



House of Commons  
Committee of Public Accounts

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# Pay Modernisation: A new contract for NHS consultants in England

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**Fifty-ninth Report of Session  
2006–07**

*Report, together with formal minutes, oral and  
written evidence*

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## Summary

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In October 2003, the Department of Health (the Department) agreed a new national contract for NHS medical consultants in England. This was the first major revision of the consultant contract for over fifty years. The need for a new contract was outlined in the NHS Plan 2000, as part of a wider pay modernisation agenda aimed at obtaining more, better paid staff, working differently. There was also a general consensus between employers, consultants and the Government that a new contract was needed. However, it took three years of negotiations between representatives of the UK Health Departments, the NHS Confederation and the British Medical Association before the terms and conditions were agreed.

The Department intended that the new contract would benefit consultants through better pay and increased recognition of their NHS work. At the same time, employers would get greater control and management of their consultants' workload, and patients would benefit from a more flexible and responsive service. The Department hoped to reward those consultants who made the biggest contribution to NHS work and reduce the average number of hours worked per consultant, in exchange for increased productivity. These benefits were dependent on the introduction of a mandatory and rigorous process of workload planning for individual consultants (job planning).

The implementation of the contract was rushed and the NHS has yet to see many of the intended benefits. Over the first three years, the Department allocated an additional £715 million to NHS trusts which was £150 million more than originally estimated as necessary to fund the contract. NHS trusts still believe, however, that the contract has been under-funded. Although consultants' pay has, on average, increased by 27% (from £86,746 to £109,974) and their working hours have decreased, there are, as yet, no measurable improvements in productivity.

The Department has succeeded in increasing the number of consultants working in the NHS, from 28,750 in October 2003 to 31,990 by September 2005, although there was an increasing trend before the introduction of the contract. The number of hours consultants work in private practice has neither increased nor significantly decreased. Other intended benefits have not been realised: for example the proportion of time consultants spend on direct clinical care is less than intended, and the contract has not been used to extend and develop new services for patients.

On the basis of a report by the Comptroller and Auditor General,<sup>1</sup> we examined the contract negotiation; the cost implications; the effectiveness of the implementation process; and the extent to which the expected benefits for patients and the NHS had been realised. We took evidence from witnesses from the Department and the NHS.



## Conclusions and recommendations

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- 1. The Department underestimated the cost of the new contract by at least £150 million.** It did not model its financial assumptions in a rigorous way and did not draw, for example, on all available workload data. The Department should use sufficient, relevant and reliable data to cost new policies more accurately.
- 2. The Department did not pilot the new contract before implementation, and it underestimated the scale of change in introducing the new contract.** The implementation of the new contract was rushed and hospital trusts concentrated on getting new consultants on to the new contract, rather than planning how to use the contract to improve the delivery of services. Major new Human Resource policies should be fully piloted within the NHS before implementation to test any assumptions and effects.
- 3. Many hospital managers negotiated more hours with consultants than their NHS trust could afford.** NHS trusts failed to set a cost envelope and clinical managers agreed hours of work based on historical patterns of working, which they could not afford. In taking the contract forward, NHS trusts should set boundaries within which managers should negotiate individual contracts based on a clear understanding of what work the trust needs and can afford.
- 4. Productivity of consultants has decreased, consultants are now working fewer hours than they did under the old contract, and activity per consultant has reduced.** The Department expected that the new contract would deliver productivity gains of 1.5% per year through efficiency gains and quality improvements. The Department's original method for evaluating productivity suggests it has decreased by 0.5% in the first year of the contract. The Office of National Statistics has now developed more sophisticated measures of productivity but figures are not yet available for 2005 and 2006. NHS Employers should help NHS trusts identify appropriate ways of measuring and comparing productivity of consultants locally.
- 5. NHS trusts with their clinical managers did not have the time or expertise to negotiate or carry out effective job planning.** The Department and NHS Employers should develop training aids and tools, such as electronic job plan software, to help managers improve their capability and capacity to carry out effective job planning, and NHS trusts should allocate enough time to medical managers for job planning.
- 6. In the first two years of the contract, job planning tended to follow historical patterns of service provision, with insufficient links to organisational objectives and little consideration of redesigning services, such as introducing evening clinics, to meet patient needs.** NHS trusts should agree job plans, in partnership with consultants or teams of consultants, which are consistent with organisational objectives and reflect feedback from patients. Whilst job plans should be renegotiated annually, managers and consultants should assess individual job plans more frequently and agree to modifications, where appropriate, if they fail to meet patient needs.

7. **The proportion of time consultants spend on direct clinical care has not reached the expected 75% level, and NHS trusts have not used the contract to extend patient services, such as providing out-patient clinics at the weekend.** NHS trusts should negotiate job plans for consultants based on the Department's objective that at least 75% of their time should be spent on direct clinical care. They should use the job planning process, in partnership with consultants, to redesign services and improve the patient experience. NHS Employers should identify and share good practice in using job planning to extend patient services and tailor them to patient need.
8. **Consultants' pay has, on average, risen by 27% in the first three years of the contract compared to the Department's prediction of a 15% increase.** Higher pay has helped improve recruitment and retention and has halted a rising trend in the amount of private practice carried out by NHS consultants. The increased pay will only be justified, however, if the expected improvements to productivity are achieved. In return for their increased pay, consultants should increase their support for service redesign with the aim that productivity gains will be achieved by working differently.

# 1 The negotiation and initial implementation of the consultant contract

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1. In October 2003, the Department of Health (the Department), supported by the NHS Confederation, and the British Medical Association (BMA) agreed a new contract for NHS consultants in England. The new contract was part of the Government's policy, set out in the NHS Plan in 2000, to have more and better paid staff working differently. The Department was concerned about medical staff leaving the profession, and based on consultation the general public felt that medical staff should be better rewarded. NHS managers wished to exercise greater control over the consultant workforce in order to match doctors' time with patient needs.<sup>2</sup>

2. The specific aims of the new contract for consultants were set out in a business case that the Department provided to the Treasury in 2002.<sup>3</sup> The Department expected the new contract to: improve the management of consultant's time; prevent an increase in private practice; improve recruitment and retention of consultants; reduce waiting times; increase productivity against a falling trend; extend patient services; and increase the time consultants spend on direct clinical care. By giving managers in NHS trusts greater control of their consultants' workload, the Department expected the contract to lead to a greater proportion of time being spent effectively.<sup>4</sup>

3. Previous attempts to reform the consultant contract had proved unsuccessful and the contract had remained largely unchanged since 1948. By 2000 however there was a general consensus that a new contract was needed. Negotiations between the four UK Health Departments,<sup>5</sup> employers' representatives from the NHS Confederation and the BMA commenced in February 2001, but the terms presented difficulties for all parties and the negotiations proved complex and slow to conclude. In October 2002, consultants rejected the terms of a new contract, which the Department had expected NHS trusts to begin implementing in April 2003. It was not until July 2003 that the revised terms were finally agreed. In all, it took two and a half years to reach agreement. In developing the new contract, alternative models based on research from other countries that have used different ways of rewarding doctors, such as fee per service, were considered but dismissed.<sup>6</sup>

4. In October 2003, 60% of consultants voted to accept the terms. Although the contract was optional for existing consultants, the Department nevertheless expected trusts to implement the new contract for as many consultants as possible by April 2004. As an incentive to consultants to sign up to the new contract, those that signed by October 2003 had their pay backdated to April 2003, and those that committed to the new contract between 31 October 2003 and 31 March 2004 had their pay backdated by three months

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2 C&AG's Report, paras 1.5, 1.16; Qq 1, 2

3 C&AG's Report, para 1.8; Qq 1, 8, 11

4 Qq 12–13

5 England, Scotland, Wales and Northern Ireland

6 C&AG's Report, paras 1.10–1.16; Qq 52, 53

from the point of commitment, subject to agreeing a job plan within three months.<sup>7</sup> In agreeing to the new contract, consultants believed that they would finally be rewarded for the full extent of their NHS work, whilst employers felt that the new contract would give them more control over their consultants' working week.<sup>8</sup>

5. During the negotiations, the Department did not pilot the impact of the terms under discussion. It did consider piloting some of the proposals in 2003 to see how they might work in practice, but was opposed by the BMA negotiators who wanted to expedite the agreement so as to obtain a reduction in hours and to catch up, as they saw it, with comparable professions in terms of pay. The Department therefore costed the impact of the new contract using the results of a diary exercise that had been conducted at the beginning of the negotiations and which had been jointly accepted by the Department and the BMA.<sup>9</sup>

6. The contract was based on the concept of a mandatory "job planning" process. A job plan is an explicit outline of a consultant's duties, responsibilities and objectives of the coming year, which is agreed by the consultant and their clinical manager. As part of the negotiation for the new contract, a consultants' working week was redefined into Programmed Activities (PAs) of four hours (or three hours at evenings and weekends), with a standard contract consisting of 10 PAs. A standard week was therefore expected to be approximately 40 hours long. The new contract also introduced the ability for managers to contract additional hours paid at plain time rates, and introduced a code of practice for NHS consultants working in private practice (see **Figure 1**).<sup>10</sup>

7. In implementing the new contract, the Department overestimated clinical managers' capacity and ability to achieve such a significant change for NHS Trusts in such a short space of time.<sup>11</sup> Whilst job planning had been a requirement since 1991, at that time consultants' contracts were held by regional health authorities and it was the mid-1990s before responsibility for contracts passed to NHS trusts. Even then the terms of these national contracts were such that there was no compulsion for consultants to have job plans. In the past, NHS trust managers were supposed to get consultants to agree job plans but, in reality, they had no levers to impose this requirement. Consequently managers had little control over their consultants. The introduction of the new contract and mandatory job planning was therefore a significant shift in control.<sup>12</sup>

8. Under the new contract, all NHS consultants are obliged to negotiate and agree a job plan in partnership with clinical management. In these negotiations each consultant is expected to agree the number of programmed activities in their contract, and how these programmed activities will be used.<sup>13</sup>

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7 C&AG's Report, paras 1.17–1.18; Qq 11, 13

8 Q 11

9 Qq 3, 77–80

10 C&AG's Report, page 16; Q 88

11 Qq 20–23, 31–32, 38, 61, 70

12 Qq 27, 40–41, 101–110

13 C&AG's Report, figure 9; Q 2

Figure 1. Comparison of the terms of the old contract with the new contract<sup>14</sup>

	OLD CONTRACT	NEW CONTRACT	OUTCOME OF IMPLEMENTATION
<b>Numbers and costs</b>	In October 2003 there were 28,750 consultants whose pay in 2002–03 was, on average, £86,746 and the total pay bill £2.4 billion.	Expected to increase consultant numbers and Department provided an extra £565 million funding for first three years.	By September 2005 there were 31,990 consultants and average pay in 2005–06 was £109,974. Pay bill increased to £3.8 billion in 2005–06. The Department increased additional funding by £150 million to £715 million. By 2006, 89% of consultants were on the new contract.
<b>Working week</b>	Minimum of ten 3.5 hour sessions, typically a 38.5 hour week, although consultants reported they were working 51.6 hours.	A full time contract is ten programmed activities (PAs) of 4 hours or 3 in premium time, typically a 40 hour week. Work above the standard contract can be negotiated.	Following implementation consultants agreed, on average, contracts of 11.17 PAs or just over 44 hours per week. However consultants reported they were working 50.2 hours per week.
<b>Job planning</b>	Since 1991 it has been a requirement for managers to agree job plans with consultants (based on a typical week). However, job plans were not prescribed in contractual terms and conditions.	The new contract makes it mandatory for consultants to have a job plan. A job plan is expected to be a prospective agreement detailing the number of programmed activities that will be spent on direct clinical care, on supporting activities, and additional responsibilities.	Job plans are now held by around 96% of consultants on the new contract. Job planning is seen as increasing the management control over consultants but few are based on the defined needs of the trust and, as yet, consultants are not working sufficiently differently.
<b>Direct clinical care</b>	Contract only differentiated between regular NHS activities which were fixed and flexible supporting activities.	An average of 7.5 programmed activities is expected to be dedicated to direct clinical care in a standard 10 PA contract.	When the contract was implemented in 2004, consultants were spending 74% of their time on direct clinical care. This reduced to 73% in 2005 and only 12% reported that time on clinical care had increased under the new contract.
<b>On-call work</b>	Not set out how on-call work should be recognised.	Recognised and rewarded at a rate that is determined by frequency of on-call work and likelihood of recall to the hospital.	On-call availability payments were higher than anticipated by the Department with more consultants claiming the higher supplement for returning to work whilst on-call.
<b>Premium time and additional work</b>	No extra pay for premium time or additional work.	In premium time (after 7pm and before 7am) the duration of a programmed activity is reduced from 4 hours to 3 hours. Additional work above 10 PAs is paid at plain time rates.	Many consultants have agreed contracts above 10 PAs to more fairly recognise their workload. The average amount of PAs delivered in premium time is not known nationally.
<b>Private practice</b>	Consultants on a full time contract could carry out private practice but limited to 10 % of NHS wages. On a part-time contract no maximum income but NHS salary reduced by 1/11 <sup>th</sup> .	Allowable but consultants must first offer an additional 4 hours (1PA) to the NHS. Private Practice Code of Conduct for contracts introduced.	Private practice has remained relatively unchanged.

