House of Commons
Committee of Public Accounts

Department of Health: managing NHS hospital consultants

Eleventh Report of Session 2013–14

Report, together with formal minutes, oral and written evidence

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Committee of Public Accounts
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examine “the accounts showing the appropriation of the sums granted by 
Parliament to meet the public expenditure, and of such other accounts laid 
before Parliament as the committee may think fit” (Standing Order No 148).

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Committee staff
The current staff of the Committee is Adrian Jenner (Clerk), Rhiannon Hollis 
(Clerk) Sonia Draper (Senior Committee Assistant), Ian Blair and James McQuade 
(Committee Assistants) and Alex Paterson (Media Officer).

Contacts
All correspondence should be addressed to the Clerk, Committee of Public 
Accounts, House of Commons, 7 Millbank, London SW1P 3JA. The telephone 
number for general enquiries is 020 7219 5708; the Committee’s email address is 
pubaccom@parliament.uk
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Summary

The NHS currently employs approximately 40,000 consultants (4% of all NHS staff). Most consultants work in hospitals treating patients and managing clinical work. Some consultants do other work that benefits the NHS, such as training future doctors. The total employment cost of consultants was £5.6 billion in 2011-12 (13% of all NHS employment costs).

In October 2003, the Department of Health (the Department) introduced a new consultant contract (the contract), with an overarching objective of improving the management of NHS consultants. By 2012, an estimated 97% of consultants were on the new contract. The new contract significantly increased consultant’s pay in 2003-04 with the bottom of the consultant pay band increasing by 24% and the top by 28%.

The new contract was a missed opportunity to deliver a step-change in consultant performance and has provided poor value for money to the taxpayer. While many of the expected benefits of the contract have been fully or partly realised, the Department was not ambitious enough in setting these targets. In particular, consultant productivity has continued to decline. In addition, the contract also does not facilitate around-the-clock care for patients as it allows consultants to refuse to work during evenings and weekends. This has contributed to hospital trusts (trusts) paying consultants up to £200 per hour for additional work.

The NHS needs to be more focused on delivering the best possible care for patients, but the performance management structures and incentives for consultants are often not properly aligned to achieve this. While we welcome the Department’s plan to publish the performance of individual consultants in ten speciality areas, performance information remains poor and is not transparent. The use and quality of annual appraisals is patchy with many, for example, not assessing whether consultants have met the objectives set out in their job plans. Consultants’ pay progression is not linked to performance and Clinical Excellence Awards, designed to reward consultants for exceptional performance, are the norm rather than the exception.

There are shortages of consultants in some geographical areas, for example hospitals in deprived areas, and in some specialities such as geriatric medicine. As a result some trusts are reliant on locum consultants, who provide less continuity of care for patients as well as being more costly to the NHS.

Improved performance management is essential if we are to avoid incidents of poor performance such as those witnessed at Mid Staffs. Most organisations rely on performance management procedures to get the most out of their staff. We consider the failure by the NHS to implement a proper culture of performance management as a crucial
factor in the poor standards of care recently witnessed.

On the basis of a Report by the Comptroller and Auditor General,¹ we took evidence on the management of NHS hospital consultants from the Department of Health.

¹ C&AG’s Report, Managing NHS hospital consultants, Session 2012-13, HC 885.
1. **Conclusions and recommendations**

   1. **The significant increase in consultant pay did not improve productivity.** The contract increased the bottom of the consultant pay band by 24% and the top by 28% between 2002-03 and 2003-04. While many of the stated benefits of the contract have been fully or partly realised, the Department’s objectives were not ambitious enough, with consultant productivity continuing to fall after the contract was introduced. In its business case supporting any future renegotiation of the contract, the Department should set ambitious targets that deliver significant productivity growth.

   2. **The contract does not facilitate the provision of around-the-clock care and trusts continue to pay too much to secure work above contracted levels.** The contract allows consultants to refuse to work at evenings and weekends. As a result, hospitals struggle to provide the appropriate level of consultant-led care for patients. Rather than paying standard contract rates, this has contributed to some trusts paying up to £200 per hour for additional work which is often done at weekends. In order to improve services for patients, the Department must ensure that any future contract is flexible enough to allow seven day working and should set a maximum limit on payments for additional work.

   3. **Information on consultants’ performance is inadequate.** Comparable data to measure consultants’ clinical performance is limited. Only 43% of trusts and 27% of consultants consider that information currently available is good enough to assess individual consultant performance. In 2008, the Department withdrew its national toolkit to measure productivity levels and now only 8% of trusts believe there is effective national guidance to measure individual consultant productivity. We welcome the Department’s plan to publish consultant performance in ten speciality areas. However, the Department urgently needs to make sure that individual consultant performance is measured consistently and published in every speciality area, and support this with appropriate national guidance.

   4. **Consultants' performance is not managed effectively.** The NHS needs to be focused on delivering the best possible care for patients. But the performance management structures and incentives across trusts are rarely aligned to achieve this. Consultants are rarely held to account for their performance through appraisals. For example, nearly half of trusts do not assess whether consultants have met the objectives set out in their job plans during appraisals, and pay progression is linked to years in service rather than performance. To tackle this issue, all trusts should improve the value for money of consultants by linking the achievement of job plan objectives and good clinical outcomes with the appraisal process and pay progression.

   5. **Clinical Excellence Awards do not always reflect exceptional performance.** Clinical Excellence Awards, costing some £500 million a year, are designed to reward consultants who deliver over and above what is normally expected. Yet six out of ten consultants hold an award, indicating this is the norm rather than the exception. In addition, the performance of award holders is not reviewed regularly. The Department must review the criteria for giving a Clinical Excellence Award to make
sure it truly reflects exceptional performance above the norm and introduce more routine reviews of awards already made.

