BMA survey of the consultant contract in a changing NHS

Central Consultants and Specialists Committee

August 2010

STANDING UP FOR DOCTORS

BMA

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Introduction

It has been more than half a decade since new contracts were introduced for consultants and the BMA Central Consultants and Specialists Committee (CCSC), which commissioned this survey, believe it is important to have a valid and representative picture of consultants' opinions of their working lives.

As senior clinical leaders in the NHS, it is essential that the views of consultants are recognised if the NHS is to work coherently and constructively. As the pressure on employers to make financial savings within a changing NHS grows, it is likely that some employers will seek to introduce changes which will impact on consultants' working arrangements. It is therefore essential that we have an accurate understanding of consultants' working lives. Findings from this survey will help us to identify and prioritise our work on behalf of consultants and strengthen evidence to the Review Body on Doctors' and Dentists' Remuneration (DDRB) in 2010.

The survey asked about established contractual and working arrangements and addressed issues that affect consultants but which also relate to the wider economic climate within which the NHS operates. The information from this survey will help us to better understand the range of working arrangements that consultants currently experience including aspects of working life that consultants value most and factors that affect their motivation.

Methodology

On 23 March 2010, a postal survey was sent to a random sample of 3,000 doctors registered as consultants on the BMA membership database in England, and all doctors registered as consultants on the BMA membership database in Scotland, Wales and Northern Ireland. A total of 7,827 questionnaires were sent out across the UK. The questionnaire asked respondents about the number of programmed activities (PAs) they worked and the composition of their clinical and non-clinical responsibilities, in addition to assessing attitudes toward clinical awards and potential changes to consultants' working arrangements in the future.

Response

The survey was closed to further responses on 13 May 2010 when the weekly response rate declined to less than 50 questionnaires per week, giving a response rate of 27.5 per cent (2,152 of 7,827). A total of 801 responses were received from Scotland, 797 from England, 364 from Wales and 190 from Northern Ireland.

Initial analysis of the data indicated a response bias in terms of country of work and gender. There was an expectation of respondent bias for country of work due to over sampling in Scotland, Wales and Northern Ireland which would allow for country specific analysis.

Data analysis in this report has been weighted to the UK consultant population for each country and for gender to account for any response bias and there may be small differences in the figures due to rounding. After weighting, the total response rate was adjusted to 2,093, where responses from individual nations reflect their weighted proportions.

Key findings

- Respondents on the new consultant contract were contracted to work an average 44.0 hours per week (11 PAs) but actually worked an average additional four hours per week, equivalent to one PA above their contracted level.
- Respondents were contracted to work an average 32 hours (eight PAs) of direct clinical care PAs (DCCs) per week but actually worked an average of 36 hours (nine PAs).
- Of those respondents who indicated their DCCs had increased since starting on their new contract, 42.2 per cent reported that the increase was employer driven.
- Of those respondents who reported that their supporting professional activities PAs (SPAs) had decreased, 65.4 per cent reported the decrease was employer driven.
- Of respondents whose SPAs had not changed since their new contract, more than nine in 10 (91.1 per cent) said they would not be willing to accept a decrease in future.
- 84.4 per cent of respondents were opposed or strongly opposed to employers using decreases in consultant SPAs to meet increased clinical demands.
- 25.5 per cent of respondents reported increased out of hours working in the last year.
- On average, 12.1 per cent of respondents' working time was outside of 7am to 7pm Monday to Friday (England, Wales and Northern Ireland) or 8am to 8pm Monday to Friday and 9am to 1pm Saturday (Scotland), an increase from 9.3 per cent in 2008.
- Of those respondents who reported changing their working patterns in the last year, 61.4 per cent reported doing so because of a decreased availability of middle grade doctors and 48.5 per cent changed their working pattern to improve the standard of patient care.
- Of those respondents who had not changed their working pattern in the last year, 72.9 per cent would be willing to change to increased out of hours working.
- Within their job, respondents were least satisfied with the ability to drive improvements in patient care and their relationship with NHS management and were most satisfied with the amount of variety in their work and with their colleagues and fellow workers.
- The majority of respondents stated they would recommend a career as a consultant to an undergraduate student or junior doctor.
- 80.7 per cent of respondents reported having a very strong or strong desire to practise medicine.

Results

Respondent characteristics

The majority of respondents were consultant members in England (80.8 per cent). 10.9 per cent of respondents reported they worked primarily in Scotland, 5.1 per cent in Wales and 3.2 per cent in Northern Ireland. (table 1)

The highest proportion of respondents reported their specialty as medicine (20.7 per cent) followed by anaesthetics (17.2 per cent) and surgery (17.1 per cent). Of the respondents who reported their specialty as medicine, 17.7 per cent reported their sub-specialty as geriatrics, 12.5 per cent as general medicine and 9.1 per cent as cardiology. Of the respondents that reported their specialty as surgery, 32.6 per cent of respondents reported their sub-specialty as general surgery, 24.0 per cent as traumatic and orthopaedics and 18.3 per cent as otolaryngology. (tables 2, 3 and 4)

28.1 per cent of respondents to the survey were female (603 of 2,093) and 71.2 per cent (1,491 of 2,093) were male. The mean age of respondents was 49 years and ranged from 30 to 73 years.

86.0 per cent (1,801 of 2,091) of respondents worked full time and 13.9 per cent (290 of 2,091) were part time. A higher proportion of female than male respondents reported working part time. (figure 1)

The majority (78.4 per cent; 1,640 of 2,093) of respondents obtained their primary medical qualification in the UK, 6.7 per cent (140 of 2,093) of respondents obtained their qualification elsewhere within the European Economic Area (EAA) and 14.9 per cent (311 of 2,093) obtained their qualification overseas (non-EEA). 2.9 per cent (61 of 2,093) of respondents reported working as a medical academic.

Respondents with 10 to 14 years of experience were the highest proportion of responders to the survey. (figure 2)

Over nine in 10 respondents (94.2 per cent; 1,958 of 2,093) held a 2003/4 consultant/academic contract. 5.8 per cent (122 of 2,093) of respondents reported remaining on the pre-2003/4 consultant contract.

Table 1 – Which region do you mainly work in?

	Frequency	Per cent
East Midlands	104	5.0
East of England	146	7.0
London	314	15.0
North East	118	5.6
North West	237	11.3
South Central	115	5.5
South East Coast	113	5.4
South West	185	8.8
West Midlands	152	7.3
Yorkshire and The Humber	203	9.7
Other England (if respondent received a Scotland, Wales or Northern Ireland questionnaire)	5	0.2
Scotland	227	10.9
Wales	106	5.1
Northern Ireland	67	3.2
Total	**2,093**	**100.0**

Table 2 – Specialty

	Frequency	Per cent
Surgery	358	17.1
Medicine	434	20.7
Anaesthetics	360	17.2
Pathology	115	5.5
Public Health	5	0.2
Obstetrics and gynaecology	98	4.7
Occupational medicine	11	0.5
Ophthalmology	62	2.9
Paediatrics	167	8.0
Radiology	148	7.1
Psychiatry	252	12.0
Emergency medicine	50	2.4
Other*	34	1.6
Total	**2,093**	**100.0**

*Some respondents indicated 'other' specialty areas of work in addition to their main specialty or areas already accounted for by the pre-determined specialty categories (eg child and adolescent psychiatry, oncology and various paediatric sub-specialties.

Table 3 – Medicine sub-specialty

	Frequency	Per cent
Cardiology	40	9.1
Dermatology	24	5.5
Diabetes and endocrinology	36	8.2
Gastroenterology	38	8.6
General medicine	55	12.5
Genito-urinary/sexual health	14	3.2
Medical oncology	20	4.5
Nephrology/renal	24	5.5
Neurology	22	5.0
Rheumatology/rehabilitation	32	7.3
Thoracic/respiratory medicine	31	7.0
Geriatrics	78	17.7
Other	26	5.9
Total	**440**	**100.0**
No reply	8	-

Table 4 – Surgery sub-specialty

	Frequency	Per cent
Otolaryngology	61	18.3
General surgery	109	32.6
Neurosurgery	13	3.9
Urology	36	10.8
Traumatic and orthopaedic surgery	80	24.0
Other	35	10.5
Total	**334**	**100.0**

Figure 1 – Full time/part time working by gender of respondent

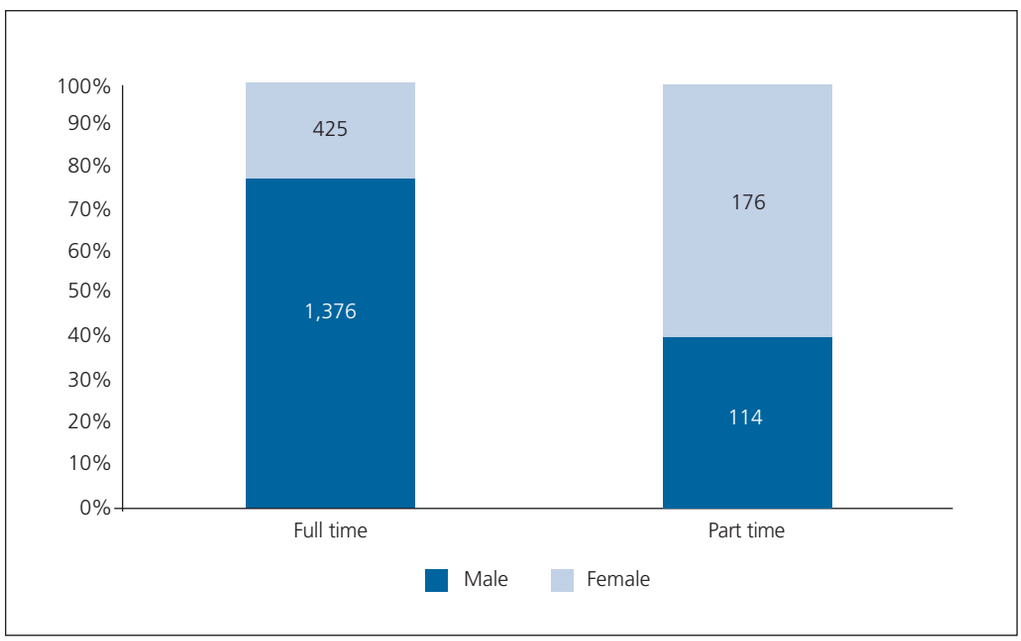
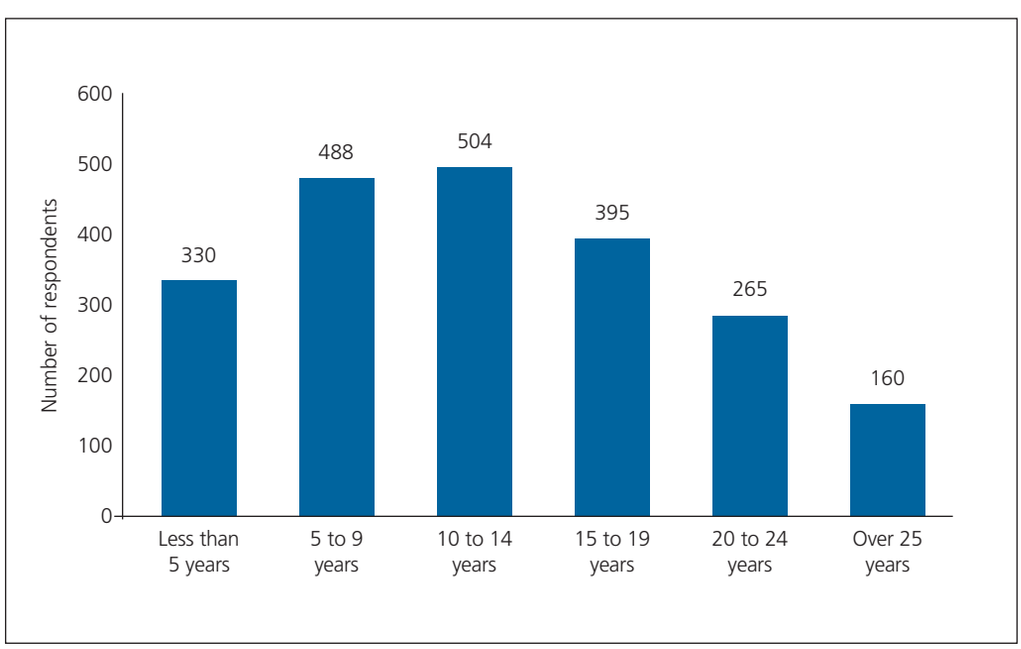