Source: Department of Health, and C&AG's report, Figures 1 and 4

9. Taking into account the scale of change, NHS trusts did not have the time to implement the new contract as intended, and as a result there was wide variability in the way that job plans were developed and used by trusts.<sup>15</sup> As the implementation was rushed, most job plans were based on a simple diary exercise which was just a description of existing practice rather than a prospective agreement. Few job plans took into account the needs of the trust, and most were based on what the consultant either did in the past or what the consultant wanted to do in the future.<sup>16</sup> Implementation costs in terms of management time have been considerable. The initial round of job planning placed a major administrative burden on trusts at a time when they were gearing up for other pay modernisation initiatives.<sup>17</sup>

10. Medical directors and clinical directors led the job planning, but a lack of capacity in medical management was a particular issue. Some clinical managers lacked the time, and sometimes the skills and information, to negotiate job plans effectively and the finance directors' involvement often lagged behind. Many clinical managers are practicing consultants, employed on rotation for short periods of time, and lack training in aspects of medical management.<sup>18</sup> Consultants told the National Audit Office that this latter practice created an incentive for clinical managers to be naturally sympathetic to their colleagues when agreeing job plans. The Department did not necessarily accept that this risk had in fact materialised.<sup>19</sup>

11. Most NHS trusts found that the guidance produced by the Department was useful, but approximately half felt it was not timely and that some parts were unclear and ambiguous. There was also a lack of tools and training given to medical managers to help the implementation of job plans in NHS trusts. The Department, through its consultant contract implementation team, delivered 70 workshops to trusts and developed a consultant job planning toolkit. The Department subsequently instructed the employers' representative, NHS Employers, to work with trusts to improve the job planning process and to identify how to maximise the use of the contract, including developing tools and sharing good practice.<sup>20</sup>

12. In the past, consultants controlled what they did and when they did it. Trust chief executives recognised that the new contract provided transparency to the consultants' working week and gave managers greater control. The introduction of mandatory job planning reduced the variability in approach, leading to job plans that are broadly similar within and between trusts.<sup>21</sup> Despite three rounds of job planning, however, there is still little evidence that the contract has led to consultants working differently. The Department, nevertheless, believed that when people reflected on the contract they would

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15 C&AG's Report, para 2.21; Qq 54–57

16 C&AG's Report, para 2.16; Qq 3, 19, 21, 80

17 C&AG's Report, para 2.27; Qq 22–23; and Kings Fund report, *Assessing the New NHS Consultants Contract: A something for something deal*, May 2006

18 C&AG's Report, paras 2.19, 2.24; Qq 22–23

19 C&AG's Report, para 2.24; Qq 111–112

20 C&AG's Report, paras 2.25–2.27; Qq 40, 55–58, 69–71

21 Qq 20, 56–57

consider it to be an important step forward, not only for the NHS but for the relationship between consultant medical staff and the management of the service.<sup>22</sup>

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22 Qq 23, 113, 116

## 2 The cost of introducing a new contract for NHS consultants

13. In the NHS Plan 2000, the Government set out its policy to have more, better paid staff. The policy was developed in response to concerns from the medical professions that consultants' pay lagged behind comparable professions and people were leaving the profession, particularly through early retirement of consultant medical staff. It also reflected the views of the general public, obtained through consultation, that medical staff should be better rewarded for their contribution to the NHS. From the outset, therefore, the Department took the view that consultants should have a pay increase over and above inflation, in the region of 15% over three years. In the event, the average annual pay awarded to consultants increased by 27% over the first three years, from £86,746 in 2002–03 to £109,974 in 2005–06.<sup>23</sup> The total spent on consultants' pay, taking into account increases in the numbers of consultants and an increase in employers pension contributions, has risen from £2.9 billion in 2003–04 to £3.8 billion in 2005–06.

14. In April 2002, the Department estimated that the new contract would add £565 million to the consultant wage-bill in the first three years. However, the Department ended up providing £715 million to fund the new contract, or £150 million more than the Department had estimated it would cost (see **Figure 2**). The new contract has consequently cost the NHS much more than the Department estimated.<sup>24</sup>

**Figure 2. The estimated difference between the cost and funding of the new contract<sup>25</sup>**

	2003/04 £million	2004/05 £million	2005/06 £million	TOTAL £million
Department's estimate of the additional cost (April 2002 business case to Treasury)	125	175	265	565
Actual additional funding allocated to NHS	133	182	400	715
Increased additional funding provided to NHS	8	7	135	150

Source: C&AG's Report paragraph 2.3 and figure 6 and Appendix 6

15. The Department increased the funding of the contract by £150 million in the first three years because the average number of programmed and level of on-call availability supplements negotiated with consultants were higher than expected. It later estimated that the contract actually cost around £90 million more. This estimate was based on a national survey carried out by the Department in 2004 which asked trusts about the average number of programmed activities they had contracted. The Department's estimations were also based on aggregated data on consultants' job plans rather than the actual pay bill.<sup>26</sup>

23 C&AG's Report, figure 1; Qq 1, 29

24 C&AG's Report, para 2.6; Qq 37, 64, 76

25 C&AG's Report, para 2.3; figure 6; Appendix 6

26 C&AG's Report, paras 2.2–2.6, 2.9–2.10; Qq 2, 5

16. The National Audit Office calculated the cost of employing consultants since 2002–03, using financial returns from all NHS trusts and some additional data from foundation trusts, and estimated that the costs were between £150 million and £200 million more than originally predicted.<sup>27</sup> Indeed, the view from 84% of NHS trust chief executives was that the contract was not fully funded. The Department pointed out that NHS trusts would always say that they wanted more money and that whilst the contract might have placed financial pressures on some trusts, many had managed their financial affairs adequately.<sup>28</sup>

17. The Department accepted that the new contract had cost more than it predicted, but believed that the excess was due to NHS trusts negotiating a higher than expected number of programmed activities and emergency on-call activities with their consultants (**Figure 1**). Furthermore, the extra cost of the contract was small compared to the total wage bill, and difficult to control across 300 organisations. NHS trusts did not monitor the cumulative cost of what individual managers and consultants had negotiated and so failed to keep the cost of the contracts within the funding limits. Since 2005–06, the average number of PAs that NHS trusts have agreed with consultants has decreased and therefore the cost pressure has reduced.<sup>29</sup>

18. The Department considered that the implementation could have been improved by piloting the new contract. It accepted that it had not always adequately estimated the impact of the new contract, partly because of the poor quality of the data used. In particular, much of the data that underpinned the consultant contract was based on surveys and agreements with the BMA. Over the last year the Department has introduced new arrangements to ensure that it costs policies more adequately. It has applied this lesson in relation to its new contracts for other staff, such as the Agenda for Change contracts for nurses and healthcare professionals, which it piloted prior to implementation.<sup>30</sup>

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27 C&AG's Report, paras 2.4, 2.6; Appendix 6; Q 4–5

28 C&AG's Report, para 2.8; Qq 4–6

29 C&AG's Report, para 2.2; Qq 3, 13–14, 36 60–65, 69, 71

30 Qq 37, 65–66, 72, 77–80

## 3 Realising the benefits of the new contract

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19. In its business case to the Treasury, the Department was explicit in its expectations for the new contract. The intended gains were categorised into productivity benefits (including better management of consultants' time) and participation benefits (such as preventing an increase in private practice work). The Department considered that improved management and control of consultant time would result in consultants working differently. This change was expected to deliver year-on-year productivity gains, greater provision of patient care in the evenings or weekends, and an increase in the proportion of time spent on direct clinical care.<sup>31</sup>

20. The main benefit to NHS trust managers of the new contract is that, as a result of the job planning process, the transparency of consultants' workloads has increased. Through improved planning trusts are now able to manage the hours worked by consultants more effectively, which has in turn helped trusts meet the needs of the European Working Time Directive. The new contract has also contributed to an improvement in recruitment and retention of consultants, which was a particular issue at the time that the contract was negotiated. There are also more consultants whose job is to see patients rather than to supervise other doctors, and patients are now more likely to see or be managed by a consultant than they were a decade ago.<sup>32</sup>

21. The business case stated that the Department expected to see year-on-year consultant productivity gains of 1.5% against a decreasing trend. The Office of National Statistics (ONS) productivity measure, used at the time, showed that overall NHS productivity had been falling by 0.5% year on year from 1997 to the end of 2004. In 2006, the ONS introduced a revised measure which included additional aspects of quality, such as health gain. This adjusted measure showed that productivity for the whole NHS increased by between 0.9 and 1.6%, year-on-year, from 1997 to 2004. It is difficult to say how much of any aggregate change in NHS productivity can be assigned to the consultant contract. It is also too early to measure the effect of the contract on NHS productivity as figures for 2005 and 2006 are not yet available.<sup>33</sup>

22. Few trusts have defined or put in place local measures of either consultant or other workforce productivity. Indicators which provide a proxy for productivity suggest that consultant productivity has not improved as a result of the new contract. For example, the average amount of activity carried out by individual consultants has reduced. The number of consultants increased by 13% in the two years following the agreement, but the amount of consultant-led activity increased by only 9%. Furthermore, the number of patients treated (episodes) per consultant decreased year-on-year until 2005–06, when it stayed static (see **Figure 3**).<sup>34</sup>

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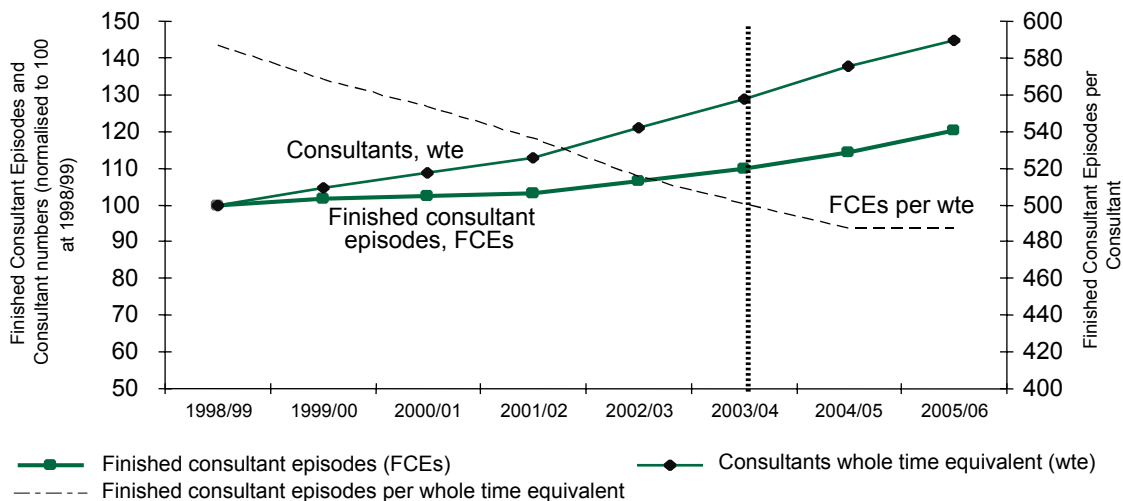
31 C&AG's Report, para 3.1; Qq 1, 11

32 C&AG's Report, para 3.3–3.4, 3.12; Qq 29, 33, 48, 50

33 C&AG's Report, paras 3.9–3.10; Appendix 7; Qq 1, 8–9, 33–34

34 C&AG's Report, paras 3.7–3.8; figures 11 and 12; Qq 7, 20

**Figure 3: The increase in consultant numbers has not been matched by an equal increase in consultant-led activity**



Source: C&AG's Report Figures 11 and 12 and Q7

23. In the National Audit Office's survey the consultants themselves reported that they were not yet working in any very different way from how they worked before the new contract was introduced. Despite the significant pay rises, consultants reported that they had low morale and were reluctantly adopting a clock-watching attitude. There has also been a failure to increase flexibility in services for the patient in the way intended, although improved consultant availability has been achieved in some hospitals by the use of team job planning. The Department believed that the contract helped bring about other changes, such as improvements in emergency care with consultants providing their input earlier in the consultation, and the adoption of a multidisciplinary approach to cancer care.<sup>35</sup>

24. One of the other intended benefits of the contract was that there should be greater provision of evening clinics and extensions of operating times. However, both trusts and consultants reported that there had been no change in these services as a result of the contract. The Department accepted that there had not been a significant increase in this area but believed that the contract provided a lever to increase such provision at no extra cost.<sup>36</sup>