6. **Consultants are not incentivised to work in the areas where they are most needed.** There is a shortage of consultants in some geographical areas and specialities, such as hospitals in deprived areas and in geriatric medicine. This makes some trusts reliant on locum consultants, who provide less continuity of care for patients as well as being more costly to the NHS. In its response, the Department should explain in detail how it will tackle this issue. It must give consideration to stronger incentive mechanisms to attract consultants to geographical areas and specialities where there are shortages, without financially disadvantaging the organisations concerned.
The value for money of the 2003 consultant’s contract

1. NHS consultants, the majority of which work in hospitals, treat patients, manage clinical work in hospitals, and undertake work that benefits the NHS (for example, training future doctors). At September 2012, the NHS employed 40,394 consultants (38,197 on a full-time equivalent basis) across a range of speciality areas, making up 4% of the NHS workforce. In 2011-12, the total employment cost of consultants was £5.6 billion, some 13% of NHS employment costs.²

2. In October 2003, the Department introduced a new consultant contract with an explicit objective of increasing consultants’ pay.³ In return, the contract was intended to provide: a new career structure and remuneration package for consultants; a stronger contract framework to allow managers to better plan consultants’ work; and better arrangements for consultants’ professional development. By 2012, an estimated 97% of consultants were on the contract.⁴

3. Between 2002-03 and 2003-04, the bottom of the consultant pay band increased by 24% and the top by 28% with total earnings per full-time equivalent consultant increasing by 12% in real terms.⁵ Between 2003-04 and 2005-06, the Department gave the NHS £715 million (£839 million in 2011-12 prices) of funding to cover the additional cost of the contract. In 2005-06, the recurring additional funding to the NHS, to cover the increased cost of the contract and the increased number of consultants, was in the region of £400 million a year.⁶ The Department told us that the contract was negotiated in a “very different environment from today” at a time when the NHS was going to expand by a third.⁷

4. The Department’s business case to HM Treasury for the new contract set out a number of expected benefits. By 2012, many of these benefits had been either fully or partly achieved.⁸ For the key indicator of consultant productivity, the expected benefit was for an annual average improvement of 1.5 percentage points against a declining trend. While this expected benefit was achieved, consultant productivity continued to decline following the introduction of the contract (Figure 1).⁹ Consultant productivity is difficult to measure. The Department’s measure divides the Office for National Statistics’ Hospital and Community Health Services outputs by the number of consultants although this is not adjusted for changes in the quality of consultants’ work.¹⁰ We understand the difficulties

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² C&AG’s Report, para 1
³ Q 1; C&AG’s Report para 8
⁴ C&AG’s Report, para 2
⁵ Qq 1-2, 4; C&AG’s Report para 8
⁶ C&AG’s Report para 8
⁷ Q 1
⁸ Qq 1-2, 13; C&AG’s Report Figure 4
⁹ Qq 1-4
¹⁰ Qq 5-6, 12, 15-16
the NHS faces in measuring productivity, but the improvements sought from the new consultants’ contract were absurdly unambitious.

<table>
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<th>Annual average change in consultant productivity</th>
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<tr>
<td>Hospital and community health services output</td>
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<td>(% annual average change)</td>
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Change in productivity due to efficiency improvements (target 1.5 %)  1.6

NOTES
1. Office of National Statistics Hospital and Community Health Services (HCHS) data is not adjusted for quality.
2. Output data and consultant numbers are for England only.
3. Some elements of HCHS output is not consultant-led. However, this only makes up around 2% of the total HCHS output figure. Therefore, we have not excluded this data.

5. A patient-centred NHS requires consultant led services throughout the week, including during evenings and weekends. While most consultants do work beyond their contractual requirement, the contract allows them to refuse to work during evenings and weekends. The Department agreed that this was a problem and said it was something it “would like to see rectified”.

6. Under the new NHS structure, Clinical Commissioning Groups will set out their ambitions for the types of services their patients need, which may include hospitals providing services seven days a week throughout the year. While some hospital trusts may choose to introduce some flexibility around the contract to enable them to respond to these ambitions, the Department acknowledged that the consultants’ contract remains a barrier to delivering high quality care seven days a week. The Department added that it wanted a more flexible contract to provide improved services for patients and that it was currently involved in negotiations with the British Medical Association (BMA).

7. There is wide variation in the amount of money hospital trusts pay for additional work by consultants to reduce waiting lists. Most trusts use locally agreed rates of pay to secure additional work above that agreed in consultants’ job plans. These rates can vary between £48 and £200 per hour. Hospital trusts will make different decisions about how to manage fluctuations in patient demand with some trusts choosing to pay for additional work rather than employ additional staff. The Department said that the NHS was often competing with what consultants could earn from undertaking private sector work.

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11 Qq 51-52
12 Qq 51-53, 101
13 Qq 14, 49, 66; C&AG’s report, para 10
3 Managing NHS consultants

8. Our predecessor committee’s last report on the consultant contract highlighted the importance of effective performance management of NHS consultants. However, information to measure consultant clinical performance remains inadequate. Comparative data on clinical performance is limited, even at team level. A survey by the NAO found that only 43% of trusts and 27% of consultants considered that information was good enough to assess individual consultant performance. As highlighted in the Francis Report, the NHS does not have a shared culture with the patient at the centre. A key part of this is the lack of reliable, publicly available information on the quality of services patients receive.

9. Consultant productivity is difficult to measure due to the multi-disciplinary environment in which consultants work. In 2008, the Department withdrew the toolkit which had helped trusts compare individual consultant productivity levels. The Department told us that the reason that the toolkit had been withdrawn was because it was very difficult to compare the productivity of consultants that work in different specialities and settings, adding that centrally-driven guidance often quickly becomes “out of date and useless”. However, only 8% of trusts now consider that there is effective national guidance to measure individual consultant productivity.

10. Much of the consultant level performance data that is collected is not available to the public. While some specialities, such as cardiac surgery, have published clear data on outcomes and performance, this is not the case for every clinical area. The Department told us that by the end of 2013 it plans to publish performance information for individual consultants in nine surgical specialities and one medical speciality.

11. We were concerned that trusts were not getting the best from consultants as a third of consultants said that their employer did not adequately hold them to account for their performance. In addition, over two-thirds of trusts stated that non-clinical managers found it difficult to challenge consultant’s performance. A further 43% reported that clinical managers found it difficult to do so.

