

**National Assembly for Wales**  
Public Accounts Committee

# **The Consultant Contract in Wales: Progress with securing the intended benefits**

September 2013



Cynulliad  
Cenedlaethol  
Cymru

National  
Assembly for  
Wales

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## Public Accounts Committee

The Public Accounts Committee was established on 22 June 2011.

### Powers

The Committee's powers are set out in the National Assembly for Wales' Standing Orders, with its specific functions of the Committee are set out in Standing Order 18 (available at [www.assemblywales.org](http://www.assemblywales.org)). In particular, the Committee may consider reports prepared by the Auditor General for Wales on the accounts of the Welsh Government and other public bodies, and on the economy, efficiency and effectiveness with which resources were employed in the discharge of public functions.

The Committee also has specific statutory powers under the Government of Wales Act 2006 relating to the appointment of the Auditor General, his or her budget and the auditors of that office.

### Current Committee membership



**Darren Millar (Chair)**  
Welsh Conservatives  
Clwyd West



**Mohammad Asghar (Oscar)**  
Welsh Conservatives  
South Wales East



**Jocelyn Davies**  
Plaid Cymru  
South Wales East



**Mike Hedges**  
Welsh Labour  
Swansea East



**Sandy Mewies**  
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**Julie Morgan**  
Welsh Labour  
Cardiff North



**Jenny Rathbone**  
Welsh Labour  
Cardiff Central



**Aled Roberts**  
Welsh Liberal Democrats  
North Wales

# Contents

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<b>Foreword</b>	<b>5</b>
<b>The Committee's Recommendations</b>	<b>6</b>
<b>Introduction</b>	<b>8</b>
Who are we?	8
Why did we conduct this inquiry?	8
<b>1. Consultant job planning</b>	<b>10</b>
Leadership from the Welsh Government	13
Using the right information to inform job planning	18
Training to improve consultant job planning	23
<b>2. Consultants' working hours</b>	<b>27</b>
The impact of private practice on working hours	31
The impact of private practice on waiting times	34
<b>3. Supporting Professional Activities (SPAs)</b>	<b>38</b>
<b>4. Underpinning service modernisation</b>	<b>41</b>
<b>5. Recruitment and retention</b>	<b>44</b>
<b>Witnesses</b>	<b>47</b>
<b>List of written evidence</b>	<b>48</b>



## Foreword

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NHS consultants play a key role in our Health Services. Since it was introduced in 2003, the Consultant Contract in Wales has clearly delivered tangible benefits, with recruitment and retention having improved. However, it is disappointing to see that some of the key intended benefits have not been fully realised.

Many consultants either do not have their job plan reviewed annually, or consider the process to be a tick-box exercise. We believe that this in turn limits Health Boards' ability to marshal and plan their resources effectively, weakening their ability to plan for the demands ahead. Moreover, a significant proportion of consultants are working hours each week beyond the European Working Time Directive. The dedication of individual consultants to addressing patients' needs is commendable, but we are concerned that in the long-term this may prove unsustainable. We also believe there is room for improvement around the contract's potential impact on Supporting Professional Activities, Service Modernisation and Consultants' Recruitment and Retention.

We are disappointed that on a number of these issues, the Welsh Government has not provided more dynamic, strategic leadership. Instead, we had the impression that individual Health Boards were largely left to implement the benefits of the contract- or not- by themselves, with limited input from the Welsh Government.

Given the seismic nature of the changes required of Health Boards in Wales, we consider that every effort should be made to render maximum public value from the existing consultant contract. We believe it is vitally important that NHS bodies strengthen their arrangements for working with consultants and that they undertake job planning more effectively to ensure that they deliver the services which their local populations need. We have made a number of recommendations in this report with the intention of enabling this.

We are grateful to all the witnesses who contributed to our inquiry, and look forward to the responses of both the Welsh Government and the Auditor General for Wales to our recommendations.

## The Committee's Recommendations

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The Committee's recommendations to the Welsh Government, and one recommendation to the Auditor General for Wales, are listed below, in the order that they appear in this Report. Please refer to the relevant pages of the report to see the supporting evidence and conclusions:

**Recommendation 1.** We recommend that the Welsh Government publishes a timetable of its actions to provide strategic leadership on job planning arrangements in Wales, including the development of all-Wales guidance and how it intends to hold Local Health Boards to account for its implementation. (Page 17)

**Recommendation 2.** We recommend that the Welsh Government co-ordinates and facilitates the development of a coherent all-Wales information framework on desired consultant outcomes. This should incorporate working with a range of NHS organisations, including Health Boards, the British Medical Association and General Medical Council.. (Page 23)

**Recommendation 3.** We recommend that the Welsh Government continues to engage with stakeholders to improve the job planning process, including the development of appropriate training for Clinical Directors. (Page 26)

**Recommendation 4.** We recommend that the Welsh Government works with NHS organisations to develop national guidance on consultants' working hours, and actions that Health Bodies can take to reduce the need for excessive working hours (Page 31)

**Recommendation 5.** We recommend that the Welsh Government engages with NHS organisations to develop options for gathering management information on the total number of hours worked by consultants per week (including work outside the NHS). (Page 34)

**Recommendation 6.** Given the lack of clarity on this issue, we recommend that the Auditor General for Wales conducts a value-for-money investigation into Local Health Boards' processes and procedures for patients moving between private and NHS practices. (Page 37)



**Recommendation 7.** We recommend that the Welsh Government publishes an indicative timeline for its work to develop All-Wales definitions and guidance related to the objectives of Supporting Professional Activities (SPAs). This should enable greater clarity on the types of SPAs needed, and enable their value to be measured and demonstrated. (Page 40)

**Recommendation 8.** We recommend that the Welsh Government ensures that its refreshment of All-Wales training material on job-planning includes emphasising the importance of using job-planning as an opportunity to discuss service modernisation, and improve clinical practice and patient care. (Page 42)

**Recommendation 9.** We recommend that the Welsh Government provides us with annual updates on its work with health boards and the deanery to develop and implement specific strategies for recruiting specialist consultants to address workforce and expertise shortages. (Page 46)

# Introduction

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## Who are we?

1. The Public Accounts Committee is a cross party committee of the National Assembly for Wales, made up of 8 Members from all 4 political parties represented at the Assembly. The Public Accounts Committee is not part of the Welsh Government. Rather, the role of the Public Accounts Committee is to ensure that proper and thorough scrutiny is given to the Welsh Government's expenditure. In particular, we can consider reports prepared by the Auditor General for Wales on the accounts of the Welsh Government and other public bodies, and on the economy, efficiency and effectiveness with which resources were employed in the discharge of public functions.

## Why did we conduct this inquiry?

2. The first consultant contract was introduced in the UK in 1948 and essentially remained unchanged until new contract negotiations started in 2000.<sup>1</sup> Following various negotiations a Welsh contract became binding on all consultants in Wales on 1 December 2003.<sup>2</sup>

3. The Auditor General's report '*Consultant Contract in Wales: Progress with Securing the Intended Benefits*' was published on 28 February 2013. The report found that consultant recruitment and retention have improved since the amended contract was introduced in 2003, with the number of full-time consultants increasing by 37 per cent between 2004 and 2011. However, the report also found that:

- some consultants are still working excessively long hours, with one in six are working at least 46.5 hours and often exceeding the 48-hour European Working Time Directive limit;<sup>3</sup> and
- the amended contract has not driven service modernisation in the way originally envisaged.<sup>4</sup>

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<sup>1</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Summary, Paragraph (Para) 1

<sup>2</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Summary, Para 2

<sup>3</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Summary, Para 25

<sup>4</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Summary, Para 28

4. The report also highlighted that less than half the consultants who responded to a survey felt that the amended contract and job planning had led to better clinical practice, and even fewer of them thought it had improved patient care and consultants' working methods.
5. We considered that there was considerable merit in conducting a short inquiry into issues raised by the report. We took evidence from:
- Welsh Government officials;
  - The British Medical Association (BMA);
  - Cardiff and Vale University Health Board; and
  - Hywel Dda Local Health Board.
6. We are very grateful to all the witnesses who contributed to this short inquiry, without whom we could not have completed this report.