25. Consultants also felt that the new contract had not had an impact on the proportion of time spent on direct patient care. As part of the new contract, direct clinical care was expected to account for 75% of programmed activities with the other 25% spent on supporting professional activities, additional NHS responsibilities and external duties. For most consultants with job plans of 10 or more programmed activities, the ratio between direct clinical care and supporting activities is below 3:1.<sup>37</sup>

26. A 1998 survey showed that consultants spent 49.8 hours on direct clinical care (equating to 68% of their time). The Department's survey of NHS trusts in 2004 showed that 8.27 programmed activities (equivalent to 33 hours or 74% of consultants' time) was spent on direct clinical care, which had decreased slightly to 7.93 programmed activities

35 C&AG's Report, para 27; Qq 17, 38

36 C&AG's Report, figure 2; Qq 17, 19, 85, 114

37 C&AG's Report, para 3.19; Qq 11-13

(72.6%) in 2005. So although the 75% target for direct clinical care has yet to be reached, the proportion (though not the absolute amount) has increased since 1998.<sup>38</sup>

27. The Department acknowledged that not all of the benefits of the new contract had been achieved yet. There was greater control over consultants working in private practice and pockets of good practice in some NHS trusts in relation to the provision of more flexible services, but these were not yet significant. The Department believed that the contract had put the building blocks in place to facilitate the delivery of more care out of traditional hours and to reflect local needs.<sup>39</sup>

28. At the outset, the new consultant contract was seen by Government as a “something for something deal”. The first “something” was clearly the £715 million additional funding but the other “something” was still not clear. Whilst the key reason for failing to realise the benefits was poor implementation of job planning, the new contract provides levers to improve the way that consultants work and match consultants’ time to the needs of the patients and users.<sup>40</sup>

29. The Department acknowledged that its stated intention was to realise productivity improvements from the outset, but considered that the measures included in the business case were a rather crude analysis. Instead, the complete change in culture at the local level required to implement the new contract so as to deliver all the expected benefits would take longer to be pervasive. The contract therefore needed to be seen more as a longer term solution.<sup>41</sup> For the long term effects to be seen, however, there is an immediate need for consultants and managers to work in partnership and demonstrate that NHS trusts are receiving value for money for the substantial costs incurred on the new contracts.

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38 C&AG’s Report, figure 2; Qq 14–15

39 Qq 17–19, 49–50

40 Q 116

41 Qq 1, 9, 31, 33

# Formal minutes

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**Wednesday 10 October 2007**

Members present:

In the absence of the Chairman, Mr Alan Williams was called to the Chair

Mr Richard Bacon  
Angela Browning  
Mr David Curry

Mr Philip Dunne  
Mr Austin Mitchell  
Mr Don Touhig

## **Draft Report**

Draft Report (Department of Health: Pay Modernisation: A new contract for NHS consultants in England), proposed by the Chairman, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 29 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

*Resolved*, That the Report be the Fifty-ninth Report of the Committee to the House.

*Ordered*, That the Chairman make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned until Monday 15 October at 4.30 pm.]

## Witnesses

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**Monday 30 April 2007**

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**David Nicholson**, Chief Executive, National Health Service, **Nic Greenfield**, Director of Workforce (Education, Regulation and Pay), Department of Health, **Andrew Foster**, Chief Executive, Wrightington, Wigan and Leigh NHS Trust and **Professor Hugo Mascie-Taylor**, Interim Chief Executive, Leeds Teaching Hospitals NHS Trust

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# Oral evidence

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## Taken before the Committee of Public Accounts

on Monday 30 April 2007

Members present:

Mr Edward Leigh, was in the Chair

Mr David Curry  
Mr Sadiq Khan  
Dr John Pugh

Mr Alan Williams  
Mr Iain Wright  
Mr Derek Wyatt

**Sir John Bourn KCB**, Comptroller and Auditor General, **Tim Burr**, Deputy Comptroller and Auditor General, **Karen Taylor OBE**, Director, Health Value for Money Audit, National Audit Office were in attendance.

**Paula Diggle**, Treasury Officer of Accounts was in attendance.

### REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

#### Pay Modernisation: A New Contract for NHS Consultants in England (HC 335)

*Witnesses:* **David Nicholson**, Chief Executive, National Health Service, **Nic Greenfield**, Director of Workforce (Education, Regulation and Pay), Department of Health, **Andrew Foster**, Chief Executive, Wrightington, Wigan and Leigh NHS Trust and **Professor Hugo Mascie-Taylor**, Interim Chief Executive, Leeds Teaching Hospitals NHS Trust, gave evidence.

**Q1 Chairman:** Good afternoon and welcome to the Public Accounts Committee where we are today considering the Comptroller and Auditor General's Report on pay modernisation in the NHS, *Pay Modernisation: A New Contract for NHS Consultants in England*. We welcome David Nicholson, Accounting Officer and Chief Executive of the Department of Health; Clare Chapman, the recently appointed director general of workforce at the NHS; and her deputy director, Nic Greenfield—*[Interruption.]* I am reading from my notes, but I see that they cannot be right; there has been a slight change of personnel. Perhaps you can tell us who is on the witness panel, Mr Nicholson.

**David Nicholson:** We have Nic Greenfield, Director of Education, Regulation and Pay at the Department of Health, Andrew Foster, the Chief Executive of Wrightington, Wigan and Leigh NHS Trust, who was the director of workforce at the Department, and Professor Hugo Mascie-Taylor, medical director of Leeds Teaching Hospitals NHS Trust, who worked with NHS employers on the contractual discussions.

**Chairman:** There is no Clare Chapman?

**David Nicholson:** No.

**Q2 Chairman:** Okay. On that basis, we shall begin. Perhaps you could start, Mr Nicholson, by looking at the overall cost of the contract and what it has achieved. Paragraphs 25 and 26 of the executive summary deal clearly with those matters. The simple question we have to put to you is why did the contract cost £715 million in the first three years, £150 million more than was estimated, without any discernible increase in productivity?

**David Nicholson:** First, the contract was part of a Government policy set out in the NHS plan, which essentially said that we should have more and better paid staff, particularly doctors. As many honourable Members will remember, at the time, there was a great deal of concern in the medical professional about people leaving, particularly because of the early retirement of consultant medical staff; a view from the general public that medical staff should be better rewarded; and a view in managerial circles that we needed to have a better settlement with consultant medical staff about how their time was managed, so we could better connect their time with patients' needs. Those were the reasons for the policy. Right from the beginning, we took the view that consultants should have a pay increase over and above inflation of something in the region of 15% over three years—the calculations that set that out are in the document. We wanted the consequences of that to be a better-managed consultant medical staff with, over time, improved productivity. As you can see from the National Audit Office Report, we set out 10 expectations of what we would get from the new contract, most of which we have achieved or it is too early to tell, and we are working on those that we have so far not delivered. On productivity, there was a relatively crude measure set out in the original business case, which was essentially the number of patients treated divided by the number of consultant medical staff. That is a crude measure of productivity by any stretch of the imagination. When we originally did the contract, it looked as if productivity was falling by about 0.5% a year. By the time we got to the contract as a whole, productivity was falling by 3% a year. It is too early to tell whether we are going to get many of the productivity gains

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that we wanted, but the position at the moment, for the last year for which we have information, the relationship is flat.

**Q3 Chairman:** That is an incredibly long, discursive answer that has ignored the point that I put to you. I did not ask you about whether you were trying to achieve the object of having more doctors, which you presumably have, or better pay, which has also happened; I asked you why the new contract cost £150 million more than was estimated. You have not even attempted to answer that question.

**David Nicholson:** I am happy to go on.

**Chairman:** I should be grateful if you attempted to answer the question that I put to you.

**David Nicholson:** Obviously, the calculations in relation to the contract were complex; we spend significant amounts of money on consultant medical staff pay, as you are well aware. When we implemented the contract, we assumed that it would cost £565 million, but as we went through the implementation process it became clear that it would cost more. At the time, the view was that it would cost approximately £150 million more, and we made sure that trusts had the funds to deliver that amount. In retrospect, we see that it cost £90 million more. There were two reasons for that. The first was that we had expected the NHS to negotiate an arrangement with local consultants such that the average number of programmed activities worked by each consultant would be 10.7, but that number turned out to be more than 11. The second part of the overrun related to out-of-hours payments. We had assumed that a third of consultants would receive the higher level of out-of-hours payments, but it turned out to be two thirds.

**Q4 Chairman:** It seems that you completely got it wrong on the hours that consultants were already working. The British Medical Association told you that they were working more than 50 hours, but you chose to believe that your estimate of 47 hours was more accurate. The NAO has now backed up the consultants' original estimate. Basically, you got it wrong, did you not?

**David Nicholson:** At the time, there were some quite complex and engaged negotiations with the BMA about those issues. Many working hours had not been counted or measured in the past. Perhaps I could ask Andrew to say something about that, because it might help.

**Andrew Foster:** One of the BMA's main objectives in the negotiations was to reduce the number of hours. For that purpose we performed a joint diary exercise which demonstrated that the average number of hours worked was 47. The BMA fully accepted that number throughout the negotiations, and it became a joint objective to reduce it. Therefore our planning assumption of 10.7 programmed activities, to which David has referred, represented an average reduction from 47 to 43 hours per week—that was a jointly held aim of both the Department of Health and the BMA.

**Q5 Chairman:** All right. We shall come back to that point because I cannot spend too much time on it. My colleagues may ask questions on it. You mentioned trust funding. You said that you funded trusts adequately, but paragraph 2.8 on page 19 says that 84% of trusts believe that the new contract was not fully funded and that it contributed to their deficits. What do you say to them about that, given that you negotiated the contract?

**David Nicholson:** First, the data do not support that conclusion.

**Q6 Chairman:** But presumably you agreed that paragraph with the NAO.

**David Nicholson:** What I am referring to is that the Department did its review of the overrun on contract costs on the basis that 95% of trusts submitted information to us. That review showed that the contract was originally underfunded by £90 million. In the event we actually provided £150 million; that is what the data said and it confirmed that there was funding. As far as the effect on deficits is concerned, most trusts are not in deficit and manage their own financial affairs adequately, as has already been discussed. Some have difficulties, and I am sure that in some circumstances the pressures resulting from the contract exacerbated them. Lastly, and frankly—

**Chairman:** I hope that you are always frank.

**David Nicholson:** Obviously I am always frank. If you ask the NHS whether it wants more money, it will almost always say that it does, and that it needs it.

**Q7 Chairman:** Anyway, the paragraph as it stands is basically true.

**David Nicholson:** It is true that, when one asks lots of trusts, they think that they should get more money, yes.

**Q8 Chairman:** Okay, fair enough. Let us try to consider the productivity point. You have already dealt with it, but I want to try to get to the bottom of it with you if I can. Figures 11 and 12, which you can find on pages 26 and 27, show that the increase in consultant numbers has not been matched by an increase in consultant-led activity or in finished episodes. Looking at these figures, we seem to have a lot more money being spent than we expected, but we do not seem to have the kind of increase in consultant-led activity that we might have hoped for. It is quite obvious from the figures what is going on—you can see in figure 11 consultant numbers going up and activity going down. In figure 12 you see finished episodes per consultant, which have gone down. It does not look as though your contract has really achieved what it should have done, does it?

**David Nicholson:** I said before—perhaps Hugo can say something about the detail in a while—that it was too early to tell in relation to productivity and that the number of FCEs per consultant is an extraordinarily crude measure of productivity. For example, many of the new consultants who have been employed are pathologists, radiologists—

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**Q9 Chairman:** May I interrupt? That is a very important point. You say that it is too early to say but I thought from the original Treasury forecast, as the NAO tells me, that there was an expected year-on-year increase in productivity from the first year. That was what you were expecting, but it has simply not happened.

**David Nicholson:** Yes.

**Q10 Chairman:** Paragraph 3.9, above figure 11, shows that you expected annual productivity gains of 1.5%. In fact, we now know that it is less than 0.5%, so something is going seriously wrong, is it not?

**David Nicholson:** But at the time I think I said that the long-term position was that that was against a background of a 0.5% reduction in productivity—a historical position. In fact, when we got to implement the contract the medium-term reduction in productivity was 3% so the reduction was even greater than we had imagined. This is a long-term solution to something that has been going on for many years, and if you look at the latest information that we have on productivity, you see that that position is flat.

**Q11 Chairman:** Let us look at it from the point of view of consultants, shall we? That is dealt with in paragraph 28 of the summary. They have got a 25% increase in pay, but apparently they are not at all happy. They seem to think that you have introduced a sort of clock-watching mentality, and that paragraph suggests that they are working much as before. So they have had a 25% increase in pay, it has cost us £150 million more than we expected, they are working much as before and they are not even happy. That rather prompts the question of what we have achieved.