Figure 2 – Years as a consultant



Pre 2003/4 consultant contract

Respondents who remained on the pre-2003/4 contract were asked a short series of additional questions. The highest proportion of respondents who remained on the pre-2003/4 contract reported that they worked on a full time contract (49.3 per cent; 56 of 114). 25.0 per cent (28 of 114) of respondents reported working on a maximum part time contract and 25.7 per cent (29 of 114) held another part time contract. (figure 3)

24.7 per cent (28 of 113) of respondents on the pre-2003/4 contract reported that they received additional notional half days (NHDs). Of those respondents, the average number of additional NHDs received was 1.9 and ranged from one to four additional NHDs. (table 5)

52.9 per cent (49 of 94) of respondents considered that their allocation of NHDs did reflect their workload although 47.1 per cent (44 of 94) did not. (table 6)

Figure 3 – What is the nature of your contract (as at March-May 2010)?

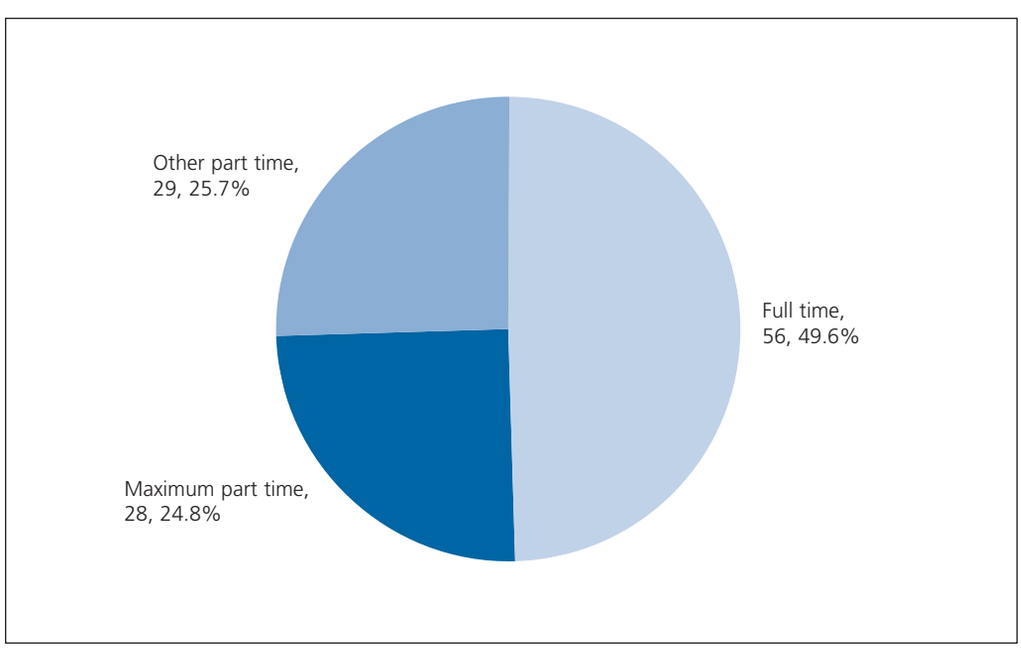


Table 5 – Do you receive any additional notional half days (NHDs)?

	Frequency	Per cent
Yes	28	24.7
No	85	75.3
Total	**113**	**100.0**
No reply	8	-

Table 6 – Do you feel your allocation of NHDs adequately reflects your workload?

	Frequency	Per cent
Yes	49	52.9
No	44	47.1
Total	**94**	**100.0**
No reply	28	-

New 2003/4 contract

The majority of respondents (79.1 per cent; 1,544 of 1,952) who reported holding a new 2003/4 contract had agreed a job plan with their employer in the last 12 months. Respondents who had not agreed a job plan were asked why. Almost one-quarter of respondents (23.1 per cent) cited employer delays as a reason for not agreeing a job plan and a further 15.9 per cent of respondents reported being unable to agree a plan with their employer at all. (table 7)

Almost three-quarters of respondents had not received any job planning training (73.1 per cent; 1,424 of 1,947). Of these respondents, over two-thirds (69.5 per cent; 963 of 1,385) reported that they would like to receive job planning training in the future.

Table 7 – Respondents' reasons for not agreeing a job plan in the last 12 months

	Frequency	Per cent
Employer delays	90	23.1
Unable to agree one	62	15.9
Have an historic job plan/out of date	54	13.9
Not offered/not required to have a plan	52	13.4
In negotiation	47	12.1
Will soon agree a plan/awaiting confirmation	40	10.3
Never had one	13	3.3
Insufficient time	13	3.3
Not initiated process/intend to start soon	10	2.6
Have a job plan but not satisfied with it	9	2.3
Other	26	6.7
Total	**416**	**-**

Note: Multiple response question.

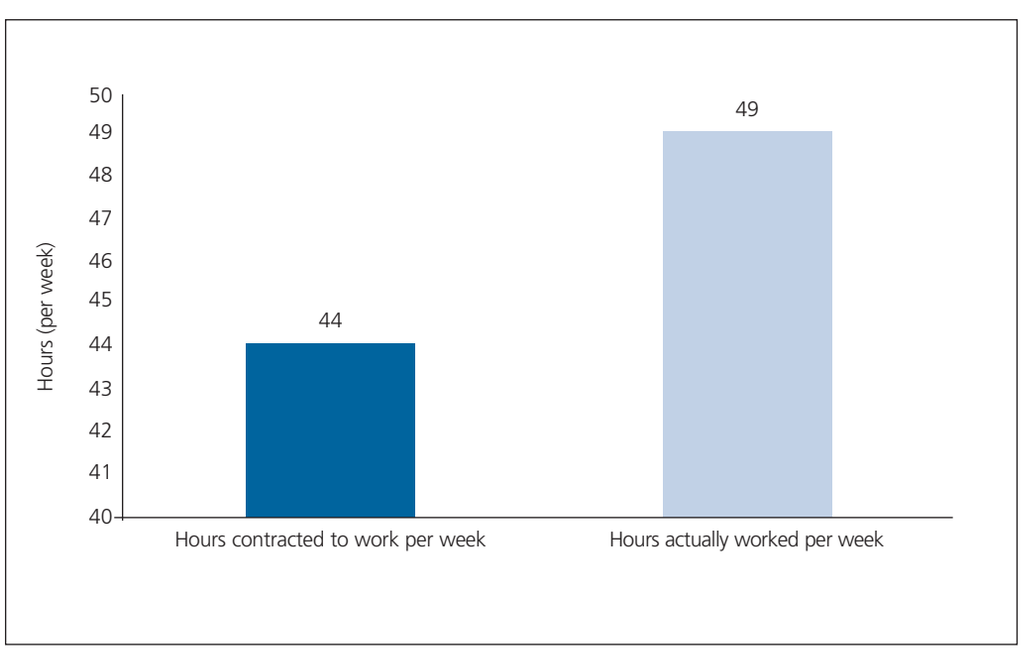
Programmed activities (PAs)

Respondents were asked how many direct clinical care (DCC), supporting professional activities (SPAs), additional NHS duties and external duties PAs they were contracted to provide. In addition, respondents were also asked to consider how many PAs they actually work in an average week.[1]

The median number of hours that respondents were contracted to work per week for all PAs was 44.0 hours with a mean of 43.1 hours and a range of 4.0 to 72.0 hours (n=1,924). This is equivalent to 11 PAs and comparable with results from a survey of UK consultants in 2008 where whole time contracts were an average 11.3 PAs.[2]

The median number of hours actually worked per week was 49.0 with a mean of 47.9 hours and a range of 2.0 to 80.0 hours per week (n=1,658). This is equivalent to 12.25 PAs per week and similar to results from 2008 where average total full time hours were 50.7 per week (12.7 PAs).[3] Respondents reported a median difference of four additional hours worked each week (mean=6.1 hours), equivalent to one additional PA over and above their contracted weekly hours. (figure 4)

Figure 4 – Number of hours contracted to work per week/hours actually worked per week



1 For ease of comparison in the present report, self completed respondent data on PAs were converted to hours, where one PA is equivalent to four hours.

2 Health Policy and Economic Research Unit, Survey of consultant opinion – report, July 2008, BMA, London.

3 ibid.