## 1. Consultant job planning

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7. The Auditor General's report notes that job planning arrangements for consultants were first introduced in 1991, but were effectively a timetable of commitments which rarely reflected actual working patterns and responsibilities. It was recognised that for the amended contract in Wales to be implemented as intended, it would need to be underpinned by a more vigorous approach to job planning which was mandatory for all consultants. Most NHS trusts developed local guidance to supplement that produced by the Welsh Government and other bodies such as the BMA. This local guidance helped ensure that job planning was applied consistently within individual organisations.

8. However, the Auditor General's report found that over time the focus on job planning within NHS bodies in Wales has gradually diminished. Local audits found that many consultants do not have an annual review. On average across Wales only 61 per cent of consultants reported that their job plan was reviewed annually. The report states that:

“Our audit work found managers were often not involved in discussions, which would appear contrary to one of the key aims of the amended contract which is to foster closer working between consultants and NHS managers.”<sup>5</sup>

9. The report also noted that there were inconsistencies between- and within- different NHS bodies in their approach to job planning. The report states that almost all consultants received an annual job plan review in Abertawe Bro Morgannwg University Health Board compared to a much smaller proportion in Hywel Dda Local Health Board and Betsi Cadwaladr University Health Board.

10. Evidence from the BMA also suggested that in many instances job planning was not done well and is often just a tick box exercise:

“We believe that effective, consistent job planning is vital in developing the potential of service improvements and modernisation of the health service, and we encourage our members to engage with job planning. However, all too often,

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<sup>5</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Summary, Para 37

as consultants working in the NHS in Wales, we find that job planning is simply a tick-box exercise where you sit down, agree on a timetable and clinics and then off you go, or, it is seen by our members as a way for the managers to reduce your SPA sessions and reduce the amount of money that they are going to pay you.”<sup>6</sup>

11. The BMA commented that the lack of job planning reviews across Wales was partly a result of the ineffectiveness of such meetings when they actually did happen:

“Talking about objectives and outcomes is rare in most job planning meetings. In my job plan meeting with my managers, we spent about half an hour talking about my timetable, the clinics that I do and the number of patients seen and so on. In the end, I asked whether we were going to discuss outcomes and objectives, and I was met with blank faces... after a few times of going to a meeting where you feel that there is no improvement in the service or in what you can do as a consultant, you are going to think, ‘What is the point? I could be doing something better with my time than a pointless tick-box exercise.’ That is the problem.”<sup>7</sup>

12. The Auditor General’s report commented that such meetings were more often effective when a wider range of staff were involved in job planning discussions:

“As a minimum, the consultant will need to meet with an appropriate clinical manager. However, to ensure that job planning becomes an integral part of business and service delivery planning appropriate input is also needed from directorate or general managers.”<sup>8</sup>

13. We considered that input from directorate or general managers was particularly important, because the resource implications of consultant activities have clear links to an organisation’s corporate and

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<sup>6</sup> National Assembly for Wales Record of Proceedings (RoP), Public Accounts Committee, 19 March 2013, Para 141

<sup>7</sup> RoP, Public Accounts Committee, 19 March 2013, Para 142 and 147

<sup>8</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Summary, Para 37

directorate objectives.<sup>9</sup> For example, job planning is inextricably linked to work planning. We considered that if a Health Body's consultants were not being engaged in effective job planning, this inevitably means that the Health Body is ill prepared to accurately marshal its resources to meet demand for services. A symptom of poor job planning processes could have an impact on waiting times, with insufficient opportunities for outpatient appointments.

14. In making these comments, we recognise that Health Boards have sought to bring together different Trusts and inherited a range of approaches to job planning from their predecessor bodies. This created anomalies within specialties and across the new organisations.<sup>10</sup> Indeed, many of the new local health boards inherited different working patterns. In some instances, this amounted to a full session difference in the average number of consultant sessions worked across different parts of the new organisations (as was the case for Hywel Dda Local Health Board).<sup>11</sup> Where there were wide variations in the number of sessions in job plans, consultants with fewer sessions told the WAO they were aware of the discrepancies and felt they were not being treated fairly.<sup>12</sup>

15. Hywel Dda Local Health Board noted that Health Boards have had to accommodate different approaches to job planning:

“we started from four very different places, with good points in all the job planning, and not so good points in other bits. We are currently working through learning from each other on the good points, developing consistency, using the job planning framework that has been rolled out, to make sure that we have a consistent approach across Hywel Dda. That will lead to a consistency in the workload.”<sup>13</sup>

16. Going forward, we believe it is vital that Health Boards take action to:

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<sup>9</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Para 4.18.

<sup>10</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Para 4.9

<sup>11</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Para 4.31 and Exhibit 19 on page 47

<sup>12</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Para 4.31, 4.32, 4.33

<sup>13</sup> RoP, Public Accounts Committee, 23 April 2013, Para 52

- improve the quantity of consultants engaged in job planning;
- improve the quality of job planning, including annual job plan reviews.

### **Leadership from the Welsh Government**

17. The evidence of our short inquiry did not convince us that the Welsh Government had historically given sufficient urgency to providing strategic leadership to Health Boards on improving job planning arrangements. The Auditor General's report notes that the Welsh Government had previously introduced a requirement that each NHS body would prepare an annual report that set out the progress being made with implementation of the contract and how they were tackling the auditors' recommendations. The annual reporting requirement was in place between 2006 and 2009.<sup>14</sup> However, the Wales Audit Office report notes that:

"NHS trusts' annual reports were largely self-reported developments and the Welsh Government accepted these on face value... Our local audit work has subsequently shown that the descriptions of progress set out in the annual reports was overly optimistic and did not identify important issues such as the frequency of job planning and the quality of the processes that were in place to support it."<sup>15</sup>

18. The report also comments that:

"Regular and significant changes to the number of DCCs and SPAs were seen to be indicative of a meaningful job planning process, whilst the absence of any changes suggested that local processes were less effective. Whilst the proxy arrangements measured change, they did not identify the quality of the job planning process and any associated outcomes."<sup>16</sup>

19. Moreover, the sheer scale of the variation between different Health Boards' job planning statistics did not convince us that there had been a sufficiently effective unified approach to this issue. For

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<sup>14</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Summary, Para 30

<sup>15</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Summary, Para 31

<sup>16</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Para 3.26

example, Cardiff and Vale University Health Board told us that 95% of their consultants had now completed a job plan.<sup>17</sup> By contrast, Hywel Dda Local Health Board acknowledged that when their last annual report was produced:

“I think that only 35% in Hywel Dda said that they had had an annual review. The data that we collected last year show that that is now up to almost 60%, so we still clearly have a long way to go.”<sup>18</sup>

20. We asked Hywel Dda Local Health Board whether they felt they had been sufficiently held to account by the Welsh Government on this issue. They responded:

“there was a formal need to report following the initial implementation of the contract. We have kept that going in the board and it is part of the performance management framework by which health boards and trusts are held to account to the Welsh Government. The number of appraisals, which would include a job plan review for medical staff, that are conducted is part of the performance reporting mechanism.”<sup>19</sup>

21. Cardiff and Vale University Health Board suggested that they had not been obviously held to account on this matter, but their Chief Executive observed that “I do not particularly feel the need to have my feet held to the fire, because we think this is a really serious issue anyway.”<sup>20</sup>

22. Going forward, Welsh Government officials emphasised that work was already in hand to progress job planning arrangements. One official said:

“It would surprise me if there was any health board or trust that did not, as part of its workforce plans, have a significant pace and commitment about job planning. There is a wide awareness of the importance and value of job planning out there. It is slightly surprising that so few consultants reported that they were getting a job plan, and I wonder whether that is

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<sup>17</sup> RoP, Public Accounts Committee, 23 April 2013, Para 13

<sup>18</sup> RoP, Public Accounts Committee, 23 April 2013, Para 17

<sup>19</sup> RoP, Public Accounts Committee, 23 April 2013, Para 21

<sup>20</sup> RoP, Public Accounts Committee, 23 April 2013, Para 25



to do with the level of formality and structure associated with those interviews. They should be quite structured and they should include a consideration with the consultants of objectives to be met through clinical service delivery and SPA time. There is a level of formality that, perhaps, is not always present. However, it is very much on the radar of all the health boards and trusts already. So, this is ongoing work, and it is disappointing to see that so few consultants feel that they have had a formal job plan interview.”<sup>21</sup>

