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THE PRIME MINISTER

29 June 1988

Dear Tony

Thank you very much indeed for your letter of 1 June enclosing the further report you have prepared together with Professor Ian McColl, Professor Cyril Chantler and Dr. Clive Froggatt. This is an extremely helpful further input to the work of the NHS Review and I am most grateful for your hard work.

Yours ever

Margaret

The Lord Trafford

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MEDICAL AUDIT

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HC 30 76(a-b)

MEDICAL AUDIT

Note by the Secretary of State for Social Services

Background

1. Medical audit is a critical analysis of medical activity in terms of process, outcome and implications for the management of resources. It is a potentially powerful tool for improving the quality of care and use of resources. It encompasses measurement of clinical outcome, scrutiny of clinical efficiency and productivity, assessment of patient satisfaction and fulfilment of contractual duties. As a full understanding of medical practice is essential, much of the analytic activity in medical audit is undertaken by colleagues in the same specialty - so called "peer review".

2. There have been encouraging developments in medical audit recently. Examples are:

* the Confidential Enquiry into Perioperative Deaths, a major study of all deaths within 30 days of surgical operation in 3 regions, now to be extended nationally with DHSS funding.

* a working party of the Royal College of Physicians, which is studying ways of extending the use of medical audit.

* the development of national protocols for checking standards in several branches of pathology.

Action proposed

3. The major unresolved problem at present is that consultants most in need of audit can refuse to participate. There are two specific steps we can take to help deal with this problem, and I propose that we do so:

* A number of medical Colleges are moving towards making participation in audit a condition of a unit being allowed to train junior doctors. We should press them hard to do this.

* We should make participation in an audit programme a condition of employment under a revised consultant contract, and require junior doctors to participate also.

We must also make sure that our other proposals serve to embed medical audit into the system, for example through the criteria for hospitals to become "self-governing"; and that we encourage similar developments in nursing.

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4. We need to determine responsibility for undertaking and overseeing medical audit, and to establish a new national body to support and monitor the initiatives which are needed at local level. I suggest we invite the Colleges to take this on in the first instance, with suitable non-medical representation. But if they are unwilling we should be ready to set up a body ourselves, with professional assessors.

5. Associated with the process of medical audit are two other developments which I suggest we should promote:

* further work on health outcome assessment: at present there is a paucity of information on the effectiveness of medical care to back up measurements of efficiency.

* continuing education: it is crucial that consultants maintain and develop their skills throughout their careers. We need to ensure that both managers and the medical Colleges reinforce this by making clear what they expect consultants to achieve in this regard.

6. There will be some modest additional costs associated with an expansion of medical audit, health outcome assessment and continuing education, and we shall need to assess these and take them into account in the normal PES process.

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CONSULTANTS

Note by the Secretary of State for Social Services

1. I attach a paper which offers a fairly full discussion of the scope for changes in the employment and management of consultants.

2. The main potential changes are listed in paragraph 5. But I suggest we focus mainly on the handling of the issues raised, not only in their own right but also in the context of the review as a whole. We must be clear about the extent to which we are prepared to face a row with the profession.

3. There are two main dimensions to the handling issues:

* whether any or all of the changes should be

  - negotiated, at whatever financial price emerges from the negotiations, or

  - imposed, at whatever political price we judge to be worth paying.

* whether any or all of the changes should be

  - confined to new consultants, or

  - negotiated for, imposed on or offered (on a take it or leave it basis) to existing consultants.

4. I suggest we consider carefully how these issues bear on the list in paragraph 5. For example, short-term contracts are most unlikely to be negotiable at any price, although it might be publicly defensible to impose them on new consultants and offer them to existing consultants; and major changes to the distinction awards system may be negotiable only for new consultants. On the basis of our conclusions I shall have a more detailed set of proposals drawn up for inclusion in our review package.

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CONSULTANTS

Note by the Secretary of State for Social Services

Introduction

1. This paper discusses the need for changes in the employment and management of consultants. Some factual information about hospital medical staffing is appended.

2. My aim is to:

* clarify the relationship between professional and management responsibility.

* ensure that NHS consultants are clear about, and committed to, their service responsibilities, the resources available to them, and their accountability to management.

* make it easier for NHS management to ensure that consultants meet their contractual commitments.

* keep in view the importance of the profession's commitment to other important changes arising from the review or, for example, from the resource management initiative.

3. We must preserve both the freedom of consultants to take clinical decisions within the boundaries of accepted professional standards, and their 24-hour responsibility for their patients. The major problem is that some consultants tend to argue or assume that their accountability is only to their patients. While this is true for individual clinical decisions, it is unacceptable for management to have little authority or influence over those who are responsible for committing most of the service's resources.

4. We must address two questions: what changes should we make to achieve these ends? And how do we implement those changes?

What changes should we make?

Summary

5. The main changes we need to consider, ranked in broad terms from the easiest to the most difficult to deliver through negotiation, are as follows:

(i) reviewable job descriptions

(ii) new disciplinary procedures

(iii) participation of local management in the selection of consultants

(iv) moving contracts from Regions to Districts and, in due course, to self-governing hospitals

(v) a new reward system to replace distinction awards

(vi) short-term contracts.

