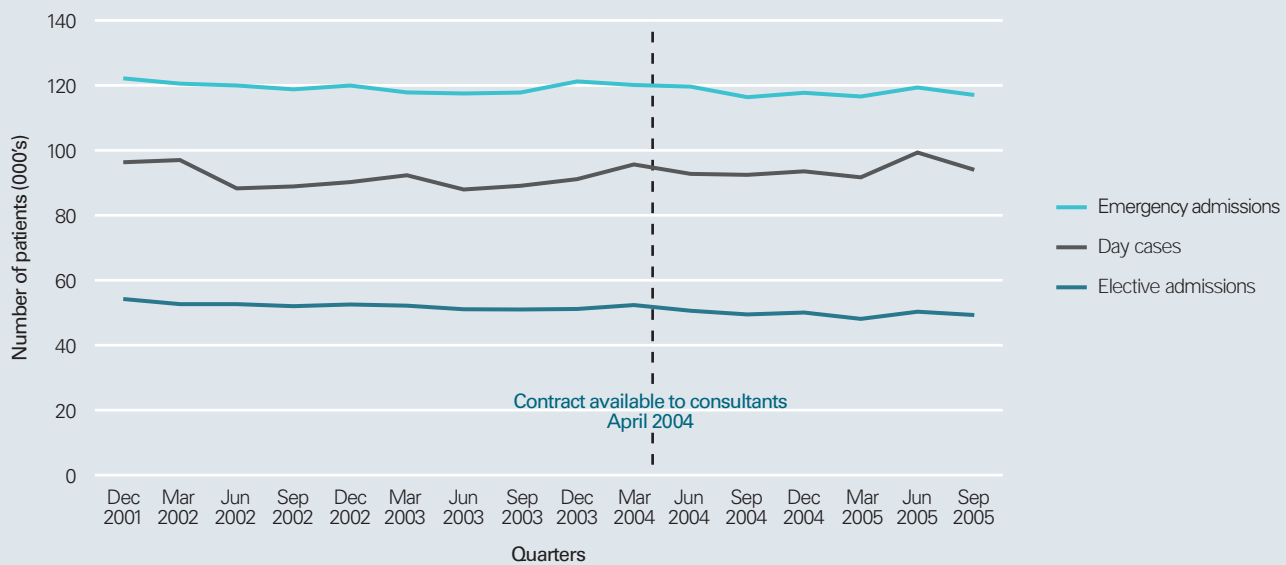
96. All sampled boards expressed concern about the impact of MMC, and noted the potential MMC gives for additional pressure on medical staff time. At the time of our fieldwork, most boards were unable to accurately assess the impact that MMC will have on working patterns and service delivery.

⁴⁸ *Delivering the benefits of pay modernisation in NHS Scotland*, HDL (2005) 28, SEHD, July 2005.

⁴⁹ Report on benefits realisation, SAMd, September 2005.

Exhibit 11

Activity data for emergency admissions, day cases, and elective admissions



Source: Activity data, ISD, December 2001 to September 2005

It is difficult to assess the impact of the contract on patient care

97. The new contract has not been introduced in isolation. The NHS is undergoing other major restructuring and reforms, such as the wider modernisation of pay, which affect all areas of the health service. It is therefore impossible to isolate the effects of one particular contract, especially if there are no consistently applied performance indicators. Boards need to identify performance measures that can be used to promote improvements and monitor impact. As there is no central guidance on specific indicators, the approach of boards will vary.

98. Consultants themselves do not currently see the new contract as improving patient care. Only seven per cent of consultants on the new contract who responded to our survey agreed that patient care had improved since the new contract was implemented.

99. Boards feel that it is too early to see comprehensive changes as a result of the consultant contract. There are some examples of direct benefits, although these appear to be isolated examples at this stage ([Case study 1, page 28](#)).

100. The time that consultants spend carrying out direct clinical care may be under pressure with the new contract. There is evidence that consultants previously did some emergency work and professional development work outside of their contract.⁵⁰ This work was traditionally hidden, but has now been pulled into core-contracted time. The inclusion of emergency work in the contract is seen as a positive development by 47 per cent of respondents to our survey who had transferred to the new contract.