Direct clinical care (DCC)

Respondents reported that they were contracted to work a median of 32 DCC hours per week with a mean of 31.5 hours and a range of two to 60 hours per week. This is equivalent to eight PAs (n=1,899). Respondents actually worked a median of 36 DCC hours per week with a mean of 35.0 hours in a range of one to 64 hours; equivalent to nine PAs (n=1,561). The median difference between DCCs that respondents were contracted to work and DCCs actually worked was 3.0 hours per week (mean=4.3 hours); or 0.75 PAs above respondents' basic contracted amount.

57.7 per cent (1,110 of 1,924) of respondents reported that the number of DCCs in their job plan had not changed since transferring to or starting on the new consultant contract. (table 8)

Of the respondents who indicated their DCCs had increased, the mean increase was 1.3 PAs per week (range=0.1 to 9.0 PAs, n=393). 42.2 per cent (170 of 403) of these respondents reported that the increase was employer driven and 21.6 per cent (87 of 403) increased their DCC PAs through personal choice. (figure 5)

Of the respondents who indicated their DCCs had decreased, the mean decrease was 1.6 PAs per week (range= 0.25 to 7.0 PAs, n=350). 42.3 per cent (158 of 374) of these respondents reported that the decrease was through personal choice and 33.1 per cent (124 of 374) reported the decision was employer driven. (figure 6)

Other reasons reported by respondents for the change to their DCC PAs included that the change was mutually agreed between employer and employee and, for those respondents who reported an increase in their DCCs, a change was necessary to meet clinical or workload/workplace demands.

Table 8 – Has the number of DCC PAs in your job plan changed since you first transferred or started on the 2004 contract?

	Frequency	Per cent
Yes, increased	425	22.1
Yes, decreased	390	20.2
No	1110	57.7
Total	**1,924**	**100.0**
No reply	33	-

Figure 5 – Reasons for the increase in direct clinical care (DCC) PAs

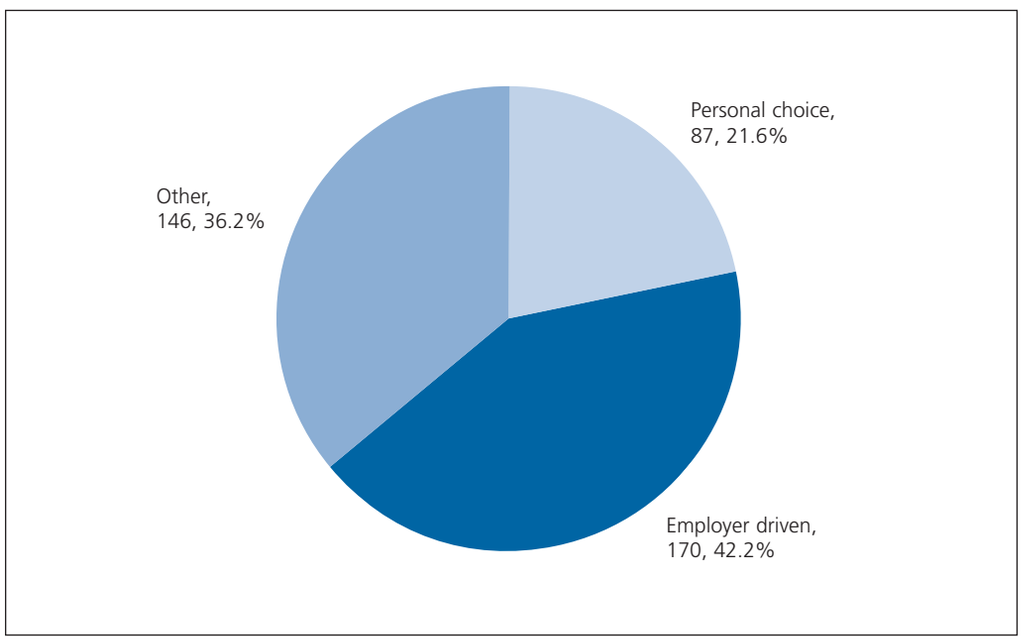
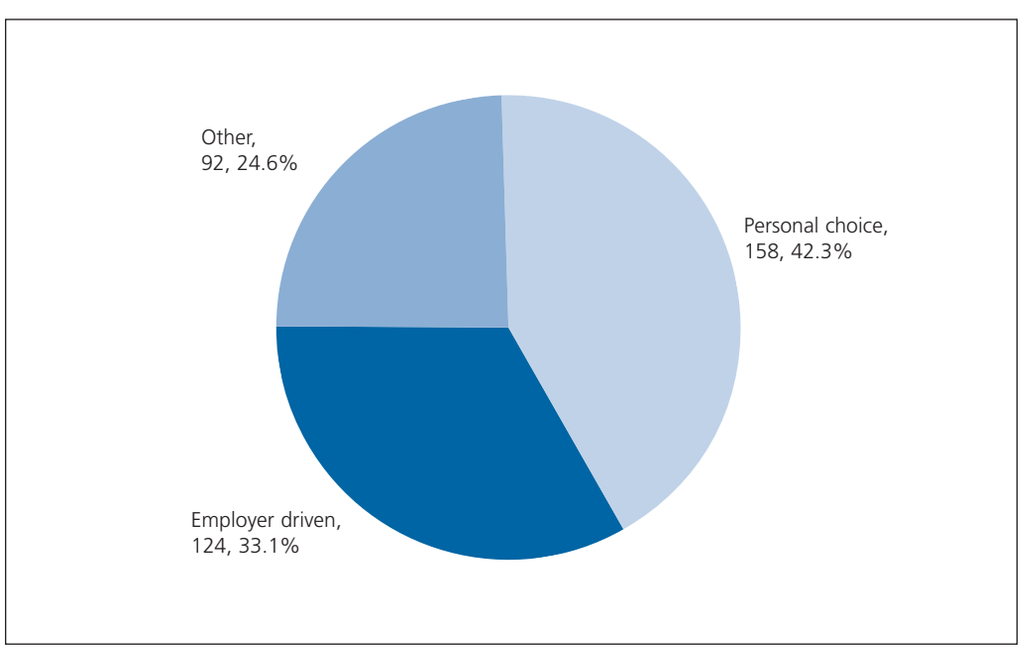


Figure 6 – Reasons for the decrease in direct clinical care (DCC) PAs



Supporting professional activities

Respondents reported that they were contracted to work a median of 10 SPA hours per week with a mean of 9.2 hours in a range of one to 40 hours. This is equivalent to 2.5 PAs (n=1,876) per week and consistent with the average of 2.5 contracted SPAs in 2008.[4] Respondents reported that they actually worked a median of 10 SPA hours per week with a mean of 9.8 hours and a range of one to 64 hours. This is equivalent to 2.5 PAs (n=1,520). For most respondents there was no difference between contracted SPAs and the number of SPAs actually worked.

72.1 per cent of respondents reported that the number of SPAs in their job plan had not changed since transferring to or starting on the new consultant contract. For those respondents who indicated their SPAs had increased, the average increase was 1.1 PAs with a range of 0.2 to 6.5 SPAs (n=111). Of those respondents who indicated their SPA PAs had increased, 34.1 per cent (43 of 126) reported that the increase was through personal choice and one-fifth (21.4 per cent; 27 of 126) reported the increase was employer driven. (figure 7)

For those respondents who indicated their SPAs had decreased, the average decrease was 0.9 SPAs with a range of 0.1 to 5.0 SPAs (n=343). Almost two-thirds of respondents (65.4 per cent; 254 of 388) reported that the decrease in their SPAs was employer driven and 14.0 per cent (54 of 388) reported their SPAs had decreased through personal choice. Other reasons reported by respondents for the change to their SPA PAs included the need to meet new clinical or workload/workplace demands or a change in their personal circumstances, such as a new role or responsibility. (figure 8, table 9)

Respondents whose SPAs had changed were asked about the impact of this change on various professional areas of their job. Respondents that had not yet experienced changes to their SPAs were asked which professional areas they felt could be affected by such changes in the future. Areas identified as having already been affected by changes, or at most risk of being affected in future, included training, continuing professional development (CPD), medical education and audit. Both groups of respondents reported job planning as least likely to be affected. (figure 9)

Of those respondents who reported that their SPAs had not changed since the new 2003/4 consultant contract, only 8.9 per cent (111 of 1,243) reported that they would be willing to accept a decrease in the number of SPAs in their job plan in the future.

Respondents were asked about the level of flexibility in the way they worked their SPAs. More than four in 10 respondents (44.4 per cent) reported total flexibility which mirrors findings from 2008 in which 44.2 per cent of respondents reported total flexibility.[5]

4 Health Policy and Economic Research Unit, Survey of consultant opinion – report, July 2008, BMA, London.

5 ibid.

Almost one-third of respondents (29.9 per cent) reported that zero to one of their SPAs were fixed in time and/or place. Some respondents also reported other issues such as having no flexibility at all and frequently being too busy to undertake their SPAs. (table 10)

Almost one-quarter of respondents (23.8 per cent) reported that they believed that SPA PAs had been reduced for new consultant appointments only, within their trust or board. 15.1 per cent of respondents reported that SPA PAs for all consultants had been reduced by their employer and 37.9 per cent of respondents reported that their employer had not reduced the standard number of SPA PAs for consultant contracts. (table 11)

The overwhelming majority of respondents (84.4 per cent; 1,634; of 1936) were either opposed or strongly opposed to employers using decreases in consultant SPA PAs to meet increased clinical demands. Only 5.8 per cent (113 of 1,936) of respondents were in favour. (figure 10)

Table 9 – Has the number of SPA PAs in your job plan changed since you first transferred or started on the 2004 contract?