6. The following paragraphs discuss each of these in turn. In addition, I am proposing in a separate paper that participation in medical audit programmes should be a condition of employment under a revised contract.

Reviewable job descriptions

7. Consultants' contracts are currently held at either Regional or Teaching District level. Sir Roy Griffiths's Management Inquiry suggested

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that what matters most is who manages the contract rather than where it is held: the management of consultants' contracts is no more successful in teaching districts than in other districts. We need job descriptions and programmes of work which are established at district level; which are regularly reviewable; on which each consultant could be called to account; and which distinguish clearly between purely professional matters and those in which consultants are no different from other staff.

Disciplinary procedures

8. I am already in discussion with the profession about disciplinary procedures, and in particular the need to provide managers with more rapid and effective sanctions for use in the relatively few cases where allegations of professional misconduct or incompetence are insufficiently serious to warrant dismissal. We are close to agreement, and I see these new procedures as an important part of the overall package.

Participation by local management in Consultant appointments

9. Consultant appointments are recommended - and almost invariably confirmed by the health authority - by essentially professional Advisory Appointments Committees whose primary consideration is the professional suitability of the candidate. There is no provision for District or unit managers to take a full part in these proceedings so that account is taken of the willingness and ability of the candidate to adhere to district policies on resource management. I suggest that we change the Appointment Regulations to permit the participation of local management in the selection of consultants.

Moving contracts from Regions to Districts

10. Moving contracts from Regions to Districts would usefully underline the authority of local management, and I suggest we do that also. This

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would be unpopular with the profession, although perhaps less so if we change the composition of District Authorities to reduce the "political" element (and I am working separately on this). For hospitals which in due course become "self-governing", this change would be a precursor to those hospitals holding consultants' contracts themselves - which many in the profession might prefer. If this initiative is to succeed, it will be important to ensure that more clinicians become involved in local management and that, through this and other means, management arrangements are strengthened.

Distinction awards

11. Distinction awards for consultants were introduced in 1948. Their purpose is to enable a significant minority of consultants to achieve higher earnings for distinction and merit comparable with those available in other professions. An award takes the form of a superannuable increase in salary at one of 4 levels (ranging from £6260 to £33,720 per annum) which, once awarded, remains payable until retirement. An independent Advisory Committee on Distinction Awards makes annual recommendations about new recipients: apart from the Vice-Chairman, this is a professional body which takes advice from many professional sources and Regional Health Authority Chairmen. In their April 1988 report the Doctors and Dentists Review Body expressed concern about the operation of the distinction awards system and have suggested the introduction of an upper age limit for recipients, an examination of the concept of fixed-term awards renewable after review, and a greater involvement of management in the awards process.

12. I agree with the Review Body that we need to overhaul the distinction awards system and make it more consistent with the current needs of the NHS. Our aim would be to provide a continuing incentive to consultants not only to excel in clinical terms but also to make a valuable contribution to the development and management of the service. This could be achieved, for example, by

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* making awards for future award holders reviewable after, say, 5 years.

* widening the criteria for awards to encompass the consultant's contribution to the development and management of the service.

* injecting a stronger management voice into the awards process.

Changing the distinction awards system in this way would make it more akin to performance pay, especially if "awards" were made reviewable.

13. We should need to consider the position of existing award holders. Making all awards, old or new, subject to review every 5 years would give existing award-holders five years' notice of the possibility of withdrawal and a full opportunity to earn its retention. On the other hand the profession would argue strongly that:

* awards recognise proven distinction and merit in the past, and therefore cannot be removed without gross injustice to the individuals concerned.

* award-holders will have arranged their financial affairs on the basis that awards, once given, become part of salary and are retained until retirement; and to remove the award of a consultant with a maximum award, for example, would reduce his salary by some 50% at a stroke.

If the changes were confined to new award holders it would be many years before the new system applied to all consultants. The actual length of time depends on various assumptions about the way in which the new scheme

would operate, but a reasonable estimate would be 15 years or so, with 50% of consultants on reviewable awards within about 6-7 years. Colleagues might think it sufficient to tackle other aspects of the contract whilst limiting changes here to new award holders.

Short-term contracts

14. Consultants are appointed to posts without term subject to 3 months notice, and can be dismissed or made redundant. There are two major ways in which consultants differ from other employees:

- First, the normal expectation is that once appointed a consultant stays in the same post until retirement age - perhaps for some 30 years. This is a matter of custom and practice.

- Secondly, although consultants can be dismissed in much the same way as other NHS staff (with specific procedures which health authorities must follow before a consultant can be dismissed on grounds of professional misconduct or incompetence), they have a right of appeal to the Secretary of State against dismissal. This is in addition to their rights under general employment law and applies to all forms of dismissal including redundancy. Because the Secretary of State has the power to direct that employment should continue, this procedure can act as a disincentive to authorities considering redundancy, but it does not actually prevent redundancies being made.