**David Nicholson:** I will reflect back. The old contract had been in place since at least 1948. This was a new contract that we tried to implement over a relatively short space of time. The key thing about it is the potential that it gives local management to connect consultant workload with what patients need. There is some evidence around that they are beginning to do that, but I acknowledge that it is slow. I do not know whether Hugo wants to say something about that.

**Professor Mascie-Taylor:** I do not know whether you want me to return to the question of productivity or whether you feel that you have dealt with it fully.

**Chairman:** If you wish to return to it you must speak up and look at me, please, rather than read your notes.

**Professor Mascie-Taylor:** I would be delighted to do that. The figures that David quoted are absolutely pertinent. If you choose to judge consultant productivity as activity—the business case itself did not suggest that but stressed that quality was part of it as well as activity measured by finished consultant episodes—and even if you are prepared to take finished consultant episodes as the measure of productivity, then as David has tried to point out and as I learned in preparing for this, the

productivity of consultants as measured by activity over a five-year period preceding the contract had fallen by 3% a year. That has been reversed, which seems to me a telling point. Since the contract came into place, it has proved far more straightforward and simple to manage in a partnership way, not an authoritarian way, in partnership with consultants to render what they do more efficient and effective. I think that part of that has changed the picture of productivity that you are painting. To turn now to how they feel about it, there is no doubt that some consultants are concerned that the level of autonomy that they enjoyed prior to the new contract has lessened, but frankly, I think that that was part of the institution of the contract. There was a perception among both doctors and employers that a new contract was needed. The previous contract had been in place for more than 50 years. Therefore, with respect, I think that this Committee might look at it over a period of years. What will we achieve with the new contract? We should look back and say, “At that point in time, we introduced it. Where are we now?” after five and 10 years.

**Chairman:** That is fine. You have explained it very well from your point of view. Thank you. I have other questions, but other Members wish to speak.

**Q12 Mr Wright:** As far as I can see, the change in consultants’ contracts was meant to do five things: increase the proportion of direct clinical care, provide the patient with greater flexibility in service provision and local needs, increase productivity, reward commitment to the NHS and increase control of what consultants do as health managers. Does that seem reasonable?

**David Nicholson:** Yes.

**Q13 Mr Wright:** Is there not a bit of a conflict between those objectives? If you must pay more for fewer hours, are you not hitting productivity to start with? The objectives are not consistent, are they?

**Andrew Foster:** Yes, they are.

**Q14 Mr Wright:** Can you tell me how?

**Andrew Foster:** Because you get a greater proportion of time being spent effectively. Prior to the new consultant contract, there was no effective control of consultants’ working lives. There was no way to plan what they did and when. The idea was that they would do fewer hours, but that those hours would be more controlled. Spending an increased proportion of that time on direct clinical care does in fact reconcile those points.

**Q15 Mr Wright:** Can we take those five points, then? It was meant to increase the proportion of direct clinical care. In July 2002, the then Secretary of State for Health said in the House of Commons: “The framework agreement that we have reached with the British Medical Association will increase the time consultants spend on direct clinical care.”—[*Official Report*, 16 July 2002; Vol. 389, c. 137.] Table 2 of the Report—our survey of consultants, the latest Department survey—shows that it has been reduced. Why is that?

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**David Nicholson:** There is a real issue here and a technical issue, in our view, about the numbers, and we have set that out in the document. As you put it, part of our strategy was to reduce doctors' number of hours, and we have done that, but as for the hours that they continue to work, our judgment is that the proportion spent on direct clinical care has gone up.

**Q16 Mr Wright:** I have a lot to cover, Mr Nicholson; I apologise. Paragraph 3.25 of the Report states explicitly: "We found that the contract has not increased the amount of direct clinical care offered by each consultant." That is a failure to start with, is it not?

**David Nicholson:** Yes, but we believe that it has.

**Q17 Mr Wright:** So you dispute what the NAO said?

**Andrew Foster:** Yes. It is in the document, and we have said so as well.

**Q18 Mr Wright:** Can I go on to the second objective, the provision of greater flexibility for the patient in terms of service provision? That has not happened either, has it? The vision, which I can fully buy into, that a working man or woman could have operations on weekends or evenings to suit them simply has not materialised, has it?

**David Nicholson:** Yes. It has materialised, but only in a very small series of hospitals. That is absolutely true.

**Q19 Mr Wright:** Given that we are paying them 25% more, why is it not happening a lot more?

**David Nicholson:** Where there has been a real benefit is in other kinds of care. I will give you examples of two. One is emergency care. Typically, in the past, when a patient was admitted to a hospital as an emergency, they were unlikely to have seen a consultant very early in their stay. Now, as a part of the changes that have been adopted, typically an individual will see a consultant, a senior doctor, early. We are now in a position where our medical assessment units and emergency assessment units are staffed by senior doctors. As part of the contractual arrangements, we have been able to put that in place. The second area is in cancer care. Increasingly, it is a multidisciplinary activity—a lot of different sorts of consultants will sit together to work out the best care for a particular patient. The contract has enabled us to manage our consultants in such a way that we can co-ordinate it as we have never been able to do before. Although I accept that there has not been a significant increase in the amount of outpatient care out of hours, though we have the potential to do it, there have been real benefits in how our consultant medical staff are organised.

**Q20 Mr Wright:** In terms of a real change in how health care is provided by being responsive to the needs of a local area and to those of individual patients, this new contract has not helped in the slightest. The contract was based upon historical data about what consultants already did, so that is a

non-starter in itself. Commissioning bodies, such as primary care trusts, were hardly consulted at all; that is another thing. Why has there not been greater power to say, "This is what this area needs, and this is why this particular contract will be shaped along those lines"? That has not happened, has it?

**David Nicholson:** With all of those things, we have the building blocks in place to enable them to happen, and I am sure that they will happen over the next few years. However, it is not true to say that there have not been significant improvements to patients, because there have been, around the areas that I have just described. I do not know if Hugo wants to add anything.

**Professor Mascie-Taylor:** I do not think that I would fully agree with your analysis. There is quite good evidence that the proportion of time spent on direct clinical care has increased rather than decreased—I am happy to go through that evidence with you, if you wish. That is the first point. The second point is that the contract has allowed the sort of flexibility that David has outlined. The benefits of those, in terms of out-of-hours care, have shown up enormously in the quality of acute care, which is increasingly consultant-based, rather than consultant-led. When patients are now acutely ill, they are far, far more likely to see a consultant at the time of their admission, or very shortly afterwards, than they were some time ago. I think that there has been a significant increase in the quality of acute care, and a considerable increase—as there has to be—in the working of multi-disciplinary teams, although I would concede that most of that is in-hours, not out of hours. I would agree with you, though, that the next challenge will be how we can provide more care out of the traditional working hours. In order to do that, we have to do a number of things, but I suppose the headline would be that we have to gear up the whole hospital, not just change the consultants. We have to be prepared to work right across the hospital, in all the various departments, to gear it up for evening work. What this contract allows us to do is—and it was carefully constructed, I think—to do that between the hours of seven in the morning and seven in the evening at no additional cost. The building blocks, from the consultants' standpoint, are in place, but the challenge is whether we can build on them.

**Q21 Mr Wright:** I am very conscious of the time, so I need to move on, but leading on from that is the essential management control of consultants and what they do. As I said, from reading this Report, I did not get any confidence that local needs, in terms of commissioning requirements, were fully drawn in. The other thing is that consultants have an enormous amount of power, which does not seem to have been affected at all. In fact, it has influenced the Report a great deal. Just concentrating on agreeing job plans without knowing what amount and type of activity they are required to run their organisation efficiently—that is paragraph 2.16—the Health Committee says: "There has been a disastrous failure of workforce planning. Little if any thought has been given to long-term or strategic planning."

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Again, I put it to you that that is because the consultants are able to shape what they do according to their own needs. Is that not true?

**David Nicholson:** No, I do not think that it is true, but as I said before, we have had the same contract in place now for 50 years. This is a big change. To expect everything to happen at the beginning is unlikely, because these are big cultural changes that we are talking about: the way in which we manage, the way in which consultants interact—

**Q22 Mr Wright:** Do you accept, Mr Nicholson, that it has been a big change for local health organisations to take into account?

**David Nicholson:** Absolutely. A big change.

**Q23 Mr Wright:** Why did you not help them more, in terms of local management capacity?

**David Nicholson:** All that I can say is that if you look in appendix 5, you will see a whole list of ways in which the Department and the centre helped NHS organisations to implement it. Change does not happen in that sort of way; it takes time, effort, experience and knowledge. As far as I am aware, there are very few health systems in the world that have tried to implement something of this nature. It is a quite fundamental change in the relationship between consultant medical staff and the organisations.

**Q24 Mr Wright:** But, Mr Nicholson, let me quote to you page 9 of the King's Fund Report about the consultants' contract. It says: "One key constraint on implementation has been local management capacity. Implementation costs in terms of management time have been considerable. The initial round of job planning placed a huge administrative burden on trusts at a time when they were gearing up for other pay modernisation initiatives (such as *Agenda for Change*) . . . The lack of capacity in medical management has been a particular issue, as medical directors and clinical directors have led on job planning. 'For three months I did hardly anything else,' said one medical director, who had to cancel clinical work because of job planning." It simply has not worked, has it?

**David Nicholson:** In a sense, you have just reinforced the scale of the change that we were trying to make. To be frank, is that not what medical directors are there to do: to manage the medical work force? Job planning is a central part of that. It seems a perfectly reasonable place to be.

**Professor Mascie-Taylor:** I do not fully agree with your analysis. The evidence suggests that it is a complex, complicated contract. It implies not only a contractual change, but an enormous cultural change. Under the old contract, consultants had five to seven fixed sessions, each of which was three and a half hours. Those were the hours for which they would be most clearly accountable. Under the new contract, they have 7.5 four-hour PAs, so the amount of time about which they have to clear and accountable to their organisation about what they are doing has hugely increased. Producing that change is complex and difficult, and it has been the

role of medical managers and HR directors to introduce it. I agree that, in the first year of the contract's implementation, the emphasis was on getting consultants on to the contract, bedding it down and getting people used to working with it. It has to be a partnership, and that partnership was achieved. In the first year in which the contract was in place, the number of PAs for the average consultant was 11.17. As the system has become more tightly managed, that has come back to 10.83, which is, remarkably, very similar to the initial estimate. In a period of three years, getting the contract in place was a huge challenge. More than 90% of consultants are now on it; initially, the PAs were just above 11, which was higher than estimated. As it has been more closely managed, that has been pulled back. You need to—

**Q25 Mr Wright:** My time is up. When reading the Report, I was struck by history lessons from the 1970s, when strong unions bargained with management and were suspicious of management and negotiated greater pay deals for less work. People complained that British industry was on the bones of its backside as a result. Do you see the analogy?

**David Nicholson:** No, not at all.

**Q26 Mr Wright:** Are you happy with the way that the contract is working?

**David Nicholson:** I am never happy with the way that anything is going, as a matter of principle. I am a manager; I am there to improve services and efficiency all the time. I believe that we now have a different settlement with our consultant medical staff, which enables significant amounts of their time to be properly managed. That is the most important thing for us.

**Chairman:** Thank you. I must appeal for shorter answers, gentlemen.

**Q27 Mr Khan:** Mr Nicholson alluded to our history going back to the '40s. Is not Mr Wright being a bit unfair, however? Has not the ability of doctors to be unreconstructed been one of the sacred cows of the NHS since the 1940s? Many Secretaries of State have scars on their back from trying to take on consultants. Would that be a fair summary?

**David Nicholson:** I do not know whether they have scars on their backs. I have worked in the NHS for—

**Q28 Mr Khan:** Let me ask you this: how do you explain the inability to get job planning off the ground until recently, which appendix 1 sets out succinctly, despite the fact that job planning has been mandatory since 1991?

**Andrew Foster:** Job planning was not mandatory; it was revised and recommended. When we started the consultant contract negotiations, which I led, one of the key objectives was a proper system of job planning. The figures that we had at the time showed that less than 50% of consultants had ever had a job plan and less than 10% had ever had their job plan

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reviewed, so it was a major gain for everyone to have a job plan that was reviewed once a year. That was a central device of the contract.

**Q29 Mr Khan:** Sure. My point is that there are other professional people in the NHS who have had “job planning” since 1948. Yes?

**David Nicholson:** Yes.

**Q30 Mr Khan:** The Report is not completely critical, although the NAO can, understandably, sometimes be accused of making crude summaries of cost-benefit, which do not help when it comes to the NHS. For example, consultants’ pay before the contracts lagged behind comparative professions. That was a concern that I know you had. The number of consultants who are being recruited and retained has gone up, although the increase is not as steep as that of the pay of some consultants who have remained in the profession. I understand that, in addition, we were not abiding by the European working time directive. It seems that you are being criticised for acting lawfully when hitherto you might have been acting unlawfully. Is that fair?

