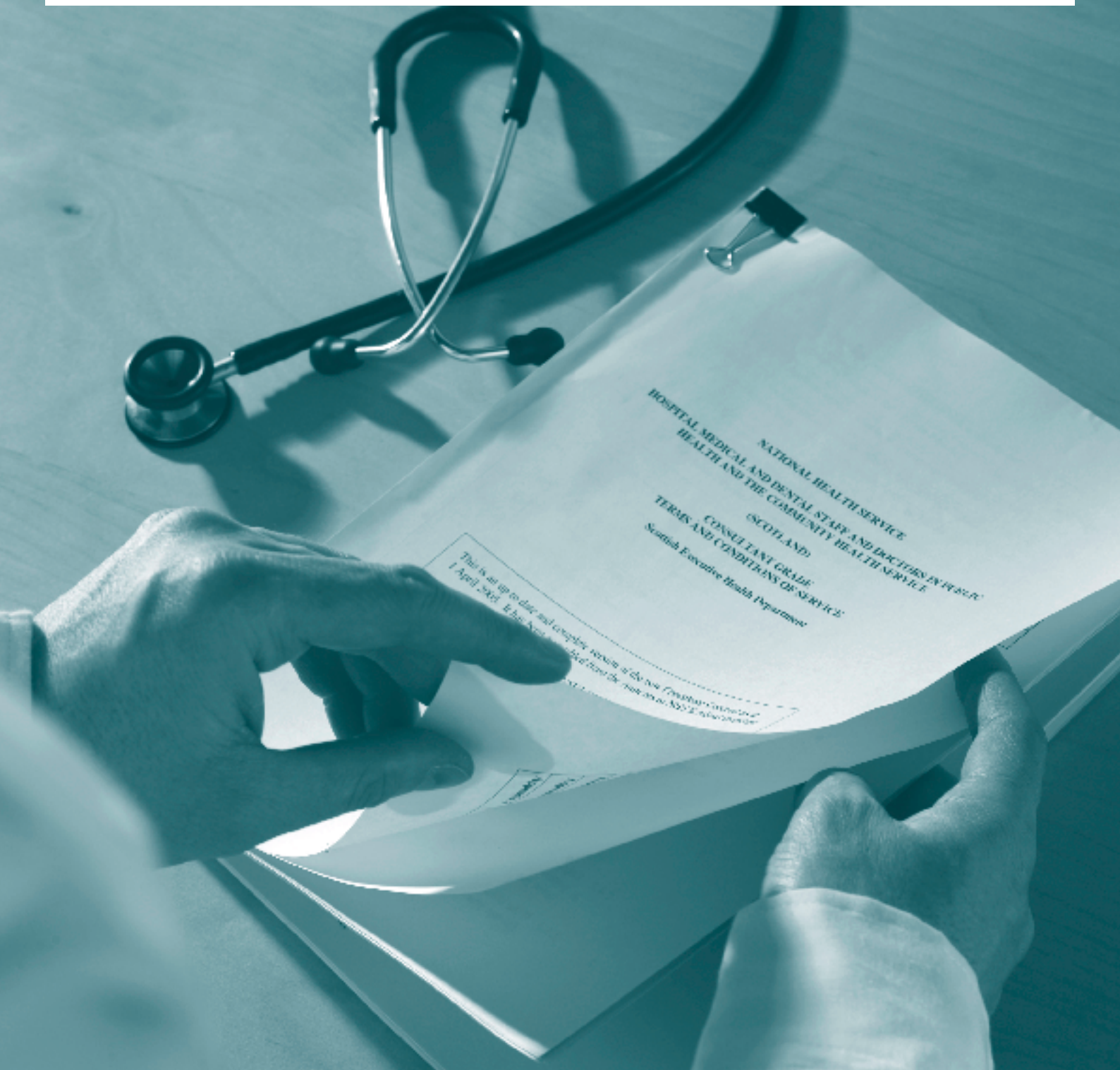


# Implementing the NHS consultant contract in Scotland

Key messages / Prepared for the Auditor General for Scotland

March 2006



# Key messages

## Background

**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.<sup>1</sup> This contract is the first major change to consultants' terms and conditions since the 1948 agreement. 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)<sup>2</sup>
- 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.** The Scottish Executive Health Department (SEHD), the British Medical Association (BMA) and NHS boards agreed the detail of the new contract in partnership, based on a UK-agreed framework to ensure equity in terms and conditions across the UK. In Scotland, 98.5 per cent of consultants have signed up to the new contract.

**3.** The NHS in Scotland has spent an additional £235 million on the contract since it was implemented and the pay bill for consultants has increased by 38 per cent. These figures increase to £273 million and approximately 44 per cent when we include inflation and on-costs, such as National Insurance (NI) contributions.

**4.** The success of the contract depends on high-quality job planning, strong financial management and sound information and monitoring systems,

both at boards and at the SEHD. This was the first of three major new contracts implemented for NHS staff in Scotland and lessons can be learned for implementing other large-scale agreements, such as Agenda for Change, the new contract for nurses and most other NHS staff.