12. Annual appraisals are a fundamental tool for measuring the performance of consultants and improving patient care. But the use and quality of annual appraisals across trusts is patchy. 17% of consultants had not had an appraisal in the last 12 months.
Nearly half of trusts do not assess the achievement of individual job plan objectives for all, or most consultants during their annual appraisal.\textsuperscript{23} The Department agreed that the appropriate use of annual appraisals to assess clinical performance would help to avoid a situation similar to the events at Mid Staffordshire NHS Foundation Trust.\textsuperscript{24}

13. While 97\% of consultants have a job plan, which sets out a consultant’s duties and objectives, 16\% had not had their job plan reviewed in the last 12 months. In addition, 43\% of trusts stated that some consultant job plans were rolled over to the next year without review.\textsuperscript{25}

14. The performance management systems and incentives for consultants are often not properly aligned to improve patient services and consultant performance.\textsuperscript{26} Consultant pay progression is the norm; it is linked to the number of years in service, not to performance. The Department told us that the contract had been intentionally designed in this way. It added that there were circumstances in which the incremental rise could be withheld, although it did not provide any examples of when this had happened.\textsuperscript{27}

15. Clinical Excellence Awards are designed to reward consultants performing above expected standards, through pensionable increments to their annual salary.\textsuperscript{28} There are national and employer-based Clinical Excellence Awards. In 2011-12, the Awards totalled £500 million. The majority of consultants (61\%) hold an award, with 47\% holding an employer-based award. Clinical Excellence Awards are also not regularly reviewed to make sure that individual awards are still warranted and are value for money.\textsuperscript{29}

16. The Department agreed that Clinical Excellence Awards are not working in the way they were intended.\textsuperscript{30} The Department told us that it had asked the Advisory Committee on Clinical Excellence Awards, which oversees the awards, to make sure that activity and outcome data are included in award applications.\textsuperscript{31} The Department also said that the Review Body on Doctors’ and Dentists’ Remuneration, an independent expert pay review body, had made a number of recommendations to reform Clinical Excellence Awards. For example, the review body had suggested that the proportion of consultants holding employer-based Clinical Excellence Awards should be closer to 25\% of consultants, rather than the 47\% at which it currently stands.\textsuperscript{32} The Department accepted its recommendations as a basis for negotiating any changes to the awards with the BMA. However, it would not
tell us if it expected some consultants to get a pay cut following the review on the grounds that it could not predict what the outcome of the negotiations would be.  

17. Consultants can choose where they work and the majority of consultants continue to work in the area where they undertook their training. Certain geographic locations, for example deprived areas, have shortages of consultants. There are also not enough consultants in some specialities, such as geriatrics to serve an ageing population. In 2011 it was reportedly not possible to fill 50% of trainee posts in geriatric medicine. The shortage of consultants in some areas makes some trusts heavily reliant on locum consultants, who provide less continuity of care for patients as well as being more costly to the NHS. 

18. The Department told us that Health Education England and local education boards are looking at long-term workforce planning to ensure that demand in different regions and specialities is met. It said that these organisations were looking at how they could attract junior doctors to particular areas. The Department told us that there were also other ways to ensure that consultants, which are a costly resource for the NHS, work in areas with the greatest demand. The contract allows hospital trusts, under certain circumstances, to award a recruitment or retention premium on top of basic salary. Such premiums can be used as a way to address consultant shortages; however the costs of making these extra payments are borne by the local health trust and are not funded centrally.
Formal Minutes

Wednesday 12 June 2013

Members present:

Mrs Margaret Hodge, in the Chair

Mr Richard Bacon  Mr Stewart Jackson
Stephen Barclay   Fiona Mactaggart
Jackie Doyle-Price Nick Smith
Chris Heaton-Harris Ian Swales
Meg Hillier        Justin Tomlinson

Draft Report (Department of Health: managing NHS hospital consultants), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 18 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Eleventh Report of the Committee to the House.

Ordered, That the Chair 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.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Monday 17 June at 3.00 pm]
Witnesses

Monday 18 March 2013


List of printed written evidence

1 South West Whistleblowers Health Action Group Ev 26
2 NHS in England Ev 28
3 Department of Health Ev 28
4 British Medical Association Ev 30
5 Gary Walker Ev 30
List of Reports from the Committee during the current Parliament

The reference number of the Government’s response to each Report is printed in brackets after the HC printing number.

Session 2013–14
Oral evidence

Taken before the Committee of Public Accounts
on Monday 18 March 2013

Members present:
Margaret Hodge (Chair)
Mr Richard Bacon
Stephen Barclay
Jackie Doyle-Price
Chris Heaton-Harris
Meg Hillier
Mr Stewart Jackson

Fiona Mactaggart
Austin Mitchell
Nick Smith
Ian Swales
Justin Tomlinson

Amyas Morse, Comptroller and Auditor General, National Audit Office, Gabrielle Cohen, Assistant Auditor General, NAO, David Moon, Director of Management of Hospital Consultants, NAO, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Examination of Witnesses


Q1 Chair: Welcome. We hope to spend just over an hour on the first issue of consulting and then talk to you a little about gagging clauses, but we will leave the IT for another time, because of business in the House.

The introduction of the new consultants contract cost the taxpayer a lot of money and benefited consultants enormously with a 24% to 28% increase in their potential rate of pay. Yet productivity has gone down. What went wrong?

Sir David Nicholson: The consultant contract was negotiated in a very different environment from today, as you know. It was a time when the NHS was about to expand by about a third. We went into the negotiations on the contract with the express view of increasing pay for staff in the NHS—not just consultants, but all staff—and having more of them. So the environment was very different, but even in that environment we identified a whole series of benefits that the contract should give to NHS consultants and patients. We have been working through that since, and you can see that the Report reflects on all of that.

One part of it was improving productivity. We set ourselves the target of improving productivity by 1.5% on trend, and that is broadly what we delivered.

Q2 Chair: Hang on. You have reduced the rate of lack of productivity. We do not have an improvement in productivity. Going back, I remember that the purpose was, of course, to improve the service, but if you are paying 24% to 28% more on the pay rates for a consultant—I accept that in the Report it says that, on average, it was a 12% increase to the pay bill—you expect improvements in productivity. If you go around the table, I think that if any one of us—whatever world of work we were in before we became Members of the House—saw that sort of pay increase, we would expect an improvement in productivity. You did not get it. What went wrong? Can you answer that question? I know that there are broader objectives, but it seems that the issue at the heart of this is that a lot of money was thrown at consultants in the NHS with a dreadful return for the taxpayer.

Sir David Nicholson: As I say, the objective, as set out in the NAO Report, was delivered.

Q3 Chair: What objective?

Sir David Nicholson: The objective of improving productivity at the time by 1.5%, and that is what it—

Q4 Chair: I cannot believe you can think—sorry, I didn’t realise we were going to get into this sort of debate—that a 24% to 28% increase in potential earnings justifies a continued reduction in productivity over time relative to the money put in. I accept that the loss of productivity was less than it had been before, but it is still a loss of productivity. If that is what you are measuring yourself on, it is just too unambitious a target for you to set yourselves, to put it politely.

