DEPARTMENT OF HEALTH AND SOCIAL SECURITY
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From the Secretary of State for Social Services

CCB/UP/H

SECRET 3A-F

Paul Gray Esq
Private Secretary
10 Downing Street
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5 July 1988

Dear Paul,

NHS REVIEW

I enclose Sir Roy Griffiths' paper on Consultants for the meeting of the Prime Minister's Group on the NHS Review which is to take place on 8 July.

Copies of this letter and enclosure go to the Private Secretaries to the Chancellor, the Chief Secretary, the Minister for Health, and the Secretaries of State for Scotland, Wales and Northern Ireland; to Professor Griffiths and Mr O'Sullivan at the Policy Unit and to Richard Wilson at the Cabinet Office.

Yours sincerely,

Geoffrey Podger

GEOFFREY PODGER
Private Secretary

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CONSULTANTS' CONTRACTS

This note summarises the points on consultants' contracts which I was making at the last meeting.

Before moving to change the contracts, either as to tenure or other terms and conditions, and deciding whether to extend these changes to all consultants or simply to new appointments, we should decide:-

1. what it is we are seeking to achieve;

2. to what extent this is possible under the existing contract;

3. if it is not possible, what changes to the contract are necessary;

4. what dangers we are running in making changes only to contracts for new appointments.

We are looking to the consultants to provide high quality of care, more efficiently, more expeditiously and more conveniently to the patient (the right product at the right time at the right price). We should not underestimate the extent to which improvements are being made under the various management initiatives (there are many hospitals, including Guy's which have taken on effectively the messages from the Management Inquiry and are producing results.) The involvement of the clinicians comes not from any road to Damascus enlightenment or from any stroke of the legislative or contractual pen, but from an understanding by management and clinicians that the running of hospitals is like the running of any other business and depends on clear responsibilities, clear targets, a good budgetary system and a system of appropriate rewards and incentives (not all personal).

Have these successes been exceptional and do we require any change in contract to make them the norm and to facilitate and accelerate progress?

The starting point is that the contracts with consultants are contracts of employment and not like those of GP's, contracts with independent contractors for services. There

is always in any contract of employment a vast middle ground between absolute employer rights under a contract and absolute employee rights - in other words how far does management prerogative cover the middle ground? In areas of the private sector over the last 10 years the middle ground has as a matter of will, been largely reclaimed. We should do it in the Health Service. The nature of the contract is that consultants can be required then to perform those activities which are at the heart of the contract, whether expressed or implied. The specific obligations are generally set out in terms of sessions etc. I believe that consultants can be required to take part in management processes such as budgetary cost control, clinical review and a quality audit as being integral and being implied in their contract of employment. Other flexibilities such as a requirement to move to day surgery (which might be regarded as requiring a change to clinical practice) can be controlled by allocating the money and resources for day surgery as distinct from in-patient surgery. In short I believe that most of our requirements are achievable with the present consultants' contract. Their active co-operation would of course be positively sought, but if refused the consultant would run the risk of dismissal.

There remains two substantive issues which are not covered by contract. Existing contracts are generally quite specific that the appointment is to a particular position at a particular hospital. This should be changed in any new contracts if it is thought desirable. Secondly, it is clear that if a consultant is asked to take on duties substantially different from his existing duties, such as in any organisation would be regarded as a new job, then this would have to be re-negotiated in the individual case, e.g. if asked to take on substantive management duties such as a part-time general manager outside the normal implications of his work. Against this background we have to consider the three issues which, many suggest, have to be addressed if we are looking for real advance.

1. Moving the contracts from region to district.

2. A new reward system to replace the distinction rewards.

3. Short term contracts.

A common factor in the background of all three is that management aspects have not been regarded as part of the basic contract. In 1. above the Management Inquiry made it quite clear that it did not matter legally where the contract was held (in most companies it is held by the company itself). The real question is who has the management authority, subject to the appropriate appeals procedure, to discipline. It should be made quite clear that the regions should, providing the district have exercised discretion within reasonable limits, accept the district's recommendations on disciplinary matters and that the district in effect should be seen to have the appropriate management authority vis-a-vis consultants.

Under 2. there are already proposals in HC29 for a new reward system. It should be made clear that no award should be made where, whatever the professional merits, there have been reservations as to the consultant's participation in the management tasks implicit in his contract. Additionally some awardsshould be given for special excellence in the areas of management.

ie John Moore's paper on consultants.

On the question of tenure the legal position is as set out in paragraph 14 of HC29, i.e. contracts are subject to 3 months notice, with the expectation by custom and practice that they will continue. The justification for this practice is that it simply reflects the fact that the NHS is a monopoly employer and a consultant has a right to expect that his employment will be for life. The reality is that the consultants' contracts, like the GP's contracts, have rarely been managed by anyone and the contracts rarely terminated except for the most flagrant breach. To effect substantive change it has to be made clear that performance in terms of quality audit, and participation in management processes such as budgeting and resource allocation, are part of a consultant's job and to go for any kind of change in the overall contract without tackling these matters will be to ossify the contract even more. The suggestion of a 7 year renewable contract would become by custom

and practice again a life contract. In any case it is almost laughable to suggest that a 7 year contract will give flexibility. It has no precedent other than biblical; even company law expressly forbids Directors more than 5 year term contracts without shareholder approval and, in any case, term contracts are most exceptional in the private sector. Term contracts will in any case probably have a ratchet effect on costs, with the cost for renewal escalating.

I am not under-estimating the strong passions aroused everywhere by considerations of tenure and the holding of the contracts by districts. Both have become regarded as symbolic pre-requisites of change. We should seek the appropriate change by management action within the contracts and only go for changes of tenure and to district contracts if they can be achieved without tremendous extra cost. If politically it is adjudged necessary to move on these matters, then it should be appreciated that the moves are not for managerial reasons. We should also expect, if we make these moves, consultants to put many other issues on the table; payment for 24 hour cover and possibly overtime, where currently we get away quite cheaply.

Revised disciplinary procedures and the right to move doctors within the Health Service are flexibilities worth negotiating. The former is in any case under review and I would simply add into contracts with new consultants the right to move them at least anywhere within the region or district. Otherwise I would be careful in being absolutely explicit in contracts for new consultants about quality audit involvement in management, unless we make it quite clear that we are merely being quite explicit about what is already the implicit in existing contracts.

In short to contemplate making large payments to buy out tenure or move contracts from regions is playing with the form without tackling the substance of the problem. It is a change in behaviour by management process and not a change in contract by legal process that we should be seeking to achieve. Our position is essentially that the contract is subject to 3 months notice. Consultants have a right to expect from a monopoly employer

that they will continue in employment with the NHS, but this can only be on the basis that they are doing what can reasonably be demanded, i.e. provide good quality care at a reasonable cost and will take part in the management process, including medical audit, which will achieve and evidence this.

If we are prepared to spend large amounts of money (estimated at least £100M.) to achieve changes in tenure and holding of the contract at district level - that is if negotiable at all - I think that money would be better spent on tackling directly some of the major problems such as waiting times etc. For a figure of £10M. per annum we could appoint say 200 new consultants specifically to those districts and specialties where waiting times are long - this would if specifically targetted, have a dramatic effect on changing the behaviour of consultants everywhere. We could appoint 50 - 100 immediately from the ranks of Senior Registrars and others who are queuing for appointment; the rest would take longer, 2 - 4 years. This would have the added advantage of containing costs by an improvement in the supply side to meet any growth in the private sector. If we added to this the putting out to competitive tender of clinical services, as a first priority in the districts and specialties where the waiting times are long, we could transform the position.

4th July, 1988
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