101. Due to increases in spend and boards' ability to work with consultants to manage their time better, it is reasonable to expect to see an increase in productivity and more appropriate use of consultants' time. Analysis of activity data on emergency admissions, day cases and elective admissions shows no evidence of an increase in activity since the introduction of the contract in April 2004 ([Exhibit 11](#)). Outpatient activity data shows a mixed picture, with variation since the implementation of the contract ([Exhibit 12, overleaf](#)).

102. These figures, however, do not include any measurement of increases in non-clinical work, such as providing training and supervision, and are not sensitive to any moves to make more appropriate use of consultants' time. The impact on activity levels and appropriate use of consultants' specialist skills should be monitored and reviewed as part of effective management systems.

50 Survey of consultants, Audit Scotland, September 2005, and interviews with a sample of NHS boards.

Exhibit 12

Activity data for outpatients



Source: Outpatient activity data, ISD, from December 2001 to September 2005

Some job plans are not sufficiently detailed

103. Accurate and detailed job planning is central to the new contract to ensure that changes to consultant work are linked to service priorities. Job planning had been undertaken previously, but the new consultant contract requires that robust job plans are put in place and negotiated at least annually. The job plan should include service and personal objectives and define all NHS work undertaken by the consultant. Establishing new systems and processes to support accurate and timely appraisal and job planning for consultants has been a challenge for boards.

104. Guidance issued with the contract included a template for carrying out a diary exercise, which asked consultants to gather data on workload and type of work over a few weeks.⁵¹ This could then be used to establish baseline workload and provide information for job planning. This self-reporting approach is

symptomatic of the lack of data about consultant work before the new contract on which to base job plan negotiations. There are indications, from our work at boards and feedback from the consultant survey, that workload was reported as high.

105. An aim of the new contract was to have clear objectives for consultants. In year one, job plans were not as robust as they could have been. Our survey showed that only one in three consultants on the new contract felt they had a clear job plan linked to improving services. But boards aim to improve the quality of job planning in subsequent years, specifically by linking objectives to service needs.

106. Most boards used the template for job planning provided by the SEHD. As part of this review, we looked at a sample of job plans (Exhibit 13), and found wide variation in the quality of job plans both among and within boards.

107. There is also evidence from interviews and survey responses that the work done by consultants since the introduction of the new contract has continued much as before. If consultants have signed off job plans that do not reflect their work, there is a risk that they will remain dissatisfied with the process.

“The surgical consultants agreed to continue ‘service as usual’ for two EPAs.”

A consultant response from Audit Scotland national survey of consultants, September 2005

108. Job plans were, in part, designed to clarify what resources consultants require to meet their objectives, such as additional secretarial support. Our review of job plans shows that this is often not the case, and 15 per cent of consultants who replied to our survey and were on the new contract felt that where they had identified a resource requirement it had been met.

51 New consultant contract, PCS (DD) 2004/02, SEHD, March 2004.

Exhibit 13

Some job plans have objectives linked to service delivery and act as a mechanism to develop working patterns and measure progress

Objective	How objectives will be met and resources required	Timescales
Improved on-call rota.	Establish cross-site A&E consultant rota as part of integrated A&E service. This may be linked to the review of services.	Review annually as part of consultant job plan review. Aim to achieve within 18 months.

A number of job plans do not have any meaningful or measurable objectives linked to service delivery

Objective	How objectives will be met and resources required	Timescales
Accumulation of recommended number of Continuing Medical Education (CME) points.	Adequate study leave and budgetary support.	250 points every five years.
Will aim to deliver 42 weeks of clinical services per annum.	—	—

Source: Review of sample of job plans, Audit Scotland, September 2005

109. However, 46 per cent said that they found the job planning process useful and 47 per cent said they have positive relationships with managers.

110. Boards have invested considerable time and money to implement the contract, particularly in the job planning process. This was especially resource-intensive for clinical directors who generally carried out individual job planning with each consultant within their specialty. This has changed the role of the clinical director. Managers and consultants require new skills to negotiate the job plans and use the new contract in line with service plans. Training and guidance is necessary in this area, and this is not yet evident at all boards.

