

# **CONSULTANT CONTRACT IMPLEMENTATION**

## **RESULTS OF DEPARTMENT OF HEALTH NATIONAL SURVEY**

**POSITION AT 29<sup>TH</sup> OCTOBER 2004**

**February 2005**

## INTRODUCTION

1. This report is based on returns to a survey issued by the Department of Health (DH) in October 2004. The survey was designed in consultation with Strategic Health Authorities (SHAs) and the British Medical Association. The purpose of undertaking the survey was to establish the position as at 29<sup>th</sup> October 2004, and to help SHAs and the DH identify implementation issues and progress towards achieving maximum sign-up to the new contract. A copy of the survey questionnaire is attached (Annex C).

### Issuing the survey and processing the returns

2. The survey questionnaire was sent to Consultant Contract Leads in Strategic Health Authorities (SHAs) to issue to PCTs and Trusts to establish the position **as at 29<sup>th</sup> October 2004**. Approximately **95%** of Trusts submitted returns. Foundation Trusts were not obliged to complete a return, and two chose not to do so. Completed questionnaires from individual Trusts were returned via the SHA to the Department of Health to be processed.
3. Some returns were incomplete and in some cases, there were apparent anomalies in the processed data. In these cases, organisations were asked to check their returns and to provide missing data. Some returns remained incomplete – eg some Trusts choosing not to include part-time consultants even though the survey and guidance asked for this to be provided pro-rata to a whole time equivalent.
4. Some respondents were unable to provide information on the increase in consultant pay, although the issue of costs was touched on by many in the 'Comments' section of the questionnaire (see Annex B).
5. Once all returns had been processed and missing data and anomalies had been identified and checked, the draft summary findings for NHS Trusts and PCTs were sent to the appropriate SHAs for verification.

## **FINDINGS**

6. The findings summarised in this report are shown, by SHA, in the attached tables. (Annex A)

### **Consultants on the new contract**

7. Table 1 shows the percentage of consultants who had signed up to the new contract as at 29<sup>th</sup> October 2004. Sign-up ranged between SHAs from 57.2% to 92%. Overall, **76.9%** of consultants in those organisations who responded had accepted and signed the new contract at that date.
8. This was an increase on the August 2004 figure of 68%. We expect, and SHAs have indicated, that this figure will have further increased since the survey, as more consultants have signed up to the new contract, including all those appointed to new posts.

### **Agreed programmed activities per job plan**

9. Table 2 shows the average number of programmed activities per week in consultants' job plans. These ranged from 10.22 to 11.57, with an overall average of **11.17**.

### **Agreed programmed activities for direct clinical care**

10. A 10 PA job plan was expected to include 7.5 PAs for direct clinical care and 2.5 PAs for supporting professional activities – although there is flexibility to recognise individual circumstances and local needs.
11. Table 3 shows the number of PAs per job plan for Direct Clinical Care. Figures range from 6.44 to 8.55, with an average of **8.27**. This figure should be viewed in the context of the average number of PAs per job plan being **11.17**.

### **Number of programmed activities allotted for unscheduled on call work**

12. The new contract distinguishes between *scheduled* work that is done on call, which should be timetabled and included in the job plan; and *unscheduled* work that should be estimated and an average programmed into the job plan.
13. Tables 4 and 5 show:
  - an average of **60.3%** of consultants had one or less programmed activity in their job plans allotted for unscheduled care
  - an average of **5.2%** of consultants had more than one programmed activity in their job plans allotted for unscheduled care

From this, it can be inferred that **34.5%** of consultants have no programmed activity in their job plans for unscheduled care

### **Number of programmed activities allotted for scheduled out of hours work**

14. Out of hours work is defined as work done during the weekend and between 7pm and 7am during the week.
15. Tables 6 and 7 show:
  - an average of **45%** of consultants had one or less programmed activity in their job plans allotted for scheduled out of hours work
  - an average of **13.7%** of consultants had one or more (but less than two) programmed activities in their job plans allotted for
16. The survey also asked how many consultants had two or more programmed activities in their job plans allotted for scheduled out of hours work. The answer to this was **nil** from all but one SHA, where the figure was **0.01%**

From this, it can be inferred that **41.3%** of consultants have no programmed activity in their job plans for scheduled out of hours work.

### **Number of consultants in each on call category**

17. The new contract has two categories of on call. Broadly, category A is for consultants who are usually required to return to work, and category B is for those who typically respond over the telephone.

18. Tables 8 and 9 show:
- an average of **68.1%** of consultants were in category A
  - an average of **24.9%** of consultants were in category B
19. The comments showed that Trusts felt they needed clearer guidance on category A and B payments and that there were inconsistencies between Trusts in the application of the rules.

**Additional cost resulting directly from the new contract for the financial year 2003/4- ie increase in consultant pay**

20. The information provided in response to this question was insufficient to generate robust figures.

**Payment of recruitment and retention premia**

21. Responses from individual Trusts are attached at the beginning of Annex B.

**Additional comments**

22. Respondents were also asked whether there were any issues emerging from the contract implementation that they wished to raise. Annex B lists the comments.

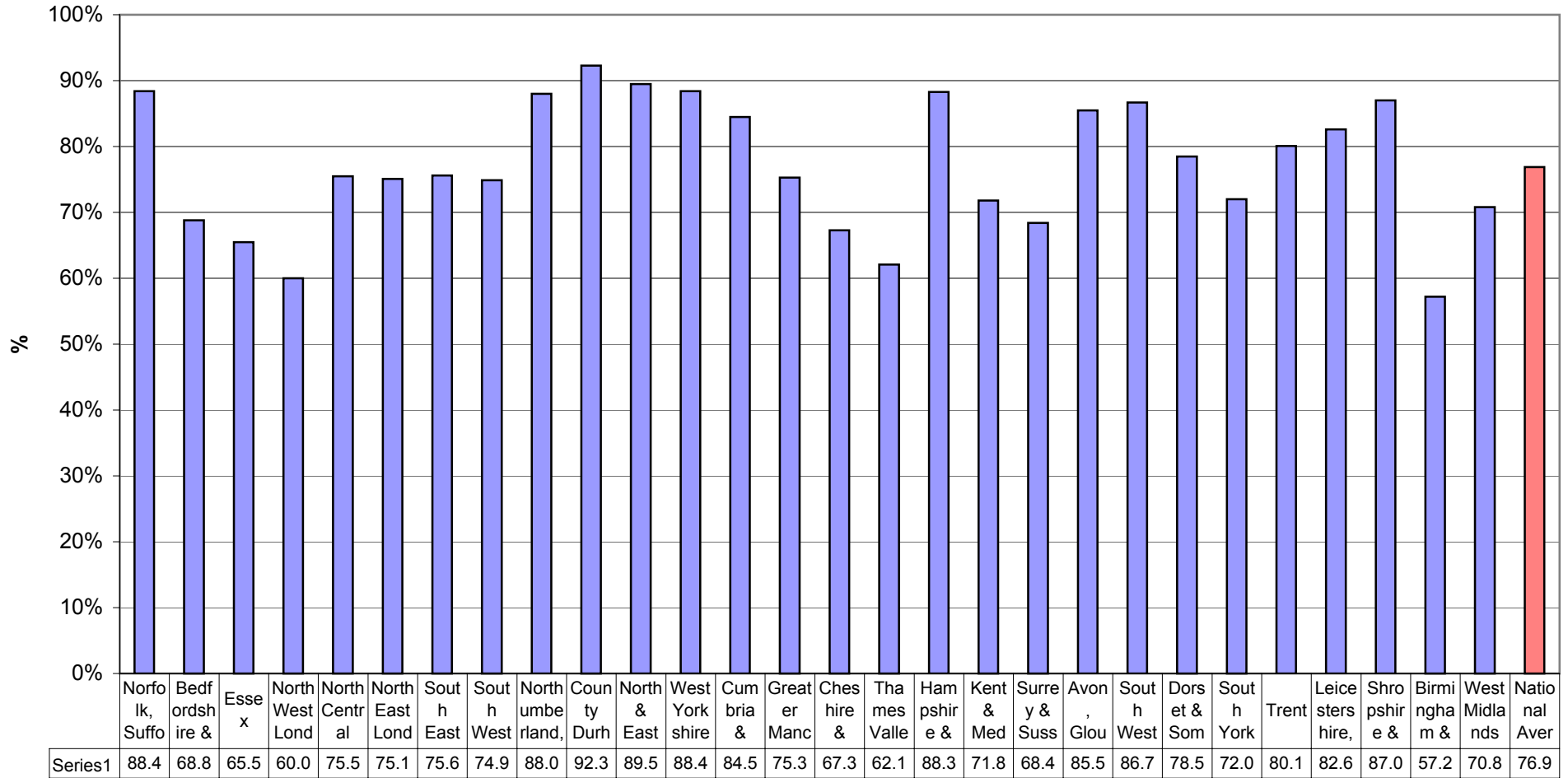
**CONCLUSIONS**

23. The survey findings show a positive picture of the implementation of the contract as at 29<sup>th</sup> October 2004, and we believe that this has continued subsequently.
24. Based on the figures here, and reports from SHAs, we estimate that around 80-85% of all consultants will be on the new contract now; and this percentage will continue to increase as more consultants transfer and all new appointments (after October 2003) will be onto the new contract.
25. The average number of programmed activities reflect the effort that has gone into the job planning round. The Consultant Contract Implementation Team (CCIT) launched their Job Planning Toolkit in January 2005 at a national conference, sharing the platform with the BMA. This was followed by a programme of regional workshops. CCIT have continued to work with SHAs and NHS Trusts to ensure that an effective, prospective approach to job planning continues to be applied to help NHS Trusts and consultants to arrive at standard full-time job plans of 10 programmed activities.