## The study

**5.** Audit Scotland has reviewed how the contract has been implemented in Scotland. Our focus was on both the national approach and what happened in boards. In carrying out the study we:

- interviewed medical directors at most NHS boards and the two special health boards that employ consultants to consider local implementation
- interviewed managers at a sample of boards
- 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
- surveyed all consultants in Scotland seeking views on the impact of the new contract, with a 52 per cent response rate.

## Key findings

**1** 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.

- Implementing the contract has been a challenge to the NHS due to the complexity and cost of the contract and changes in the way consultants and managers work together. In the first year of the contract, boards have focused on the practical task of transferring consultants to the new contract, and they are only now beginning to explore its potential for improving services.

- Few of the boards we visited were able to provide evidence of having integrated implementation of the contract with local priorities for services. Only two of the ten boards we sampled had evidence of a more thorough process linked to planning.

- Boards and consultants need to develop, and agree, well-defined job plans linked to service priorities so that the contract is used to deliver improvements in patient care. This is not yet happening well in many boards – job plans were not well developed in the first year. However, 46 per cent of consultants on the new contract who responded to our survey said they found the job planning process useful, showing that it is seen as having potential benefits.

**2** Prior to the introduction of the new contract, the SEHD set out a number of anticipated benefits for the NHS in Scotland. However, it has not provided timely guidance to ensure these benefits are planned from the outset.

- In 2002, the SEHD issued a letter outlining the expected benefits of the new contract. This did not set out specific performance indicators and monitoring systems to help boards plan for the benefits.

<sup>1</sup> NHS Workforce Statistics, Information and Statistics Division, as at September 2003.

<sup>2</sup> EWTD is a directive from the Council of the European Union (93/104/EC) to protect the health and safety of workers.

- The SEHD issued a further letter in July 2005 requiring boards to produce action plans demonstrating how they are using pay modernisation schemes to achieve national priorities and improvements in patient care.<sup>3</sup> These plans give an indication of service initiatives and some changes linked to workforce, but they are not comparable across NHS board areas. They do not show clear benefits to the NHS and to patient care as a result of the new contract, and they do not provide a coherent monitoring tool. The SEHD is continuing to work with boards individually to develop these plans and revised plans are expected in Spring 2006.
- The SEHD, boards and the BMA 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, the SEHD did not always give clear direction to boards, striving for a consensus approach to decision making, which was not always reached. This approach resulted in some inappropriate local variation in how boards implemented the contract and a risk of inequity in the local contracts agreed with consultants. The timing of guidance also caused problems, as a lot of detailed guidance on specific elements was issued after the contract had already been implemented.

**3** Although some initial changes to services are evident, it is difficult to identify the overall impact of the contract on

patient care, or on consultants, at this stage. The SEHD and boards are just beginning to assess the impact of the contract.

- It is difficult to identify the impact on patient care, partly because other major changes to the NHS have been introduced at the same time and partly because measures were not agreed at the outset. Both the SEHD and boards are at the very early stages of attempting to identify the impact. [Exhibit 1](#) summarises progress against the expected benefits.
- Boards feel that it is too early to see comprehensive changes as a result of the consultant contract, although there are some examples of improvements in services. 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.
- Due to increases in spend and boards' ability to work with consultants to manage their time better, it is reasonable to expect to see more appropriate use of consultants' time and an increase in productivity. Analysis of data shows no evidence of an increase in activity since the introduction of the contract, although this does not measure all elements of consultants' work.<sup>4</sup> The impact on activity levels and appropriate use of consultants' specialist skills should be monitored and reviewed as part of effective management systems.

- A central aim of the contract was to address excessive working hours and have less tired doctors, leading to safer and improved patient treatment. The effect on consultants' work is not clear, but there is evidence that consultants are working more than their contracted hours. Half of survey respondents on the new contract reported that their contract does not reflect their working hours. In addition, just over half of all respondents said they work over 48 hours per week, which is above the EWTD limits. There are indications that boards are not monitoring this effectively – 93 per cent of consultants working over 48 hours per week said they had not signed a EWTD waiver.

**4** 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.<sup>5</sup> This represents a 38 per cent rise over the three years to 2005/06. This figure increases to approximately 44 per cent if we include on-costs and inflation.<sup>6</sup> The cumulative additional cost over these three years is £235 million.<sup>7 8</sup> This increases to £273 million when inflation and on-costs are included.

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

4 Data on emergency admissions, day cases, elective admissions and outpatient attendances, ISD, December 2001 to September 2005.

5 This excludes the cost of superannuation, inflation, employers national insurance (NI), clinical academics and locums. If we include inflation and on-cost, these figures rise to £291 million for 2002/03, £419 million for 2004/05 and a projected £441 million for 2005/06. This means an increase to the pay bill of 51 per cent.

6 This 44 per cent only includes a proportion of superannuation. Employers' superannuation increased from 5.5 per cent 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.

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

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

## Exhibit 1

### 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.
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.
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.
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.