Sir David Nicholson: Well, it was the target that was set at the time as far as the contractual descriptions were—

Q5 Chair: A target was set that we would continue to sanction a year-by-year loss of productivity? I can’t believe that.

Sir David Nicholson: Let me explain. We have had a conversation on a number of occasions about the measurement of productivity and how difficult that is. Indeed, the NAO says in its Report how difficult it is to measure consultant productivity.

Q6 Chair: But you have agreed the figure they have in the Report?

Sir David Nicholson: Yes, we have agreed the figure that you have in there. What it does not include is the
0.5% that the ONS use for quality gain, which would in fact take it into a positive place. That is the issue I would like to concentrate our attention on. It is not just a question of dividing the number of consultants by the number of patients that are treated. There have been dramatic and significant changes—we knew there would be—over the period in the way we deploy our consultant medical staff. Putting it in a simple way—I am sure that Bruce can think of other examples—when I was managing a hospital you would have a consultant general surgeon who would do almost every kind of operation you could imagine. They would both diagnose and treat cancer patients—breast cancer patients and others. We now have a multidisciplinary scene. Now, you may have five, six or seven consultants involved with an individual patient to get the best possible outcomes for that individual. That is what has been happening across the past 10 years or so.

Q7 Mr Jackson: Can I come in on that specific point? Paragraph 1.20 on page 24 of the Report refers to the “toolkit to compare individual consultant activity”. If you have said a specific decision was taken on that. If you establish a toolkit, keep it going for two or three years and then discontinue it, of course you can’t measure the productivity of consultants, to the extent that only 8% of trusts stated that there was effective national guidance on measuring consultant productivity. Why did you do that?

Sir David Nicholson: Part of the issue here is that it is very difficult to take a total picture of consultant productivity. If you are a geriatrician—

Q8 Mr Jackson: No, hold on. We’re not talking about that. We’re talking about a comparison of individual consultant activity, which could have been done by discipline. I suppose my question specifically is, why did you begin it and why did you discontinue it?

Sir David Nicholson: I was just going to answer the particular question you have described. Even among geriatricians, depending on how you organise your service they have very different roles. Some geriatricians work almost entirely in the community; some work in hospital. One of the things you find with any kind of centrally driven guidance like that is that it very quickly becomes out of date and useless. What we have developed in its place is a whole series of measures. We publish literally hundreds of measures of consultant activity at the moment. We have developed NHS Comparators, which is a website that people can use to compare; the health care information centre provides tools, help and support for people to do that, and various commercial organisations are able to do that.

Q9 Mr Jackson: It is not working. Look at the figures; 92% of trusts are saying there is no effective national guidance on measuring consultant productivity. For all these initiatives you mentioned, it clearly is not working for the people who are tasked with managing consultants’ activity and productivity and whether they are, so to speak, competitive compared with other consultants.

Sir David Nicholson: I have to say, I visit lots of hospitals, and have lots of discussions with clinicians, doctors and managers, and no one has ever said to me, “The only thing we need is a nationally developed tool to do this.”

Q10 Chair: Okay, let’s take you further on that. The view of this Committee is that we threw money at it and we just didn’t get value out of it. Even if you do not have a national tool to look at whether or not consultants are performing, you would have thought each trust would do it. If you look at page 36 of the Report—agreed by you—68% of trusts said that they found it difficult to challenge consultants’ performance and 43% of clinical managers found that difficult. Only 67% of consultants agreed that their trust held them to account, so a third did not. Only 52% of trusts assess the achievement of an individual job plan for a consultant; 17% of consultants have not had an annual appraisal in the last 12 months and 66% of trusts never review the annual bonus payments they get. It is outrageous. All the way through, we shovel money at them. You do not have a national tool, as Stewart says, and then you look at it on a trust-by-trust basis, and no one is assessing their performance.

Sir David Nicholson: That is not what the Report says in total. The total Report says that we either fully or partially met the objectives.

Q11 Chair: Sir David, I have to say to you that many trusts are not assessing performance. Another interesting thing that comes out of the Report is that a heck of a lot of consultants have far less confidence in the trusts’ ability to manage them than there are trusts that believe they are managing them. The whole thing is littered with a set of conclusions that suggest we shoved money at this; we did not have the national protocols in place that enabled us to measure performance, and at trust levels nobody really bothers to look at whether or not our consultants are providing value for money.

Sir David Nicholson: I do not think that is what it says. You are talking about a broader question about how individual organisations are managed; how they work and how they organise themselves.

Q12 Chair: No, we are talking about two things. We are talking about a lot of money going. Stewart raised the issue of national protocols. I am saying, okay, if you do not accept national protocols, look at the trust-per-trust protocols. If they are not working in a third of trusts, or half of trusts in some cases, that is not a little bit. It seems to me that there has been a substantial failure since 2003—10 years ago—to find a way of measuring clinicians’ performance.

Dean Royles: May I come in? One of the questions about consultant productivity that is not asked is how difficult is it to measure? It does say that there is not a good way of measuring consultant productivity within the NHS. These are very complicated arrangements. When we look at the consultant workforce we are faced with the enormous task of increasing the size of the consultant workforce and changing the way they work, with an ambition to increase the pay they get and make them more under
the managerial control of the organisation. What the Report says is that on the ambitions set out for introducing this, it offers value for money. It is there in the Report. It says that this offers value for money in the NHS.

**Chair:** Say that again.

**Dean Royles:** Well, if you look on page 13.

**Q13 Chair:** The Report actually says that it cannot come to a conclusion on value for money, I am afraid. You might have pulled out one sentence, but the Report says that for however many billions—£5.6 billion—that we are spending on this, we cannot show value for money. Which one are you looking at?

**Dean Royles:** Someone has handed it to me. I will just find the conclusion. On page 13, paragraph 16, it says, “Most of the expected benefits of the contracts have been either fully or partly realised which has improved the value for money of consultants to the NHS.”

**Jackie Doyle-Price:** Most of the expected benefits have been fully or partly realised.

**Q14 Fiona Mactaggart:** Partly realised. If we look at figure 4 on page 20, we see, for example, that one of the ambitions was, “Secure extra work at standard contractual rates. Partly realised.” If you look at the Report in more detail, that “partly” could be one or two hospitals. I suspect that it might be more than one or two, but quite clearly, the majority of hospitals are not securing extra work at standard rates, but are paying premium rates.