	Frequency	Per cent
Yes, increased	134	6.9
Yes, decreased	407	21.0
No	1,393	72.1
Total	**1,934**	**100.0**
No reply	24	-

Figure 7 – Reasons for the increase in supporting professional activity (SPA) PAs

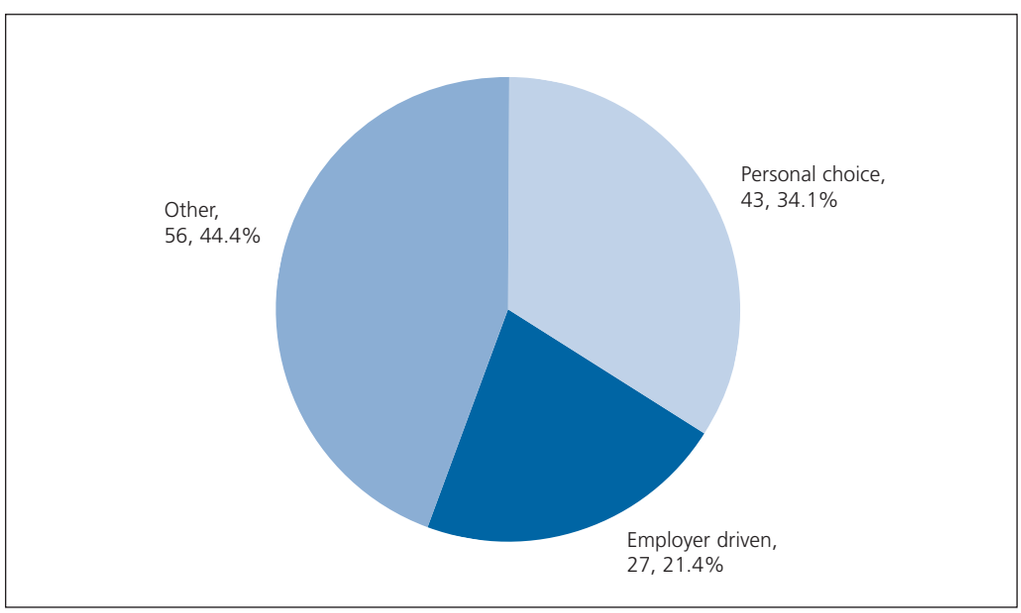


Figure 8 – Reasons for the decrease in supporting professional activity (SPA) PAs

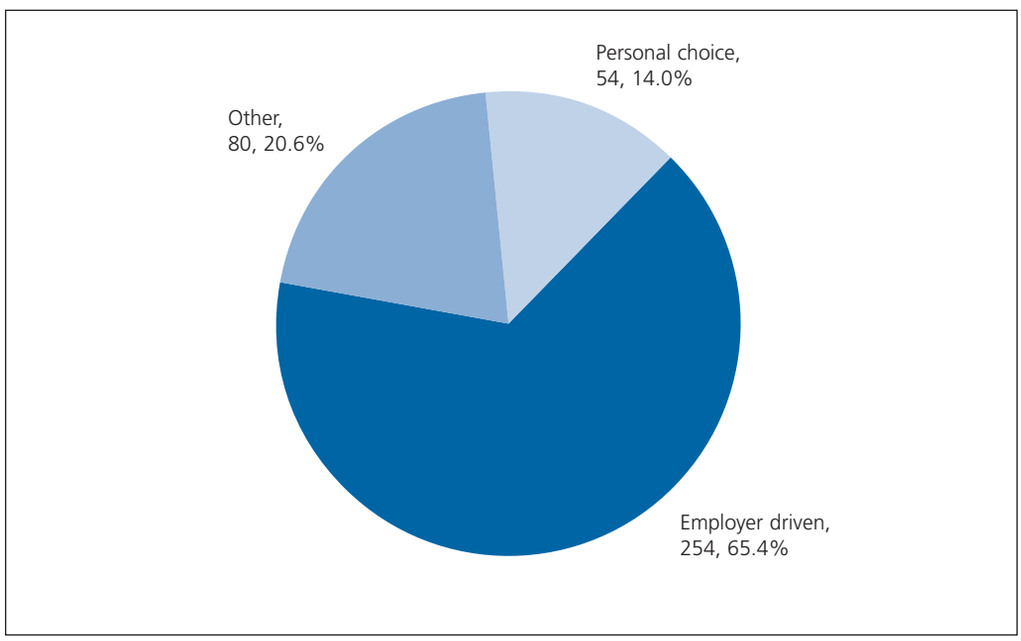


Figure 9 – Which of the following areas have been most affected/would be most affected by changes to your SPAs?

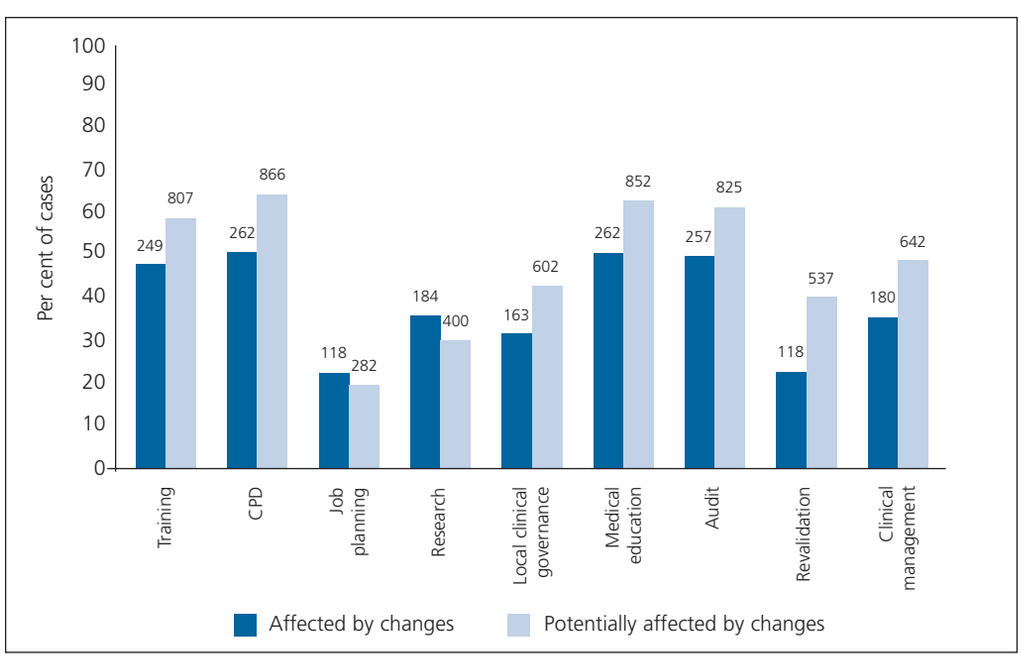


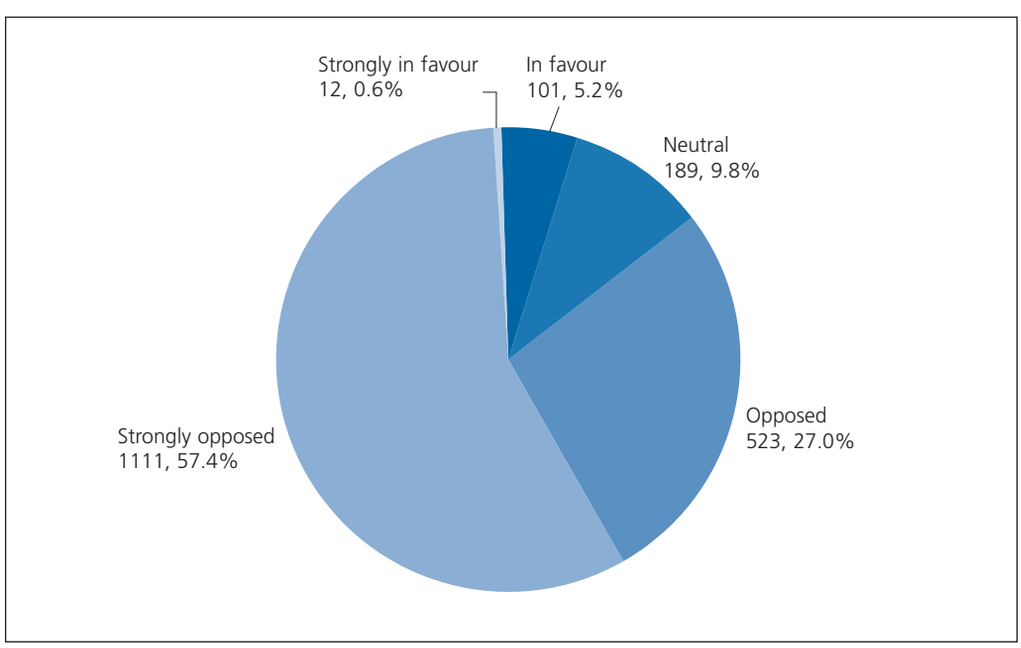
Table 10 – How much flexibility do you have in the way your SPAs are worked?

	Frequency	Per cent
Total flexibility	894	44.4
0 to 1 SPAs fixed in time and/or place	603	29.9
2 to 3 SPAs fixed in time and/or place	381	18.9
More than 3 SPAs fixed in time and/or place	70	3.5
Other	66	3.3
Total	**2,014**	**100.0**
No reply	138	-

Table 11 – To your knowledge, has your employer reduced the standard number of SPA PAs (2.5 SPAs for 10 PA contract) for consultant contracts?

	Frequency	Per cent
Yes – all consultants	291	15.1
Yes – new consultant appointments only	460	23.8
No	733	37.9
Don't know	447	23.2
Total	**1,931**	**100.0**
No reply	26	-

Figure 10 – What is your view about employers using decreases in consultant SPA PAs to address increased clinical demands faced by NHS organisations?



Additional NHS duties

Respondents reported that they were contracted to work a median of four hours per week for additional NHS duties, with a mean of 5.8 hours and a range of 0.4 to 32 hours per week. This is equivalent to one PA per week (n=662). The median additional NHS duties hours actually worked was five hours per week with a mean of 6.9 hours and a range of 0.1 to 40 hours, which is equivalent to a median of 1.25 PAs actually worked per week (n=674). For the vast majority of respondents there was no difference between contracted and actual worked hours of additional NHS duties.

One-quarter of respondents (24.0 per cent) reported an increase in their additional NHS duties since transferring or starting on the new consultant contract and 70.3 per cent reported no change to their number of additional NHS duties PAs. (table 12) For those respondents who reported an increase in their additional duties, the average increase was 1.5 PAs per week (range: 0.1 to 15.0 PAs, n=366). Of these respondents, half (49.9 per cent; 213 of 427) reported that the increase was through personal choice and 26.5 per cent (113 of 427) reported that the increase was employer driven. (figure 11)

For those respondents who reported a decrease in their additional duties, the average decrease was one PA per week with a range of 0.25 to 4.0 PAs per week (n=82). Half of respondents (51.1 per cent; 54 of 106) who reported a decrease in additional NHS duties indicated the decision was employer driven and 36.0 per cent (38 of 106) indicated the decision was a personal choice. Other reasons cited by respondents included a combination of personal choice and employer influence, mutual agreement and a change of personal circumstances such as obtaining a new position within their organisation. (figure 12)

Table 12 – Has the number of additional NHS duties PAs in your job plan changed since you first transferred or started on the 2004 contract?