23. Welsh Government officials commented that the Welsh Government had a role:

“to set direction in line with ministerial policy decisions; to ensure... that there is an all-Wales approach in relevant areas rather than seven different variant themes; and, to seek assurance that appropriate progress is being made... and to support and intervene... For example, if there are any problems or variation from expectations, we will take necessary action with the body involved. That means that NHS bodies have direct responsibility for implementing and monitoring the contract to ensure that benefits are realised and to discharge that responsibility within their own organisational settings, but importantly, that will require them to work together, where appropriate. We are particularly focusing on the work of the NHS employers’ unit, which acts on behalf of the NHS bodies to make sure that there are national standards, guidance, appropriate speciality information frameworks, which is one of the recommendations, and monitoring systems, and we will be involved with that work as necessary.”<sup>22</sup>

24. The BMA suggested that a new guide to consultant job planning would also help, saying that the Welsh Government:

“needs to engage with the BMA, so that we can drive things forward. We do not need to reinvent the wheel. The job planning guidance that has been done in England is good and we can adapt that to the Welsh contract and perhaps organise some joint training, particularly for clinical directors. You do not have to pass an exam to be a clinical director; you just have

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<sup>21</sup> RoP, Public Accounts Committee, 19 March 2013, Para 47

<sup>22</sup> RoP, Public Accounts Committee, 19 March 2013, Para 9

to be keen. They are trained as consultants; they are not trained as managers. Often, they become clinical directors and think that they know what their contract is, but that is not always the case.”<sup>23</sup>

25. We asked Welsh Government officials whether they would ensure that local job planning arrangements were supported by updated all-Wales guidance. They responded:

“Our intention would be to establish a work stream with some urgency, which we will initiate in terms of setting the direction. However, we would make sure that the NHS is fully involved and that the NHS employers’ unit and other relevant parties play a significant role.”<sup>24</sup>

26. Given that the Welsh Government had been aware of the findings of the Auditor General’s report prior to its publication, we asked officials if they could not have responded to the issues it raised more urgently. However, officials stated that job planning was an issue that they would be:

“raising with the chief executives this afternoon. As you can see from the report, every health board has its own individual report. So, you are quite right, they are aware of their current position. They will be able to assure, or otherwise, that they have taken immediate action to at least start the actions that need to be put in place, which would take some time to do to get through all of the consultations to make sure that job plans are in place.”<sup>25</sup>

27. Indeed, the evidence of our inquiry clearly suggested that different Health Boards had been taking action to improve their job planning arrangements. Cardiff and the Vale University Health Board described that they had contracted Ernst & Young to help review and improve their processes<sup>26</sup> and Hywel Dda Local Health Board had taken steps to learn from good practice, stating that representatives from Cardiff and Vale University Health Board had:

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<sup>23</sup> RoP, Public Accounts Committee, 19 March 2013, Para 165

<sup>24</sup> RoP, Public Accounts Committee, 19 March 2013, Para 18

<sup>25</sup> RoP, Public Accounts Committee, 19 March 2013, Para 34

<sup>26</sup> RoP, Public Accounts Committee, 23 April 2013, Para 47

“recently come and given a presentation to our doctors and managers and we are now working through the lessons that we have learned from them to take forward the job planning for us.”<sup>27</sup>

28. However, our impression was that individual Health Boards were taking action to address this issue unprovoked by the Welsh Government. While we welcome the sharing of good practice amongst Health Boards, this appeared to be happening on Health Boards’ own initiative, rather than as a result of a clear direction from the Welsh Government enabling an ‘all-Wales approach.’

29. Additionally, we were unclear as to whether the recent emphasis on improving job planning arrangements by Health Boards was indebted to any prioritising by the Welsh Government, as opposed to the General Medical Council. Hywel Dda Local Health Board commented that:

“starting in April, the focus is very much on job planning from a professional point of view, because it is part of the secondary care doctors’ appraisal. So, in order for them to be revalidated, they have to have an up-to-date appraisal, and that would include job planning. From the medical perspective, it is coming much more through the revalidation route. The discussion around job planning is very much there but it is being ramped up now.”<sup>28</sup>

30. We consider that the Welsh Government should take action to provide clear, strategic leadership that ensures that all NHS organisations are consistently addressing NHS consultant job planning.

**We recommend that the Welsh Government publishes a timetable of its actions to provide strategic leadership on job planning arrangements in Wales, including the development of all-Wales guidance and how it intends to hold Local Health Boards to account for its implementation.**

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<sup>27</sup> RoP, Public Accounts Committee, 23 April 2013, Para 49

<sup>28</sup> RoP, Public Accounts Committee, 23 April 2013, Para 29

## Using the right information to inform job planning

31. We believe that work to improve the quality of job planning should include information on the outcomes that consultants are seeking to achieve. The Auditor General's report notes that in September 2005 the Welsh Government launched a Consultant Outcome Indicators (COIs) project. It was a jointly sponsored initiative between the then NHS trust chief executives and the Welsh Government. The aim was to develop a suite of outcome indicators for individual consultants which could be used as a tool to inform job planning discussions. The project was an innovative initiative that had the potential to significantly enhance job planning and appraisals.<sup>29</sup> The project was launched following successful pilot exercises undertaken by the former North West Wales and Bro Morgannwg NHS trusts.<sup>30</sup> Welsh Government officials commented to us that in terms of its principles:

“the project seemed extremely well-intentioned and appropriate; there was an attempt to look at the various issues that related to definitions of good consultant practice and the development of indicators, and expertise was engaged to bring that to bear.”<sup>31</sup>

32. However, Welsh Government officials said that there were:

“limitations... in terms of the systems and the availability of relevant information. Our patient administration system did not provide appropriate, adequate information that was sufficiently detailed to allow it to get real traction with consultants, and the sense was of gradual detachment by consultants from the process. The information that they were getting did not seem to be as relevant as they would want for their clinical practice.”<sup>32</sup>

33. The BMA concurred that the information gathered by the project was not sufficiently relevant to clinical practice:

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<sup>29</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Para 2.9

<sup>30</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Para 2.12

<sup>31</sup> RoP, Public Accounts Committee, 19 March 2013, Para 49

<sup>32</sup> RoP, Public Accounts Committee, 19 March 2013, Para 49

“the problem was... clinicians were not involved from the beginning. The outcomes that were set for my speciality had nothing to do with what a dermatologist does day to day. We tried to invite CHKS to come along to a meeting of the Welsh dermatology forum, which is our specialist advisory group for dermatology, and we said, ‘These are rubbish. Can we work with you?’ We had one meeting and they were positive, but we never saw them again, so that did not fill us with confidence. If we were to do something like that again, the key is to have clinician involvement right from the word ‘go’. Maybe it needs to be done at a more local level, rather than on a national level, because different areas will have different priorities. There are certain quality and patient satisfaction issues that are relevant across the board for every speciality, but, if you are a pathologist, it is quite different from being a neurologist.”<sup>33</sup>

34. The Auditor General’s report says that on-going concerns about the quality of the indicators led to the project being closed down in 2009, without having achieved most of its intended aims with the exception of promoting a greater awareness of outcome measures and the limitations of existing NHS information systems. The report describes the decision to close down the project as “a pragmatic one.”<sup>34</sup>

35. However, the Auditor General’s report clearly indicates that there remains an ongoing need for job planning to be supported by meaningful information and data on the delivery of consultant’s intended outcomes. This was confirmed by a survey which found only 53% of the consultants who responded had access to information from local clinical or management information systems to support job planning discussions. Very few respondents (3%) relied solely on the health board/trust’s information, with most taking their own (52%) or using the health board/trust’s information plus their own (28%). The remainder (11%) took a range of different sources of information while 7% took no information at all to the meeting.<sup>35</sup> The Auditor General’s report concluded that there remained a need for a standard set of

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<sup>33</sup> RoP, Public Accounts Committee, 19 March 2013, Para 190

<sup>34</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Summary, Para 22

<sup>35</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Para 4.15

acceptable outcome measures for all specialties to support job planning. It recommends that the Welsh Government should:

- establish all-Wales groups to identify the core data sets that form the information frameworks for each specialty, and to identify where data can be sourced centrally from NHS Wales informatics systems to complement locally available data; and
- identify fair and meaningful measures of consultant productivity that can inform debate on benefits realisation, and enable a clearer assessment of the value for money that is being achieved from the pay modernisation that resulted from the amended consultant contract.