**David Nicholson:** It is certainly true that one of the criteria that we used was a reduction in the number of hours that consultants work, to bring them in line with the European Working Time Directive.

**Q31 Mr Khan:** In which case, you must be frustrated about definitions of productivity. To use teaching as an analogy, it could be argued that one teacher teaching 60 children is more productive than three teachers each teaching a class of 20. Similarly, although consultants are working fewer hours and acting within the law, and the quality of treatment is improving, each of them might be treating fewer patients individually.

**David Nicholson:** At the same time, we are trying to create what Hugo described as a consultant-based service. We want more hands-on direct patient care, as opposed to managing through a team, which is why emergency care has become an issue. You are much more likely to see a member of the consultant medical staff now than you were in the past.

**Q32 Mr Khan:** Can one of the chief executives explain, briefly, the difficulties that they had previously in managing consultants? I understand from the National Audit Office Report that two thirds of trust chief executives can now, at last, manage consultants in a transparent way. What was happening before?

**Andrew Foster:** On the day on which the negotiations concluded, there was an item on the BBC’s 9 o’clock news about the consultant contracts. An orthopaedic consultant was asked whether he was going to vote for the new contract. He said no. The interviewer pointed out that there was 25% more money available and asked why did he not want to accept the contract. He said that it was very simple. Without the contract, he could choose when to come in to work, when to leave work and, when at work, what to do. If he accepted the contract, he said, some managers might have a say

in his working life, and that would not be acceptable. He was unconsciously describing the complete culture change that was intended to result from the contract, and which is slowly being delivered by it. Many of the objectives that you have described are being achieved and many will take longer to be completely pervasive. However, I am confident that that complete culture change at the heart of it is happening.

**Q33 Mr Khan:** That culture change is presumably difficult to measure with a snapshot analysis of “patients going through the conveyor belt” hours worked.

**Andrew Foster:** Impossible.

**Q34 Mr Khan:** Could I carry on with productivity? I gather from reading paragraph 3.9 of the Report on pages 26 and 27—I think that the Chairman alluded to this point—that you might have been frustrated, Mr Nicholson, by the crude analysis of productivity, which led to the Office for National Statistics changing the definition of productivity. Can you explain the problem that you had with the crude analysis before and what should happen from now on? That is not captured in the NAO data, is it, because the NAO looked at figures before 2006, rather than from then onwards?

**Professor Mascie-Taylor:** I have looked hard at the NAO figures, and inasmuch as I understand them, even in those crude terms, they demonstrate a small increase in activity per consultant. I believe that that is right. It seems to me that the other issues are softer. The quality of care that patients receive is softer than whether they receive care or not. One is very easy to measure; the other is much harder. However, as we move to a health service in which doctors in training are trained for much shorter periods—less experienced and less able to deal with patients effectively—but in which there are far more consultants whose job it is to see the patients rather than to supervise others who see them, then there are significant quality gains. I find it difficult to articulate how one could measure those easily, but I think that everybody’s experience of the health service—both those who work in it and those who have been its patients—is that they are now far more likely to see or be managed by a consultant in hospital than they were a decade ago.

**Q35 Mr Khan:** Even the NAO accepts that the productivity of the NHS increased by between 0.9% and 1.6% year on year between 1997 and 2004.

**Professor Mascie-Taylor:** We can bandy productivity figures around, because they have to be defined very carefully and we do not have perfect data. However, I do not see in the Report anything to suggest that there is a great decrease in productivity. In fact, I see it in rather the reverse way.

**Q36 Mr Khan:** Yes. Mr Nicholson, how do you defend the two biggest charges against the Department of Health: first, that you spent more

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than you estimated that you would spend; and secondly, which is linked, whether you are providing value for money?

**David Nicholson:** We made the original calculation, but once we got into implementation, the word from the service was that there was not enough money in it. We did a quick calculation and that showed us that the trusts were about £150 million short. We ensured that the trusts got that £150 million. In practice, however, that turned out to be £90 million when we did it retrospectively.

**Q37 Mr Khan:** So the 84% of trusts that believe they have been outmanoeuvred by you are being unfair, because the figures do not bear that out?

**David Nicholson:** They do not bear that out, no. There were two issues. First, the number of PAs that consultants were agreeing with their trusts was more than we had suggested. However, we are now back at the level that we originally thought that they should be. Secondly, there was the issue of on-call payments. We agreed with the BMA that a third of consultants should get the higher on-call arrangements. In fact, two thirds of consultants have those arrangements.

**Q38 Mr Khan:** Putting aside for a second the crude analysis of productivity, can you understand the frustration that some people have? The Department has form when it comes to not negotiating accurately contracts and improvements with people in the NHS—for example GP contracts, which have been in the press a lot recently. Other examples include contracts in relation to *Agenda for Change* and now consultants' contracts. What is your response to the fact that because you have form in being over-indulgent, over-generous and not spending carefully taxpayers' money, we have to assume that you are not providing value for money?

**David Nicholson:** Obviously, you gave a series of examples. If you look at the amount of money that we spend on those things, you see that it is enormous. As we have said in discussions before, we have not always got it right. That is partly because a lot of the data that we work from is not of the highest quality and much of the data that underpinned this discussion was based on surveys and agreements between ourselves and the BMA. All I can say is that we have had arrangements in place for the last 12 months to ensure that we cost the nature of our policies more adequately. Obviously the proof of the pudding will be in the eating.

**Q39 Mr Khan:** My time is almost up, but I have two final questions. How do we deal with these ungrateful consultants who get a 27% pay increase and are now having to explain their behaviour and hours to chief executives? Of course, the public perception is that they are out playing golf, which I know is incredibly unfair, because I think that they are playing tennis. How do we deal with morale, an issue raised by the Chair?

**David Nicholson:** The first thing that I would say is that we regularly measure staff satisfaction across the NHS. Over the past year, the satisfaction of

medical staff has gone up, and not down. Although there is a lot of noise in the system, if you look at whether people are satisfied or very satisfied with their job, you find that most medical staff would say that they are content with the arrangements. These are really big cultural changes that the medical staff are going through. Staff are moving from a situation in which they had a great position of power.

**Q40 Mr Khan:** When you say staff, do you mean consultants?

**David Nicholson:** Particularly consultants, but all medical staff as well. They are moving from a position of great power both in the system and in the relationship with their organisations. It was often said that consultants worked somewhere rather than for somebody. We are changing that, and that is a very painful thing for a professional group to go through, but it is necessary.

**Q41 Mr Khan:** My time is now up. My final question is about job planning. It has been mandatory since 1991. That was telegraphed ages ahead. Trusts have been overpaid—£150 million as opposed to £90 million—yet they still feel that the proposal was rushed through and they are still unhappy. What are you going to do to ensure that the trusts have the relevant skills that they need to work in partnership with the Department rather than against it?

**Andrew Foster:** I know that you want to be quick. First, let me say something about the payslip. The history of the negotiation, which I will not go into at length, is that it was first negotiated and then rejected by the BMA. Then there was a period of uncertainty and then it was negotiated again. I say that only to explain that the NHS was not sitting there with the certainty that a certain amount was going to be paid. However, with regard to what we are now doing to support the NHS—I am now on the receiving end of that support—there is basically a programme working through NHS employers to support employers and to get the best benefits out of the contract by giving them guidance by sharing examples of best practice and so on.

**Q42 Chairman:** To clear up the record, Gentlemen, you said in answer to Mr Khan that it was not a requirement for trusts to do job planning. However, paragraph 1.3 on page 12 says, “The need for better planning of consultants' work was highlighted in 1991 when the Department introduced a requirement for hospital managers to introduce job planning.” It really beggars belief, when this requirement was established as long ago as 1991, that you, Mr Foster, said that there was no effective control over consultants. What is worse about this situation is that, if you look at paragraph 2.16 on page 21, you will see that job planning is still not being used effectively. Paragraph 2.16 says, “Trusts concentrated on agreeing job plans without knowing what amount and type of activity they required to run their organisation efficiently.” So it was a requirement, but it was not being carried out.

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**Andrew Foster:** But it was not in the consultants' contracts, terms and conditions. You can place a requirement on the management, but if there is no requirement on the consultants to play ball, how can you achieve anything?

**Q43 Chairman:** That seems to me to be absurd.

**Andrew Foster:** You may say that, but—

**Chairman:** That is an absurd answer. Anyway, others would like to come in.

**David Nicholson:** Can I just say something about that?

**Chairman:** You may, indeed.

**David Nicholson:** At the time, I was a hospital manager who was not implementing job planning in the way that has just been described. However, it was not until the mid-1990s that the contracts of employment for all consultant medical staff based in hospitals were held by the hospital itself. In the hospital that I was running at the time, the contracts were held by the regional health authority. So it was quite a different world and quite a different culture when job planning was first suggested and it was extraordinarily difficult to carry out what that requirement suggested.

**Chairman:** It seems a strange organisation where one hand does not know what the other hand is doing, but still, there we are.

**Q44 Dr. Pugh:** There are some consultants who are still on the old contract, are there?

**Andrew Foster:** Yes.

**Q45 Dr. Pugh:** And the NAO says that they are getting paid, I think, 25% less on average. I suppose that one good point of comparison to work out how well the contract was working would be to compare the performance of those consultants against the performance of consultants on the new contract, and assess how efficient or effective they were. Do we have any data on that?

**David Nicholson:** I have certainly seen no information on that area. However, I suppose that we have some views about it.

**Q46 Dr. Pugh:** Well, let us have your views then.

**Professor Mascie-Taylor:** I have seen our data on this area. The number of consultants on the old contract is declining quite rapidly. My impression—it is an impression—

**Q47 Dr. Pugh:** And they are performing less well, are they?

**Professor Mascie-Taylor:** I really do not have a measure; I cannot tell you whether they are, or not. What I can tell you is that health care is absolutely team-based and what the new contract offers that the previous one did not is the ability for doctors and managers to work together in a way that is transparent and explicit, to make that team working more effective. That is much, much harder to achieve with doctors on the old contract.

**Q48 Dr. Pugh:** May I just pick up on the word that you used then, which was “transparent”? Does “transparent” mean that, under the old contract, you simply did not know what you were paying for, and under the new contract you have a better idea of what you are paying for?

**Professor Mascie-Taylor:** Yes.

**Q49 Dr. Pugh:** Right. That is a gain, a plus, a step forward, I guess. However, there has been no more productivity and we can identify that there has been a certain amount of confusion, and so on. One further gain that I thought that you could possibly claim, given that we all have this image of NHS consultants being like James Robertson Justice in all the *Doctor* films, is in regard to whether there has been a shift in power. In other words, have the consultants now got less power, in terms of running and managing the hospital, than they had in the past, and are now more employees of the hospital rather than the power-brokers?

**Professor Mascie-Taylor:** That shift is taking place. I think that it is important to point out, despite the image that you have of consultants, that the fact that this process is transparent and explicit is welcomed not only by patients and employers but by the great majority of consultants, who work hard and wish to refute the claim that they are constantly playing tennis, or golf, or whichever they fancy. It is in everybody's interest that this process is open and clear and transparent.

**Q50 Dr. Pugh:** The other allegation, of course, is that they are not constantly playing tennis but constantly earning money by practising private medicine. How much private medicine is now indulged in, or participated in, or done by people primarily working as NHS consultants? Do you have any figures for that? Obviously, if they work less for the NHS and their hours are reduced, the percentage of work in private medicine may go up. However, in terms of hours of private medicine work, what do the figures look like?

**Andrew Foster:** The figures we have show that the proportion of time spent on private practice has not changed through the contract, but then neither was that one of the objectives of the contract. One of the real objectives of the contract was to have some clear and transparent understanding about what was—

**Q52 Dr. Pugh:** So even though the hours that consultants work have gone down, the proportion has stayed the same?

**Andrew Foster:** Those are the figures that we have. But what we did not have under the old contract was the ability to require consultants to tell us what they were doing in the private sector and when. As a result there was a general perception—probably far more perception than actuality—that consultants were spending illegitimate time in the private sector. That was why it was a common objective of both sides to the negotiation to have a transparent system and this code of conduct on private practice, which clearly accepts that the NHS comes first and states what consultants are doing and when.

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**Q53 Dr. Pugh:** They are legally bound to tell you under the new contracts.

**Andrew Foster:** They are indeed. That is a great improvement on the old system.

**Q54 Dr. Pugh:** Other models of incentivising consultants were not fully considered. For example other methods of paying consultants have worked on productivity, by giving doctors a financial incentive simply to see more patients. Why was that not considered, over and above targets, I mean?

**Andrew Foster:** It is not true to say that it was not considered. Various alternatives were considered at the time of the formulation of the contract and the route that was chosen was judged to be the preferred one. In the period between the rejection of the first consultant negotiation and the second one, the NHS was encouraged to experiment with alternative forms of payment and there was a separate pilot to conduct a fee-for-service model, which carried on even beyond the introduction of the new contract.