	Frequency	Per cent
Yes, increased	446	24.0
Yes, decreased	107	5.7
No	1,310	70.3
Total	**1,863**	**100.0**
No reply	94	-

Figure 11 – Reasons for the increase in additional NHS duties PAs

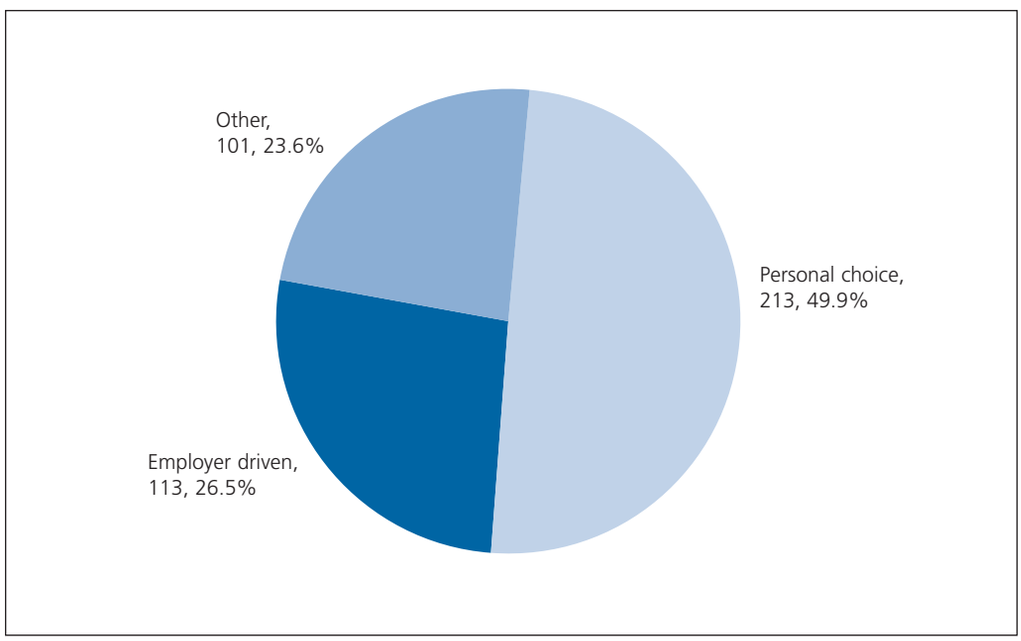
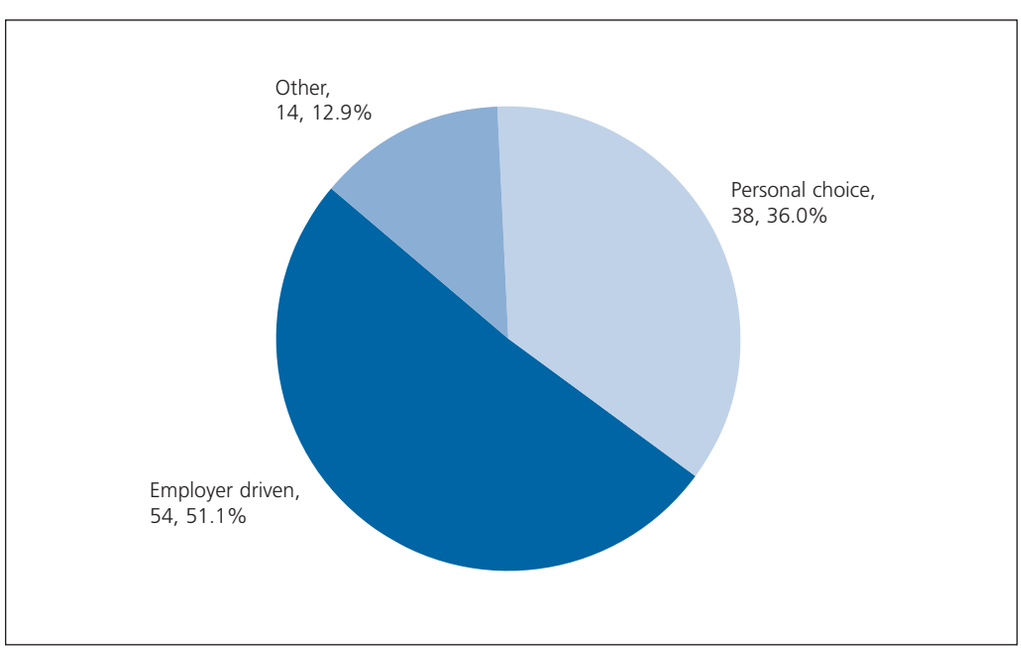


Figure 12 – Reasons for the decrease in additional NHS duties PAs



External NHS duties

Respondents reported a median of four hours of contracted external duties per week with a mean of 5.6 hours and a range of 0.4 to 40 hours. This is equivalent to a median of one PA per week (n=235). The median number of hours actually worked for external duties was four hours with a mean of 5.6 hours and a range of 0.25 to 50.0 hours per week (n=381). For the majority of respondents there were no differences in hours contracted and hours worked.

13.1 per cent of respondents reported that their external duties PAs had increased since transferring or starting on the new consultant contract. In contrast, just 3.1 per cent of respondents reported that their external duties had decreased. A majority of 83.8 per cent reported that their external duties PAs had not changed. (table 13)

For those respondents who reported an increase in their external duties, the average increase was 1.2 PAs with a range of 0.1 to 7.0 PAs per week (n=178). The majority (79.2 per cent; 165 of 208) of these respondents indicated the increase was due to personal choice. 4.9 per cent (10 of 208) replied that the decision to increase their external duties PAs was employer driven. (figure 13)

For respondents who reported a decrease in their external duties PAs, the mean decrease was 0.9 PAs (range=0.25 to 7.0 PAs, n=36). Of these respondents, almost six in 10 (58.0. per cent, 29 of 50) indicated that the decision was employer driven and one-third of respondents (32.0 per cent, 16 of 50) reported the decision was a personal choice. Other reasons cited by respondents for changes to their external duties PAs included acquiring advisory or academic responsibilities besides their main role. (figure 14)

Table 13 – Has the number of external duties PAs in your job plan changed since you first transferred or started on the 2004 contract?

	Frequency	Per cent
Yes, increased	230	13.1
Yes, decreased	55	3.1
No	1,468	83.8
Total	**1,752**	**100.0**
No reply	205	-

Figure 13 – Reasons for the increase in external duties PAs

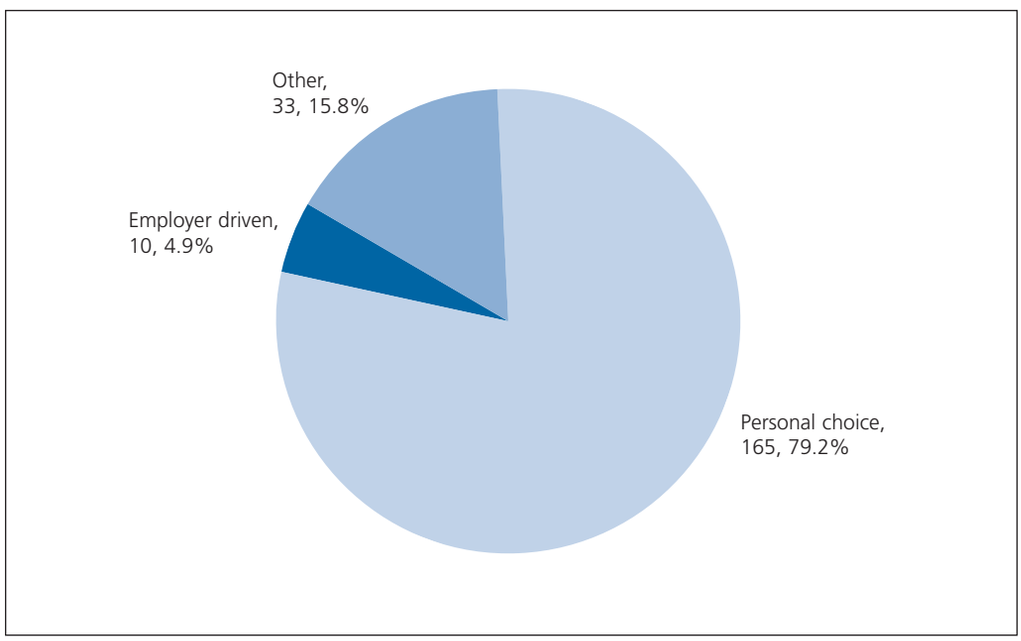
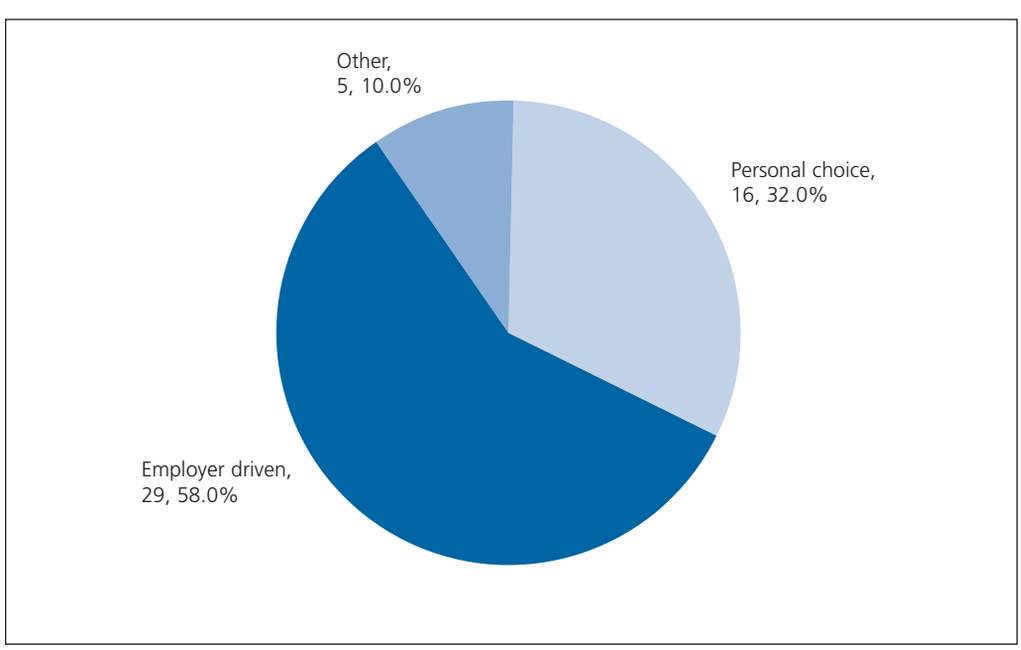


Figure 14 – Reasons for the decrease in external duties PAs



Affiliation to a higher education institution (HEI)

36.2 per cent (682 of 1866) of respondents who were not medical academics reported having a formal teaching or research role at a higher education institution (HEI). Of those respondents, 67.6 per cent (456 of 674) held an honorary contract with an HEI. Respondents who reported an allocation of time specifically for this role worked a median 1.1 PAs per week (n=585) although PAs ranged from 0.1 to 12 PAs per week. For 54.4 per cent of respondents (362 of 666) PAs worked in the course of their role with an HEI were included in their total contract PAs.