**Dean Royles:** That is not the case. A standard consultant contract is 10 programmed activities. That means that they work a morning and an afternoon five days a week. What you see in the Report is consultants working on average something like 11.5 programmed activities, but they are at standard rate. By the time you get to 12 programmed activities, you have people working a 48-hour week, so when you do additional work over and above that to comply with the working time directive you do occasional and ad hoc work, which means that your payment is a one-off at a premium rate as opposed to being paid it for months and months as part of the contract. I go back to the point about the consultants. Comparing consultants like for like in their work is very difficult, and that is not one of the questions we are asked. One consultant may be working eight programmed activities and another may be working 12 programmed activities. When you look at their activity you see that there is a huge disparity in the level of work that they do.

**Q15 Mr Jackson:** You are giving 61% of consultants clinical excellence awards when you have already given them roughly a 20% pay rise on average in 2003, and productivity is going down. What sort of private sector company would that regime be apparent in?

**Dean Royles:** Productivity was going down by something like 1.8%, and the ambition was to seek to improve productivity.

**Q16 Chair:** So it went down by less. You can’t argue that.

**Dean Royles:** Only if you don’t take the quality into account. When you add in 1.5% plus an additional 0.5% for qualitative gains, you get an increase in productivity—

**Q17 Stephen Barclay:** But your commissioning wasn’t driving quality.

**Dean Royles:** I think when you look at things like waiting time, lists and mortality rates improving—

**Q18 Mr Jackson:** Can I try to understand clinical excellence awards? The Report says that 47% of the 61% are employer-based awards, but there is no routine or systematic examination of the efficacy of those awards. They are not reviewed in a timely way, and value for money, locally and nationally, is not looked at. Why are you awarding people clinical excellence awards for doing their job when you have already paid them a significant increase in 2003?

**Dean Royles:** I would agree in part, which is why we gave evidence to the Doctors and Dentists Review Body that the clinical excellence awards were not working in the way we wanted them to work. It has now announced that there should be a review of that, and we would be very happy to get into a discussion with the BMA about how we review clinical excellence awards in future.

**Q19 Chair:** Are you suggesting that you are going to cut them so that some consultants will have a cut in pay after the review?

**Dean Royles:** What the Doctors and Dentists Review Body says is that it should limit the amount of—

**Q20 Chair:** Are you suggesting that some consultants who have benefited from clinical excellence awards to some absurd level will get a cut in pay after implementation of the review?

**Dean Royles:** It depends on what we negotiate. The Government have accepted that the DDRB report, which puts some parameters around what should be paid, should form the basis of negotiation.

**Q21 Chair:** Just say yes or no. Are you expecting any consultants to get a cut in pay after this review is implemented?

**Dean Royles:** I can’t predict what the outcome of the negotiation will be.

**Q22 Chair:** I think the reason you are evading the question is that there isn’t a chance in hell of any consultant getting a cut in pay after the review. Isn’t that what you are actually saying to me?

**Dean Royles:** Well, the DDRB recommends that there should be fewer awards to fewer consultants, but that forms the basis of negotiation.

**Q23 Chair:** So are you going to cut existing awards?

**Dean Royles:** We have to go into negotiation. It would be unwise of me to go into negotiation saying what we intend to achieve before we start the negotiation.
Q24 Chair: Do you realistically believe that some consultants will get a cut in pay?  
Dean Royles: Well, the DDRB—

Q25 Chair: Do you realistically believe that? You must have in your brain when you go into negotiation that there is less money in the NHS, and we found in the Report that loads of consultants are making lots of money, not having improved their productivity. Are they likely to get less money at the end of the process?  
Dean Royles: We go into the negotiations on the basis that productivity has improved, and that it has delivered value for money, according to the Report, and then start negotiation on that basis.

Q26 Chair: We obviously don’t agree. You aren’t answering the question. The only other thing to say of course is that the BMA has turned down the review anyway, so I don’t know what you will be negotiating with them.

Q27 Stephen Barclay: Stewart was exploring whether commissioning was driving value for money, but if you don’t have comparative clinical data on surgeons’ performance, what incentive is there to improve clinical performance. Because commissioning will be financially driven, not clinically driven?  
Dean Royles: I think what the Report says is that there is no national basis on which to have a look at it, but there are many different tools that people use in their organisations to examine their own performance, both on the basis of activity—

Q28 Stephen Barclay: Sure, but you don’t dispute the premise that if you don’t have the comparative data on clinical performance, commissioning is not driving those improvements. You accept that as a premise.  
Sir Bruce Keogh: Would you mind if I came in, please, Chair? It is a complex issue. At the time, the new consultant contract, it is fair to say that medicine was relatively simple, and effective and relatively safe, and subsequently it has become complex, very effective and potentially dangerous when things go wrong. Not only has the practice of medicine changed significantly, so have the organisational relationships associated with it. What we have seen in that time is improved clinical outcomes associated with increased consultant involvement, so the measurement of consultant productivity is quite complex. It is not simply a matter of just taking the activity and then dividing it by the number of consultants, because diagnostic and support staff, such as anaesthetists, radiologists and pathologists, are not included in that calculation. Yet what we are seeing is that for every hospital admission, the number of consultants involved in each admission is steadily rising. There are all sorts of explanations for that: one could be more consultant involvement; another is more specialisation; another is that the patients have more co-morbidities; and another is, of course, that the juniors’ contribution is restricted by the European working hours. What we have also seen in this time is a year-on-year reduction of about 3% in mortality in hospitals. The standardised mortality ratio between 2001 and 2011 has gone down by 55%. We have seen reductions in MRSA and reductions in waiting lists, so there is a bit of me that wonders whether productivity should be measured in terms of the patient outcome, rather than simply a numerator and denominator related to activity—

Q29 Stephen Barclay: That is quite a long answer to my question. You mentioned HSMR. Where is England in international comparators if we take, say, the sample that Dr Foster uses? I think they look at seven countries. Where is England at the moment on those international benchmarks?  
Sir Bruce Keogh: I do not know the answer to that.

Q30 Stephen Barclay: You do not know.  
Sir Bruce Keogh: No.

Q31 Stephen Barclay: Have you not discussed it with Dr Foster?  
Sir Bruce Keogh: I have, but they sent an anonymised set of data.

Q32 Stephen Barclay: So we do not know where we are internationally? You are saying that these are improving, so I would have thought that one of the things you would look at is where we are internationally.  
Sir Bruce Keogh: That is a very fair question.

Q33 Stephen Barclay: But you do not know the answer.  
Sir Bruce Keogh: The point that I was trying to make was that we are improving.