**Q55 Dr. Pugh:** What did it show?

**Andrew Foster:** It did not show any increase in productivity. It is interesting to note that the whole of the rest of the world that relies on a fee-for-service model is now desperately trying to get out of it.

**Q56 Dr. Pugh:** May I now go to a more simple question? We have had a lot of talk about job plans and so on. Job plans are obviously new to consultants. What does a consultant's job plan consist of because there seems to be variation from different trusts? Is there a *pro forma*?

**Professor Mascie-Taylor:** The job plan in my experience, in increasing detail defines what the consultant does—

**Q57 Dr. Pugh:** Increasing detail?

**Professor Mascie-Taylor:** Yes. As job planning becomes more sophisticated and as it is embedded then in increasing detail the job plan describes what activities the consultant will undertake throughout their working week. There is the potential to annualise it. There is a complexity that one can use if one wishes. But the essence of this is that it makes explicit to all parties that which the consultant is supposed to do and the pay they get.

**Q58 Dr. Pugh:** So if I looked at a job plan in one trust it would look very similar to a job plan in the next trust. It would not simply be a diary in one place and a very detailed set of descriptions in another.

**Professor Mascie-Taylor:** It would be more similar than it is different. There may be differences from speciality to speciality, hospital to hospital, but broadly speaking, the principle is the same. Yes, they would look broadly similar.

**Q59 Dr. Pugh:** One thing that the NAO commented on was that the lack of trust-wide systems led to variability in approaches to job planning. Have you picked that up and how do you address it?

**Andrew Foster:** Again, through the support from NHS employers to provide guidance and share best practice. But there is a common core. Every job plan has a timetable working week, setting out what happens on Monday morning, Monday afternoon and so on. They would all have that as their common core. But as Hugo said, the more sophisticated organisations have gone into considerably more detail and others can learn from that.

**Q60 Dr. Pugh:** Do the more sophisticated organisations pass best practice around so that job plans are not simply there but monitored and evaluated?

**Andrew Foster:** Yes they do.

**Nic Greenfield:** Perhaps I can say a little bit about the NHS Employers' work. We have commissioned NHS Employers to identify how we can make best use of the contract in its full form, particularly how we can maximise the benefit of job planning by looking at best practice. That also covers how that is linked with appraisal and the objectives of the organisation. We are looking at how we measure productivity, how we benchmark different organisations and the aim of it all is to drive service improvement. We have 60 organisations actively engaged in that process.

**Q61 Dr. Pugh:** One thing that is said about job plans is that they are designed almost to encourage retention: people know what they are doing, where they are going, how things will progress and therefore they stay with the same institution. Would there not be a tendency within a trust if they desperately need a certain specialist or consultant to provide a service and maintain their service to make the plan exactly what the consultant wants on the grounds that they are not immune from market forces?

**Andrew Foster:** Yes.

**Q62 Dr. Pugh:** Is there such a tendency?

**Andrew Foster:** Yes. If you are recruiting to a shortage specialty and you are determined to get a consultant at a certain time—

**Dr. Pugh:** You want a paediatrician or something like that.

**Andrew Foster:**—and there are not many around, you will design a job plan that is going to be appealing. I am not saying that you would fiddle it.

**Dr. Pugh:** Not demanding but appealing.

**Andrew Foster:** You would make it attractive to good recruits, as you would do with any job. There is a second device to deal with pay issues, which was never transparent under the old contract. You now have the ability to explicitly pay a recruitment and retention premium of up to 31% where there are defined market shortages. That is the way to do it, rather than by devious, underhand methods, if you like.

**Q63 Dr. Pugh:** I would not want you to engage in devious, underhand methods. This is a bit of a mess, that has been a long time in the cooking. There have been an awful lot of discussions and what is

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established in the NAO Report is an awful lot of confusion from a variety of different sources, from consultants, the trusts and so on. Why is there so much confusion about the outcome when there has been so much discussion about what is to happen in the first place?

**David Nicholson:** I do not accept that it is a mess. As I said earlier, these are very important building blocks which, for the first time, enable managers and clinicians to organise their work for the benefit of patients in a way that we have never been able to do before. I do not think that is a mess. The complexity of implementing anything on the scale that we are trying to do it is obviously significant, and you can see some of its aspects. There are 180 hospitals across the country, all with their own culture and way of doing things and implementation is very difficult in those circumstances, there is no doubt. We do not operate a Soviet-style system, where you can send instructions from the top, which get delivered straight away locally. It does not work like that; we need to work with clinicians.

**Chairman:** It did not work in the Soviet Union either.

**David Nicholson:** That is true.

**Q64 Derek Wyatt:** Good afternoon. If a FTSE 100 company said it was going to overspend by £150 million but only overspent by £90 million, I would probably fire quite a lot of the people. Was anyone fired for this incompetence inside the system?

**David Nicholson:** No. In relation to that particular calculation, which was 2.3% of the total wage bill, no one was fired.

**Q65 Derek Wyatt:** So no one was actually responsible for that overspend—no one got kicked, nothing happened?

**Andrew Foster:** It was not a central overspend. This was an overspend that took place in 600—

**Q66 Derek Wyatt:** You made the overspend. You said it would cost £565 million, you made funding available for £715 million, but it did not actually make that.

**Andrew Foster:** But the overspend occurred in 600 separate, independent employing organisations.

**Q67 Derek Wyatt:** Let me come to that. First, as a result, did anybody in the Department go on additional courses in finance, management or planning or are you the same core people with no extra additional training or education as a result of all this?

**Andrew Foster:** That question is posed in a rather inappropriate way, but I would say that I personally led this negotiation—

**Q68 Derek Wyatt:** Yes or no?

**Andrew Foster:** I led this negotiation on the consultant contract and then the negotiation for *Agenda for Change* and we learned a lot of lessons from the consultant contract that we were able to deploy in making *Agenda for Change* more successful. But in the last 12 to 18 months—

**Q69 Derek Wyatt:** I take that as a no, then.

**David Nicholson:** That is a yes. We did learn the lessons.

**Q70 Derek Wyatt:** No one has gone on any additional training? There have been no MBA courses, no finance, no London Business School, nothing? It is the same core people.

**David Nicholson:** There are, first, different, new people in the system. We reorganised the financial function to appoint an NHS financial controller whose specific responsibility is the delivery of these sorts of things in relation to inter-finance, and we have enhanced the training and support to our finance function in the Department. It is unrecognisable from what it was 12 to 18 months ago.

**Nic Greenfield:** May I add a word? First, I have come into the team since then as Director of Pay Policy. To answer the question specifically, I am a qualified accountant; that did not exist before. In addition, in *Agenda for Change*, we have implemented 12 early implementer sites. We have piloted and tested it very thoroughly and, indeed, with the issue around unsocial hours payments, we decided not to progress to conclude the payment and are still negotiating on that because we are not sure of the modelling and the outcome of it yet. We have learned those lessons.

**Q71 Derek Wyatt:** The Department negotiated a contact that was based on fewer hours than consultants worked and trust-negotiated contracts with consultants for more hours than they could afford. If it were down to the 600 trusts, how did it work in the supply chain of training? Did it go straight to the trusts, and you told them to get on with it? Did it go to the regional boards or to the trust? Where was the supply chain for the decisions?

**David Nicholson:** It would have gone straight from the Department to the individual employing organisations. The job in those bits of the system—in those circumstances, the strategic health authorities were in the middle—was to help and support organisations to implement it, to share good practice and make sure that there was a relative consistency in the implementation. For example, at the time I was a strategic health authority chief executive in Birmingham and we made sure that all of our trusts delivered the number of PAs that we wanted across the whole of the patch so that one hospital did not agree to more than another, and there was consistency.

**Q72 Derek Wyatt:** Was there a one-week course for the PCTs? What was it? The Report states that most trusts felt that guidance on implementing the new contract was not always clear or timely. You sent it down, and then what happened? You then did what: sent three people or six people down? Did they do a week's course? What happened?

**Nic Greenfield:** You have seen appendix 5 to which David has referred and the wealth of guidance that we provided. We also supplemented it. I worked in an SHA at the time and attended more than 70 workshops over the period of the implementation of

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the contract. We have also kept with NHS Employers a team that has helped roll out the improvements and we now have a major work force change team that is further developing the contract. It was not a spot change; it was a massive change in culture. We continue to try and derive improved benefit from it.

**Q73 Derek Wyatt:** How do you know that the trusts, PCTs and whoever else is involved now have the core competency to continue this? What training have they undertaken? Obviously, there is a disconnect between what you are saying and what they are saying.

**Andrew Foster:** There is evidence, for example, in the fact that the number of programmed activities is reducing year on year and that the guidance and training issued is being used constructively in the annual job plan review to make the use of the contract more sophisticated each year and reduce the hours, which led to the cost overrun in the first place.

**Q74 Derek Wyatt:** But do you think that there is a lack of competency inside the trusts themselves and that, if you have done a better analysis, this would not have happened?

**Andrew Foster:** It is not as simple as that. This was a very complicated thing to try to achieve with 30,000-odd individual consultants having 30,000 individual negotiations. Yes, some people might not have done it as well as we would have liked, but it is completely wrong to say that they were not given advice, support and training. There was a plethora of it.

**David Nicholson:** If I look back, the big issue that we learned from it was that we did not pilot it. We did not get on-the-ground action from which people could learn lessons to implement elsewhere. We went for the whole thing straightaway. That was partly because we were unable to agree with the BMA a set of pilots, and that I think we could have done better.

**Q75 Derek Wyatt:** What percentage of the old consultants have not signed?

**Andrew Foster:** About 10%. That was the last official figure. It is probably less than that now.

**Q76 Derek Wyatt:** What are you going to do with them?

**Andrew Foster:** They continue to have the opportunity to transfer to the new contract. They have the right to remain on the old one. Because no new people can go on to the old contract, as time goes by eventually no one will be left on it.

**Professor Mascie-Taylor:** My experience is that consultants who remained on the old contract are moving slowly to the new contract.

**Chairman:** We shall have to have a break for seven or eight minutes for a Division. I apologise.

*Sitting suspended for a Division in the House.*

*On resuming—*

**Chairman:** We are now *quorate*, so we can resume, Mr Wyatt.

**Derek Wyatt:** I have finished.

**Q77 Mr Curry:** Mr Nicholson, we have had a number of conversations about why things seem to go wrong so consistently. I sometimes get the impression that centrally, the NHS is like a colonial administration: it controls the governors' compound and has some idea what is happening in the villages. You yourself said that you did not know what was happening out there.

**David Nicholson:** I do not think that I said that.

**Q78 Mr Curry:** When the Committee has queried costs and why they are getting out of control, or why there seemed to be no estimate of costs, you or your predecessor have said that it is difficult to know what out there could provide a statistical basis on which to make realistic estimates. Is that still the case, or does the Department now have a clear idea of how to estimate things and how to get an impression of what the consequence of its actions will be?

**David Nicholson:** In terms of the work force, that was the first time in the history of the NHS that we have tried to organise major pay modernisations in the way that we did, so it is not surprising that we did not have data to cover every eventuality. We learned a lot of lessons from that as reflected by the implementation of the *Agenda for Change*. We have learnt much more about how to do this sort of thing.

**Q79 Mr Curry:** You said that you would have liked to run a pilot, but you did not because the consultants organisations would not agree. Is that right?

**David Nicholson:** On reflection, having been through what we have been through, it would have been more helpful to run a pilot. The implementation of the agenda for change means that we have run pilots, such as that for pathfinder trusts.

**Q80 Mr Curry:** I find the fact that the consultant organisation would not agree astonishing. I do not recall any Minister answering a question in this place and saying, "Yes, the Government believe that it would be helpful to have a pilot, but the consultants do not agree". Do you not think that the consultants could have been brought to agree?

**David Nicholson:** I said that, in retrospect, that would have been helpful and that we would have got a better position out of it.

**Q81 Mr Curry:** It was said that you could not agree with the BMA—I noted that expression.

**Andrew Foster:** The initial negotiations were expected to last for around six months and we were expected to begin implementing the contract in April 2003. When the negotiations became protracted and some difficult issues arose, we said that it would be helpful to pilot some of the proposals to see how they work in practice. The BMA was opposed because it thought that there would be a delay in the date of implementation, and that it had been promised that date at the beginning. Effectively, the BMA held us to the position that we had from the beginning.

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**Q82 Mr Curry:** So you accept that you were taking a risk in going ahead without a pilot programme that you felt would have given you management information that would, at the end of the day, get you a better contract.

**Andrew Foster:** So we had to use alternative methods. We relied on the joint diary exercise at the beginning of the negotiations, which had been jointly accepted by ourselves and the BMA. We conducted a series of desk-top exercises; in other words, imaginary implementations. We tried using those techniques.