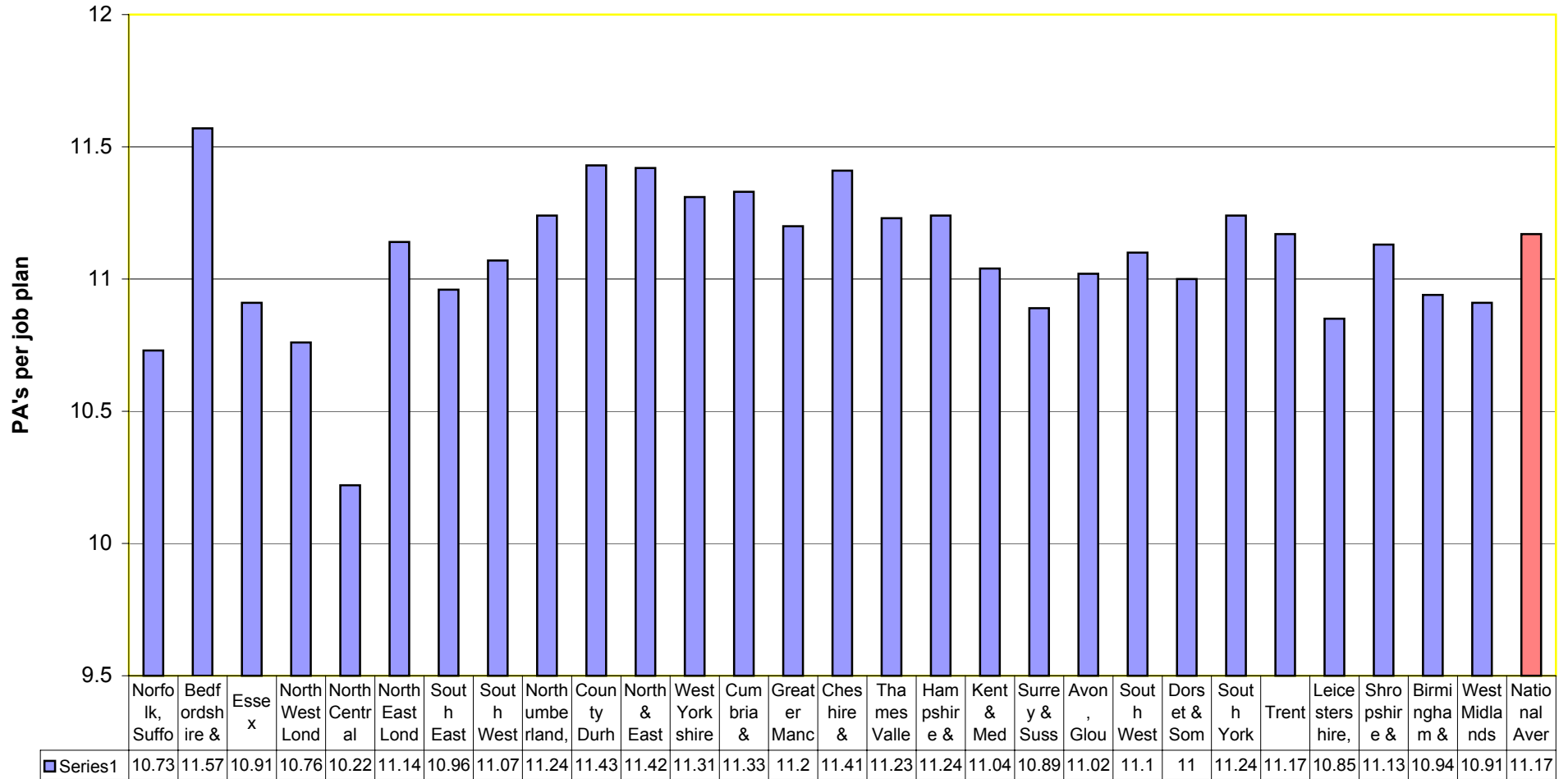
26. A more detailed breakdown of the findings for individual NHS Trusts will be shared with them, via SHAs, to identify any specific issues and to inform the job planning process locally.

**SURVEY FINDINGS**

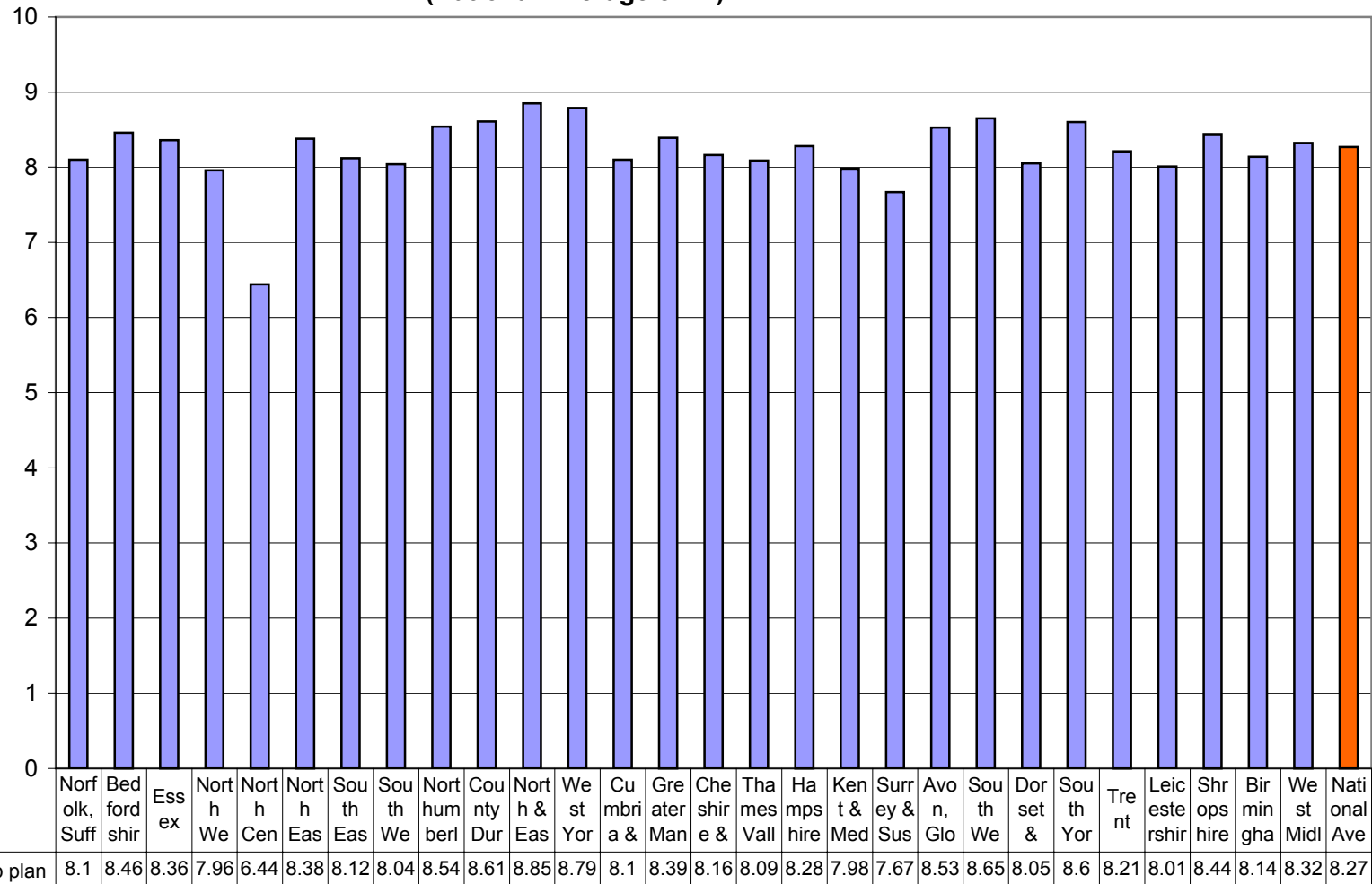
**Table 1**  
**% Consultants on New Contract October 2004**  
**(National Average 76.9%)**