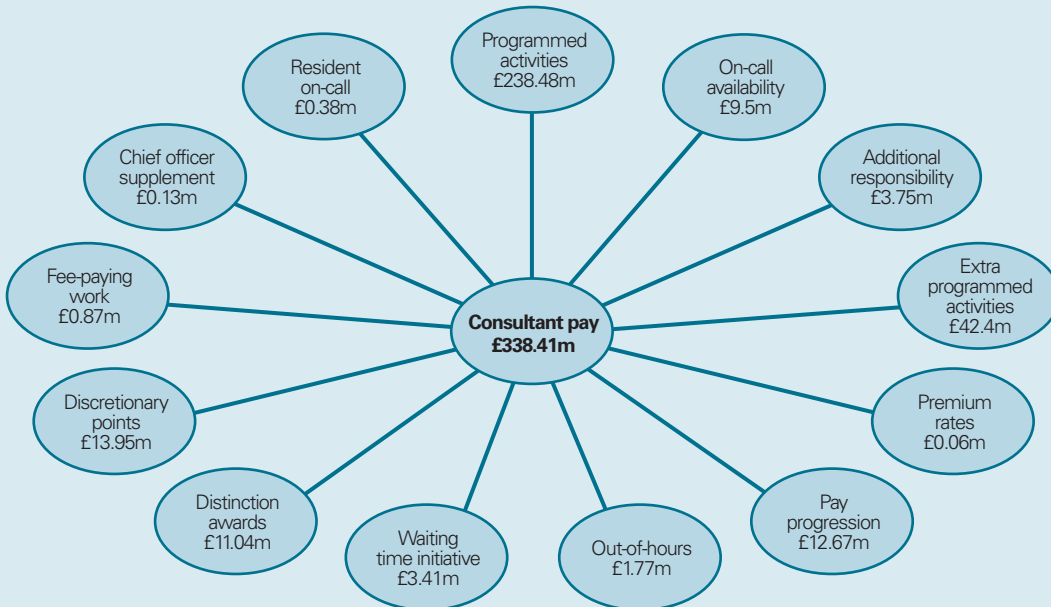
Source: Extract and summary of letter from SEHD Director of Human Resources 1/7/2002 and Audit Scotland fieldwork



## Exhibit 2

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: Audit Scotland, September 2005

- The new contract was implemented in April 2004, but pay was backdated to April 2003. We asked boards to identify actual costs for the initial three years from 2003/04 as part of our audit.<sup>9</sup>
  - Consultants are paid for working an agreed number of programmed activities. In addition to this basic salary, boards can buy additional activity from consultants, called extra programmed activities (EPAs). Consultants can also receive additional payments at higher hourly rates for waiting times work and some other categories of work. Exhibit 2 shows the various categories of consultant pay and the total costs for 2004/05.<sup>10</sup>
  - Some boards are not routinely monitoring all elements of contract costs and had to provide estimates for some categories. The lack of routine monitoring will make it difficult for boards to identify areas for improvement.
  - The new contract was intended to be in place by April 2003, but was delayed until 2004. Because of this delay, a one-off payment backdating the pay increase to 1 April 2003 was available to consultants if they agreed to transfer to the new contract within certain timescales. The total cost to the NHS in Scotland was £76 million.<sup>11</sup> This was part of the overall pay settlement and was not intended to bring immediate benefits in patient care.
  - The cost of the contract has increased financial pressures for boards. The SEHD provided additional non-recurring funding of £70 million in 2004/05 to help with financial pressures including pay modernisation. In addition to this one-off funding, boards received budgetary uplifts of approximately seven per cent in 2003/04 and 2004/05. The additional cost of the contract in 2004/05 was £78 million.
- 5** 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. The model underestimated the overall financial impact by around £171 million for the first three years.
- The SEHD produced a number of cost estimates both before and after the new contract was implemented. The first cost estimate, in March 2003, was based on the UK Department of Health costing model. This estimated that the cumulative additional cost of the new contract would be £64 million for three years, underestimating the cost by £171 million. Cost estimates

<sup>9</sup> Costs for 2005/06 are estimated costs as at September 2005.

<sup>10</sup> Exhibit two shows a total pay bill figure of £338 million for 2004/05. This differs from the £335 million pay bill figure shown in the text as boards are not monitoring all elements of the contract cost.

<sup>11</sup> Consultant contract data collection, Audit Scotland, September 2005.

improved as boards began to calculate local estimates and began to sign up consultants to the new contract. However, most boards were still unclear on the expected cost when they started to implement the contract.

- The SEHD issued the original framework for the contract to boards in 2002. This gave them an opportunity to begin costing the contract locally at this stage, although there was no central requirement to do so. However, most boards' planning for the contract before implementation was minimal.

### Key recommendations

The Scottish Executive Health Department should:

- provide timely and effective guidance when implementing major new schemes, identifying actions that boards are required to take, providing national support and monitoring whether the actions happen
- 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
- identify baseline information against which benefits for patients and the NHS can be clearly measured before implementing national schemes

- 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.

NHS boards should ensure that:

- job planning is sufficiently accurate and detailed to provide an effective management tool that will deliver the expected benefits to patients and the NHS
- robust planning and monitoring takes place as early as possible, to allow them to prepare for the impact of new initiatives with significant costs
- systems for monitoring the individual cost elements of the consultant contract are developed, to enable them to manage and reduce costs over time.

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