Q34 Stephen Barclay: Actually, my premise related to the warning given to the Department in 2008, which I understand the Department did not act on, from Don Berwick. He warned about the lack of comparative clinical data. Stewart explored how you have not driven value for money. More worryingly, he warned in 2008 that you were not driving improvements in performance. Were you aware of those reports, Sir David?  
Sir David Nicholson: Do you want me to answer that question or the one before?

Q35 Stephen Barclay: Yes, please.  
Sir David Nicholson: Okay. On the Don Berwick position and the need to get comparative clinical data from across the world, we absolutely knew we had an issue with that, and that was one of the reasons why the National Quality Board was set up. One of the first things we did, if you remember, was that we published a whole set of comparative data in 2007–08. Part of the role of the National Quality Board is to publish comparative sets of data.

Q36 Stephen Barclay: You were aware of the US reports—the Don Berwick report—that came out in 2008.  
Sir David Nicholson: I did not know about those reports until the Mid Staffordshire inquiry, when they were raised with me at the inquiry itself. They were
Q37 Stephen Barclay: But the Department is paying for reports from someone who now—five years later—has been brought in as the Prime Minister’s expert on this.

Sir David Nicholson: And he is a fantastic leader.

Q38 Stephen Barclay: If he writes a report flagging serious concerns, why would you, as chief exec, not be told about them?

Sir David Nicholson: The results of that—i.e., we need to look at comparative data—were taken up as part of the next stage review. I did not see that particular report, but we accepted the recommendations underneath it, because it came through the report that Ara Darzi did. I think we are well aware of the issues. As Bruce says, we have been working quite hard around mortality and comparative mortality across the NHS in England over the past few years. Indeed, as Bruce says, it has improved by some 55% over the last 10 years, which as a rate of improvement is reasonable, but obviously not good enough. We need to go further. As we become more sophisticated and understand better the comparative data, we can do more.

About commissioning, about comparative—

Q39 Chair: Can we stick to this, because we are slightly going off the thing? Fiona had something to come back to on the issue that we were talking about. Then I am going to go to you, Chris.

Q40 Fiona Mactaggart: It seems to me that two things are lurking here. Sir Bruce, you are a cardiac surgeon by training. We have much clearer data on some areas of cardiac surgery than anywhere else. I do not think I understand why we cannot have the kind of clarity and accountability in every area that has been achieved, for example, in children’s cardiac surgery, even if it is about a team. One of the things that we know is that clinicians will keep other people on the team alert, even if the public cannot. There is an issue about having some transparency in performance that we are trying to get you on, because we think that the Report does not reveal transparency in performance.

Sir Bruce Keogh: I agree with you entirely. In fact, Mr Barclay tried to pursue that question last time I was here.

Q41 Stephen Barclay: It has only been about eight surgery, just to put it on the record, came from the whistleblower, not from the Department. It was the whistleblower that led to the changes that led to the heart surgery data being published. That is correct isn’t it?

Sir Bruce Keogh: Actually, I might want to take a different view on that. The decision to publish results in heart surgery started to emerge at an annual general meeting of the Society of Cardiothoracic Surgeons in 1997, when we agreed to collect activity and outcome data on every single surgeon. We followed that up and I was responsible for it. We followed that up by notifying people who fell outside certain statistical limits, and their trusts, and then subsequently that eventually led—to be honest, I think the driving force was a freedom of information request from The Guardian—to us putting it out into the public domain. It did not really come from a whistleblower; it came from a speciality that felt that it needed to rehabilitate itself and felt poorly represented as a result of the events in Bristol.

Q42 Chair: Sir Bruce Keogh: That has led us to a position where I am in the process now of working with 10 different specialties—nine of them are surgical, one of them is medical—to produce results for the individual clinicians. I am hoping that we will get into that place towards the end of summer this year. It is in the NHS planning guidance. It is not a popular move, but it is one that we are pursuing with vigour. I hope that I will be back in this Committee at some point, demonstrating that we have succeeded.

Fiona Mactaggart: Will that give us a tool where we really can be clear about productivity? It seems to me, reading this Report, that we are not. For example, there is a great measure which says, “How many consultants have job plans?” It is 80%, or something like that, but I would like to ask you—any of you—how many consultants take very much notice of their job plans? I think it is rather a lower percentage than have them.

Dean Royles: I think the Report says that 97% of consultants have a job plan.

Q43 Chair: Can you deal with Fiona’s question?

Dean Royles: Well, we run hospitals on the basis of those job plans, so when consultants say that they are in clinics or operating theatres, we generally have patients there that are being seen by the consultants at that particular time. In addition, they have additional programmed activities to do training and development and work for Royal Colleges, for example. But the job plan is the basis on which we deliver services within the organisations that we run.

Q44 Fiona Mactaggart: Have them.

Dean Royles: Well, we run hospitals on the basis of those job plans, so when consultants say that they are in clinics or operating theatres, we generally have patients there that are being seen by the consultants at that particular time. In addition, they have additional programmed activities to do training and development and work for Royal Colleges, for example. But the job plan is the basis on which we deliver services within the organisations that we run.

Q45 Fiona Mactaggart: You say “we”. Who is we?

Q46 Chair: Hang on a minute—16%. Look at the Report. For heaven’s sake, let’s have a little bit of honesty in this discussion. Paragraph 2.21 on page 37 says, “16 per cent” of those consultants “had not had their job plan formally reviewed in the last 12 months. Further, 43 per cent of trusts stated that some of their job plans were rolled over without review. On average
Chair: And you ignore the rest of the paragraph.
Dean Royles: Part of the issue with job planning is that we do job planning based on the commissioning of services, and what we have seen during the entire period is constant churn with the commissioning of services. We have had primary care groups, primary care trusts and now CCGs, and each time, organisations have to re-establish contacts and relationships with those. These job plans should be based upon the services that are being commissioned, and there is constant churn around that.
Chair: I think it is just a poor show.
Dean Royles: I am being entirely honest. The Report states that 97% of consultants have got a job plan. The Report does—

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Q47 Fiona Mactaggart: My question was how many take much notice? The evidence that the Chair has given—
Chair: And you ignore the rest of the paragraph.
Dean Royles: But I am very happy to continue that. First, if you look at when the Report was done, the survey was carried out between April and October last year—right in the middle of the first industrial action for 40 years in the NHS.
This particular time was in the run-up to industrial action and pension increases and the immediate aftermath. So, in that context, I think the survey results that came in are pretty impressive. In addition to that, job planning is based around the commissioning of services—