Working arrangements

Respondents were asked about the percentage of their working hours that were outside 7am to 7pm Monday to Friday in England, Wales and Northern Ireland or 8am to 8pm Monday to Friday and 9am to 1pm Saturday in Scotland. Respondents reported an average of 12.1 per cent of their time working out of hours, although out of hours working ranged from 5 to 90 per cent of respondents' time (n=1,389). This represents a slight increase from 2008 when time spent working out of hours was an average 9.3 per cent.[6]

Respondents were asked if they had discussions in the last year with their employer about changing their working patterns with regard to resident on call, shift working and increased out of hours working. Figure 15 shows that a relatively small proportion of respondents entered discussions about resident on call (7.7 per cent) or shift working (8.9 per cent) with their employer, and fewer still subsequently experienced changes to their working patterns. In contrast, over one-quarter of respondents (26.7 per cent) had discussions with their employer about working increased out of hours and almost the same proportion (25.5 per cent) actually experienced a change to their out of hours working.

Of the respondents who reported changing their working patterns in the last year,[7] responses by respondents indicated that 61.4 per cent (310 of 771) did so because of a decreased availability of middle grade doctors, 48.5 per cent (245 of 771) to improve the standard of patient care, 31.4 per cent (159 of 771) reported the decision was financial/employer driven and 10.9 per cent (55 of 771) changed their working patterns through personal choice.

Of the respondents who had not changed their working patterns in the last year,[8] responses by respondents indicated that most would be willing to change to increased out of hours working (72.9 per cent; 442 of 902) but respondents were less likely to be willing to change to shift working (50.5 per cent; 306 of 902) or resident on call (25.5 per cent; 154 of 902).

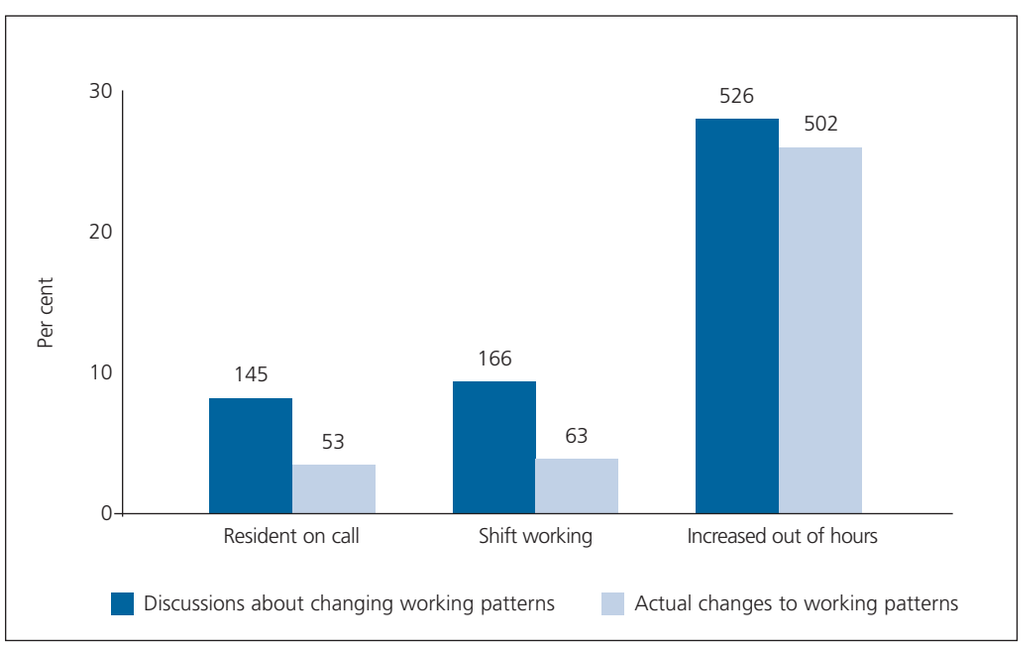
6 Health Policy and Economic Research Unit, Survey of consultant opinion – report, July 2008, BMA, London.

7 Note: multiple response question. Percentages quoted reflect per cent of cases.

8 ibid.

4.0 per cent of respondents (83 of 2,093) reported currently working resident on call. Of those respondents, 79.5 per cent (66 of 83) received a premium PA rate and 20.5 per cent (17 of 83) received greater than premium PA rate. Of those respondents who received greater than premium PA rate, five of 10 received three times their normal PA rate.

Figure 15 – Percentage of respondents that have had discussions with their employer about changing working patterns and actual changes to respondents' working patterns in the last year



Note: Figure 15 includes per cent responses for two questions and is not per cent of cases answering both questions.

Clinical Excellence Awards (CEAs), Distinction Awards (DAs), Discretionary Points (DPs) and Commitment Awards

Over two-thirds of UK respondents (69.6 per cent; 1,447 of 2,078) reported currently holding a clinical award (CEA, DA, DP or Commitment Award). 60.6 per cent (1,239 of 2,048) of respondents were either supportive or very supportive of a review of clinical awards schemes for consultants, although 24.2 per cent (496 of 2,048) of respondents were unsupportive of such a review. Respondents without an award were slightly more likely to be supportive of a review (63.2 per cent) than respondents with an award (59.3 per cent). Respondents with an award were more likely to be unsupportive of a review (28.1 per cent) than respondents without an award (15.3 per cent). (table 14, figure 16)

In the event of a potential review of clinical award schemes, respondents were asked which of a variety of proposals would be most agreeable. Respondents were most likely to indicate that they would agree with a change to incorporate money in the consultant salary (44.7 per cent; 867 of 1,939). The majority of respondents disagreed with proposals to abolish national and local award schemes at all (63.4 per cent; 1,211 of 1,910) and an even higher proportion disagreed with abolishing local schemes and retaining national schemes (72.2 per cent; 1,315 of 1822). (figure 17)

Table 14 – Support for a review of clinical award schemes for consultants, by award holding status of respondent

	Holder of a clinical award		Non-holder of a clinical award	
	Frequency	Per cent	Frequency	Per cent
Very unsupportive of a review	189	13.3	72	11.6
Unsupportive of a review	211	14.8	23	3.7
No view	179	12.6	134	21.5
Supportive of a review	525	36.8	193	31.0
Very supportive of a review	321	22.5	200	32.2
Total	**1,425**	**100.0**	**622**	**100.0**

Figure 16 – To what extent would you support a review of the clinical award schemes for consultants?

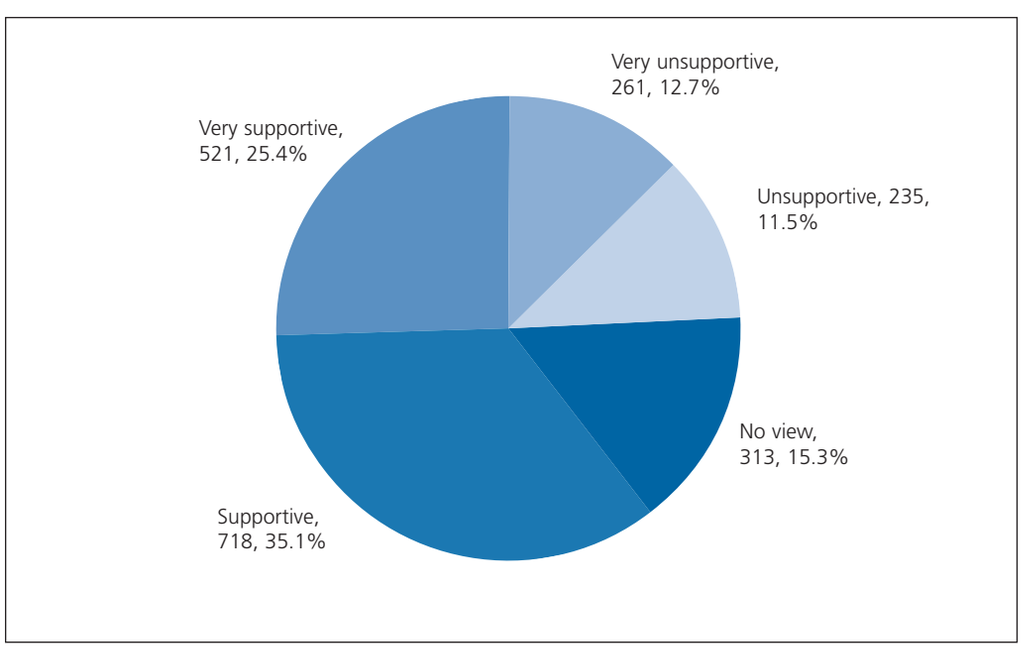
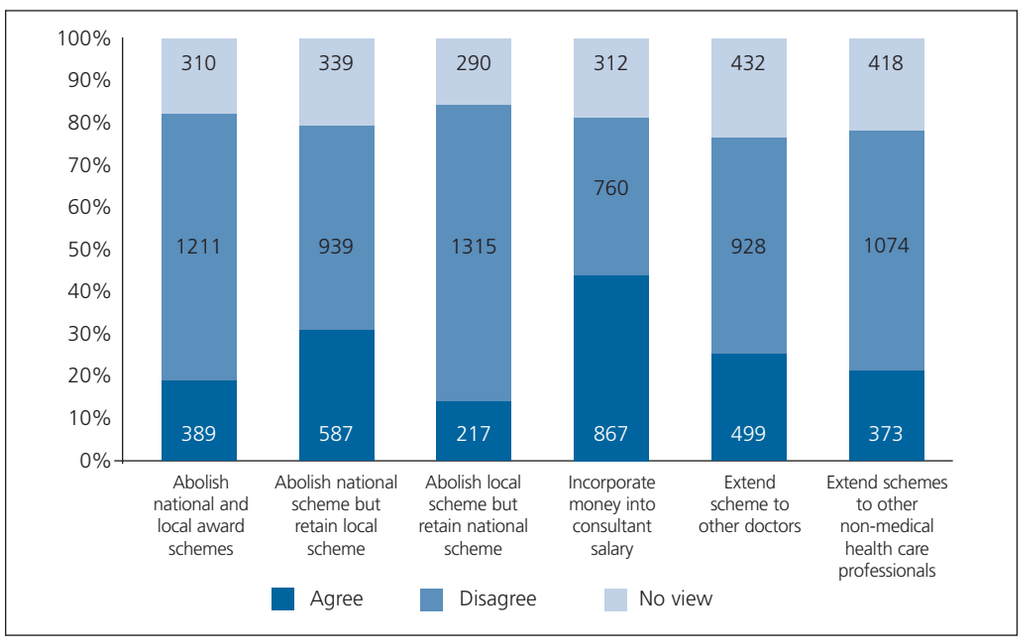


Figure 17 – If clinical award schemes for consultants were to be reviewed, to what extent would you agree with the following proposals?