36. The Welsh Government concurred that there was a need to develop meaningful outcome measures. They argued that this was not a simple task and that:

“it is quite complex territory. The core thing for us is to make sure that it links with what we want to achieve around improving patient safety and quality, and to use that as the focal point for why we want to have clarity about what comes from individual contracts... we are increasingly concerned not just about productivity, which is incredibly important, but also matters about quality, safety and effectiveness. A traditional and narrow approach to productivity that might look at the number of attendances or the number of outpatients that are seen in a session and say that an increase is more productive, also needs to be aligned with an understanding of the patient experience and the outcomes associated with that. It is not just about a simple division of the number of patient interactions divided by time.”<sup>36</sup>

37. The BMA concurred that it was important to look beyond simplistic outcomes:

“I can see more and more patients in a fixed time in clinic, but, just like a GP in a busy practice, less time with each patient means less quality and satisfaction, and potentially poorer outcomes. So, the quality of service, rather than the quantity of widgets delivered, has got to be measured, and that is really hard. Nobody has got their head around that. There are very

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<sup>36</sup> RoP, Public Accounts Committee, 19 March 2013, Paras 55 and 64

small pockets of sub-specialties where quality outcomes are measured, but even they are very un-robust—no, not un-robust, but insensitive—measures: for instance, very black-and-white things such as mortality after an operation for something or other. They are very fixed, but, in the greater scheme of the NHS, very small outcomes.”<sup>37</sup>

38. The evidence of our inquiry indicated that in the absence of all-Wales outcome indicators, different NHS bodies were developing their own sets of intended outcomes. Hywel Dda Local Health Board noted that they were doing “some work jointly—managers and clinicians—to start developing some meaningful outcome indicators... for example, mental health.”<sup>38</sup> Similarly, Cardiff and the Vale University Health Board said that:

“we are trying to establish benchmarks that would give us a sense of what we should be expecting from a consultant surgeon, for example... One is an internal benchmark. For example, if a surgeon has, let us say, two operating lists a week and we set a particular case mix for those in agreement with the consultant for those operating theatres, then what is the range of output we should expect from those operating lists over the course of a week or a year?... It is slightly more difficult when you get into some of the medical specialties where some of the doctors, some of the consultants, do not perform procedures, and so a ward round is harder to count: what is the output of a ward round? What we talk about there is what we would expect the product of a ward round to be, and we agree with consultants about the timing and the frequency.”<sup>39</sup>

39. The BMA also noted that:

“all doctors now, as part of revalidation, have to do what they call 360-degree appraisal, which includes patient satisfaction outcomes—that is, surveys of patient satisfaction. Also, as part of our clinical work, as part of our SPA activity, we do regular clinical audit, which is often about quality, looking at what we are achieving. There is a lot of clinical audit and clinical

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<sup>37</sup> RoP, Public Accounts Committee, 19 March 2013, Para 196

<sup>38</sup> RoP, Public Accounts Committee, 23 April 2013, Para 75

<sup>39</sup> RoP, Public Accounts Committee, 23 April 2013, Paras 63 and 66

governance activity going on within health boards that is about measuring quality, but that does not figure in any of these consultant outcome indicators. Those are just counting the numbers of patients whom you see, new to follow-up ratios, waiting times, and things such as that.”<sup>40</sup>

40. We considered that there would be merit in the Welsh Government working with different Local Health Boards, the BMA and General Medical Council to develop a coherent set of all-Wales consultancy outcome indicators. These could usefully take account of local priorities, and the nature of different consultancy specialisms, but would enable an overarching set of objective outcomes for the delivery of consultancy services in Wales. In his report, the Auditor General recommended that:

“NHS bodies develop an information ‘framework’ to support job planning, on a specialty-by specialty basis. Clinicians and managers will need to work together to identify the components that need to be included in such a framework for each speciality but it would be expected to include: information on activity; cost; performance against local and national targets; quality and safety issues; workforce measures; and plans and initiatives for service modernisation and reconfiguration.”<sup>41</sup>

41. We concur with this recommendation. We note that since the publication of the Auditor General’s report, Welsh Government has established a Task and Finish Group:

“to look at the work with the Office for National Statistics to try to see if we can disaggregate that work that is done on a UK basis. Also, one of the important things is to understand what happened with the consultant outcomes indicator project and some of the products from that, to see if we can build on those and use that as a platform for moving forward, picking up on some of the work that is already being undertaken and different approaches that may take us down a different road than was originally envisaged in 2003-04.”<sup>42</sup>

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<sup>40</sup> RoP, Public Accounts Committee, 19 March 2013, Para 205

<sup>41</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Recommendation 3

<sup>42</sup> RoP, Public Accounts Committee, 23 April 2013, Para 82



42. We look forward to the Task and Finish Group taking forward these actions.

**We recommend that the Welsh Government co-ordinates and facilitates the development of a coherent all-Wales information framework on desired consultant outcomes. This should incorporate working with a range of NHS organisations, including Health Boards, the British Medical Association and General Medical Council.**

### **Training to improve consultant job planning**

43. The Auditor General's report notes that in 2004, the implementation of the amended contract was accompanied by comprehensive training on job planning in NHS trusts. However, because the same staff in these organisations were undertaking job plan reviews each year, the need for on-going training tailed off. The Auditor General's report comments that successive organisational changes and the recruitment of additional consultants and new clinical directors have meant that training has once again become important to ensure consistency.<sup>43</sup> We were concerned that there may be a lack of clarity on the role of a clinical director- particularly in relation to job planning. We considered that effective training could help to address this issue.

44. The BMA told us that Clinical Directors often did not have the appropriate knowledge and skills to undertake effective job planning:

“clinical directors are often self-appointed or it is Buggins's turn and a case of, ‘Oh, do I have to? Okay then, I'll do it for the next couple of years’. It is seen as the thing that you have to do eventually. It is just one of those things and you get paid a bit extra to do all this paperwork and stuff that you do not really want to do. It is not seen as professional or, by many people, as a development opportunity. It is seen more as something that must be done.”<sup>44</sup>

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<sup>43</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Summary, Para 34

<sup>44</sup> RoP, Public Accounts Committee, 19 March 2013, Para 181

45. Cardiff and the Vale University Health Board concurred that there was indeed a need for training, describing that their approach to this issue was based on:

“very comprehensive training, as those conducting the job planning conversations need to understand the parameters that they are working to and they need to understand how to run those conversations successfully. It is based on a presumption that the employer needs to have a clear view in mind as those discussions start about what they would like from consultants working together, ideally in teams, so that we can then place the individual contributions from consultants into a team setting, based on what we think the patients in that particular service require from the consultants.”<sup>45</sup>

46. The BMA told us that it had offered to deliver joint training to clinical managers in partnership with NHS organisations, but indicated that this offer had not been taken up:

“The BMA has offered joint training at local health board level via the local negotiating committees and, on an all-Wales level, we have offered Welsh Government a national programme of joint job planning training for managers and consultants, which is what we should be doing. We should be working together, but it has not taken us up on that offer. We would hope that, as a result of today, we could move forward with a programme of joint training.”<sup>46</sup>

47. We were surprised by these remarks, because the Welsh Government had previously advised us that- to improve job planning processes- it would be working closely:

“with the relevant professional bodies and, in particular, the British Medical Association to make sure that we have its full engagement and input into all processes.”<sup>47</sup>

48. Subsequently, Hywel Dda Local Health Board commented that:

“certainly locally it [training] has been done very much in conjunction with our local negotiating committees, with which

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<sup>45</sup> RoP, Public Accounts Committee, 23 April 2013, Para 10

<sup>46</sup> RoP, Public Accounts Committee, 19 March 2013, Para 143

<sup>47</sup> RoP, Public Accounts Committee, 19 March 2013, Para 10

the BMA negotiates performance within the local health boards.”<sup>48</sup>

49. We asked the BMA through written correspondence whether they were aware of any joint-training in relation to job planning taking place at local health board level. The BMA advised us that our question was considered by members of the Welsh Local Negotiating Forum at their June meeting. The BMA informed us that representatives of Local Negotiating Committees from each health board area, as well as from Public Health Wales, were present at this meeting, but:

“none of the representatives present were aware of joint training on job planning presently taking place at local health board level in their local areas, or within Public Health Wales. Members from Abertawe Bro Morgannwg Health Board said they were aware of efforts locally to produce joint guidance for job planning, but also indicated they were not aware of any joint job planning training actually taking place. Representatives from Betsi Cadwaladr Health Board said they were aware that local joint guidance existed for job planning, but they could only recall one meeting taking place on job planning that had been held some 4-5 years ago. As such, BMA Cymru Wales is not aware of any joint job planning training presently taking place in any part of Wales.”<sup>49</sup>

50. In subsequent written correspondence the Welsh Government clarified that:

“The original joint job planning 'tour' with the BMA was part of centrally agreed implementation arrangements to bring in a new process in 2003. Since then, job planning training has continued to be carried out locally as is appropriate. Matters of general concern have been identified and discussed at both the All-Wales Workforce OD and Medical Directors meetings. The implementation of the Consultant Contract is also discussed at an all-Wales level as part of the Working Differently Working Together Programme board. It is therefore true to say that joint training is not taking place at an All-Wales level. However, I am advised that NHS bodies would welcome BMA's involvement in

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<sup>48</sup> RoP, Public Accounts Committee, 23 April 2013, Para 124

<sup>49</sup> Dr Sharon Blackford, Chairman, Welsh Consultants Committee, Consultant Contract in Wales, 1 July 2013.

further job planning training to highlight the messages from the WAO report at local level. Finally, Welsh Government has formally commissioned the NHS Task and Finish Group to refresh All-Wales training material. BMA Wales will support this work.”<sup>50</sup>

51. We note the Welsh Government’s remarks on these issues, and consider that there would be benefit both in:

- the Welsh Government developing All-Wales training material around job-planning, including input from the BMA and other health bodies into the development of such; and
- NHS bodies engaging with the BMA to involve it in developing local job planning training.

52. We look forward to the Welsh Government taking forward the actions that it has stated it intends to take.

**We recommend that the Welsh Government continues to engage with stakeholders to improve the job planning process, including the development of appropriate training for Clinical Directors.**

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<sup>50</sup> Consultant Contract in Wales, 20 June 2013, Director General, Chief Executive, NHS Wales.

## 2. Consultants' working hours

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53. The Auditor General's report says that the contract's original intention was for all consultants in Wales to have a 37.5 working week. This was later relaxed and the expectation is that consultants should not work more than 12 sessions (a session lasts 3-4 hours). Currently, only a third of consultants in Wales have 10-session contracts:

“This reflects the fact that many consultants are willing to work additional sessions to increase activity, take on management responsibilities or to help the development of their own clinical practice. This flexible arrangement directly benefits both the NHS and the individual consultant.”<sup>51</sup>

54. The report found that around one in six consultants are working 12.5 sessions (46.5 hours) or more, with the vast majority working in excess of the 48-hour European Working Time Directive (EWTd) limit.<sup>52</sup> The report also notes that working excessive hours is not confined to full-time consultants, with 23 consultants on part-time contracts working 10 sessions or more (making them full-time posts in practice).<sup>53</sup>

55. The report found that in some circumstances, additional sessions were the result of a consultant taking on management responsibilities over and above their clinical commitments, whilst in others the consultant was a single-handed practitioner with a high workload. However, in general terms, none of the health boards or trusts had undertaken any detailed work to understand why some consultants had excessive workloads, or whether these sessions were needed in the first place. Only Cardiff and Vale University Health Board had formal arrangements to review job plans that exceeded 12 sessions.<sup>54</sup> The report warned that without such review, NHS bodies may be failing to identify risks associated with excessive clinical workloads, or

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<sup>51</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Summary, Para 24

<sup>52</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Para 3.7

<sup>53</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Para 3.8

<sup>54</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Paras 3.9 and 3.10

missing opportunities to secure better value for money by challenging whether some additional sessions are necessary.<sup>55</sup>

56. Across Wales, consultants are providing an additional 334 sessions above the 12 session threshold. The report notes that if these additional sessions had to be undertaken by employing new consultants, an additional 47 consultants would be needed. The report says that this raises concerns about the long-term sustainability of this arrangement and the impact on service delivery and the quality of care if this position is not actively managed.<sup>56</sup>

57. There appeared to be mixed evidence from our witnesses about whether or not the long hours that some consultants in Wales worked was an urgent issue in need of address. For example, the BMA stated that many consultants would be happy to work for longer hours:

“Many consultants are happy to take on extra work, particularly to keep waiting times down, but also to improve care for emergency patients... I personally deal with patients with acute stroke in the middle of the night. We deal with ward referrals of patients with neurological problems admitted through A&E and via their GP, and that takes time out of those working-week sessions. Consultants are very willing to drive more and more to be involved in that type of work. I do not think that there is a lot of pressure to do more voluntary work, but many consultants work over and above their contracted hours to keep the service running and to do a quality job.”<sup>57</sup>

58. Similarly, the Welsh Government’s Deputy Chief Medical Officer considered that there were advantages in terms of value for public money in some consultants working longer hours:

“Most health boards and trusts have probably reached the view that having one or two extra sessions is a relatively cost-effective way of increasing clinical activity, because you just pay for the clinical session, you do not pay those associated costs. It would not necessarily make value-for-money sense to

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<sup>55</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Para 3.9

<sup>56</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Para 3.11.

<sup>57</sup> RoP, Public Accounts Committee, 19 March 2013, Para 209

amalgamate all those sessions to get everybody down to 37.5 hours.”<sup>58</sup>

59. By contrast the Welsh Government’s Director General for the Department for Health, Social Services and Children considered that:

“There would be a cost to that, but there is also a cost to people working greatly extended hours. So, part of the strategy to reduce the dependency on extended hours would be to potentially increase the number of consultants employed, because that might be a much more cost-effective and satisfactory way to deliver that.”<sup>59</sup>

60. Cardiff and Vale University Health Board specifically stated that they would be concerned if an individual was regularly working long hours:

“you might worry about a consultant who appears to have a very packed job plan. There is an issue there about how confident we are that, at all times, you are functioning at the very best of your capabilities, for example. One of the reasons for doing job planning in this way, and trying to do it in a team setting, wherever possible, is that you can try to balance that out across the team, if you need to.”<sup>60</sup>

61. We asked the BMA whether there was any sense that working long hours was ‘a badge of honour’ amongst consultants. In response, the BMA acknowledged that that:

“Saying that it is a badge of honour is a slight exaggeration, but there is an element of truth in it... There is a bit of a macho culture. You could say the same about many top-level professions.”<sup>61</sup>

62. We appreciate that many consultants will be happy to work longer hours with the intention of positively improving the health and safety of patients. This is commendable, and we do not criticise consultants for doing so. But at the same time, we are concerned that a consultant who is exhausted from work long hours may be more susceptible to

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<sup>58</sup> RoP, Public Accounts Committee, 19 March 2013, Para 24

<sup>59</sup> RoP, Public Accounts Committee, 19 March 2013, Para 25

<sup>60</sup> RoP, Public Accounts Committee, 23 April 2013, Para 73

<sup>61</sup> RoP, Public Accounts Committee, 19 March 2013, Para 256

mistakes or misjudgements. While such mistakes may then subsequently be picked up in a consultants' appraisal, this may be too late for the patients concerned. Rather than reactively seeking to address some consultants' long hours only when performance issues arise, we believe that the Welsh Government and Local Health Boards need to be proactively seeking to reduce the need for any consultant to work above the 12 session threshold.