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Q48 Chair: It has nothing to do with industrial action over two weeks or whatever it was. This is to do with a tool that you invented, which was supposed to improve performance and increase productivity, and it is not being used across the piece.
Dean Royles: Part of the issue with job planning is that we do job planning based on the commissioning of services, and what we have seen during the entire period is constant churn with the commissioning of services. We have had primary care groups, primary care trusts and now CCGs, and each time, organisations have to re-establish contacts and relationships with those. These job plans should be based upon the services that are being commissioned, and there is constant churn around that.
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Q49 Chris Heaton-Harris: I will come back to Mr Royles in a second. I should say at the outset, Sir David, that I have just finished reading the Francis report, and I am now in that group of people who think you should not be in the role that you are in. I apologise for saying that in this forum, but I think, having read it completely, there is no accountability with the chief accounting officer of the NHS, and I struggle with that a great deal.
We have now heard, from the various questions, about how we have put more money into something where we get questionable improvements and no measurements. We have had a pay increase—this is for you, Mr Royles—plus the clinical excellence awards that we heard Mr Jackson talk about, and you said that the cuts in waiting times were a result. I have just asked all the PCTs in England, via freedom of information, about the waiting list initiative payments that go on. Some hospitals do not do it, but this is extra money that goes essentially to consultants to do the stuff that you have just agreed they should be doing through this new contract.
You get places such as Calderdale and Huddersfield with payments of £2.4 million in 2011–12 and North Bristol trust with payments of £1.8 million in 2011–12, and some trusts with zero. First, how do you explain those massive payments on top of the already generous contracts that these people have? Secondly, how come some trusts do it without making these payments and some trusts rely on massive additional payments?

Dean Royles: If we look at the period of time of the contract, I think waiting times have come down from some 18 months to 18 weeks, so each of those payments represents more patients being treated and having operations that they otherwise would not have had so quickly. It is not measured in quality, by the way. All those patients who have waited less are not counted in that crude productivity thing. It is a really important aspect of whether we are building up quality or not.
In addition to that, where people have wanted to do more work and activity for patients, where they have got consultants who are perhaps working those additional hours as part of plan and want some periodic one-off payments to get through some waiting lists, payments are being made. I would suggest that those payments are made to treat patients.
Chair: I don’t think your question has been answered, Chris.

Sir David Nicholson: When you run a hospital, you have to make judgments about what activity you are going to do in a particular year. You have to make judgments about how many patients you are going to have referred from general practice, how many will be seen in out-patients and how many in in-patients; you make judgments about emergency care. You make a whole set of judgments and you have to predict what is going to happen, and sometimes things do not work out as you had predicted: sometimes activity gets higher than you thought and sometimes it gets lower than you thought. When it gets higher than you thought, you have a problem. What do you do in those circumstances? Do you flex your existing work force to treat those patients and deliver to that demand, or do you take more people on? That, in a sense, is what you are seeing in different organisations. Different organisations are dealing with different patient demand in a particular area. It can be absolutely cost-effective to flex your work force in the short term to get over a particular hump. That is the kind of thing you see there.
That is the first thing. The second thing is that these organisations are operating in a market where the private sector is prepared to pay more for that extra time than the NHS very often did. You have to take account of that market you are working in; otherwise you simply cannot treat your patients. The most important thing in these circumstances is to ensure that access to services for those patients is maintained.

Q50 Chris Heaton-Harris: What Sir Bruce is doing now—I welcomed his answer about outcomes, because surely if we are going to learn anything from what has been going on around us in the last few
months, outcomes is where we are going to be focusing and measuring. The question the Report brings forward is: has this contract worked? Are we getting decent value for money from consultants? I am slightly worried about Mr Royles’ earlier reply, his non-committal way, because he just has to go into negotiations with different groups of people on this matter. When you are giving a group of people a huge 20% plus pay rise, and then there are extra bits on top, and if you are a platinum standard person you get £75,000 a year extra for up to five years, it seems like you are going into a negotiation with two arms tied behind your back and without much of a story to tell.  

Dean Royles: The reason I have been careful in my choice of words is that, over a period of time, we have built up a very strong relationship with the BMA. We approach these things in a joint problem-solving way, so we go in and we say, “Look, there’s limited money, and we have the DDRB report which has made some recommendations about changing clinical excellence awards and introducing, for example, a principal consultant grade and changing the junior doctors’ contracts as well, and we want to do that in the context of the sort of things that Bruce and the Commissioning Board are doing, which is to have more seven-day working.” When I look at those things together, what I want to get into discussions with the BMA about is how we look at the contracts, the use of clinical excellence awards and how we reward people with the service changes that we want to make, so that we can approach it in the best possible way together, not with the threat hanging over them of pay and conditions, but in a way that might be a more mature and responsible way in which to go into those discussions when we look at pay, so that we can seek to improve services. As an approach that has served us particularly well in the past.

It is important to consider that this Report was done at a time of industrial action, yet we are still getting people and staff survey results that show that job satisfaction rates for consultants are something like 85%. Most private sector organisations would be happy with job satisfaction rates like that. We get consultants that—

Chair: Everybody would be delighted if they are earning over £100K for doing less.

Sir David Nicholson: Could I go back to a point that Mr Barclay made about commissioning and making the change happen and clinical activity? [Interruption.] No, I can’t.

Chair: Yes, you can go back. What I am shaking my head about is that what in a sense is being demonstrated in the evidence you are giving is that it is so theoretical—so removed from the reality of what is happening in our hospitals. That is what I feel. Satisfaction rates of 85%? It would be daft if they weren’t. I just heard Sir Bruce saying that medicine wasn’t complicated before 2003. I could not believe that statement. They are not located in the NHS I know in Barking and Dagenham.

Sir Bruce Keogh: To be fair I don’t recall saying that.

Chair: You did. You said before 2003 medicine was much simpler.

Sir Bruce Keogh: I did not say before 2003.  

Mr Jackson: You said at the time of that report, which is 2003.

Chair: Sorry, Sir David. Have another go.