Supply of CCT holders

Over half of respondents (56.4 per cent; 1,160 of 2,056) felt it was either likely or somewhat likely that there will be an oversupply of doctors at CCT level in their own specialty in light of the tight financial conditions that the NHS will face in time to come. (figure 18)

Across specialties, the perceived likelihood of an oversupply of doctors at CCT level varies considerably. Greater than 30 per cent of respondents in obstetrics and gynaecology (37.0 per cent; 34 of 92), surgery (35.1 per cent; 124 of 353) and anaesthetics (31.8 per cent; 113 of 355) felt that their specialty was very likely to experience oversupply in the next three to five years, more than all other specialties. There were no respondents in public health or occupational medicine that felt oversupply within their specialty was likely at all. (figure 19)

Figure 18 – Given the increase in specialty training posts a few years ago and the tight financial conditions that the NHS will face in the next three to five years, it is possible that there will be an oversupply of doctors at CCT level. How likely do you think it will be that there will be an oversupply of doctors in your specialty?

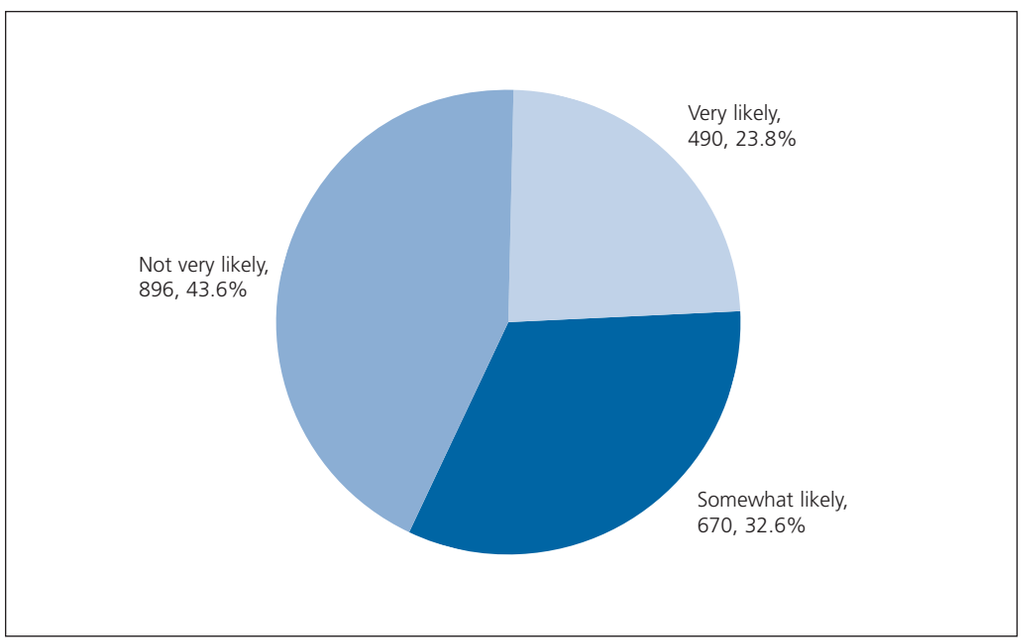
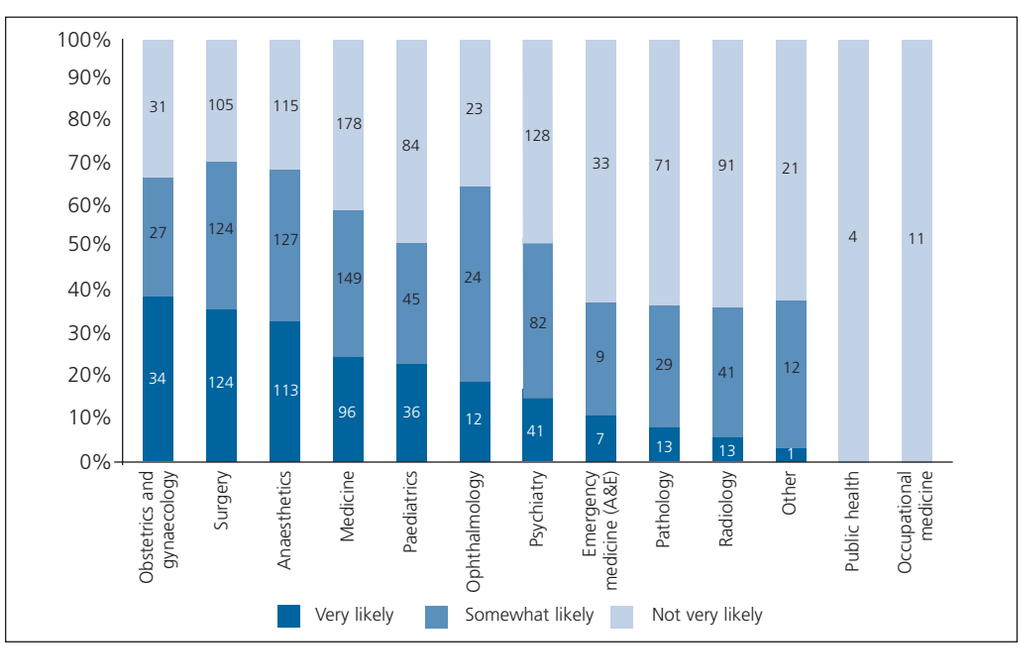


Figure 19 – Perceived likelihood of an oversupply of doctors at CCT level, by specialty of respondent



Respondents were asked to rank several positions affecting consultants that could arise from a possible oversupply of CCT holders from one to nine (where 1 is most damaging and 9 is least damaging). Among 1,695 respondents the potential introduction of a sub-consultant grade was, on average, considered to be most damaging to consultants. (table 15)

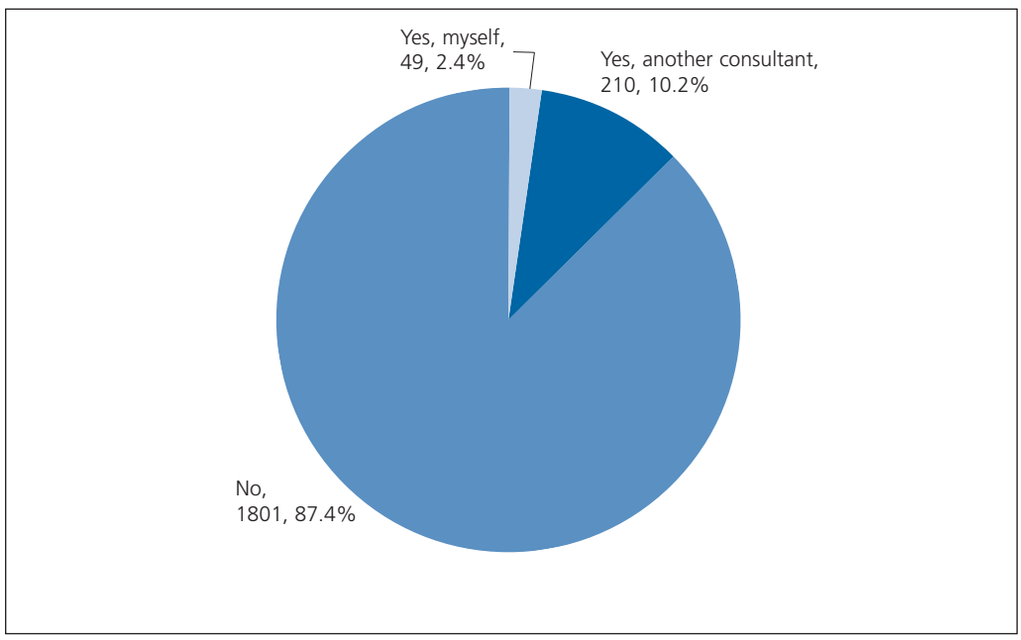
Table 15 – In response to the possibility of an oversupply of CCT holders the following positions have been suggested or implied by governments across the UK in relation to the consultant workforce. Please rank from 1 to 9 the position that you would find the most damaging to consultants, with 1 being most damaging and 9 being least damaging

	Average rating (1-9)
The introduction a sub-consultant grade	3.9 *(Most damaging)*
Required to work resident on call/shift working/increased out of hours work	4.0
Decrease in SPA PAs and increase in DCC PAs for consultants	4.3
CCT holders appointed in specialty doctor posts	4.4
Limited pay progression on consultant pay scale	4.6
Decreased study leave entitlements	5.2
Lower consultant starting salary	5.3
Introduction of a maximum level of PAs for individual consultants (ie no more than 10 PAs for each consultant)	6.5
Reduction or removal of clinical awards (eg CEAs, distinction awards, discretionary points)	6.9 *(Least damaging)*
Total number of respondents	**1,695**

Recruitment and Retention

2.4 per cent (49 of 2,060) of respondents had personal experience of a recruitment and retention premia being used within their organisation. 10.2 per cent (210 of 2,060) knew of another consultant with experience of a premia within their organisation. 87.4 per cent (1,801 of 2,060) of consultants were unaware of the use of a recruitment and retention premia at all in their organisation. (figure 20)

Figure 20 – Have you had any experience or knowledge of the recruitment and retention premia being used within your organisation for consultants?