**Table 2**  
**PAs per Job Plan**  
**(National Average 11.17)**

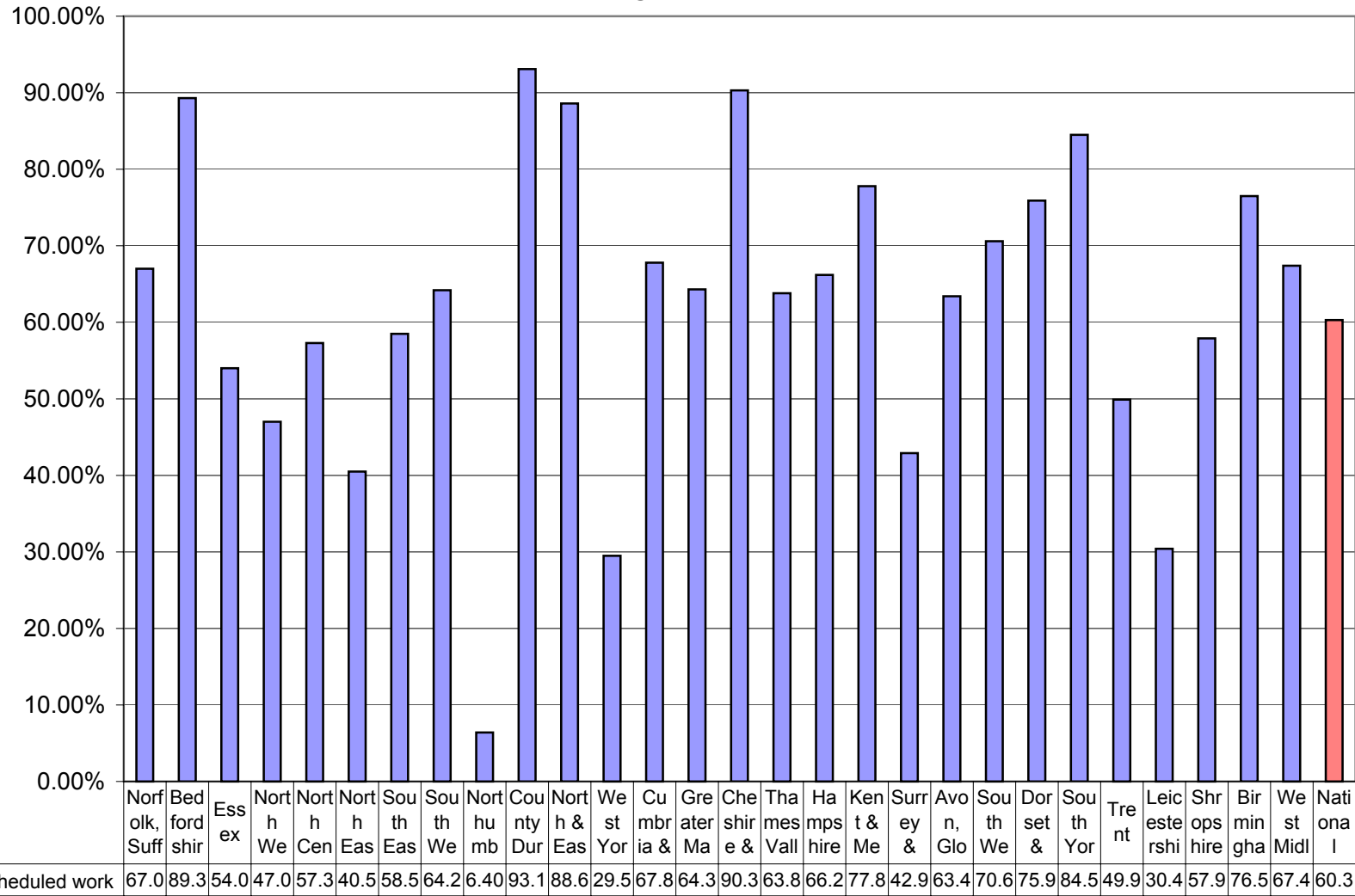


**Table 3**  
**Direct Clinical Care Pas per job plan**  
**(National Average 8.27 )**

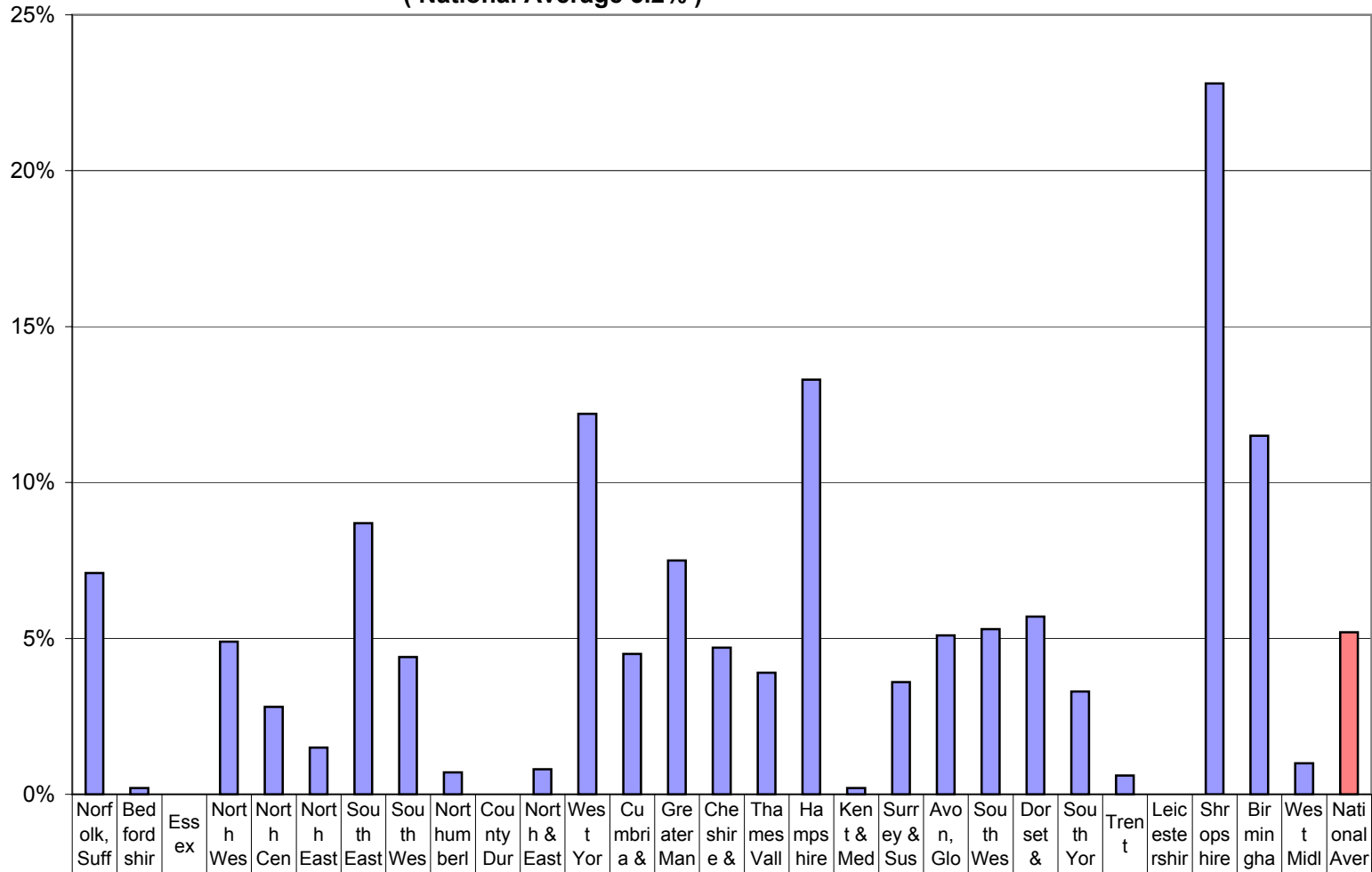


■ Direct Clinical Care Pas per job plan

**Table 4**  
**% 1or less PAs for unscheduled work**  
**(National Average 60.3%)**

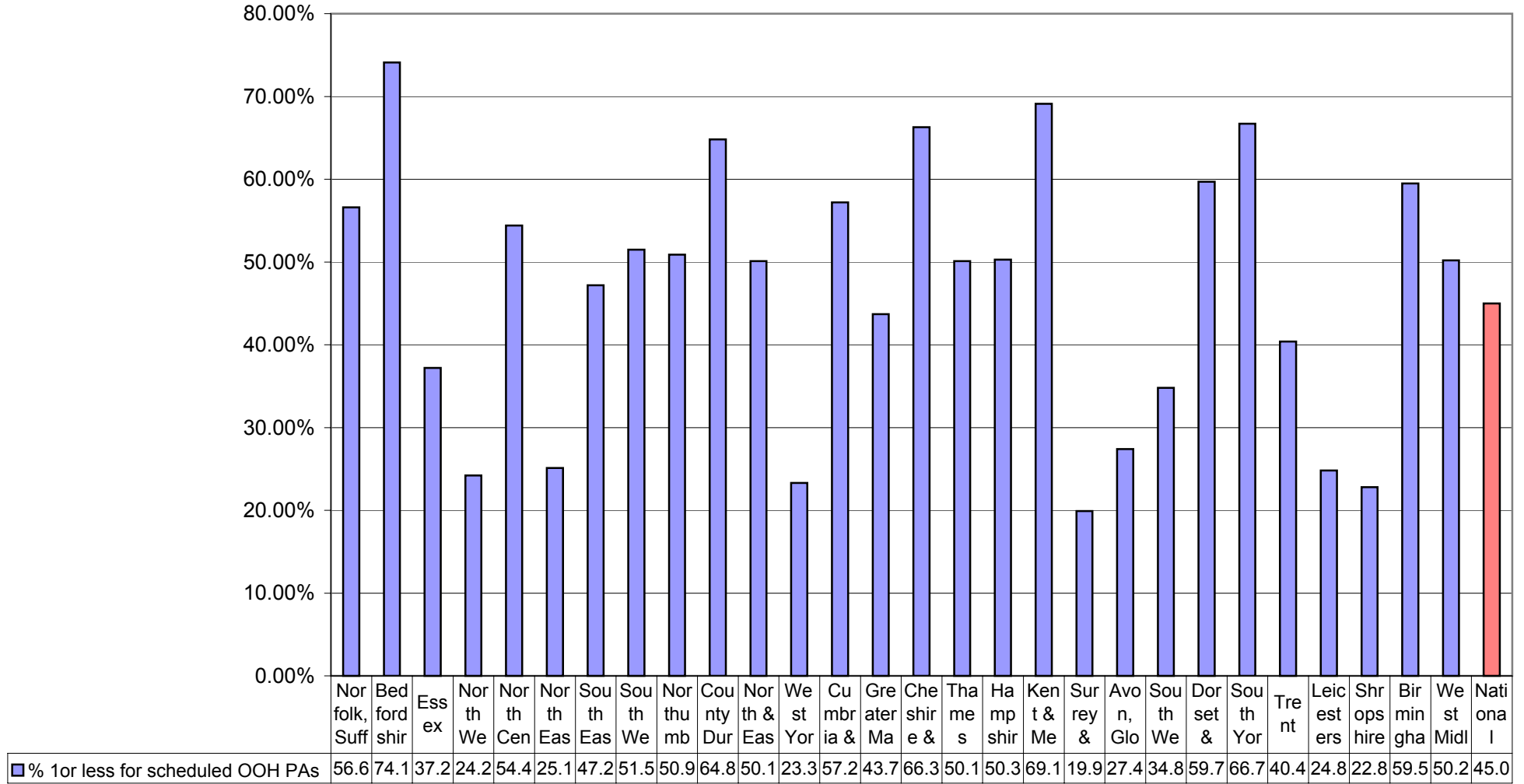


**Table 5**  
**% More than 1 PA for Unscheduled Work**  
**( National Average 5.2% )**



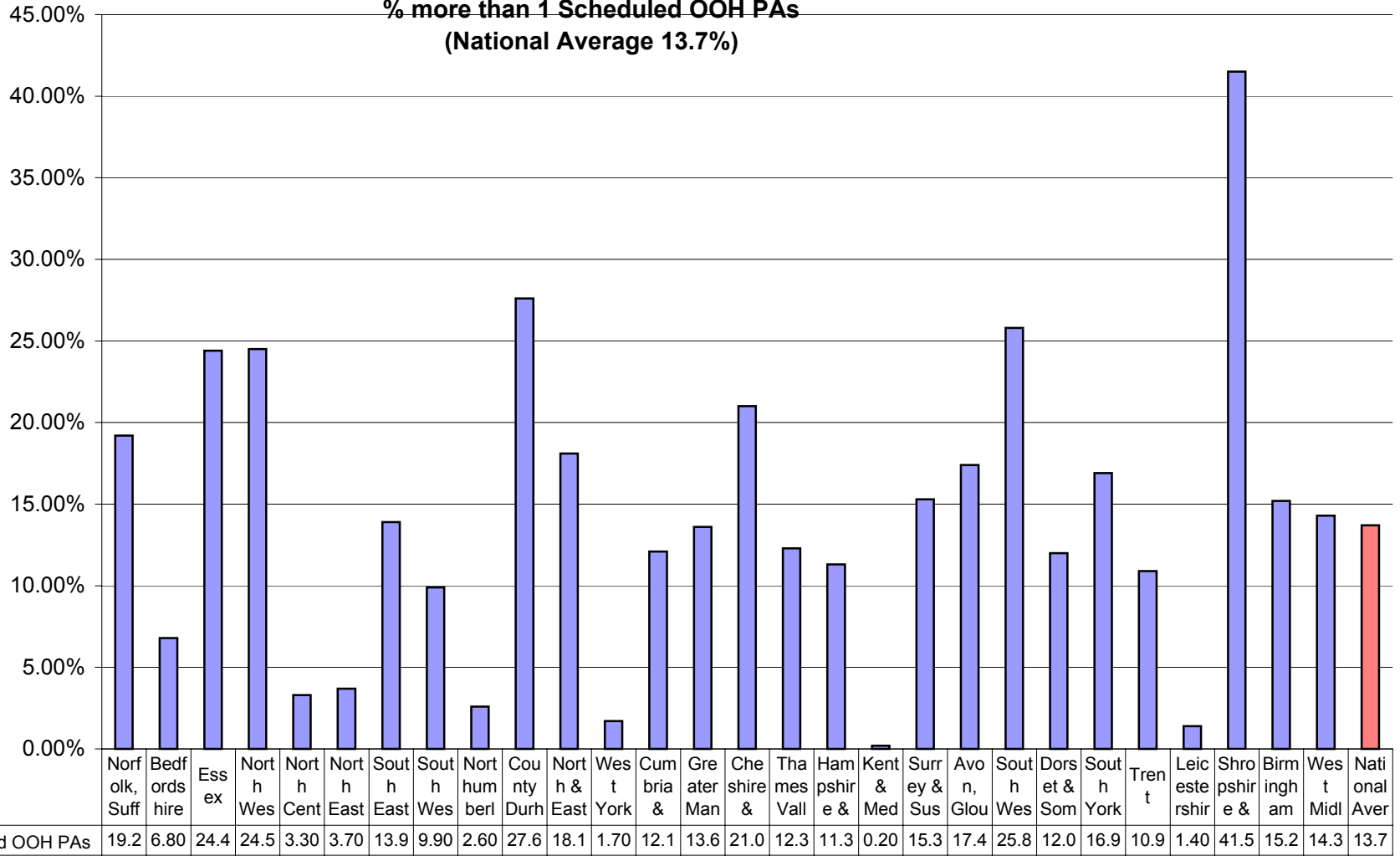