111. The SEHD issued a training pack in March 2005 which was used by some boards. However, only 19 per cent of survey respondents on the new contract said their board has provided training in job planning. This is a central

area for development given that the quality of job planning underpins the success of the contract.

112. The SAMD benefits group recommended that a national process for job plan reviews be put in place in 2006/07. This should help provide a degree of consistency across Scotland. The group also recommended that common objectives would be useful across staff groups, which boards should address in future job planning rounds.⁵²

Consultants are working over and above their contracted hours

113. A central aim of the contract was to address excessive working hours and have less tired doctors, which would lead to safer and improved patient treatment.⁵³ From both our interviews at boards and responses to the consultant survey, there is evidence that consultants are working more than their contracted hours. Over half of consultants who

responded to our survey said they work over 48 hours per week, which is above the EWTD limits, while 51 per cent of consultants on the new contract felt their job plan did not reflect their working hours. This was particularly the case for those consultants who have been in post between five and 15 years.

114. Almost two-thirds of consultants feel that the contract has not reduced their working hours. Some consultants, however, are happy to maintain previous service levels because of the improved payment under the new contract:

“Most of the consultants I know still work in excess of the hours they are contracted for and do SPA work in their own time, but do this more happily now that at least the new contract has recognised some of their considerable commitment to the NHS.”

A consultant response from Audit Scotland national survey of consultants, September 2005

⁵² Report on benefits realisation, SAMD, September 2005.

⁵³ SEHD Pay modernisation website: www.paymodernisation.scot.nhs.uk

115. A cap of a 48-hour working week was put in place by the PSERG in line with EWTD limits. In theory, consultants are able to work over and above this only in exceptional circumstances, but half of respondents to our survey report working over 48 hours. There are indications that boards are not monitoring this work effectively; of those consultants working over 48 hours per week, 93 per cent said they had not signed an EWTD waiver.

“The arbitrary limit of 48 hours irrespective of the hours that consultants were actually working represented a major barrier to consultants and managers attempting to implement the new contract.”

A consultant response from Audit Scotland national survey of consultants, September 2005

116. Most boards have not introduced systems to have consultants sign an EWTD waiver when they work over 48 hours, and some boards report difficulties where consultants are working over 48 hours but are not reporting such levels.

117. The introduction of a contract that specifies working hours has benefits, for example, an ability to monitor time spent on various activities and the potential to put in place systems to reduce excessive hours. However, through both interviews with boards and responses to our survey, a time-based contract is not looked on favourably by many managers or consultants. Some boards questioned how appropriate a time-based contract is for such senior medical staff. Consultants raised similar issues.

“I am rewarded for time not productivity!”

“It is the first step to de-professionalising medicine.”

Responses from Audit Scotland national survey of consultants, September 2005

There are risks to activity levels if the contract is not well managed

118. One of the intended benefits of the contract was to improve consultant productivity, however, there is a potential risk to the NHS if work over contracted hours is withdrawn. Although consultants have a professional duty to the patient, this new contract aims to manage their workload, citing reasons of safety. Most consultants are keen to see this develop quickly.

119. The SEHD has published an efficiency target for consultant productivity through the Efficient Government initiative.⁵⁴ This target specifies that boards should demonstrate an increase in consultant productivity of one per cent, per year, over the next three years. The SEHD anticipates that this will achieve time-releasing savings of £22 million in 2005/06, £46.5 million in 2006/07 and £73.9 million in 2007/08.⁵⁵ It is not clear how this will be achieved, given that indications are that many consultants are currently working over their contracted hours.

“In general surgery and academic activity the workload still exceeds the PA/EPAs awarded; if we stuck to job plans the system would collapse.”

A consultant response from Audit Scotland national survey of consultants, September 2005

120. Boards, however, report that they do not have the money or staff available to absorb work delivered by consultants over and above their contracted hours. There is a risk that the system does not have the capacity to deliver this change in the short to medium term, rather that this is a longer-term aim which will require clear and detailed planning. A further complication is that planned expansion in consultant numbers is happening more slowly than expected.⁵⁶

121. Boards are responding to this issue in different ways: some are recording work over contracted hours separately from the consultant job plan; some are including the additional work in the job plan, but not paying a contract to match the work delivered; other boards have no record of this goodwill work delivered by their consultants.