63. We note that individual Health Boards are taking action to address this issue. Hywel Dda Local Health Board advised us that the number of consultants working at their Health Board had significantly reduced, stating that:

“Back when the data were collected, just over 11% of our consultants were working over 12 sessions a week, which is over 45 hours a week. Now, that figure is down to 6%.”<sup>62</sup>

64. Cardiff and the Vale University Health Board described how it sought to address the need for some consultants to work long hours:

“usually it is because there are particular circumstances that are affecting that situation. For instance, until recently, we were struggling to recruit paediatric cardiologists to join the teams—we had two, not three—and it meant that, because the children do not go away, you have to ask people to cover the service, and they were doing that. You then have a responsibility to stay very close to that, to make sure that things are okay. We have worked very hard to make the post that we have been advertising more attractive, and I am very pleased to say that we have somebody who has just started in the last month.”<sup>63</sup>

65. Likewise the Welsh Government's Director General for the Department for Health, Social Services and Children described that when he had previously been chief executive for Abertawe Bro Morgannwg University Local Health Board:

“There were clearly some [consultants] that were [working] too long in terms of what anyone would accept as reasonable. We took action to amend the job plans to begin to bring the end of that tail inwards. That is action that we expect all health boards

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<sup>62</sup> RoP, Public Accounts Committee, 23 April 2013, Para 93

<sup>63</sup> RoP, Public Accounts Committee, 23 April 2013, Para 89



to carry out. We may be able to provide some national guidance to enable that in terms of standards. To an extent, that is an issue that has to be taken locally.”<sup>64</sup>

66. While we welcomed the actions taken by individual Health Boards to address consultants’ long hours, we were again disappointed that the Welsh Government did not appear to be taking a stronger lead on this issue. The Auditor General’s report shows the percentage of consultants working more than 12 sessions a week in 2010 ranged significantly between different health boards, from 7.2% at Cwm Taf, to 20% at Betsi Cadwaldr.<sup>65</sup> We consider it important that all Health Boards collectively seeks to reduce these percentages, enabled and facilitated by strategic leadership from the Welsh Government.

**We recommend that the Welsh Government works with NHS organisations to develop national guidance on consultants’ working hours, and actions that Health Bodies can take to reduce the need for excessive working hours**

### **The impact of private practice on working hours**

67. In Wales, the consultant contract identifies three important provisions about NHS consultants undertaking private practice:

- Firstly, they must demonstrate that they are fulfilling their NHS commitments;
- Secondly, the needs of patients in the NHS will not be prejudiced by the provision of NHS services to private patients; and
- Thirdly, any work outside of NHS commitments will not adversely affect NHS work, nor hinder or conflict with the needs of NHS employers and employees.

68. The Auditor General’s report notes that the contract in Wales differs from the rest of the UK where to keep the right to private practice a consultant must first offer an additional session to the NHS.<sup>66</sup> The Welsh Government concurred that:

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<sup>64</sup> RoP, Public Accounts Committee, 19 March 2013, Para 20

<sup>65</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Exhibit 8 page 29

<sup>66</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Exhibit 1 on page 17

“consultants have to satisfy their contractual obligations to their employers, given that that is within the contractual arrangements. The position thereafter in terms of what a consultant or doctor does is not something that we would have a direct involvement in. Our main concern is that they are employed by the Welsh NHS bodies and that they fulfil their contractual obligations to Welsh bodies.”<sup>67</sup>

69. We noted that consultants could therefore potentially be working 12 sessions a week for the NHS, and in addition working long hours in private practice as well. While recognising consultants’ right to engage in private practice, we noted that a consultant who is working long hours is potentially more susceptible to mistakes or misjudgements. We asked the Welsh Government whether it had any evidence to suggest- or disprove- that working long hours in private practice could have an impact on the quality of a consultant’s work. The Welsh Government advised us that:

“The new approach to consultant appraisal to support revalidation may help that, because that is a whole-practice appraisal and requires doctors of all types to bring evidence about outcomes and quality from all aspects of their clinical practice to the one appraisal conversation. If someone was working in too many sectors doing too many hours and there was a concern about outcomes, it would become clear through that process. The appraisal discussions are not designed for that purpose, but, if something was apparent, that would be escalated. Our position is that we know that consultants have a right to do private practice; our concern is that they are effective and productive in the NHS and that that private practice never impacts negatively in any way on any aspect of NHS care.”<sup>68</sup>

70. The Welsh Government did not appear to have any statistical information on this issue. However, the Welsh Government said that:

“If someone was clearly too tired, so that their behaviour was poor or they were somehow not concentrating or they were not working properly or whatever, we would expect all our organisations to realise that and to deal with it. We expect NHS

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<sup>67</sup> RoP, Public Accounts Committee, 19 March 2013, Para 73

<sup>68</sup> RoP, Public Accounts Committee, 19 March 2013, Para 75

care to be of the highest quality. So, we would expect organisations to assure themselves that that is the case.”<sup>69</sup>

71. Cardiff and the Vale University Health Board concurred with these remarks, noting that:

“the GMC revalidation now gives us a very clear remit to look at the entire scope of a consultant’s practice, and the convention that we agreed locally with the private providers is that there should be full disclosure of consultants’ work. Otherwise, we will not be able to fully revalidate that consultant to the GMC. So, we get an opportunity to review all of that work and, if necessary, if we have concerns about that in an appraisal context, we can advise, suggest or, if need be, instruct changes in their working week to accommodate what we would regard as a safe and not-overly-stretching working-week commitment.”<sup>70</sup>

72. The BMA emphasised to us that most consultants did not hide their private practice away, but rather:

“If asked about it in an open manner within their appraisal or job plan, they will share it. If there are issues of it impacting on NHS work, that is a matter of the health and safety of patients, productivity and whether they are breaching the terms of their contract. However, in the vast majority of cases, any private work is done outwith the contract. I do private clinics in uncontracted time; it is as simple as that. I am not contracted to work with the NHS. I can go home and play rugby with the kids and do the school run, or I can do something else of my choosing.”<sup>71</sup>

73. Cardiff and the Vale University Health Board concurred that ultimately:

“the consultant contract allows consultants to use their free time to do whatever they like. That is up to them. Our responsibility is to make sure that we have, within the working week that we are designing, a complete and transparent

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<sup>69</sup> RoP, Public Accounts Committee, 19 March 2013, Para 80

<sup>70</sup> RoP, Public Accounts Committee, 23 April 2013, Para 166

<sup>71</sup> RoP, Public Accounts Committee, 19 March 2013, Para 217

understanding about what consultants are doing and where they are.”<sup>72</sup>

74. We recognise that the current consultant contract allows consultants to use their free time in whatever way they see fit, and that having the capacity to work privately is an important factor in recruiting and retaining consultants to Wales. Nevertheless, we consider that it would be appropriate for the Welsh Government, in a suitably sensitive and facilitative fashion, to gather data on the total number of hours that consultants are working (in both NHS and Private practice). We anticipate that this management information would be of benefit to the Welsh Government in determining future trends, concerns and opportunities. We also note that this information would enable the Welsh Government to identify situations where NHS bodies contract out work to private bodies- in order to meet waiting time targets for example- with the work then ultimately coming back to the same consultants who are already working in the NHS, but who are taking on this additional work in a private capacity.

**We recommend that the Welsh Government engages with NHS organisations to develop options for gathering management information on the total number of hours worked by consultants per week (including work outside the NHS).**

### **The impact of private practice on waiting times**

75. While not directly referred to in the Auditor General’s report, we also asked our witnesses whether private practice created the potential opportunity for ‘queue jumping’ NHS waiting lists. Specifically, we had heard that patients sometimes went to see a GP, saw a consultant privately and then went onto a waiting list for a procedure. We noted that an NHS patient might have to wait months to see a consultant, whereas a private patient might see the same consultant within weeks. Even if both patients were then on the procedure waiting list for the same length of time, this would mean that for one person the total time between seeing a GP and having a procedure was shorter than for the other person. We were also concerned that this could create a perverse incentive for consultants to have longer NHS waiting times to see them, in order to increase the number of patients seeing them privately.