■ % more than 1 Pas for unscheduled work	7.10	0.20	0.00	4.90	2.80	1.50	8.70	4.40	0.70	0.00	0.80	12.2	4.50	7.50	4.70	3.90	13.3	0.20	3.60	5.10	5.30	5.70	3.30	0.60	0.00	22.8	11.5	1.00	5.20
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**Table 6**  
**% 1or less for Scheduled OOH PAs**  
**(National Average 45%)**

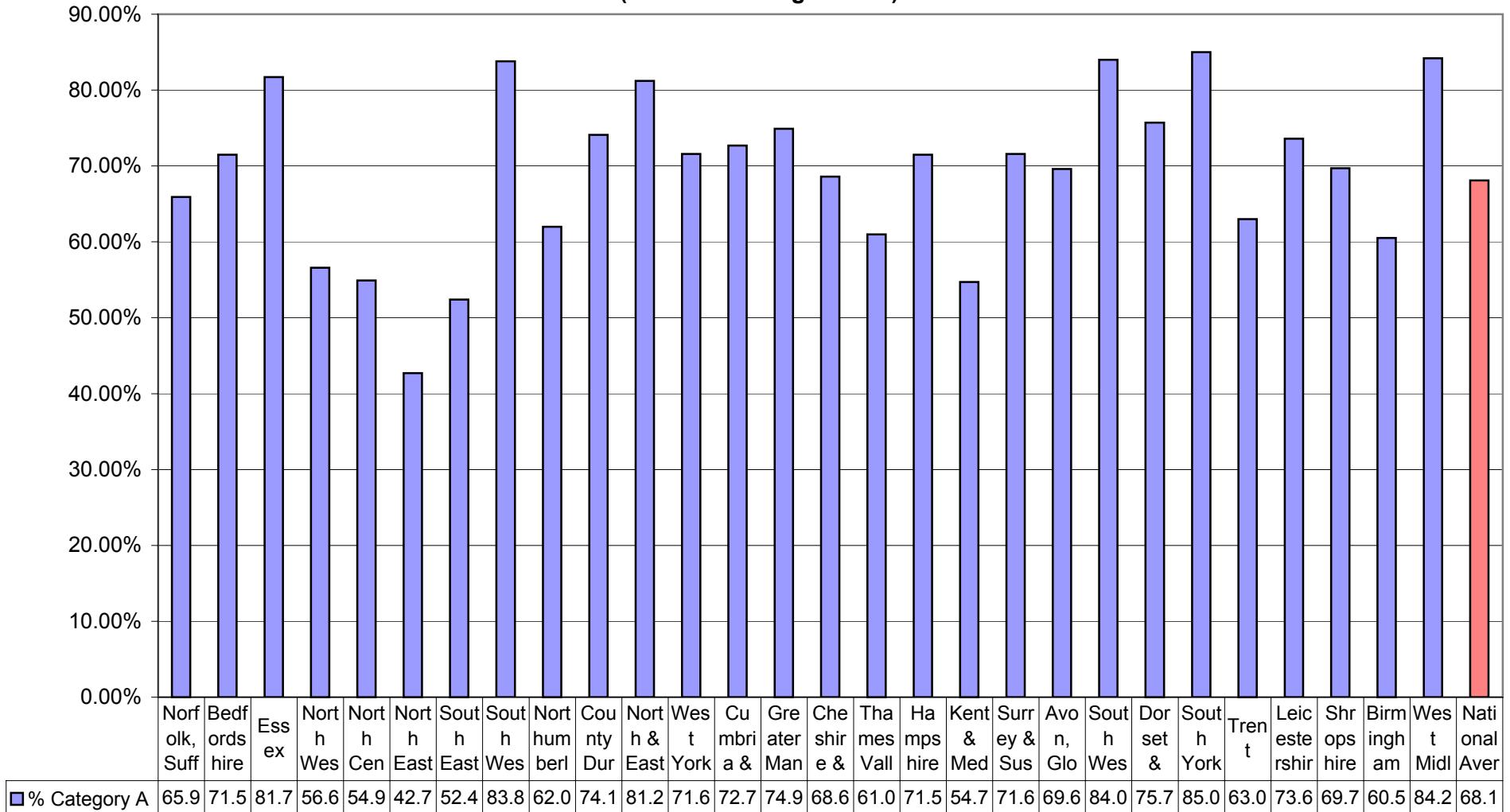


**Table 7**

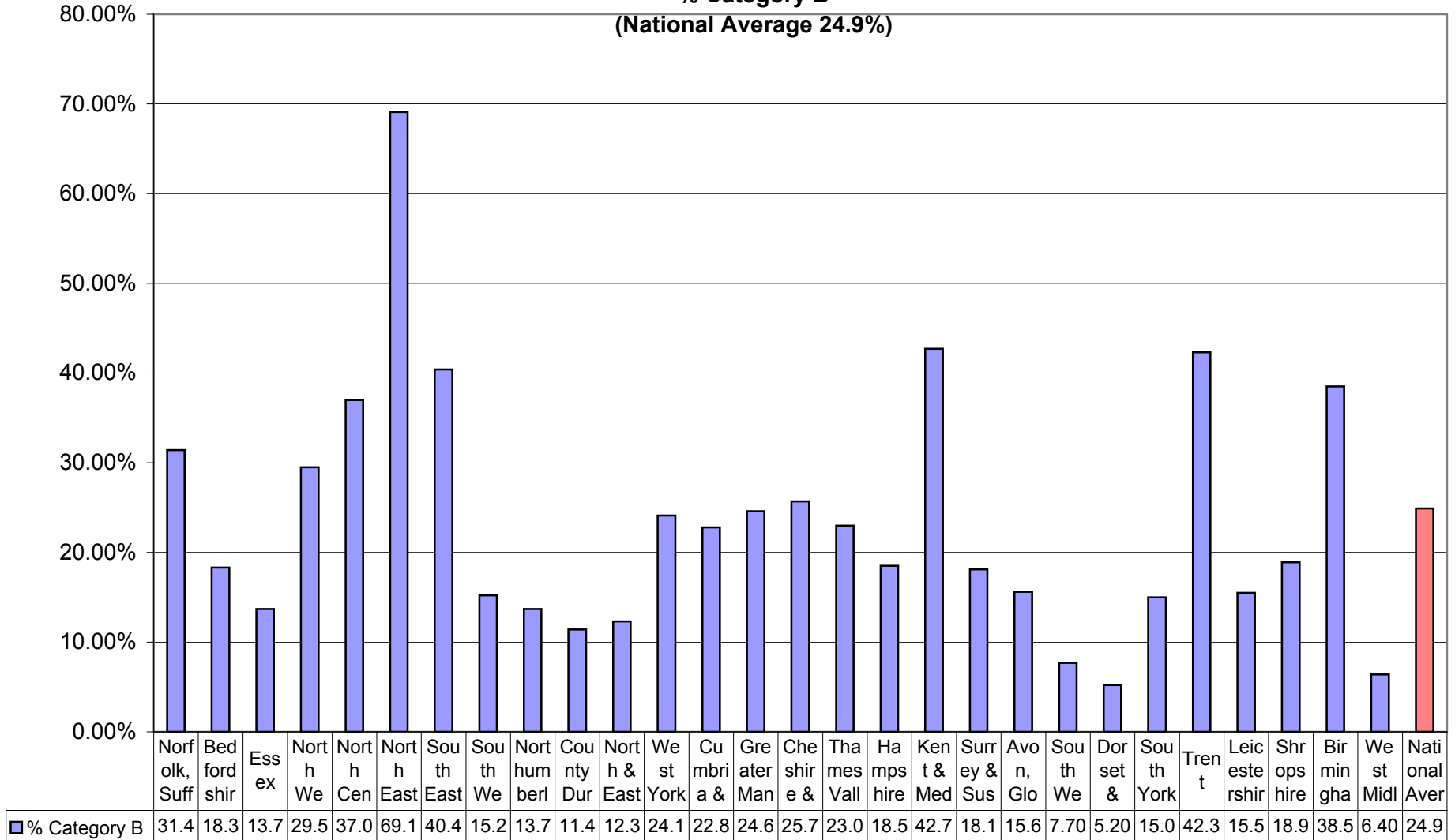
**% more than 1 Scheduled OOH PAs  
(National Average 13.7%)**