122. There is scope for boards to improve flexibility in the way care is delivered under the new contract, but this flexibility is limited and any work outside of core hours is expensive. We asked consultants if they feel they now have a more flexible approach to work since under the new contract, and only 19 per cent of respondents to our survey said they did.

123. Travel time is counted as working time under the new contract, and this may reduce available clinical time and provide a disincentive to deliver services either at other sites or in the community. Rural NHS boards raised this as a particular concern. However, it can improve conditions for consultants who have not previously had travelling time recognised as part of their working week.

⁵⁴ *Efficient government: Achievement of time-releasing savings targets*, SEHD, November 2005.

⁵⁵ Time-releasing savings are efficiency savings that do not release cash but which improve how services are provided, allowing staff to deliver more or better services with the same money.

⁵⁶ *Overview of the performance of the NHS in Scotland 2004/05*, Audit Scotland, December 2005.

Case study 2

Monitoring of private practice work, NHS Forth Valley

NHS Forth Valley has used the new contract as a way to monitor private practice work by their consultants. The board now has clearer information about the private practice arrangements of consultants under the new contract. It now records accurately when those consultants who have private practice have their fixed private commitments, so that there is certainty about when they are available to the NHS and when they are not. This reduces the risk of any potential conflict of interest that might have existed.

Source: SEHD examples of good practice issued to Parliamentary Audit Committee, 2005

Pressure on non-clinical time

124. There are pressures on non-clinical time, which have become clearer under the new contract. This includes time for education and development, and work with Royal Colleges and other national bodies.

125. As part of the new contract, consultants would usually have ten hours per week for supporting professional activities (SPAs) which include teaching, monitoring and developing skills. Respondents to our survey indicate there is pressure around this work – 12 per cent said they have no dedicated time in their contract for SPA work. Sixty-one per cent of respondents on the new contract reported that they do SPA work in their own time. There is a potential loss to the NHS if pressure on consultants' time means learning and development activities are squeezed out of the schedule. There is likely to be more pressure on consultants' non-clinical time in the future, with extra supervision and clinical work required as a result of the MMC initiative (See paragraph 95, page 28).

126. The BMA has expressed concern that the new contract is also putting pressure on external work delivered by consultants, such as representation on national groups and examining for Royal Colleges. Over two-thirds of respondents to our survey indicated that they undertake external duties, but only a quarter of consultants on the new contract have external duties recognised in their job plans. Again, this is evidence of work happening outwith the contract.

127. Over time, managers and consultants should develop a more accurate shared view of the job plans and the work that is required. This will enable discussions about work that does not fit within the hours available, and work delivered over contracted hours.

There is scope to improve monitoring of private work

128. One of the aims for the new contract across the UK was to clarify the distinction between private and NHS work, and increase the time available to the NHS from consultants who carry out private work.

129. As this is not rigorously monitored, it is difficult to quantify. Just over a third of consultants who responded to our survey indicated that they carry out some private practice.

130. Consultants must abide by the Code of Conduct for Private Practice. Under the new contract, consultants must report their private work to their employer, but most boards do not have a system for checking activity levels, although there are some examples of good practice (Case study 2).

131. Lack of monitoring of private practice makes it difficult for boards to be clear about potential conflict and minimise intrusion into NHS work as specified under the new contract. It is also difficult for the board, as the employer, to be assured that consultants are working within the EWTD limit of 48 hours if part of the consultants' work is unknown by the board.

It is too early to see the impact of the contract on recruitment

132. The contract was intended to have a positive impact on vacancies and recruitment targets. At this stage however, there is little evidence that this has happened. It will take time to see the impact of the contract on vacancy rates and recruitment of consultants, as the contract becomes established and other related schemes develop, such as MMC.

133. A recruitment and retention premium can be paid to attract new consultants. It is used in England but Scottish employers have decided not to pay this premium.