15. Broadly speaking, we could adopt one of two approaches to dealing with these difficulties:

(i) we could use the levers which the changes outlined above would give us. Reviewable job discriptions and the management of contracts at District level would make it much easier for

management to monitor and change responsibilities and, if necessary, make posts redundant. Coupled with changes to the appointments procedures, and perhaps some financial incentives to relocation, retraining and even early retirement, these changes would amount to a powerful management armoury.

(ii) we could introduce short-term, reviewable contracts, with renewal perhaps dependent on the achievement of agreed levels of service. This in turn could be done either for new consultants only or for all consultants aged less than, say, 50 or 55. Introducing short-term contracts for existing consultants would be impossible to negotiate and would therefore require primary legislation; but would add significantly to a health authority's ability to dispense with the services of someone whose performance is unsatisfactory or whose services are better deployed elsewhere.

16. Short-term contracts could be expensive. My current PES bid includes a "marker" of £50 million (an average of £3,000 or so for each consultant) for negotiating a revised consultants' contract. For a package which did not include short-term contracts that figure remains the best estimate available at present. To "buy" short-term contracts would certainly cost much more. Although the additional salaries paid to general managers are not strictly analogous, applying the same percentage increases to consultants on their maximum would represent an additional £9,000 a year as compensation for loss of security. If short-term contracts were to be offered to or imposed on newly appointed consultants from a given date, the cost even at this rate could start from as little as £7 million in year 1, with similar increases in subsequent years. If we were to impose short-term contracts on all existing consultants below the age of 55 the cost would be in the order of £108 million a year from year 1. A further option would be to offer or impose for all newly appointed consultants and to make the short-term contract available to existing consultants who wished to change it. In that case the cost would depend on the up-take and would fall somewhere between these two figures.

17. The choice between the alternative approaches in paragraph 15 is partly a matter of judgement on the merits, but is also bound up with how we achieve the changes we seek as a whole.

How do we do it?

18. There are several ways in which the implementation of these changes could be handled. I see five basic possibilities: ranging from the least to the most draconian, they are

(i) to negotiate with the profession - with a realistic hope of agreement - those changes which can be accomplished broadly within the existing contract. This would effectively confine us to the first three of the changes listed in paragraph 5 (of which the third, local management participation in appointments, would be the most difficult to secure agreement on), but would still make for a worthwhile package.

(ii) to introduce a comprehensive new contract for new consultants only, leaving existing consultants on their present contracts. The problem here is the time it would take for the change to work through: it could take up to 15 years before even two-thirds of consultants were covered by the new contract on this basis.

(iii) to introduce a new contract for new consultants, and also offer a substantial incentive - in terms of higher pay - for existing consultants to move on to that contract if they choose to do so. The problem here is the cost (see paragraph 16 above).

(iv) to proceed as at (iii), but taking legal powers to impose the new contract on existing consultants if the take-up is inadequate. This would be a surer route to securing the

changes we want, provided that care was taken not to breach the European Convention on Human Rights (as fundamental changes in an existing contract might do); but would certainly provoke a major row with the profession.

(v) to impose a new contract by law. Subject to the same human rights proviso, this would be the surest way of implementing change. But a huge row with the profession would be a certainty.

19. My initial inclination is to go at least for option (iii), as a publicly defensible way of securing major change, but - for the reasons given in 15(i) - not necessarily to include short-term contracts in the package. Colleagues will wish to discuss the possibilities, not only in their own right but also in the context of other changes we are considering which would affect the profession or require their support.

June 1988

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APPENDIX

MEDICAL MANPOWER

England and Wales 30.9.86

Sector		Number
Hospital Service (1)		38,476
Community medicine		847
Community Health Service (2)		1,385
Hospital and Community Health Services	Total	40,708
General Medical Services		28,262
Total Medical Manpower		68,970

2. **Hospital medical staffing (main grades)**

	Number
Consultant	14,584
Senior registrar	3,394
Registrar	6,250
Senior House Office	10,318
House Officer	2,977

Notes

1. Main grades only (i.e excluding "clinical assistants", many of whom are also GPs.

2. Whole-time staff only (to avoid double-counting).

Consultants - key facts

3. Consultants can be appointed as:

		Proportion
i.	Whole-time. Private practice must not exceed 10% of salary.	48%
ii.	maximum part-time paid at 10/11ths of whole-time salary. Can undertake unlimited private practice.	32%
iii.	other part-time	9%
iv.	honorary (normally University employees)	11%

b. Under his terms of service, a part-time consultant as well as a whole-time consultant is "expected to devote substantially the whole of his professional time to his duties in the NHS".

c. Whole-time consultants' salaries start at £27,500 rising by four annual increments to £35,500. In addition, 36% of consultants receive a distinction award of between £6,260 and £33,720 p.a. One per cent receive the highest award: their whole-time salary (on scale maximum) is £69,220. Some 68% of consultants are in receipt of an award by the time they retire.

d. Total HCHS medical and dental pay bill for 1987/88 estimated to be £1,516 million, including some £50 million for distinction awards.