**Table 8**  
**% Category A**  
**(National Average 68.1%)**



**Table 9**  
**% Category B**  
**(National Average 24.9%)**



### Recruitment and Retention: comments

<p>Don't pay recruitment and retention premia but, in order to recruit, being forced to pay additional expenses effectively equivalent to the recruitment premia but of course not generalised.</p>
<p>No recruitment and retention premia being paid as request to Strategic Health Authority to pay recruitment and retention for a Radiologist was refused. Individual was given an extra PA of work in order to prevent him going to another StHA area who were willing to pay such a premia.</p>
<p>20% recruitment and retention to All General Adult – including Substance Misuse, Psychotherapy and Rehabilitation.          20% recruitment and retention all Clinical Directors.          30% recruitment and retention to all High Secure hospital consultants.          30% recruitment and retention to all Medium Secure hospital consultants.          National shortage of General Adult consultants and many vacancies utilising locums. Competition from other Mental Health Trusts. National shortage of Forensic consultants and a number of vacancies. Competition from other Forensic/Secure services.</p>
<p>All three Consultants on the new contract receive a recruitment and retention premia of 5% of their basic salary. This is for a time-limited period of 4 years. It was felt justifiable by the Authority due to the difficulties in recruiting to Psychiatry Consultant posts.</p>
<p>On the old contract Histopathology, clinical radiology and anaesthetists are receiving a RR. This is time limited and will end by march 2006. There is no RR with the new contract.</p>
<p>RR premiums not yet been finalised. At present nothing is being paid, but this is likely to change in the future.</p>
<p>The impact of the use of recruitment and retention premia by XXXX Strategic Health Authority on the our ability to recruit and retain Consultants. including the impact on the wider labour market</p>
<p>The payment of a one-off recruitment premium of £10,000 assisted in the recruitment of two Histopathologists -. The Trust has a clear written policy on this issue but has no plans to make widespread use of this option.</p>
<p>RR Premia for 1 A&amp;E Consultant, due to shortage of applicants 5% for 2 years, 1 Paediatric Consultant due to shortage 5% for 2 years.</p>
<p>R &amp; R problems. one measure was to recruit all new consultants to the top of the whitley payscale. Under the new consultant contract we must now appoint new consultants to the first pay threshold. This is over £5,000 less than the salary we previously recruited to. The current SpRs have expressed their concern about the implications of the new contract on their starting salary. We lost a number of SpRs who decided to undertake locum work to enhance their earnings. The SHA agreed that we may pay a £5,000 premium to new doctors, reducing each year until they reach the 5th pay threshold. 2 consultants who receive a £5,000 pa premium, 1 consultant who receives a £3,000 pa premium and 1 part time consultant who receives a pro rata amount of £1,800 pa. All are in the specialty of psychiatry.</p>

Histopathologists - 10 consultants (30% at basic pay) - to aid recruitment and retention.
A recruitment and retention premium amounting to £20,000 per annum has been paid to the single Consultant in Learning Disabilities for the county. This speciality has proved extremely difficult to recruit into in the county and further recruitment problems are expected until a comprehensive service review has been completed and enacted - estimated 3 to 4 years."
A diminishing R&R premium is being paid to new Learning Disability psychiatrists representing the difference between the first and 5th incremental point, diminishing over 5 years. It is currently being offered to one of the newly appointed consultants and is being offered to a second consultant in line with other LD Trusts within the local SPR rotational training scheme catchment area.
A review of recruitment/retention premia at the same time may also make the contract more attractive.
Specialty: Histopathology Number of Consultants: 8 Value of R&R premia: 20% Justification: Shortage speciality. To be reviewed June 2006
3 Histopathology Consultants. £12,000 per annum. This was introduced in April 2003 due to shortage of Histopathology Consultants, this payment is due to cease in August 2006.
The R&R premia currently being paid to 5 Consultant Forensic Psychiatrists at XXXX that are on the new contract is merely a continuation of payment in response to critical market factors in High Secure Forensic Psychiatry following on from variation orders obtained by XXXX and XXXX Hospitals, these in turn were secured to combat the very high salaries being offered to Forensic Psychiatrists in the private and independent sectors.
No specific recruitment premia, however two community paediatricians are currently receiving additional PA's on a fixed term basis due to two long term consultant vacancies - this will come to an end in December as we have now managed to recruit to the positions.
30% RRP being paid to one honorary consultant, whose clinical work is carried out at XXXX Special Hospital.
Trusts are not using recruitment supplements but enhancing basic salary.
HEAD AND NECK CANCER SERVICES - £15000 per annum for a limited period of 4 years to Mr XXXX ENT Surgeon with a special interest in head and neck cancer and to Mr XXXX Maxillofacial Surgeon. The ENT post was previously advertised twice without success. This post is crucial in taking forward the Head and Neck Cancer services and , therefore, it was imperative that the Trust was able to secure this appointment without which there would have been a detrimental effect on the further development of clinical services in this speciality. This premia reflects the shortage of suitable candidates with the requisite skills knowledge and experience.
2 Psychiatrists - posts advertised 3 times in 12 months so were given 2 points up the scale and 1 paediatrician post, similarly advertised given 1 point - all three had sought BMA guidance and had be encouraged to negotiate a higher starting point despite just leaving the SPR programme
Some trusts are increasing the number of PAs to entice new consultants rather than use a recruitment premia.

## Additional Comments

Comments
Difficulties in balancing Consultant expectations/working hours with funding available. Lack of national funding or direction on PA's for external (eg National) work has been problematic.
tensions with consultants over trust's 'strict' application of rules.
Funding not forthcoming from PCTs/SHAs to cover full costs.
Of the 7 consultants not on the new contract, only one has chosen not to transfer, the others are consultants recruited via the International Fellowship Scheme who have had an extended induction period, which has delayed the job planning process and one consultant on long term sick leave.
One consultant is retiring in February 2005 and decided to adopt new job plan but remaining on old contract
issues re job planning and alignment of organisational objectives when staff member work across more than one organisation
new contract not been written with the Public Health Directorate in mind and it has been extremely difficult where there is no direct patient benefit to understand why it was added as an afterthought.
Implementation deadlines were not realistic and therefore job plans were rushed and the opportunity to evaluate working practices was lost. Guidance from the centre was still being issued as Trust's were transferring Consultants to the new contract. Clarification/guidance on Category A/B was not helpful. New Consultants do not expect to start on the minimum of the salary scale. The introduction of MMC will need to be taken into account for annual job plans with a reduction in clinical time expected. Additional guidance on payroll issues would have been helpful.
Costs
Inadequate resources and support. Very little payroll training - caused major delays to implementation,
section 6 figures given are artificially low as after negotiations, it was agreed that backpay for 2002/3 would be paid at a maximum of £3,500 per consultant (pro rata for part-time and for those consultants choosing a transitional date after 1.4.03). The recurrent impact is estimated at £620k or 6.9%
we have 1 consultant in the psychiatry specialty group with 12.5 programmed activities (in place of recruitment and retention premium) - we are in the process of recruiting an additional consultant to this specialty group.
Cost is a significant problem. The contract has helped transparency with regards to consultant pay and responsibilities, helped to deal with equality issues within the consultant workforce & helped to plan how lead roles in modernising mental health services are allocated and remunerated.
Of the 12 old contract holders, only 3 are substantive NHS - the others are Honorary Contracts. One of the 3 substantive post holders is now actively

discussing a change of mind. The Honorary posts have all had job plan discussions, they have all indicated a wish for the new contract in principle. However, the University has indicated that it will not be in a position to proceed with implementation until the next calendar year due to continuing discussions on the text of the contract.
None from the actual implementation. The PCT managed to avoid formal mediation/appeal through negotiation with the consultants concerned in reaching agreement.
Negotiations taking longer than anticipated.
Concern about the additional financial pressures being imposed upon the Trust which were not fully funded.
Substantial cost pressure to the Trust as the promised funding of an average of 11 PAs per consultant did not transpire in reality.
Majority of our posts are joint appointments with other Trusts. Have agreed about 13 job plans relating to joint appointments but can't move forward because the other Trusts have not agreed their job plans.
Consultants challenging their on call category
Insufficient funding to meet the full costs of the contract. National formula does not cover the basic cost increase and the assumed number of sessions across the country.
Survey doesn't reflect specialties within a PCT thinks PCT's should be dealt with differently (particularly given the small number of consultants in this area).
Costs have far exceeded those anticipated or funded nationally.
Regarding the averages calculated: In calculating average PAs, part time consultants have been omitted so the entries are reflective of PAs for full time consultants. Including part time consultants would cause skewing of the information. The numbers of consultants in question 1 relates only to those consultants who needed to transfer as of 31st October and not any new appointments. Regarding question 6- the figures given are per head and are based only on those consultants in this Trust (Not those with sessions here and not clinical academics (of which there are approx. 30)) We do expect for approximately 25 more consultants to move to the new contract shortly leaving only about 15 of the original old contract holders on the old contract. As advised by the SHA, the figures in questions 3 and 4 include a number of consultants with zero of these types of PAs.
Family Planning fees are still an issue - especially in Gynaecology and Microbiology. The issue of paid time for external duties is the subject of a local agreement but is still a concern
6 newly appointed consultant psychiatrists receiving recruitment premiums of 9.5% taking them to a starting salary of £71, 230 (2003/04 pay rates) for a marked time period of four years. Implementation process went relatively smoothly.
As we have no Medical Director, we experienced difficulty arranging a Mediator. Would it be possible to create a list of suitable Directors prepared to act as mediators in future?
On call challenges - Consultants signed the new contracts based on