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<sup>72</sup> RoP, Public Accounts Committee, 23 April 2013, Para 138

76. The evidence we received on this issue appeared inconsistent. Cardiff and the Vale University Health Board appeared to indicate a person could potentially speed up a process in the way we envisaged:

“The ordinary course of events would be that the patient sees the consultant privately. The consultant says, ‘I think that you need a hip replacement’ and the patient says, ‘How much is that going to cost?’ There is a conversation and the patient says, ‘I cannot afford that’. The consultant will then write to the GP to say, ‘I have seen this patient in my private clinic. This patient now needs to have a referral for a hip replacement and then the GP would make a referral.’”<sup>73</sup>

77. In subsequent written correspondence Cardiff and the Vale University Health Board advised us that:

“patients who have been seen privately and assessed as being appropriate for surgery may be directly listed for NHS treatment without requiring further NHS outpatient consultation. This is the interpretation, difficult though it is to understand, that our staff have taken from the regulations. There may be examples where the initial private consultation has not completed diagnostic workup, which may be more appropriate for non-surgical specialties such as Medicine, where the patient would be referred for further NHS outpatient consultation to complete that diagnostic workup and plan treatment. Once again, although this appears to be a means by which patients can avoid their NHS outpatient waiting list, this is the interpretation that we believe is correct from the current regulations... it would be perhaps useful to get interpretation from other Health Boards as to their view and interpretation of and scale of this problem.”<sup>74</sup>

78. By contrast, the Welsh Government appeared to advise us that patients could not speed up the total waiting process in the manner we envisaged. Welsh Government officials informed us that:

“There are procedures, guidance and rules that apply to those arrangements to make sure that there is equity in the system in

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<sup>73</sup> RoP, Public Accounts Committee, 23 April 2013, Para 182

<sup>74</sup> Adam Cairns, Chief Executive Cardiff and Vale University Health Board, Public Accounts Committee- The Consultant Contract in Wales, 2 August 2013

terms of their position on waiting lists... It should not happen. The first thing is that it will be determined by their clinical needs, but, thereafter, there should not be any outcome that disadvantages anybody who has not taken advantage of that particular route.”<sup>75</sup>

79. Similarly, Hywel Dda Local Health Board appeared confident that a patient could not speed up their total waiting time, advising us that:

“within our health board, there would be no way of being listed for an operation on the NHS without having gone through the whole referral system that we have in place.”<sup>76</sup>

80. We asked Hywel Dda Local Health Board whether this meant that having seen a consultant privately, a patient would potentially meet several months for a consultation with the same consultant. In response, Hywel Dda Local Health Board informed us that:

“The only advantage that it might give the patient is the priority of that operation, in that it is not coming cold for the priority, so it may be prioritised. Say that it is a cancer patient, who did not know whether it was a cancer: he or she went to the out-patients, got diagnosed as having a cancer, the consultant then admitting them on the NHS would know that he or she was a cancer patient and would be able to put them on the appropriate pathway to get the treatment done in the right time.”<sup>77</sup>

81. In subsequent written correspondence Hywel Dda Local Health Board advised us that:

“Subject to clinical considerations earlier private consultation should not lead to earlier NHS admission or to earlier access to NHS diagnostic procedures. Common waiting lists should be used for urgent and seriously ill patients and for highly specialised diagnosis and treatment... a private patient is unable to gain an advantage over a patient who has originally been referred as an NHS patient by swapping to NHS treatment after the original private consultation. Private consultations are only undertaken in a way that doesn’t disadvantage the

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<sup>75</sup> RoP, Public Accounts Committee, 19 March 2013, Paras 81 and 83

<sup>76</sup> RoP, Public Accounts Committee, 23 April 2013, Para 199

<sup>77</sup> RoP, Public Accounts Committee, 23 April 2013, Para 201

provision of NHS care to any other patient. All patients who are being treated under the NHS are treated in the same way and prioritised based on clinical need and not how they were added to the operating list.”<sup>78</sup>

82. We noted that while this negated the possibility of a patient speeding up their total waiting time, it did not appear efficient for a patient to effectively see the same consultant twice over (privately and through the NHS) before they could be referred for a procedure. We considered that we had a lack of clarity on whether this was actually happening in practice.

83. Overall, we considered that the evidence we received on this issue lacked clarity- despite the importance of it being a transparent process- and could benefit from more light being shined upon it. We remain concerned that this is potentially an issue which requires more detailed examination, and believe that the Auditor General could usefully consider this issue further.

**Given the lack of clarity on this issue, we recommend that the Auditor General for Wales conducts a value-for-money investigation into Local Health Boards’ processes and procedures for patients moving between private and NHS practices.**

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<sup>78</sup> Dr Sue Fish, Medical Director Hywel Dda Local Health Board, Action Point- Hywel Dda Local Health Board, 5 May 2013

### 3. Supporting Professional Activities (SPAs)

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84. The Auditor General's report says that Supporting Professional Activities (SPAs) form an important element of a consultant's working week and NHS bodies need to ensure an appropriate amount of SPA sessions are included in consultant job plans.<sup>79</sup>

85. When the amended contract was introduced in Wales it indicated that full-time consultants should 'typically' have three SPA sessions per week. This had the effect of creating an expectation in some quarters that three weekly SPAs would be the norm, regardless of the professional needs of the clinician, or the business needs of the organisation.<sup>80</sup> The most recently available all-Wales data shows that on average consultant job plans in Wales contain 2.6 SPAs, but there can be notable variations between and within organisations.

86. However, much of the debate within NHS bodies has focused on the number of SPA sessions, rather than looking more holistically at what type of SPAs are needed and how the value of them can be demonstrated.<sup>81</sup> The report highlights that:

“our local audits found that there is considerable scope to improve the management of SPA sessions through better job planning to ensure both the consultant and the NHS are realising the full benefit from this investment.”<sup>82</sup>

87. We noted that there is always a balance to be struck between the professional development of the individual, and the clinical development of the specialty that that person is responsible for. We were concerned that the evidence of the Auditor General's report suggested a potential lack of clarity on what SPAs were actually meant to achieve, and what they needed to be delivering. Hywel Dda Local Health Board advised us that they were:

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<sup>79</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Para 4.34

<sup>80</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Para 4.35

<sup>81</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Summary, Para 40

<sup>82</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Summary, Para 41



“defining what we believe should be included in an SPA. Education and teaching other doctors is very important, along with other people’s education. We have the three SPAs within the Welsh contract, but we are focusing very much on two SPAs and getting people to demonstrate the activity for those two SPAs.”<sup>83</sup>

88. The BMA noted that there were examples of good practice on this issue, but considered these to have been developed in the absence- rather than as a result- of clear leadership:

“In some departments, it is very effective. They have group job planning, if you like. They look at what needs to be delivered in an SPA, and this includes teaching and training of junior doctors. So, one person will take on the undergraduate teaching, another person will take on the educational supervision, and another person will take on clinical governance and audit. So, there are groups of clinicians doing that, but I would say that they are doing it among themselves more so than being led from above.”<sup>84</sup>

89. The Welsh Government informed us that they would set out:

“the requirements very clearly in the very near future and then we will ensure that there is detailed implementation work, to ensure that there is knowledge of the outcomes associated with those particular parts of the consultants’ work contribution and that there is appropriate monitoring of those. In many cases, some incredibly valuable work is undertaken in those particular sessions, but we need to assure ourselves that that is a consistent picture across Wales, in every organisation for every doctor... There is an increasing appreciation that one needs to relate some managerial objectives to SPA time. It may not be so explicit, in project terms, in the other health boards, but that work is ongoing everywhere... Clearly, it would not be appropriate for a consultant to come to an appraisal interview with an aspiration in their personal development plan that was unrelated to the expectations and needs of the service. So, the

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<sup>83</sup> RoP, Public Accounts Committee, 23 April 2013, Para 107

<sup>84</sup> RoP, Public Accounts Committee, 19 March 2013, Para 177

needs of the service have to be defined by the employer with the doctor in conversation during the job-planning interview.”<sup>85</sup>

90. The Welsh Government’s Task and Finish group specifically advised us that:

“There are already some definitions embedded within the contract and the guidance and we will need to be working with colleagues across Wales and with BMA colleagues as well to get a core understanding of those definitions, but allowing for local determination of how that works in practice.”<sup>86</sup>

**We recommend that the Welsh Government publishes an indicative timeline for its work to develop All-Wales definitions and guidance related to the objectives of Supporting Professional Activities (SPAs). This should enable greater clarity on the types of SPAs needed, and enable their value to be measured and demonstrated.**

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<sup>85</sup> RoP, Public Accounts Committee, 19 March 2013, Para 107 and 112

<sup>86</sup> RoP, Public Accounts Committee, 23 April 2013, Para 121

## 4. Underpinning service modernisation

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91. The Auditor General's report notes that one of the key aims behind the introduction of the amended contract in Wales was to facilitate better engagement between consultants and NHS managers in the modernisation and improvement of NHS services. However, local audit work has indicated that the amended contract and its associated job planning activities have had only limited success in securing these benefits.<sup>87</sup> Less than half the consultants who completed a Wales Audit Office survey felt that the amended contract and job planning had provided opportunities to discuss service modernisations and improvements to clinical practice. Even fewer felt it had improved patient care or changed the way they worked for the better.<sup>88</sup>

92. We asked the Welsh Government whether there was now any monitoring- at a national level- of how consultant resources were being taken into account in Health Boards' reconfiguration plans. They responded:

"we are seeking assurance from health boards involved in service change that they are paying appropriate attention to all matters in relation to the broader clinical workforce, and that they have, in detail, thought through matters about how the doctors, nurses and others can be deployed in a way to align with new service models. So, we seek assurance from the health boards that there is consideration of that."<sup>89</sup>

93. Welsh Government officials also said that the National Clinical Forum:

"may well ask questions about whether a certain pattern of working is actually deliverable within the current resources. So, it may, for instance, have a question about consultants working on a regional basis across several hospitals where there is considerable travel time. Obviously, that will be factored into the contract. It would be a matter of what would be the impact then on direct clinical care delivery. The national clinical forum

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<sup>87</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Para 3.17.