134. Foundation trusts in England appear to be creating new contracts outwith the terms of the new consultant contract, so the potential for the premium to compete with English terms and conditions may be limited.

135. Workforce planning should be used to identify significant regional difficulties and boards should only consider using the premium as part of regional and national workforce planning. But it may be helpful if the premium is used in exceptional circumstances where there is a clear case to be made.

Recommendations

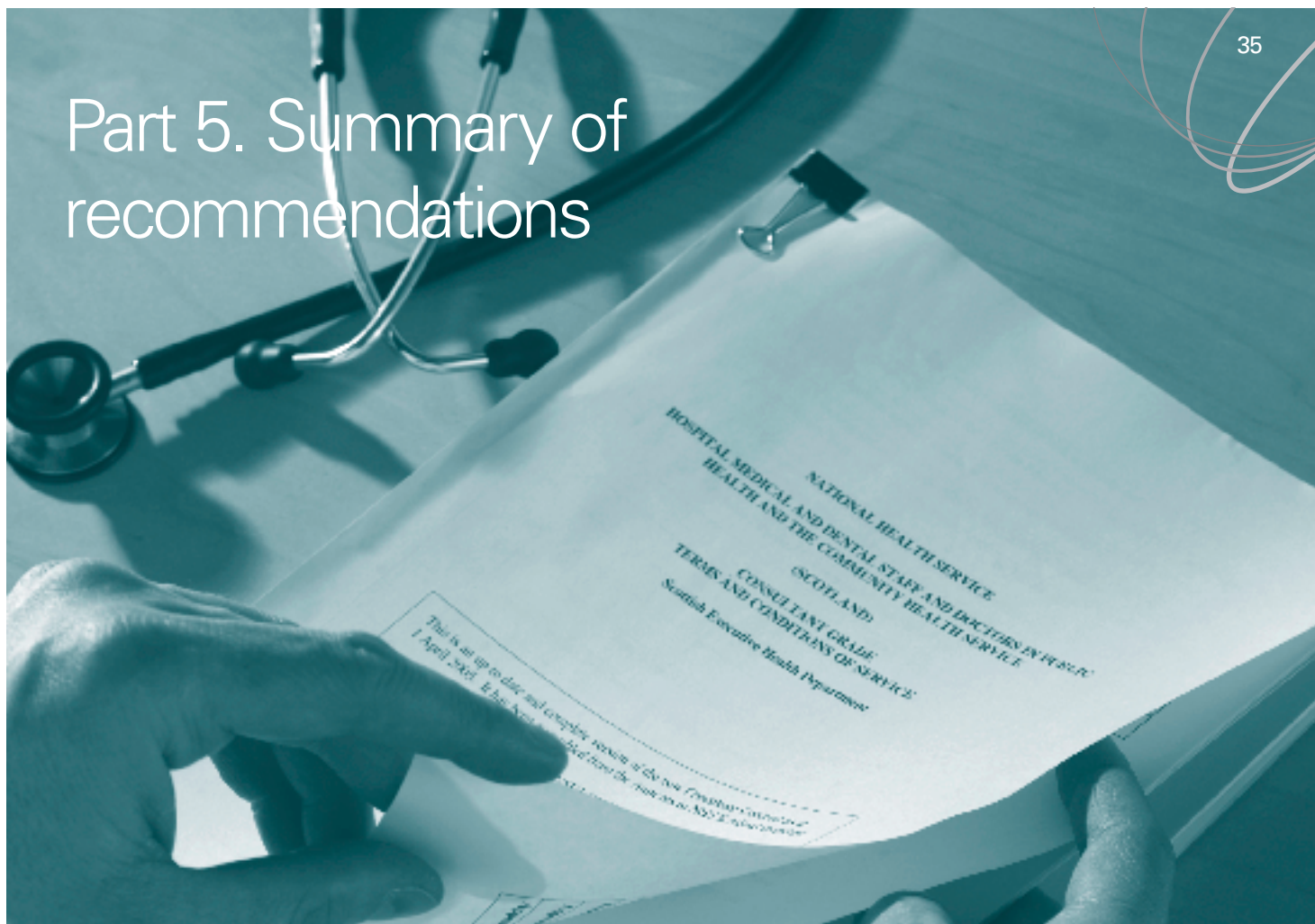
The SEHD should:

- identify performance measures and baseline information against which benefits for patients and the NHS can be clearly measured before implementing national schemes
- provide a clear statement of expected benefits for patients and the NHS, and agree with all stakeholders robust plans for implementation before agreement of national schemes.