Category B on condition that the PCT reviews on call commitment over the next few months
Directors of Public Health - on-call banding needs clarification. We have assessed as Category B but other Trusts seem to be paying Category A
On-call banding - especially for General Medicine. Variations between Trusts difficult to justify. Job Plans with commitments in excess of 12 PA's. We have maintained a limit of 12 paid PA's in contract offers, but some job plans have been agreed which recognise in excess of 12 PA's of working commitments. Resolving these issues will add further future costs to implementing new contract (especially in relation to Consultant expansion).
Lack of funding of the contract. Challenge to the service in moving to 4 hr PA's from 3.5hr sessions. A time managed contract for a group of professionals does not appear appropriate. Problems with double counting of activities within SPA's. Contract management has not been funded to manage the detail. The costings only include yr 1 of the max pt consultants, so the figure will go up in y2 and y3.
1 Consultant Chemical Pathology £12,800 - specialty with workforce problems - unfilled posts - single handed The figures we have submitted include PAs identified for key management roles over and above normal support PAs eg: 1) Associate Medical Director (in the anaesthetic figures) 2) Associate Medical Director (in medical return) 3) Medical Director (in radiology return)  It is important to be clear when comparing organisations, how such activities are rewarded ie in terms of PAs or separate payments as it will influence these statistics.
Following the questionnaire we will ensure our job plan for this years round incorporate the data you wish to capture. Currently info on 3 & 4 is our best estimate but if incorporated in this format in job plans it would be more robust.
The mediation process was undertaken for one Consultant, which highlighted the need for direct communication and understanding of seniority issues directly with the Consultant, rather than communicating through the Clinical Director. The benefits of the new contract for XXXX PCT will be in terms of recruitment and retention of highly skilled and qualified staff at this stage.
issues re. definition of on call categories, other orgs taken different interpretation & the difference between the two types of on call in relation to Pas. The job plans, where necessary have time allocated for on call work in order to provide the service. Also agreeing job plans for those on the new contract in relation to colleagues who are remaining on the old from a service delivery point of view. e.g the difference in hours between a session and a PA.
There seems to be some confusion over the issuing process for the relevant paycales (late notification of paycales MC52 to MC71). It would have been helpful to have these issued at an earlier date.
The costs quoted are based on the 2002/2003 total pay for consultants,

(gross cost) including locum consultants; no payments were made in 03/04 and arrears were paid in 04/05 for 03/04
frequent and large number of requests for information from the SHA which require a lot of man hours to supply. still have a significant number of contracts which have been issued, but where we are still having discussions re fine tuning - this makes the total number at 1 artificially low.
e.g. of good practice supported by intro of con con introduction of evening/weekend clinics, introduction of nurse led clinics, compressed paediatric rotas, flexible career options for Consultants. etc.
need clear guidance on on call rota for consultants in the PCT. costs
Clearer guidance on the on-call definitions would be helpful. We have a number of examples of good practice and modernisation across the organisation for example New Ways of Working in Anaesthesia - Practitioners are being trained by Consultants, which will ultimately release Consultant Time. Many of these practices are happening despite the Consultant Contract but we are keen that we use the Contract to support further modernisation. We are interested in and keen to share any good practice examples across XXXX .
The Trust, as a good practice site started early on the implementation and checked its information very carefully. In particular, all consultants interested in taking up the new contract were required to complete a diary for a representative period, which was then analysed and subjected to thorough and detailed challenge. Simple cross checks, such as did the amount of time the consultant spent in the hospital reconcile with the amount of time being claimed were also made. This was done in an open and constructive way which removed accidental double counting etc but demonstrated that a significant number of consultants particularly, but not exclusively, those in single handed specialties, were working average hours consistently in excess of 48 per week. The Trust agreed with the consultant body not to pay for PAs over 12 (jointly recognised as a financial pressure) with an undertaking to work to reduce this by March 2006 to 12 or less. Whilst this is a very useful driver for service modernisation, and is being responded to positively by consultants and managers, the lack of recognition of this extra work in the financial support to the Trust is disappointing. The first target is clearly the over 12 PAs but we would intend to use a similar model, building on our experience, with the 10 to 12 PAs as the next stage, where clearly there is a potential to release money for service modernisation.
issue of external duties and remuneration for these as part of the total number of programmed activities. Our Trust has taken the decision to allow paid leave to undertake duties, which have a benefit for the wider NHS. Been told there is central guidance on this issue, but other than the Terms and Conditions, none has been forthcoming.
PAs are high because of the low consultant numbers and high workload at our hospital.
consultants working more than 12 Pas but only being paid 12 and how these will be reduced to 10 within an acceptable timeframe and without losing capacity
An Associate Medical Directors commented that flexibility of the consultant workforce seems to be diminished by the contract.

Divisional Modernisation Objectives have been produced for all Consultants to work towards.

The awarding of Category A on-call was as a direct result of other local Trusts, with whom on-call rotas are shared, awarding category A.

Job planning needs to be linked closer to service plans

There needs to be equality between 'New' and 'Old' Consultants (and Junior Doctors) in the payment of fees and allowances. E.g. family planning work undertaken as part of other procedures is still claimable by those not transferring.

The data on this form applies to NHS consultants and Honorary Consultants employed by the University, MRCI & Health Protection Agency. The job planning exercise has confirmed for us that many of the Consultants were working beyond their contracts. Final agreed job plans were in some cases more than the final offer of PAs - ie there is a "Clinical Gap" of PAs being provided "in a Consultants' own time" In Paediatrics we have made offers that have been accepted with average PAs of 12.5. However the actual hours worked are higher. Previous arrangements with extra payments for cross cover in some specialties have now been consolidated into 13 PA job plans, eg in Cardiac Surgery and Cardiac Anaesthesia. Most onerous job plans are Paediatric Cardiology - this is made worse due to large geographical area now that travel time is fully counted. Also high PAs in Neonatal Medicine with 13 PA Job plan. Paed Surgery and Paed Oncology demonstrated a large gap in the work done and the number of PAs agreed in the job plan. Supplementary contracts have been raised for Clinical Tutors, NEW Deal/WTD and Major Incident Leads. CSDs and Commissioning Leads also have supplementary contracts. We developed a job plan form that calculates and summarises activities but need to develop better systems to track and monitor changes etc. Recharges to other organisations and surveys such as this rely on getting the information held in a way that can be easily interrogated. Consultants salaries have been transferred to the new contract and salaries paid once they have signed up, and this has therefore been done in batches, 87 in July, 26 in August, 62 in September, 32 in October and 21 in November. We have 20 consultants who have sought mediation and a further 10 who have out-standing queries.

In addition to generic and individual job plans, the Trust has worked with specialties to produce a workforce planning tool known as the Ready Reckoner. This has, in most cases, highlighted a gap (deficit) between the consultant resource and current service demands. In turn, this has and is producing action plans to close these gaps which includes appointment of additional Consultants but also changes in Consultant working practices and the roles of non-medical staff. In this way, the opportunities offered by the new contract are linking in with other aspects of the workforce modernisation agenda.

The 2<sup>nd</sup> PA payable for unpredictable work will need funding next year in specialties with high out of hour workloads. We can't assess this currently as we capped the unpredictable workload at 1 pa. Is the SHA going to fund this from April 2005?

Concerns of other trusts advertising consultant posts offering extra PAs and additional CEAs as standard part of the reward package. Inconsistencies

<p>with on call bandings across Trusts. Other trusts giving blanket numbers of PAs to all consultants undermines job planning and leads to disparity and feeling of harsh treatment to the consultants not given a standard 11 or 12 PAs. Will result in increased competition for hard to fill posts between Trusts subsequently leading to same negotiation situation as old contract.</p>
<p>costs &amp; shortfall of funding.</p>
<p>1) Provision for management responsibility. 2) Lack of clarity re principles of re-charging. 3) Posts being advertised on 10 PAs, when the realistic workload is higher. 4) Timescale within which it is reasonable for contract to be issued and expected to be signed before an individual loses his/her entitlement to backpay.</p>
<p>Issues over on call supplements - currently paying Category B but still discussing/monitoring, which may result in it being changed to Category A (for some, or all, on-call consultants)</p>
<p>No additional costs as there was no transfer of existing staff and the new staff went onto 10pa contracts from the date of appointment.</p>
<p>New Director of Public Health due to commence December 2004 initially on 11 Programmed Activities but reducing to 10 Programmed Activities after 6 months One Consultant on old contract has moved to different contract in a new role rather than New Consultant contract. The financial information in question 6 represents only 1 consultant as the other 3 are paid via the University as Academic Consultants</p>
<p>Concerns over Consultants not seeming to comprehend what the new contract involved, Length of time obtaining Job Plans and analysing. What guidelines are available for first reviews next year to make it simpler and quicker.</p>
<p>Implementation of the new contract has been time consuming. Some of the national guidance has been difficult to use and interpret especially information relating to category A and B payments. The contract does not translate easily to mental health. Most consultants work far more than 8 PAs per week of direct clinical care, which has made it difficult to identify capacity to have 2.5 or 3 supporting professional activities. The process has led to a much greater understanding of consultant workload. The next few years' job planning meetings are important to take this work forward.</p>
<p>Credit for GP seniority remains an outstanding issue. As was the on-call availability supplement for Public Health (DPH) which has recently been resolved as Band A.</p>
<p>Costs, lack of clear guidance for on call category, complexity of administration. concerns over inability to link personal objectives to pay progression in a realistic way. This means that real efficiency cannot be linked to pay although this will be required as a result of 'Choose &amp; Book'</p>
<p>Psychiatry - 3 consultants are paid 20% of basic salary and 7 consultants are paid 10% of basic salary - In addition, 1 consultant in community paediatrics is paid 10% of basic salary - The reason for this payment is that it was an existing recruitment premia paid and was honoured as part of the new contract. This premia is currently under review at Director level.</p>
<p>Implementation done to very tight timescales, especially in light of the time allocated to its negotiation. A number of key themes are emerging: a) we have a clearer idea of what consultants are doing; b) the time based nature</p>

of the contract has received negative comment from clinicians - it is seen as contributing to a feeling that they are not trusted as a profession; c) the contract is more expensive than imagined or predicted - much of what was given as 'goodwill' is now costed in and paid for; d) a number of initiatives (eg deanery work) are significantly 'squeezed' given the time constraints in the contract - we will need to watch for unexpected consequences in the coming year.

Family Planning fees

5 pending in o and g .7 pending in anaesthetics ,3 pending in medicine  
2 pending in surgery

are responsibility allowance pensionable? What is the retirement age for consultants under new contract? What percentages for respo allowance should be paid?

Awaiting exact number of academic consultants working within the Care Trust. 2 have rejected the new Contract. 2 are going through the appeals process. A number of other consultants have neither accepted nor refused the new contract.

Academics have not been included on this Survey as their lead employers are elsewhere. Number of Academics for Camden PCT - 15  
New Consultant Contract in process and not included in this return 5  
Consultants

all consultants working over and above programmed activities on committees, PFI and NHS plan agendas eg HAN, EWTD, etc these are not paid for in programmed activities, we have identified responsibility payments eg for Divisional Directors, lead clinicians directors of Infection etc.