**Q83 Mr Curry:** I assume that the BMA is made up of reasonable people. What sort of mentality says, "Here is something that might make for a better scheme at the end of the day, but we are not interested. We do not want to do it"? That is a real old-fashioned trade union sort of view, is it not?

**Andrew Foster:** You just have to go to the way things were at the time. The negotiators for the BMA were under considerable pressure from their own members to get the contract and get it quickly. They felt that they had been promised a pay increase, and they wanted it without any delays. I have sympathy with the BMA negotiators and their difficulties.

**Q84 Mr Curry:** So they wanted a pay increase.

**Andrew Foster:** As had been promised, indeed.

**Q85 Mr Curry:** So they wanted the pay. What mattered to them was the pay increase, not better working, more efficient working, or working more for patients—they wanted a pay increase. Is that what you are saying?

**Andrew Foster:** They particularly wanted a reduction in hours—that was their largest stated objective in the negotiations—and they wanted to catch up, as they saw it, with comparative professions in pay.

**Q86 Mr Curry:** And if because of that there were problems with patient care or problems for the trusts, that was just hard ched, was it? It just went with the game?

**Andrew Foster:** We reached an awful lot of agreement with the BMA about how benefits would be derived for all parties. When it came to publicising the contract, you will see that there were statements of what the benefits would be for everybody, and they were signed up to by both parties.

**Q87 Mr Curry:** Given that it took so long to get this contract into existence, albeit that not everybody is signed up, is it now engraved in stone? Medical technology is moving very quickly indeed. In my part of the world people are saying that they actually want people to have to go to hospital less. They want much more to be done by using modern electronics, for example. The more we can keep people at home, the better service we give them. Are we not in danger of carving in stone something that impedes?

**David Nicholson:** That seems to me the good thing about the job planning process. It is annual and the idea is that the institution, or the representative of its management, and the consultants will sit down every year and work out the best disposition of their skills for the benefit of patients. It gives you the flexibility to talk about out-of-hospital working and the rest of it in a way that you could not in the past.

**Q88 Mr Curry:** So the contract is a framework and you believe that, within that framework, it gives a significant degree of flexibility so that as medical science develops, the means of managing it can adapt with it. It will not become like the old contract—locked in stone and outdated.

**David Nicholson:** It was designed to do that.

**Q89 Mr Curry:** What is the situation as regards something that has occurred in my part of the world? As you will know, the North Yorkshire and York Primary Care Trust, as a merged trust, inherited the biggest deficit in the country. A whole series of operations and referrals to the Harrogate and District Trust were therefore deferred. The Trust came along and said, "Please can we buy now and pay later?" I do not know what the outcome of that was. Is that not the sort of thing that can dislocate this sort of contract?

**David Nicholson:** One thing that happened in the past was sometimes that patient care and patient services did not come along in a constant stream. There were times when there was more pressure on the system than at others. The contract provides the opportunity to annualise and change the flow of consultant availability to match that, so it gives you much more flexibility to deal with such issues than you had in the past.

**Professor Mascie-Taylor:** May I add to that? In the basic consultant contract there are 7.5 programme activities for direct clinical care. By negotiation that can be increased by a further two, and it can be negotiated back again. There is flexibility in the contract that did not exist in the previous contract.

**Q90 Mr Curry:** We examined a number of areas in which the NHS has claimed that we are now at the cutting edge of health management worldwide, and the famous computerised referral system is one example. Is there not a case for deciding that we are going to be a bit behind the rest of the world for a while and see how things work elsewhere? As I understand it, there was no real reference to what was happening overseas. Are there not lessons to be learned from what happens elsewhere?

**Andrew Foster:** Actually, we did an awful lot of looking at what the alternatives were. I have personally been to several other countries, and they are envious of our system of remunerating consultants and, indeed, GPs. They see it as a model that they would like to go to. That is especially true of the many parts of the world that are hooked on the "fee for service" system whereby doctors are paid for units of activity. That incentivises them to produce more units of activity without any accountability or control, and it has all sorts of

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negative consequences all over the world. So yes, our system is based on some international research, and is well respected.

**Q91 Mr Curry:** But you looked at what everybody else was doing and decided that basically that did not offer anything that we could draw upon.

**Andrew Foster:** We considered the alternatives, and we decided that something that would introduce a much better managed system of accountability would suit us best.

**Q92 Mr Curry:** Was that the case even for Scandinavia? On the whole we tend to have drawn quite a lot of information about public service management from there.

**Andrew Foster:** I cannot comment on Scandinavia in particular. Does anyone else know?

**Other witnesses:** No.

**Q93 Mr Curry:** Tell me about Mr Channing Wheeler.

**Andrew Foster:** Is he a consultant?

**Mr Curry:** Today's *Financial Times* has an article about him headlined, "US health executive offered top NHS role". The article says, "An American executive with a lifetime's experience of paying for care in the US health system has been offered the job of commercial director at the Department of Health, overseeing the purchase of care for NHS patients."

**David Nicholson:** I can tell you what is happening. Ken Anderson was the NHS Commercial Director, but he has gone off to another job. We are going through an appointments process that is being overseen by the Civil Service Commissioner, and a final decision and an announcement will be made in the next week or so.

**Q94 Mr Curry:** I appreciate that. My question was not intended to imply that anybody was inadequate or has been fired. But recruitment is taking place for a central job.

**David Nicholson:** Yes.

**Q95 Mr Curry:** It is interesting that among the people who might be appointed is a very high profile American. If he were appointed, what experience of his do you think might be useful to the NHS, in contrast with somebody who has come through our system? The nurses appointed a chief executive from America as well, did they not?

**David Nicholson:** It is difficult to comment on an individual case when the recruitment process has not ended.

**Q96 Mr Curry:** Yes. I was not referring to the specific recruitment. The news would not have been a front-page splash—in so far as the FT has splashes—were it not for the person in question being an American executive with what is described as "a lifetime's experience of paying for care in the US health system". You are obviously looking to buy a certain expertise. As far as I know, the other candidates might have that expertise too, but the suggestion is that you think that there is a body of

expertise that could usefully be brought into the NHS. I wondered if you might identify the nature of that expertise, rather than talk about the person.

**David Nicholson:** The view that we have taken is that the NHS is a huge organisation, with many responsibilities, and that we wanted to go across the world to see who was the best possible person that we could get to take on those responsibilities. We will come to the conclusion of that exercise in the next week or so.

**Q97 Mr Curry:** What is the next big challenge? The GP contract has been alluded to, along with consultant contracts, and there is also the computerised referral system. We shall no doubt have conversations about all of them in future. What is the next big thing on which you will be able to do a pilot and in which the methodologies will be more established? What should we be looking out for as the big triumph?

**David Nicholson:** If we consider the way in which the health service is changing, I think that we are moving into a different phase of change at the moment. In the past few years we have essentially seen large amounts of capacity-building in the system—more doctors and nurses, more beds and more hospitals. That is fine—it was needed to achieve the right kind of investment. Now that we have got the investment, we are going through a period of asking how we ensure that it works best for patients. That is why we are introducing pay reforms—to make sure that we can connect that investment with patient benefits. The third step will be to achieve those benefits. I do not see lots of big, national, high-profile changes. The task now is to get the benefit of all the things that you have just described for individual patients.

**Q98 Mr Curry:** And you are confident that how we measure what is of benefit for patients—the outcomes, in the jargon—is meaningful? Have we found a way to measure outcomes in the extraordinarily complex and difficult area that is health?

**David Nicholson:** I think that we are getting there. We are not quite there yet, but a lot of work is being done on clinical outcomes so that we can show which interventions work and which do not, and we are putting a much more high profile on what patients are saying about those services. That seems to be how we root those changes in reality.

**Chairman:** Thank you very much. Mr Alan Williams, you are the last questioner.

**Q99 Mr Williams:** Thank you, Chairman. To return to where I was when I wound up the last session of questions to you, Mr Nicholson, the reality that has come out clearly today is that there is an ambivalence about who controls the NHS—a delusion of management. Would you say that that is wrong?

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**David Nicholson:** We are going through a change.

**Q100 Mr Williams:** Do you control it?

**David Nicholson:** I do not control the NHS any more than anyone else does. We pull a series of levers from the centre that makes things happen. I am accountable for what happens in it; I am very clear about that.

**Q101 Mr Williams:** That is different. That is the very heart of where I am going next. There has been a wrestling to get power back where it should be. We as a Committee have been deluding ourselves for decades that we bring you here as witnesses. We are talking to people who can pull levers, but who have very few levers to hold. The levers are held by the consultants, are they not?

**David Nicholson:** I do not think that they are held by the consultants. They are held by a series of different people. We are trying to give local managers levers to make things happen, and this consultant contract is one of them.

**Q102 Mr Williams:** They have just had a 25% pay rise to do less work, and God bless them, they are unhappy. Someone asked you, “Why are they unhappy?” The answer that we got from you—I have forgotten which of you gave it, but it does not matter; I am not criticising you, because I think that it is true—is that they are unhappy because their level of autonomy has fallen. That is the answer that we were given. They are unhappy despite all the extra money and the fact that they are doing less work, because they may be losing some of their autonomy. Does that not suggest that we have the wrong people sitting here?

**David Nicholson:** I do not think so. In terms of accountability, the right person is sat here, because that is my position, but my job is to ensure that we change the NHS. The whole purpose of it is to make the NHS much more patient-focused. That is part of my job, and I am trying to set out a whole series of levers to enable us to do that.

**Q103 Mr Williams:** That sounds great, but we have been here before, as my colleagues have pointed out. It says in paragraph 1.3 that: “in 1991 . . . the Department introduced a requirement for hospital managers to introduce job planning. The job planning process required managers and consultants to agree the consultants’ duties”. That did not happen, did it? It just did not happen. Why should we believe that it will happen this time?

**David Nicholson:** Because many of the people who were sitting down with the consultant medical staff, first of all, did not even hold the contract. The contract was held by somebody else in the system.

**Q104 Mr Williams:** Hold on. If, as you are saying, they were not the people who could do it, why did you require them to do it? Answer that.

**David Nicholson:** In 1991?

**Q105 Mr Williams:** Tell me. How could you require people to do it when you knew that they did not have the power?

**David Nicholson:** Sometimes people have to use influence, don’t they? That is what we required them to do in 1991. What is clear from that is that it did not work—you are absolutely right. It did not work for a series of reasons. One is that they did not have the levers themselves—they did not hold the contracts—and the second is that there was no requirement on individual consultant medical staff to do it either.

**Q106 Mr Williams:** But you were the Department. You mean that you did not know that they did not have the power?

**David Nicholson:** Well, no.

**Q107 Mr Williams:** After all those years—in 1991, nearly half a century after the NHS was established—you did not know that they did not have the power and the consultants did?

**David Nicholson:** In 1991, my assumption is that the Department would have used the levers that were available to it at the time.

**Q108 Mr Williams:** They told other people to use the levers, but these are people whom you have already told us do not have the levers.

**David Nicholson:** The leverage that they were using was to write out a requirement to the NHS to do something. However, what clearly was the case in reality—and this is the lesson that we have learnt—is that locally, people were unable to do it.

**Q109 Mr Williams:** But, you see, we can only question you on the Report that we have. You agreed the Report, and it said that you required it, but you did not. You required something that you knew that they could not deliver. You made no attempt—not you personally, obviously, because this was way before your time—but nobody made any attempt to give them the power to require it. Why not?

**David Nicholson:** They did begin to, because after 1990–91, we had the setting up of the first NHS trusts, which meant that the transfer of the responsibility for employment of consultants moved from the regional health authorities to the hospitals. During the 1990s we saw that develop, but what did not develop was the other side of it, which was the requirement of consultants.

**Q110 Mr Williams:** You transferred it, but you required them to do something that you knew they could not deliver, and they were completely incapable of delivering, because consultants would not allow it to happen. Does anyone want to volunteer a solution to this?

**Professor Mascie-Taylor:** I wish I had a solution, but I can point out the direction of travel. If you look back at the late 1980s and early 1990s, the majority in health care delivery, and certainly in secondary

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and tertiary care, undoubtedly sat with the consultants. If you now look at the same situation, that power is much more shared between patients, politicians, managers and the professions. What has happened since the early 1990s—one could point to a whole range of examples—is that consultants have moved from a position of very substantial autonomy to increasingly being treated more and more as employees. There is both good and bad in that. There are benefits for them, as well as disbenefits. Some of them are unhappy because they think that the disbenefits outweigh the benefits; others are very happy because they believe that the benefits outweigh the disbenefits. However, addressing your question on the direction of travel as to where power lies, there are all sorts of pointers along the way of the last decade, and the consultants' contracts is yet a further example of how that shift of power is taking place both politically and in terms of process.

**Q111 Mr Williams:** From where we are reading this Report, what you have is the consultants who have power without accountability, while you have accountability but no power. That sums up the situation up to now, does it not? Can you prove why it does not?