Boards should ensure that:

- where consultants are working over their contracted hours this activity is recorded and action plans are in place to reduce such work
- consultants opting to work over 48 hours sign an EWTD waiver
- job planning is sufficiently accurate and detailed to provide an effective management tool that will deliver the expected benefits to patients and the NHS.

Part 5. Summary of recommendations



Part 2. Planning for the new contract

The SEHD should:

- ensure that national cost models are based on accurate data relating to Scotland and work with boards to accurately assess the cost of major developments before implementation
- provide timely and effective guidance when implementing major new schemes, provide national support, identifying actions that boards are required to take and monitoring whether this happens.

Boards should:

- ensure that robust planning and monitoring takes place as early as possible to allow them to prepare for the impact of new initiatives with significant costs.

Part 3. Cost and financial management

The SEHD should:

- ensure that future national contracts are clearly defined from the outset, with guidance issued in a timely manner, to avoid the risk of inconsistencies in local agreements
- work with other agencies to develop and share data about fee-paying work by consultants, including payments and activity.

Boards should:

- develop systems for monitoring the individual cost elements of the contract, to enable them to manage and reduce costs over time
- aim to reduce waiting time payments through more effective service and job planning
- ensure that pay progression is linked to achieving objectives.

Part 4. Impact of the contract

The SEHD should:

- identify performance measures and baseline information against which benefits for patients and the NHS can be clearly measured before implementing national schemes
- provide a clear outline of expected benefits for patients and the NHS, and agree with all stakeholders robust plans for implementation before agreement of national schemes.

Boards should ensure that:

- where consultants are working over their contracted hours, this activity is recorded and action plans are in place to reduce such work
- consultants opting to work over 48 hours sign an EWTD waiver
- job planning is sufficiently accurate and detailed to provide an effective management tool that will deliver the expected benefits to patients and the NHS.

Appendix 1. Advisory group members

Dr Adam Bryson OBE	Medical Director, NHS National Services Scotland
Julie Burgess	Formerly: Director of Pay Modernisation, Scottish Executive Health Department Currently: Chief Executive, Birmingham Women's Health NHS Trust
Dr Ross Cameron	Medical Director, NHS Borders
Dr Alan A Connacher	Consultant Physician, NHS Tayside, Royal College of Physicians nomination
Tim Davison	Chief Executive, NHS Lanarkshire
Dr Fiona Gardner	Clinical Director, NHS Lanarkshire
Steven Haddow	Consultant Contract Coordinator, NHS Tayside
John Matheson	Director of Finance, NHS Lothian
Dr Lewis Morrison	Consultant in Geriatric Medicine, NHS Lothian, BMA nomination
Mike Palmer	Formerly: Assistant Director of Human Resources (Workforce and Pay Policy), Scottish Executive Health Department Currently: Head of Social Inclusion and Voluntary Issues Division, Scottish Executive Development Department
Rona Webster	Human Resources Director, NHS Fife

Appendix 2. Boards sampled

Fieldwork was carried out in:	Fieldwork was not carried out in:
NHS Ayrshire & Arran	NHS Argyll & Clyde
NHS Borders	NHS Dumfries & Galloway
NHS Fife	NHS Forth Valley
NHS Grampian	NHS Highland
NHS Greater Glasgow	NHS National Services Scotland
NHS Lanarkshire	NHS Orkney
NHS Lothian	NHS Shetland
NHS Tayside	State Hospitals Board for Scotland
NHS Western Isles	

Appendix 3. Board estimates of additional cost, March 2004

Second cost estimate, March 2004, and reported additional cost of the contract by board.