Things look slightly less positive than they actually are. Beyond the 104 consultants with signed contracts are 19 who have agreed job plans and have been sent contracts to sign and 8 who have agreed job plans but haven't been sent contracts yet. This leaves only 15 outstanding, of whom 11 are at mediation. The rest either didn't opt in the first place or have changed their minds.

difficult to negotiate job plans/pay etc where consultants work at more than one Trust. Funding insufficient. Information on pay increases/pay thresholds unclear. timescale too short. little support from DoH/Modernisation Agency.

Discussions are continuing with the SHA in relation to excessive P.A.s for a minority of consultants.

We wish to move away from the culture of diary use in future years, and are concerned that surveys such as this will encourage their use in order to allow statistical returns to the detriment of the use of the contract as a local management tool to encourage better management control and service modernisation. not distinguished between scheduled and unscheduled on call PAs. NOT included prorated returns for clinical academics. This return refers to NHS consultants directly employed by the Trust alone. UCL have not yet sent us copies of any agreed job plans they have with their clinical academics. They have not yet started to issue any contracts, so assume they have yet to finalise any job plans.

difficulties reducing the number of PA's to 10 due to service needs.

still finalising job plans for some consultants and 6 surgeons are in the

formal mediation process.
What are the benefits?
continuing discussions in respect of 'shared' rotas both inter-Trust and Regional and how banding should be applied in these cases. welcome any national feedback or guidance.
Trying to implement too quickly. Many consultants above 12 PA's insufficient time to reduce workloads as a result have big cost pressure. Would have been better if agreed job plans and implemented PA's next year, when costs would have been clear. Specialist children's trust, little private practice, consultant orientated specialities, often shortage specialities, making implementation v costly. Implementation nationally poor. Changing and conflicting advice from various sources. Have lost degree of flexibility and willingness of consultants now emphasis is on time commitment. Monitoring is onerous if done correctly and little incentive for consultants to work efficiently
Locums have not been included in the above figures. The Trust has two Clinical Academics in Medicine who hold honorary contracts with the Trust and have agreed job plans. These have not been included in the above figures.
Family Planning Fees & Domiciliary Fees and the concept of not being paid twice. Whether/how working abroad should count in seniority years. Seniority Years for Oral/Maxillofacial Consultants. DoH considering uplift of the tariff to support consultant contract - not compatible.
The Trust has previously operated a locally designed contract, which has been more attractive than the national terms and conditions. This local contract has offered enhanced financial rewards in return for achievement of performance standards. The advent of the new contract, together with the initial guidance on recruitment and retention premia and the ceiling on the number of PAs, has meant that take up of the contract has been limited. The Trust is better placed to review the situation now that the "ceiling" on PAs appears to have been raised
Setting up a specialist Care for the Elderly service - £22,696 - the justification/need is in order to recruit a high quality candidate to set up a new service. It is not planned that this apply to any other doctor in that area since the justification for the payment is the leadership role that the new post is required to fulfil. Also have one consultant on the new contract who is receiving pay protection.
In many cases diary studies indicated that a higher volume of work was being done and therefore the process of agreeing job plans is perceived as reducing capacity. The costs have been high due to a large take up and the need to demonstrate fairness and apply consistent judgements across the Trust. A process of managing down to 10 PAs where additional PAs have been agreed to maintain current service levels could have been explicitly covered in the contract - local arrangements based on the provisions in Scedule 6 have been agreed to address this. A national cut off date for acceptance (i.e. a date when the entitlement to back pay was lost) would have been helpful.

we are having to recognise additional seniority for psychiatry consultants who were put straight to the top of the scale under the old contract as a R&R premia
(1) The lack of capping of PAs at a maximum level within the NHS has led to unrealistic expectations on the part of some consultants and a lack of consistency nationally. (2) The fact that universities are capping PAs has led to significant inconsistencies locally and the likelihood of increased disquiet between NHS and academic staff. (3) The appeals process is extremely bureaucratic and time consuming.
The main issue arising has been matching PAs worked with PAs paid and balancing this with financial constraints. Offers have been made and accepted but they do not match PAs worked, we therefore now need to reduce workload to match pay.
We sought and gained approval (by submission of detailed supporting evidence) from our WDC to maintain the current level of payment (Recruitment & Retention Sessions, Discretionary points, Special Hospital Lead, Responsible Medical Officer), to pay 30% non pensionable or 20% pensionable of point 5 of the (MC72) salary scale – this ensured parity under the new contract with terms and conditions under the pre existing arrangements. The current value of this premia is £24,215 per annum. Lots of specific comments about return
Difficulty in achieving immediate benefits realisation due to ltd scope for objective setting, which is reliant on the team approach. This is culture change, which will take time.
I have not recorded these additional PAs as they are not part of the consultant contract agreement but just a temporary arrangement. The agreed contract is 10 pa's (11 for the clinical lead) for all consultants. There are issues regarding consultants that have left one employer for another - the difficulty of identifying job plans for a three month period over a year ago. Also issues where the contract hasn't been accepted with the other employer yet - does this make any offer conditional upon acceptance at the new employer?
Ridiculously complicated and expensive process obviously designed with little or no thought given to PCTs or SHAs. The real problem was never the contract of employment but rather how it was managed.
Ongoing funding remains an issue and the Trust is conscious that work underway to reduce the number of Programmed Activities of 11.15 will be difficult due to high activity levels and difficulties in recruiting to key roles.
1 x Paediatric Neurosurgery. Value £14,308. Recruitment difficulty - skill shortage specialty. Serious service difficulties and reduced activity if unable to recruit.
Affordability - we cannot pay the consultants in public health for all the time they allocate to work.
Affordability, monitoring, issues of seniority
There is still more uncertainty over the practical application of the pay protection provisions of the New Consultant Contract.

Difficult to realise any benefits. 2. Would be better if whole teams were on the new contract - sometimes only one in a department.
RE QUESTION 5 : £440,000 IS THE TOTAL COST. IF THE QUESTION MEANS PER CONSULTANT THEN COST IS £440,000 DIVIDED BY 34 EQUALLYING £12,941
Contract not fully funded. Trust facing approximatel a £1.1m shortfall, despite having an average PA of 11, and a 92% take up of the new contract.
MHA Section 12 on call work in negotiation with LNC
Lack of resource for the implementation process Problems around managing unrealistic expectations particularly remuneration for Supporting Professional Activity beyond 2.5 PAs Cost pressures for next year when some will do diary cards more carefully and some will justify 2.5 PAs for SPA
UNDER-FUNDING OF THE NEW CONTRACT IS PRESENTING A SIGNIFICANT CHALLENGE TO THE TRUST. XXXX HAS A LARGE NUMBER OF CONSULTANTS NEARING RETIREMENT, SO THEIR INCREASED COSTS HAVE BEEN CONSIDERABLE. WE STILL HAVE SEVEN CONSULTANTS IN MEDIATION, SO AVERAGES COULD INCREASE.
Yes, what are the arrangements now for Locum Consultants. Under Whitely Council the rates were clear are they going to be any further guidance on this. Specifically regarding notice periods as the contract is now ambiguous.
5 consultants waiting to sign new contracts, have agreed Job Plans. Of these 5 consultants 4 of them are medical consultants and 2 are Public Health consultants. There are 2 consultants still seeking to agree Job Plans and both these consultants are from Public Health.
The additional cost at question 6 is shown as zero as the Consultant concerned reduced her working hours that effectively meant implementation was cost neutral
The number of consultants presently on the old contract are still subject to negotiation, including those on split contracts under discussion with other Trusts. We have a number of seniority, salary and funding issues. We have included our 7 Renal Consultants under Medical- all are still under discussion and are currently remaining on the old contract. 2 Agreed PA's averaged out at whole numbers. DCC PA's where marked 7 or 8 should read 7.5 and 8.5.
Lack of clarity with the terms and conditions. During the initial stages there were a lot of queries which should have been resolved between the DoH and BMA before the contract papers were released, such as on-call categorisation. It is not helpful to put too much down to Trust discretion.
Delays in advice on the appropriate on call bands caused some problems . Lack of clarity about the SPA allocation. Loss of activity in some specialities.
The shortfall in funding to the Trust, which is in the region of £220000. The remaining single Consultant on the old contract is presently still on long-term sick leave and expected to retire shortly on health grounds: they should not be regarded as a refusal of the new terms & conditions.
We have been working with the CCIT project group as one of the 5 Best Practice Development Trusts nationally around developing models and

tools to evaluate the benefits from the Contract. The SHA is aware that we are one of these Trusts - we would be more than happy to share the project work we've undertaken.

The nationally agreed job-plan template does not make it possible to answer Questions 3 & 4 of this document. The majority of our consultants have put "variable" for unpredictable on-call OR incorporated it into DCC for question 4, but not broken it down.

14 OUT OF THE 15 HONORARY CONSULTANTS HAVE AGREED TO MOVE TO THE NEW CONSULTANT CONTRACTS, HOWEVER I UNDERSTAND THE PRECISE PROCESS FOR AGREEING THE JOB PLANS FOR HONORARY CONSULTANTS IS IN THE PROCESS OF BEING FINALISED BY XXXX UNIVERSITY AND THIS HAS RESULTED IN A DELAY IN AGREEING FINAL JOB PLANS.

the timetable for implementation was too short for both the Clinical Directors, who had to undertake all of this on top of their usual clinical timetable, and for Human Resources. Such major changes would normally take more time to ensure efficient implementation.

Supporting Activities are all 2.5 - spreadsheet does not allow entry of 0.5; likewise we have contracts of 10.5 and 11.5 PAs, so the figures entered will not be completely accurate. Category for Microbiology is going to Appeal.

Absence of real clarity in some areas of T&C's where open to interpretation; More comparison between Trusts would have been useful;

Serious delays in implementing new contract resulting from: 1 Lack of medical management capacity. 2 Slow BMA response to contract drafts 3 Concerns/conflicts over key contractual obligations e.g. Section 12 Responsibilities and Additional PA's for predictable out of hours emergency work.

We are still in the process of making some final offers

- 1 The high number of Consultants here makes annual job planning a very time-consuming process, such that the value could be out-weighted by the time commitment.
- 2 Having a contract that potentially pays for every hour worked is leading to some Consultants acting less professionally than in the past.
- 3 There is a real potential that Clinical Excellence Awards will be given for commitments already being paid under the contract.