**David Nicholson:** There are all sorts of levers.

**Q112 Mr Williams:** Why did they not deliver on 1991, if you had the power?

**David Nicholson:** If you are specifically talking about the relationship between consultants and management, what we are trying to do is to give local management the power. I do not want the power to be able to tell consultant medical staff what to do; it would be ludicrous for me to do that from the centre. What I want to do is to give local managers power in order to enable them to organise services round the needs of patients. This contract is part of that mechanism.

**Q113 Mr Williams:** But, you see, in paragraph 2.24, it is actually admitted by the consultants, in effect, that there has been an inherent conflict of interests in the system. They sit as consultants, on a rotation basis, listening to the representations of their colleague consultants, and allocating them what they want. As they said: "The consultants have told us that there is an incentive to be naturally sympathetic to their colleagues' wishes." They have been looking after each other, have they not?

**David Nicholson:** I do not think that that is the case. **Mr Williams:** They said it, not me. You agreed it. It is written here.

**David Nicholson:** I agree that they said it. I don't agree with it, and I don't necessarily think that that is the case.

**Q114 Mr Williams:** I am sorry, but you must agree with it, because you agreed the Report. Did they dissent on this part of the Report?

**David Nicholson:** I agree that the consultants who were asked that said that, but I do not agree with what the consultants said.

**Q115 Mr Williams:** Okay, let me round up because I have virtually run out of time. In our briefing, the NAO sums up what it sees as the situation now. It points out that the contract has been in place for three years, which is indisputably so. But it says that there are few examples of good practice in job planning. Despite three rounds of job planning it says that there is very little evidence that they have led to working differently. Finally, it says there is difficulty in identifying anything other than small pockets of good practice. Now if that is not damning with faint praise, I do not know what is. What do you think? Is it incorrect?

**David Nicholson:** Where is that in the document?

**Mr Williams:** I said that this is in our briefing from the National Audit Office. I said to you at the outset that you can disagree with it because you have not signed up to it. This is our assessment from the NAO in the briefing that it has provided specially for this meeting.

**David Nicholson:** I think this contract has had an impact on every single hospital and on every single clinical service in this country. Basically, consulting medical staff and sitting down with local managers and local clinical leaders makes a big difference.

**Chairman:** Okay. You have made your point. Mr Wright has a final question for you.

**Q116 Mr Wright:** I just want to pick up on something that Mr Curry said. He talked about the change in Government policy away from hospitals towards the community. You seem to acknowledge the fact that the consultants' contract would allow flexibility in that. Given that in my patch—I know that it happens elsewhere too—hospital reconfiguration in terms of specialising centres seems to be driven largely by what the consultants want. What reassurance can you give me that things that used to be done in hospitals that can perhaps be done in GP practices by consultants will be done and that the consultants' contract will allow that to happen?

**David Nicholson:** That is the whole basis—

**Q117 Mr Wright:** Can you give me an assurance that that will happen?

**David Nicholson:** That is absolutely what we are trying to do.

**Chairman:** That is the answer. I think that we shall probably end there. It only remains for me to try to sum up. You had a very interesting discussion with my colleague Mr Williams. He accused you of having responsibility without power and I think he accused the consultants of having power with responsibility. He did not finish Baldwin's quote that that is the privilege of the harlot through the ages. He was far too polite to say that and I would not say it either.

**Mr Williams:** I do not need to.

**Q118 Chairman:** I do recall that Mr Milburn, who is rather more recent than Mr Baldwin, said when he announced this contract: "It is a something for something deal, where consultants earn more, but

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only if they do more for NHS patients. And it will be for NHS employers to make sure that is what the contract delivers.”

I think that we have found today that one of these somethings is absolutely clear. That is the something we are paying: £715 million. The other something—what they are delivering—is altogether more opaque. Paragraph 26 says: “There is little evidence that ways of working have changed as a result of the new contract”. Paragraph 3.26 states: “Our surveys showed that more consultants and trusts disagreed than agreed that waiting lists, patient care and service responsiveness have improved as a result of

the new contract.” I am afraid that this is a damning Report and I am sure that our own Report will be damning. Unless you wish to have the last word, Mr Nicholson, that is it.

**David Nicholson:** When people look back on this contract they will see it as a really important step forward, not only for the NHS but for the relationship between consultant medical staff and the management of the service. This gives us a fantastic opportunity to connect and a really important resource of the NHS is to consult medical staff on the needs of patients in a way we have never been able to do before.

**Chairman:** Thank you very much.

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**Letter from Mr Rob Harwood to Mr Richard Bacon MP**

I was hoping to make some comments ahead of Monday’s PAC evidence session on the 2003 Consultant Contract. If you find my comments useful but are not in a position to use them yourself please feel free to pass them on to one of your colleagues on the Committee.

NAO Report on the Implementation of the 2003 Consultant Contract

*1. Consultants still do much work over and above their contracted hours; under the 2003 contract they simply do less of it*

Many trusts have gone to great lengths to reduce the number of Programmed Activities (PAs) paid for in each consultant contract; the reductions in paid PAs often do not reflect reductions in hours worked.

The move by Trusts to reduce contracted hours has increased since April 2006 when many Trusts found themselves in a difficult financial position; trusts still have the same or greater requirement for work from their medical staff but are trying to make savings by cutting back on hours of work that are paid for.

In my own Trust consultant staff representatives are leading a review, together with the Trust, of our in-house job planning processes with the aim of introducing greater flexibility and clarity about work content and time. Our Trust has concerns that greater clarity may not mean that it can safely reduce the number of PAs it pays its consultant staff, rather it fears that it may currently under-reward some consultant staff.

*2. The DoH seems to have disregarded the results of consultants hours of work surveys when deciding on funding for the 2003 contract*

This seems to have been at the heart of the underestimation of the 2003 contract cost. The DoH has an unhappy record of cost estimation for employee contracts having underestimated costs for trainees, consultants, GPs and all other staff under Agenda for Change; all these contracts are time or output based suggesting that the DoH does not have adequate information regarding the amount of work its employees actually do on its behalf.

*3. Consultants introduce innovation into the NHS and could do more if properly resourced*

Much innovation in the NHS has been and continues to be introduced and developed by its consultant staff. However, restrictions on consultant activity can impede the introduction of new developments and this may slow the pace of change. In my own hospital, which is a successful hospital with a good management team and a good working relationship between managers and consultant staff, we have found that it has not been possible to introduce changes to working practice that would lead to throughput efficiencies because of pressures to meet existing performance targets. As an example, myself, orthopaedic surgical and anaesthesia colleagues are developing protocols to encourage early discharge, where possible, of patients following total knee replacement surgery. We have already introduced a similar programme for uni-compartment (“half knee”) replacement surgery that has reduced the time to discharge to around two days. We have not been able to advance this programme as rapidly as we would like since it is not possible to devote sufficient staff time while, in our respective departments, working to deliver existing targets.

#### 4. *Consultants do not fear the development of better job planning practices*

In many trusts there is an impression that the job planning process has been weak to date; this need not be the case, both parties can benefit by strengthening job planning. Trusts can benefit by using some of the flexibility that the annual job planning process can include to plan well and responsively for their future needs. Consultants can benefit by setting objectives, perhaps across departments, for standards of treatment and practice which could drive up performance within their own department—this would restore some control over clinical activity to clinicians. Objectives may be set for both Direct Clinical Care and Supporting Professional Activity time. All parties benefit from having absolute clarity about what time is spent working and what activity is undertaken on behalf of the health service. The impression that consultant staff contribute little time to the NHS is hopelessly inaccurate and extremely dispiriting for consultants staff who are, despite popular reporting, still working long hours on behalf of their patients—absolute clarity will help allay any uncertainty about the contribution that consultants make.

*Rob Harwood*, Consultant Anaesthetist,  
Chairman, Eastern Region Consultants and Specialists Committee

*April 2007*

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#### **Memorandum submitted by the British Medical Association**

Hospital consultants are working long and intensive hours for the NHS and are striving to lead improvements in patient care, says the BMA in its response to the National Audit Office (NAO) Report on the new consultant contract for England published today (19/4/2007).

Although the NAO reported that consultants' working hours have decreased by 1.4 hours a week, consultants' workload remains high. Dr Jonathan Fielden, Chairman of the BMA's Consultants Committee said: "It has never been easy calculating exactly how many hours consultants work for the NHS. It is clear that their workload remains high, is intensely demanding and exceedingly complex. NHS trusts have deliberately cut back on activity in recent months to save money despite consultants' willingness and ability to do more. NHS consultants have led on delivering reductions in waiting times and strive to introduce new treatments and efficiencies for patients. If trusts are failing to realise the benefits of the contract it is because they have been distracted by the pressure to balance their books and meet political targets.

"The Government accepted that the old contract failed to recognise how hard consultants worked and believed consultants should be better rewarded. The new contract is designed to more accurately reflect consultants' working patterns and aims to pay consultants for the work they agree to do. However many consultants continue to work many unpaid hours in excess of their contract through their professional dedication to patient care."

Evidence on the impact of the contract on patients was gathered almost a year ago, and there are now signs that improvements in care are becoming more apparent. Dr Fielden said:

"This is the most significant change to consultants' contracts since 1948 and it will take time for the NHS to use the tools in the contract to their full potential. Hospitals and consultants can now more clearly match activity to the needs of patients and when the contract is implemented properly we are seeing the benefits. Consultants have told us how the contract has facilitated better team working to improve continuity of care, changed working patterns to improve efficiency, allowed a greater presence of consultants on wards at key times and optimised the best use of theatre time.

A recent BMA survey<sup>1</sup> found that four out of five consultants had initiated changes to improve patient care in the last year, but many of their plans for further improvements were thwarted. Two out of three respondents Reported that planned services had been abandoned or delayed and approximately three out of five said they or their colleagues were experiencing problems because clinically effective treatments or procedures were no longer available or were restricted.

Dr Fielden said: "A key aim of the contract was to ensure consultants had protected time to develop and improve services, yet innovation is being restricted because of financial constraints. Ironically, many ideas put forward by consultants would help NHS trusts save money and improve the quality of care for patients."

The NAO is critical of the government for how much the contract was overspent. Dr Mark Porter, lead negotiator for the BMA's consultants' committee said: "The Government miscalculated the cost of the contract because it underestimated how hard consultants work for the NHS. The contract was fully costed during negotiations and the Department of Health made extra funding available to NHS trusts when it became apparent that there would be an overspend.

"The recommendations are helpful in highlighting to trusts the importance and value of the job planning process that allows resources to be matched to consultant workload. The BMA looks forward to discussing with NHS Employers how best consultants can use their contracts to maintain and increase standards of patient care."

*19 April 2007*

**Letter from Mr Andrew Thomas to the Clerk of the Committee**

The main point of my original letter was to highlight the concerns of the British Orthopaedic Association about the National Decontamination Programme which is a much bigger issue for our Trust than the Consultant Contract.

If we give the consultants a pointless above inflation pay rise then all we need to do it ease up on pay increases for a couple of years and the situation is restored. The difference with the Decontamination Programme is that, because of the arrangements between the programme and the lead banks and the contracts entered into, we are stuck with the programme for the next 20 years. One concern is that if there is a new and much cheaper technology for doing the decontamination the NHS might not get the savings and could end up in a similar situation to Trust's which have had their PFI's refinanced.

Regarding the question of the Consultant Contract we agreed that I would email you some comments on the NAO Report.

In Appendix 4 I think that it is important to understand the effect of pay drift. The point is that an established consultant does not get an annual increment. This only happens in the first few years and therefore if you appoint a lot of new consultants, as was done around 2001, the effect of pay drift is more severe for the first few years afterwards.

In Appendix 7 it is not adequate to simply look at FCE's per consultant. Our FCE's per consultant have indeed fallen but this has been more than compensated for by a large increase in day cases.

An additional point is that a higher proportion of the FCE's will now have an operation by a consultant. For example 30 years ago you might be admitted to hospital with a heart attack and looked after by very junior medical staff, whereas now you might get a stent carried out soon after admission by a consultant. Similar considerations apply in fracture surgery.

In Appendix 4 there is a lack of clarity about the difference between a consultant and a specialist. The point is that some people counted as specialists in countries such as Germany maybe working at a level which we would count as a Staff Grade or Senior SPR. Charts 19 and 20 are a little confusing as the self employed are Oxford blue on Chart 19 but Cambridge blue on Chart 20. I suspect that the distinction is not as important as it looks. I know orthopaedic surgeons in Canada who are paid a salary although their institution is reimbursed per case and also I know orthopaedic surgeons in Germany who are paid by the case and have the Porsches to show for it.

*Andrew Thomas*  
Medical Director and Company Secretary & R&D Facilitator  
Royal Orthopaedic Hospital NHS Foundation Trust

*April 2007*

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