Board	Costs for 2003/04			Costs for 2004/05			Total costs for 2003/04 and 2004/05		
	Second cost estimate (£)	Reported cost (£)	Variance (£)	Second cost estimate (£)	Reported cost (£)	Variance (£)	Second cost estimate (£)	Reported cost (£)	Variance (£)
	March 2004	Sept 2005		March 2004	Sept 2005		March 2004	Sept 2005	
Ayrshire & Arran	1,794,260	2,866,000	-1,071,740	1,794,260	3,178,000	-1,383,740	3,588,520	6,044,000	-2,455,480
Argyll & Clyde	2,778,611	4,004,146	-1,225,535	3,584,408	4,207,653	-623,245	6,363,020	8,211,799	-1,848,779
Borders	1,527,645	1,223,871	303,774	1,914,976	1,135,490	779,486	3,442,621	2,359,361	1,083,260
Dumfries & Galloway	1,448,160	1,049,000	399,160	1,597,803	1,545,000	52,803	3,045,963	2,594,000	451,963
Fife	1,790,880	1,872,000	-81,120	2,180,396	2,101,000	79,396	3,971,276	3,973,000	-1,724
Forth Valley	2,796,457	2,683,491	112,966	3,775,217	3,783,985	-8,768	6,571,674	6,467,476	104,198
Grampian	7,366,580	6,036,000	1,330,580	9,508,555	8,681,000	827,555	16,875,135	14,717,000	2,158,135
Greater Glasgow	10,305,510	16,698,375	-6,392,865	11,799,809	22,862,727	-11,062,918	22,105,319	39,561,102	-17,455,783
Highland	2,044,125	3,019,724	-975,599	2,325,493	4,371,409	-2,045,916	4,369,618	7,391,133	-3,021,515
Lanarkshire	2,758,373	1,016,819	1,741,554	3,788,166	1,505,935	2,282,231	6,546,539	2,522,754	4,023,785
Lothian	7,842,474	11,295,827	-3,453,353	8,783,571	15,579,817	-6,796,246	16,626,045	26,875,644	-10,249,599
Tayside	3,429,189	6,438,701	-3,009,512	5,553,268	6,655,193	-1,101,925	8,982,457	13,093,894	-4,111,437
Western Isles	264,886	704,789	-439,903	407,924	490,893	-82,969	672,810	1,195,682	-522,872
Total	46,147,150	58,908,743	-12,761,593	57,013,846	76,098,102	-19,084,256	103,160,996	135,006,845	31,845,849

Note: NHS NSS, NHS Orkney, NHS Shetland and the State Hospital did not return data.

Source: Consultant contract data collection, Audit Scotland, September 2005, and SEHD, March 2003

Appendix 4. Board estimates of additional cost, November 2004

Third cost estimate, November 2004, and reported additional cost of the contract by board.