<sup>88</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Para 3.19 and Exhibit 12 on page 33

<sup>89</sup> RoP, Public Accounts Committee, 19 March 2013, Para 27

may well ask such questions as, ‘Have you factored in travel times into these considerations?’, but I think that it is that sort of level of critical challenge in a way.”<sup>90</sup>

94. Hywel Dda Local Health Board advised us that service modernisation had been accompanied by a shift in consultants’ expectations:

“The newer consultants come in with an expectation that they are going to be moving to a seven-day-a-week service. It is the older consultants, nearer retirement, who are less keen. At the moment we do not have seven-day-a-week working, but we know that that is the direction of travel we have to go in, and that is the discussion that we are engaging our consultants in.”<sup>91</sup>

95. Cardiff and the Vale University Health Board said some of its consultancy specialities had already started to work seven-day weeks:

“In intensive care in Cardiff and the Vale, consultants are in seven days a week, 24/7, and surgeons and obstetricians and a number of other surgical specialties are already operating in much more of a seven-day model than others. We have just started to implement seven-day working for physicians, doing two ward rounds over the course of a weekend, but there is more that we need to do there. The business case for doing that needs to be made and we are working on that.”<sup>92</sup>

96. We are disappointed that historically the consultant contract appears to have had limited impact in providing opportunities for consultants to discuss service modernisation, or improvements to clinical practice and patient care. In the context of service reconfiguration it is particularly important that such opportunities are seized. We believe that effective training around contract and job planning should play an important role in addressing this issue.

**We recommend that the Welsh Government ensures that its refreshment of All-Wales training material on job-planning includes emphasising the importance of using job-planning as an**

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<sup>90</sup> RoP, Public Accounts Committee, 19 March 2013, Para 28

<sup>91</sup> RoP, Public Accounts Committee, 23 April 2013, Para 217

<sup>92</sup> RoP, Public Accounts Committee, 23 April 2013, Para 218

**opportunity to discuss service modernisation, and improve clinical practice and patient care.**

## 5. Recruitment and retention

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97. Before the contract was amended in 2003, Wales was experiencing significant difficulties recruiting consultants with long-term vacancies peaking at 170 at 31 March 2002. In overall terms, at the time of the Auditor General's audit, none of the health boards or trusts reported difficulties in recruiting consultants to vacancies or new posts, except to specialties where there are national shortages, such as in emergency medicine, mental health, and paediatrics.<sup>93</sup> Welsh Government officials considered that progress had been made around:

“recruitment and retention—8% to 9% vacancies [ten years ago] are down to 2%, although we still know that there are some areas of particular challenge.”<sup>94</sup>

98. The Welsh Government acknowledged that the contract had provided a pay increase to consultants in Wales, but considered that this had been appropriate:

“It has stabilised the consultant workforce. We can see now that those conversations about consultants leaving have gone and the vacancy rates have gone down. It has also provided a mechanism to increase the number of consultants, which is a good thing. It has been quite stabilising. I do not know the comparison directly with other parts of the UK, but my impression is that probably there are no huge differences. There are some small differences between the Welsh and English contracts. The Welsh contract in some ways looks a little bit more permissive, but I am not sure that would be enough to persuade someone to come to work in Wales on its own, rather than England.”<sup>95</sup>

99. The BMA concurred that the existing contract had been of benefit in recruiting and retaining consultants in Wales:

“the Welsh contract is an attractive one for doctors... We feel very strongly that we should stick with a Welsh contract and

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<sup>93</sup> Wales Audit Office, Consultant Contract in Wales: Progress with securing the intended benefits, Para 3.15

<sup>94</sup> RoP, Public Accounts Committee, 19 March 2013, Para 6

<sup>95</sup> RoP, Public Accounts Committee, 19 March 2013, Para 15

not return to a UK position because that is a way of attracting people to come to work in Wales.”<sup>96</sup>

100. Hywel Dda Local Health Board likewise considered that in general terms retention was not an issue for them, although:

“we have an ageing workforce now. Obviously, a significant number are due to retire in the next five to 10 years, so we have time to put plans in place, but it is a big challenge.”<sup>97</sup>

101. We noted the general improvement in the recruitment and retention of consultants in Wales, and our witnesses considered the existing consultant contract had played a role in enabling that. However, we are concerned whether the Welsh Government or Local Health Boards have specific strategies for addressing ongoing shortages in some specialities. The Welsh Government advised us that:

“there are particular UK-wide shortages of training-grade doctors. We are trying to do our best to counteract those shortages and ensure that Wales is seen as a good option. This applies not only to the focus of today’s discussion, which is on consultants, but to the earliest stages of people’s decisions to enter into medical education and to training-grade arrangements in terms of postgraduate education. The earlier that we can secure people’s interest in Wales, the better. However, in some areas, as you know, we are working in quite constrained circumstances with regard to the availability of specialities.”<sup>98</sup>

102. We were unconvinced that this represented a specific strategy, and asked Welsh Government officials what they were doing to attract people to specialties that had shortages, over and above what they were doing in general to attract medical people to Wales. They responded that:

“The process that would be put in place—we have our general overarching campaign—is that, for particular speciality areas, we will be making particular strides to ensure, through the work of the health boards and more generally through the work of the deanery and at a national level, wherever possible, that

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<sup>96</sup> RoP, Public Accounts Committee, 19 March 2013, Para 249

<sup>97</sup> RoP, Public Accounts Committee, 23 April 2013, Para 228

<sup>98</sup> RoP, Public Accounts Committee, 19 March 2013, Para 120

we are explaining the benefits of coming to work in Wales and making sure that we have the right messages and the right educational opportunities. It is those kinds of areas and getting the right kind of professional environment that will attract people to come to Wales to pursue their career.”<sup>99</sup>

**We recommend that the Welsh Government provides us with annual updates on its work with health boards and the deanery to develop and implement specific strategies for recruiting specialist consultants to address workforce and expertise shortages.**

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<sup>99</sup> RoP, Public Accounts Committee, 19 March 2013, Para 122



## Witnesses

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The following witnesses provided oral evidence to the Committee on the dates noted below. Transcripts of all oral evidence sessions can be viewed in full at

<http://www.senedd.assemblywales.org/ielIssueDetails.aspx?Ild=5915&Opt=3>

*19 March 2013*

*Welsh Government*

David Sissling                      Director General, Health, Social Services and Children

Ruth Hussey                      Chief Medical Officer

Chris Jones                      Deputy Chief Medical Officer

*19 March 2013*

*The British Medical Association*

Dr Sharon Blackford              Chair, Welsh Consultants Committee

Dr Trevor Pickersgill              Deputy Chair, Welsh Consultants Committee

*23 April 2013*

Adam Cairns                      Chief Executive, Cardiff and Vale University Health Board

Janet Wilkinson                      Director of Workforce, Hywel Dda Local Health Board

Dr Sue Fish                      Medical Director, Hywel Dda Local Health Board

Richard Tompkins,                      Director, Welsh NHS Employers' Unit

## List of written evidence

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The following people and organisations provided written evidence to the Committee. All written evidence can be viewed in full at <http://www.senedd.assemblywales.org/ielIssueDetails.aspx?Id=5915&Opt=3>

<i>Organisation</i>	<i>Reference</i>
Wales Audit Office	PAC(4) 07-13 (p2)
Welsh Government	Additional information
Health Boards	Additional information