The Trust Consultant Contract consists of a flat rate payment. Current postholders are negotiating, via their Local Negotiating Committee, to reach agreement on how the local Trust contract components compare with the new CC arrangements. Consultant Colleagues have been very reluctant to even discuss a move to the new contract. However, once agreement has been reached on the notional components of our local contract, each consultant will receive details of what their pay arrangements and terms and conditions would be should their wish to move to the new national contract. We are expecting to complete the negotiations by end December 2004.

Unfortunately we cannot yet answer questions 3 and 4 about scheduled and unscheduled emergency activity as we do not have a break down of this information for most of our consultants. They simply showed the average no of PAs for emergency work on their job plan summaries. This

information will be captured in the 1st review.
No Trusts are reviewing rota categories in the light of the new guidance. There needs to be a standard nationwide job plan template. Transfer from Scotland and Wales cause problems because of different salary assimilation rules. Fees continue to be paid on top. Waiting list initiative payments still continue. Problems with agreeing cover and payment when colleagues are off sick (this last one is a major headache).
This consultant is a Community Family Planning Consultant employed by XXXX PCT from 1 April 2004. Not able to provide any information re the cost implications of implementing the new consultant contract as we have no comparator.
one consultant post and that individual requested to go on the new contract but the job plan has not been agreed. This goes to appeal late November so has been entered as being on the old contract
1. Renegotiation of job plans for 2005/06 may be more challenging to keep job plans within the number of PAs agreed for 2004/05. Resistance by consultants to removal of APAs and consequent reduction to income. 2. Pay progression has a potentially inflationary impact. 3. Continued potential for 'local flexibility' e.g. fee paying services, on call bandings to generate tension/conflict. 4. Ensure opportunity to keep 'level playing field' for recruitment purposes is maintained. 5. Ensuring individual Trusts are not penalised by supporting wider NHS i.e. support for external PAs. 6. More work needed on benefits realisation and the linkages to objectives (personal, local service, Trust & National) and Consultant Appraisal & Job planning
Costs under section 7 include on costs. THE FUNDING OF THE NEW CONTRACT HAS NOT BEEN EQUITABLE AND PENALISES LARGE ACUTE TEACHING TRUSTS SUCH AS OURS. MEDIATION HAS CONCLUDED NOW BUT IT IS NOT CLEAR THAT ALL CASES ARE RESOLVED, THERE MAY WELL BE APPEALS, PARTICULARLY IN RELATION TO PAYING FOR WORK IN EXCESS OF 48 HOURS PER WEEK.
It will be difficult to reduce the additional PA's consultants are receiving. Consultants remaining on old contract seeking parity with certain elements of the new contract. Workload issues for payroll function ie ensuring seniority is kept up to date .
guidance on core bandings do not reflect actual outcomes of supplements paid, majority of consultants are paid in excess of 11PA's, under funding from StHA's, family planning fees deduction.
AFFORDABILITY IS AN ISSUE AS WAS THE NEGOTIATIONS AROUND MAINTAINING 10 PA'S. THE TRUST IS ALSO STRUGGLING TO MAINTAIN WORK WITHIN THE 10 PA'S PARTICULARLY IN LIGHT OF THE PRESSURE OF RECRUITING CONSULTANT PSYCHIATRISTS. THIS IS NOW BECOMING A BIG ISSUE FOR US.
Centre's implementation costs were incorrect. The Trust has a shortfall of £500K on back pay and well over £600K on a recurrent basis. Given the financial position of this Trust it has been very difficult to cover this.
We are currently paying Old Age Psychiatry 2 additional PA's and also

allowing them a certain number of home visits. This is to overcome a crisis in recruitment

Haven't included cost increase yet as figure and %age is meaningless for such small numbers.

PAs have grown into a status symbol for consultants which is detrimental to reducing them in the future.

**Survey questionnaire**

# CONSULTANT CONTRACT SURVEY

This survey form is part of the Department of Health's monitoring of the consultant contract implementation. The information returned here will help the NHS realise the planned benefits from contract implementation.

## Guide to completing the survey

The instructions below will help you complete the form. Please read the *Guide to the Consultant Contract Survey* for further information on the questions.

Please return the completed form by email to:

To return to the questions, click on the following links:

[Page 1](#) [Page 2](#) [Page 3](#) [Page 4](#)

### General help on completing the form

- A Only fill in cells formatted like:  or
- B Where text is formatted like [this](#) you can click the mouse on that text and go to a linked item on another page. Usually the link will help you complete the question.
- C On page 1 of the 'Survey Form', we ask you enter your Trust / PCT code. The standard codes are listed with the form. To view the list of codes, click on the link. (The SHA code will automatically appear when you enter your Trust / PCT code.)
- D Some questions require you to categorise specialties using the NHS census categories. Some clarification is given in a [LIST OF SPECIALTIES](#). If you want to check a specialty while filling in the form, click on the census category (e.g. click on 'Med' to see the list of medical specialties.)

# CONSULTANT CONTRACT SURVEY

Trust / PCT code

SHA code

**1 As at 31 August 2004, please indicate for each specialty group the:**

[Click here for help](#)

	A&E	Anaes.	Medical	Obs & Gyn.	Paediatrics	Pathology	Psychiatry	Radiology	Surgical	Dental	Public Health	Total
Total number of consultants on new contract	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	0
Total number of consultants on old contract	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	0

**2 For consultants on the NEW contract only, please indicate for each specialty group the average number of**

[Click here for help](#)

	A&E	Anaes.	Medical	Obs & Gyn.	Paediatrics	Pathology	Psychiatry	Radiology	Surgical	Dental	Public Health	Total
a Agreed Programmed Activities per job plan	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	0
b Agreed Programmed Activities for <b>Direct Clinical Care</b> per job plan	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	0

**3 For consultants on the NEW contract only, please indicate how many in each specialty group have the following number of programmed activities allotted for unscheduled on call work:**

[Click here for help](#)

	A&E	Anaes.	Medical	Obs & Gyn.	Paediatrics	Pathology	Psychiatry	Radiology	Surgical	Dental	Public Health	Total
a <b>ONE</b> or less	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	0
b <b>More than ONE</b>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	0

## CONSULTANT CONTRACT SURVEY

**4 For consultants on the NEW contract only, please indicate how many in each specialty group have the following number of programmed activities of scheduled out of hours work:**

[Click here for help](#)

[A&E](#)    [Anaes.](#)    [Medical](#)    [Obs & Gyn.](#)    [Paediatrics](#)    [Pathology](#)    [Psychiatry](#)    [Radiology](#)    [Surgical](#)    [Dental](#)    [Public Health](#)

a Less than ONE

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b ONE or more, but less than TWO

--	--	--	--	--	--	--	--	--	--	--	--

c TWO or more

--	--	--	--	--	--	--	--	--	--	--	--

**5 For consultants on the NEW contract only, please indicate for each specialty group the number in each on call category**

[Click here for help](#)

[A&E](#)    [Anaes.](#)    [Medical](#)    [Obs & Gyn.](#)    [Paediatrics](#)    [Pathology](#)    [Psychiatry](#)    [Radiology](#)    [Surgical](#)    [Dental](#)    [Public Health](#)

Category A

--	--	--	--	--	--	--	--	--	--	--	--

Category B

--	--	--	--	--	--	--	--	--	--	--	--

**6 Please indicate the additional cost resulting directly from the new contract for the financial year 2003/4.**

[Click here for help](#)

**Average increase** in consultant pay between financial year 2002/3 and financial year 2003/4 (£)

--

**Average % increase** in consultant pay between financial year 2002/3 and financial year 2003/4

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## CONSULTANT CONTRACT SURVEY

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**7 If any recruitment and retention premia are being paid, please detail them. Include number and specialty of consultants, value and justification.**

[Click here for help](#)

---

**8 Are there any issues emerging from contract implementation that you wish to raise?**

[Click here for help](#)

---

## CONSULTANT CONTRACT SURVEY

Draft future Survey Questions: **PLEASE DO NOT COMPLETE THESE QUESTIONS**

---

For consultants on the NEW contract only, please indicate the number who have not achieved pay progression this year

[Click here for help](#)

---

Please indicate the number of job plans that are currently being appealed:

[Click here for help](#)

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## LIST OF SPECIALTIES

[Click here to return to:](#)

<b>A&amp;E</b>	<b>Accident &amp; emergency</b>	
<b>Anaes.</b>	<b>Anaesthetics</b>	
<b>Medical</b>	<b>Medical Specialties</b>	General Medicine Gastroenterology Endocrinology Clinical Haematology Clinical Physiology Clinical Pharmacology Audiological Medicine Clinical Genetics Clinical Cytogenetics & Molecular Genetics Clinical Immunology & Allergy Rehabilitation Palliative Medicine Cardiology Dermatology Thoracic Medicine Infectious Diseases Tropical medicine Genito-Urinary Medicine Nephrology Medical Oncology Nuclear Medicine Neurology Clinical Neuro-Physiology Rheumatology Geriatric Medicine Medical Ophthalmology Occupational Medicine
<b>Obs &amp; Gyn.</b>	<b>Obstetrics &amp; Gynaecology</b>	Obstetrics Gynaecology
<b>Paediatrics</b>	<b>Paediatric Specialties</b>	Paediatric Dentistry Paediatric Surgery Paediatric Cardiology Paediatrics Paediatric Neurology
<b>Pathology</b>	<b>Pathology Specialties</b>	General Pathology Blood Transfusion

Chemical Pathology  
Haematology  
Histopathology  
Immunopathology  
Medical Microbiology

**Psychiatry**   **Psychiatry group**

Learning Disability  
Adult Mental Illness  
Child and Adolescent Psychiatry  
Forensic Psychiatry  
Psychotherapy  
Old Age Psychiatry

**Radiology**   **Radiology group**

Clinical Oncology  
Radiology

**Surgical**   **Surgical group**

General Surgery  
Urology  
Trauma and Orthopaedics  
ENT  
Ophthalmology  
Neurosurgery  
Plastic Surgery  
Cardiothoracic Surgery  
Critical Care Medicine

**Dental**   **Dentistry**

Restorative Dentistry  
Orthodontics  
Oral and Maxillo Facial Surgery  
Endodontics  
Periodontics  
Prosthodontics  
Surgical Dentistry  
Dental Medicine Specialties

**Public Health**   **Public Health**

Community Health Services Medical  
Community Health Services Dental  
Public Health Medicine  
Public Health Dental