Board	Costs for 2003/04			Costs for 2004/05			Total costs for 2003/04 and 2004/05		
	Third cost estimate (£)	Reported cost (£)	Variance (£)	Third cost estimate (£)	Reported cost (£)	Variance (£)	Third cost estimate (£)	Reported cost (£)	Variance (£)
	Nov 2004	Sept 2005		Nov 2004	Sept 2005		Nov 2004	Sept 2005	
Ayrshire & Arran	3,450,500	2,866,000	584,500	4,261,368	3,178,000	1,083,368	7,711,868	6,044,000	1,667,868
Argyll & Clyde	3,994,254	4,004,146	-9,892	4,506,907	4,207,653	299,254	8,501,161	8,211,799	289,362
Borders	1,084,135	1,223,871	-139,736	1,709,385	1,135,490	573,895	2,793,520	2,359,361	434,159
Dumfries & Galloway	1,025,780	1,049,000	-23,220	1,597,622	1,545,000	52,622	2,623,402	2,594,000	29,402
Fife	2,126,670	1,872,000	254,670	2,805,973	2,101,000	704,973	4,932,643	3,973,000	959,643
Forth Valley	3,020,174	2,683,491	336,683	3,844,127	3,783,985	60,142	6,864,295	6,467,476	396,819
Grampian	5,949,930	6,036,000	-86,070	6,464,174	8,681,000	-2,216,826	12,414,104	14,717,000	-2,302,896
Greater Glasgow	12,881,887	16,698,375	-3,816,488	20,842,894	22,862,727	-2,019,833	33,724,781	39,561,102	-5,836,321
Highland	2,765,581	3,019,724	-254,143	3,120,537	4,371,409	-1,250,872	5,886,118	7,391,133	-1,505,015
Lanarkshire	3,447,967	1,016,819	2,431,148	3,976,655	1,505,935	2,470,720	7,424,621	2,522,754	4,901,867
Lothian	9,018,845	11,295,827	-2,276,982	11,333,944	15,579,817	-4,245,873	20,352,789	26,875,644	-6,522,855
NSS	348,968	385,008	-36,040	481,654	1,224,961	-743,307	830,622	1,609,969	-779,347
Orkney	24,011	240,349	-216,338	34,384	202,089	-167,705	58,394	442,438	-384,044
Shetland	137,914	12,468	125,446	190,352	423,341	-232,989	328,266	435,809	-107,543
Tayside	5,244,641	6,438,701	-1,194,060	5,905,466	6,655,193	-749,727	11,150,108	13,093,894	-1,943,786
Total	54,521,257	58,841,779	-4,320,522	71,075,442	77,457,600	-6,382,158	125,596,692	136,299,379	-10,702,687

Note: The State Hospital and NHS Western Isles did not return data.

Source: Consultant contract data collection, Audit Scotland, September 2005, and SEHD, March 2003

Appendix 5. SEHD statement of intended benefits from the new contract

Strand	Benefits for patient care	Benefits for consultants
Job planning	<p>Improved ability to manage consultants' time in ways that best meet local service needs and priorities.</p> <p>Greater clarity of objectives for consultants and more effective systems for engaging consultants in joint actions to improve NHS performance and modernise patient care.</p>	<p>Stronger unambiguous framework of contractual obligations.</p> <p>A more transparent framework to ensure that consultants have the facilities, secretarial/ administrative support and other support needed to carry out their responsibilities and duties and meet agreed objectives.</p>
Working week and recognition of on-call duties	<p>More efficient use of consultants' time and an increase in the time spent on direct clinical care, contributing to improvements in NHS productivity and quality of care.</p> <p>Greater opportunities and incentives to arrange consultant-delivered care in evenings and at weekends, leading to improvements in patient access (eg, outpatient clinics) and in the quality of emergency care.</p>	<p>More consistent and equitable recognition for on-call duties.</p> <p>Agreed action to help reduce the number of consultants on the most frequent on-call rotas.</p> <p>More consistent and equitable recognition for work undertaken out-of-hours, including emergency work.</p>
New pay structure	<p>Improvements in recruitment and retention of consultants, contributing to the target increase of 15,000 consultants and GPs by 2008 (England). Increase the number of consultants in the NHS by 600, by 2006 (Scotland).</p> <p>Sustained incentives for high-quality performance over the course of a consultant career.</p> <p>Enhanced incentives for consultants to maintain commitment to the NHS up to normal retirement age.</p>	<p>A significant increase in average career earnings, with earnings in the final phase of a consultant career 24 per cent above their current level where requirements for pay thresholds are met.</p> <p>Greater opportunities for phased careers to recognise the changing focus of the consultant role over the individual's working life.</p>
Extra programmed activity (EPA)	<p>Ability to secure extra consultant activity more cost-efficiently and thereby release efficiency savings that can be re-deployed in support of better NHS care.</p>	<p>Opportunities to undertake extra work on a more predictable and regular basis for the NHS.</p>
Private practice	<p>Preventing any conflicts of interest, or perceived conflicts of interest, between private practice and NHS commitments.</p> <p>Stronger guarantees that private practice will not disrupt provision of NHS services or detract from NHS performance.</p>	<p>Preventing unfair perceptions of abuse in relation to NHS consultants with private practice commitments.</p> <p>Abolition of maximum part-time contract. Type of NHS contract based solely on agreed time and service commitments.</p>

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