Working environment

The majority of respondents reported adequate access to office space (77.6 per cent; 1,605 of 2,068), IT equipment (78.9 per cent; 1,622 of 2,056) and clinical equipment (78.8 per cent; 1,603 of 2,035). Adequate access to secretarial support was least frequently reported (70.4 per cent; 1,451 of 2,062). (figure 21)

Almost half of respondents (48.4 per cent) reported their office space environment as having personal space to work within and over one-third (38.3 per cent) reported working in a shared office space. (table 16)

Figure 21 – Do you have adequate access to the following facilities and resources that are necessary for you to undertake your work?

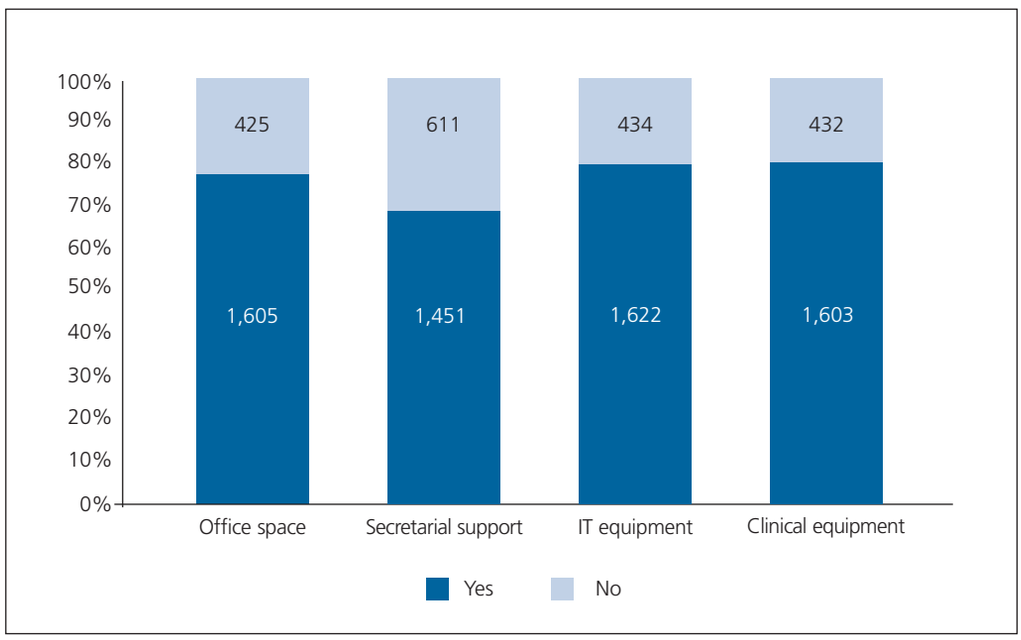


Table 16 – How would you best describe your office space environment?

	Frequency	Per cent
Personal space	1,000	48.4
Shared space	791	38.3
Hot desk arrangement	106	5.2
Open space arrangement	97	4.7
Other	72	3.5
Total	**2,066**	**100.0**
No reply	27	-

Study leave

Respondents were asked how many days of study leave[9] with pay and expenses they had taken in the last three years. Of those respondents that had been in post for three years or more (1,697), the average study leave taken was 19.7 days. This is equivalent to an average of 6.6 days of study leave per year.

9 Under the terms and conditions of consultant contracts, employees are entitled to 30 days study leave with pay and expenses in a three year period.

Of those respondents who had taken study leave in the last three years, over half (52.6 per cent) had not experienced any problems in doing so, but one-quarter of respondents (24.9 per cent) cited funding problems as a reason for difficulties in accessing their study leave. (table 17)

Table 17 – Have you had any problems in accessing your study leave time or funding entitlements?

	Frequency	Per cent
Yes, time	247	12.0
Yes, funding	514	24.9
Yes, time and funding	141	6.8
No	1,082	52.6
Not applicable – have not been in post for three years	76	3.7
Total	**2,059**	**100.0**
No reply	34	-

Job satisfaction

Respondents were asked to indicate how satisfied they were with individual aspects of their job and, taking into account all aspects, indicate their overall level of satisfaction with their job.

Respondents indicated that their overall level of satisfaction with their job was between satisfied and neutral (mean=3.7). Respondents were least satisfied with their ability to drive improvements in patient care (mean=2.8), their relationship with NHS management (mean=2.8) and the amount of time for SPAs (mean=3.1). Respondents were most satisfied with the amount of variety in their work (mean = 4.1), their colleagues and fellow workers (mean=4.1) and their job security (mean=3.9). (table 18)

The majority of respondents stated they would recommend a career as a consultant to an undergraduate student or junior doctor. Respondents were more likely to indicate that they would recommend becoming a consultant to junior doctors over undergraduates (73.6 per cent; 1,515 of 2,093 and 64.7 per cent; 1,343 of 2,093 respectively). (figure 22)

The vast majority (80.7 per cent; 1,673 of 2,073) of respondents stated they had a very strong or a strong desire to practise medicine and just 2.3 per cent (47 of 2,073) stated that they regret becoming a doctor. (figure 23)

Table 18 – How satisfied are you with the following aspects of your job?

	Frequencies						Mean score
	Very Dissatisfied (1)	Dissatisfied (2)	Neutral (3)	Satisfied (4)	Very Satisfied (5)	Total	
Physical working conditions	88	271	310	1,067	317	2,055	3.6
Your colleagues and fellow workers	39	112	184	970	757	2,062	4.1
Recognition you get for good work	173	422	487	775	202	2,058	3.2
Your remuneration	65	221	386	1,022	370	2,064	3.7
Your hours of work	99	402	466	907	191	2,064	3.3
Amount of variety in your job	16	106	190	1,064	685	2,061	4.1
Your opportunity to acquire new skills and competencies	32	248	538	976	277	2,070	3.6
Your job security	35	126	405	1,027	473	2,066	3.9
Amount of flexibility in your working hours	52	312	552	899	250	2,065	3.5
Ability to drive improvements in patient care	273	697	471	501	126	2,069	2.8
Relationship with NHS management	332	535	579	502	117	2,065	2.8
Amount of time for supporting professional activities (SPAs)	160	479	490	802	131	2,062	3.1
Taking everything into consideration, how do you feel about your job?	**26**	**254**	**310**	**1,155**	**329**	**2,073**	**3.7**

Note: Totals may vary due to weighting calculations.

Figure 22 – Would you recommend a career as a consultant to an undergraduate or junior doctor?

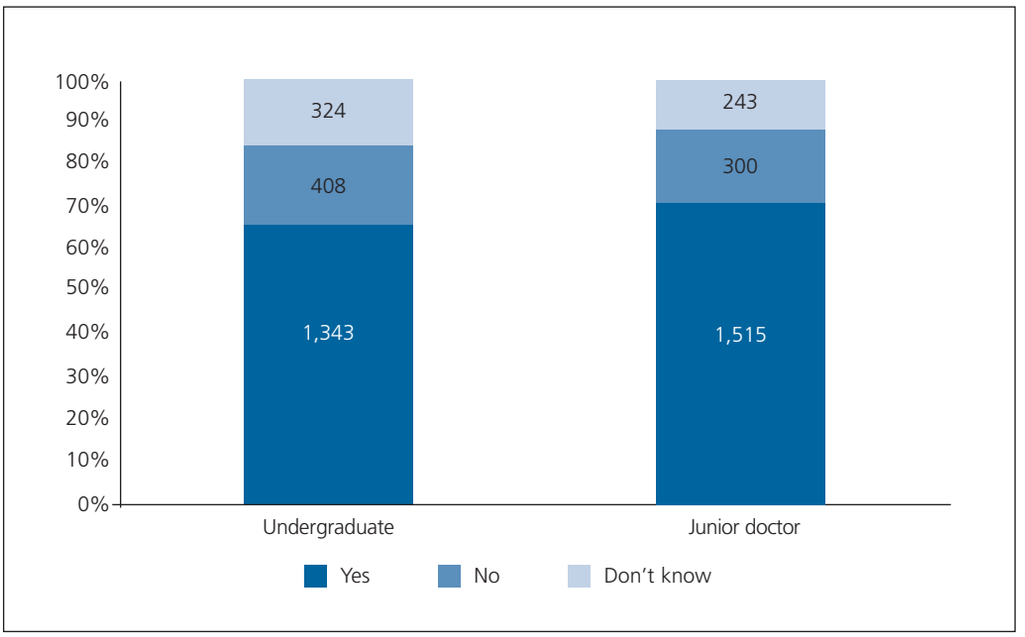
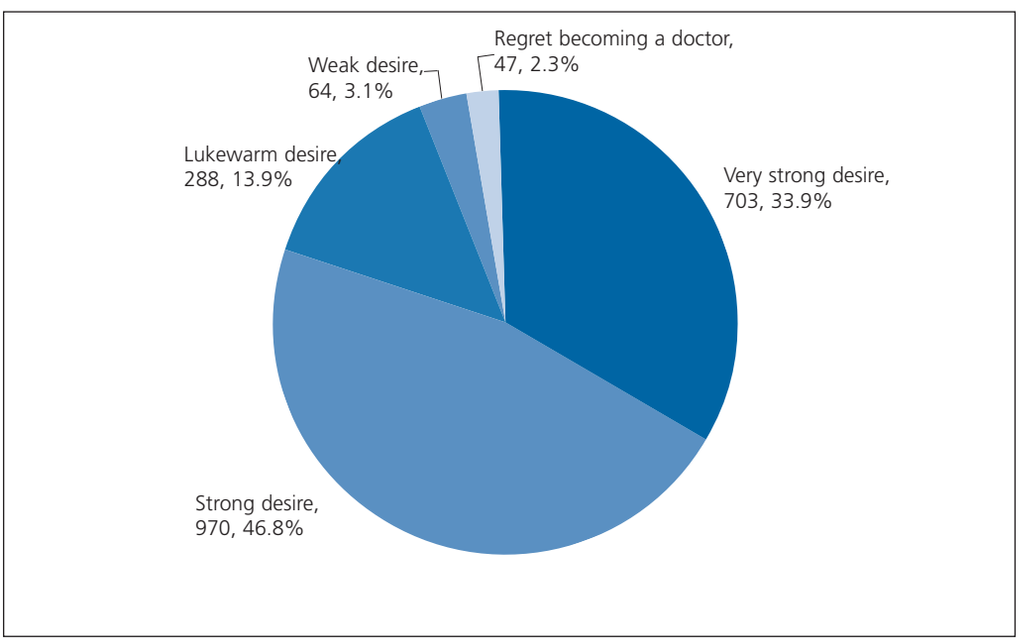


Figure 23 – Which of the following statements reflects your current views about practising medicine?



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