Sir David Nicholson: We are really talking about something much broader than just the consultant contract here. This is about the way hospitals work and all the rest of it, and it is important to say that. If you think about the future and how we are going to make change happen, we are in a completely different place now than we were in 2002. The money has essentially run out as far as the NHS is concerned; we need to think about how we can improve quality in a completely different environment, and commissioning is part of that. One of the ways we want to do that is through using the tariff system: competing not on the basis of price, but on the basis of quality. One of the main ways we are going to do that is the development of best practice tariffs. At the moment, the tariff tends to be the average of what it costs to do something. We are increasingly getting to a place where we are taking apart a hip replacement, a cardiac operation or whatever, and breaking it down into what best practice would look like, so we get the best outcomes for patients, and then all locating the resources that. That gives us the opportunity to think about the productivity of consultants and teams within that and to ensure that we use commissioning to drive change and not just to contract at one end.

That is one bit. The other bit is the business about transparency and making sure that people understand what individual consultants’ outcomes are. That is really important for the NHS going forward. We have spent too long talking to people about it and theorising, and not enough time actually doing it. That is why I think the document we put out at the beginning of this year from the Commissioning Board, publishing consultant-level data in 10 specialties—just doing it, not waiting any longer—is an enormous step forward and will give us lots of opportunities to think about the kind of productivity goals that we are talking about.

Q51 Meg Hillier: I want to touch on the issue of flexible working at weekends, evenings and so on. Page 25 of the Report says positively that “Case study participants stated that the contract can facilitate weekend and evening work” but then, rather less positively, that “Thirty-four per cent of trusts stated that the contract helped them increase the provision of services for patients.” It is worrying that the contract gives consultants the right to refuse work outside 7 to 7 Monday to Friday. Sorry, Chair, I should have declared at the beginning that three members of my extended family are doctors, two of whom are consultants in the NHS. It seems to me—perhaps Sir Bruce can pick up on this—that some specialists need to work at weekends because that is what their specialism demands. People with heart problems or whatever do not suddenly not fall ill on Saturday and Sunday, so why does the contract allow consultants not to work?  

Sir Bruce Keogh: I don’t know; it is something that I would like to see rectified. When I hear discussion about seven-day working in the NHS, that tells me that we are in the wrong place, because we should be
talking about seven-day services for patients. That is where I am very keen for us to get to.

Q52 Meg Hillier: Good; I am heartened to hear that. It brings me to an interview that you did, Sir David, with the Health Service Journal published on 14 January—think we have quoted this at you before—in which you talked about clinical commissioning groups, which is obviously a big issue for us all as they come in. You talked about your role in the overall Commissioning Board, but the article says: “He said clinical commissioning groups would often be leading changes, where they focused on general hospital and community care, but the board would ‘convene, help and facilitate it’.” What is the role of a clinical commissioning group? If my clinical commissioning group in Hackney wanted to provide a service seven days a week for patients out of any of the local hospitals, would it have a role in doing that, and how would that interact with the complexities of the contract that we have been discussing so far?

Sir David Nicholson: This is the other part of commissioning. We expect clinical commissioning groups to set out their ambitions for the kinds of services that their patients need and want, and to be involved in organisation, debates and discussions within general hospitals to make that a reality. What is obvious from what you described is that the existing contract will make it very difficult for hospitals to respond, but in a sense that is for hospitals to respond to, and that is why the negotiations on the contract as an enabler, to enable that to happen, are so important.

Q53 Meg Hillier: Can I go back to that point? You said that that is for hospitals to respond to. When a clinical commissioning group lets its demand be known, you are saying that it is down to the individual hospital, even though the contract with the consultants is a national contract? You think there is a flexibility in that?

Sir David Nicholson: Yes. It is up to each individual hospital to respond. The clinical commissioning group will be perfectly within its rights to put incentives or disincentives in the contract to enable them to do that, but each individual hospital must respond. Foundation trusts in particular have complete flexibility about how they manage and organise their work force; NHS trusts less so. I think that out of the contractual negotiations, we will see much more local flexibility being built into the national contract.

Q54 Meg Hillier: Do you foresee the private sector getting involved in this? For example, I have a City fringe element in my constituency, and it might suit some people working in that area to have much later out-of-hours services at the end of a long working day, but that might not be something that the local hospital consultants will be keen to do. Do you see competition from the private sector coming in and doing that? Would that undermine what the NHS could provide? There is a real issue here, because there is now a requirement to have a competitive tender for all those services.

Sir David Nicholson: There is not a requirement to competitively tender for those services.

Q55 Meg Hillier: Not in hospitals? There is some requirement for competitive tendering. Where does it begin and end? Perhaps I just got confused.

Sir David Nicholson: The position on competition in the NHS is that competition is an important tool for commissioners to use, but it is for commissioners to decide when to use it, and they have to be open and transparent in the way they use it. But they should use it only in areas where there is evidence that it works, and where they are meeting a particular patient need—in other words, for outcomes, not ideology. We put something at the end of last week or the beginning of this week to clarify this, because there was quite a lot of confusion about what we were trying to do. When clinical commissioning groups want to provide more flexible services for patients in different areas and the local NHS hospital will not respond, if they cannot get the change in the local organisation, I think that looking to other providers is a sensible thing to do.

Q56 Meg Hillier: What you just said is fascinating to me because in Hackney our out-of-hours GP service was taken over by a private contractor because the local co-operative fell by the wayside. The GPs were told about a year ago that they could bid for the contract and they would get it to run it as a GP-run service, but they have now been told that was wrong advice and there has to be open competition. The north-east regional health board in London has been told that there will be a legal challenge if it is not open to competition.

Sir David Nicholson: I don’t know about the local circumstances you describe, so I cannot speak openly and tell you about that.

Meg Hillier: I appreciate that.

Sir David Nicholson: But the position on out-of-hours services is that they are commissioned by clinical commissioning groups. I will follow that up for you.

Meg Hillier: I have to say, in the brave new world of the NHS we are not even getting responses from the bodies that made these decisions because they about to become defunct. There is a real issue underneath your layer about how accountable the NHS is to my constituents and, in fact, my GPs and CCG on this issue. I think I need to raise this with you outside the meeting, and I will do.

Q57 Chair: David, did you want to come in on a point of clarification?

David Moon: GP out-of-hours services will not be the responsibility of clinical commissioning groups, surely, because there is a conflict of interest? I thought it was the Commissioning Board’s responsibility.

Sir David Nicholson: They are commissioned by clinical commissioning groups.

Meg Hillier: Chair, in that case, can I just say—Chair: This is not quite on consultants, Meg. We have a lot to do on consultants. We can come on to out-of-hours contracts after the recess. We have got a briefing on it.

Meg Hillier: I know, but it is on Cornwall.

Chair: It is just that we have a heck of a lot to cover on this.
Meg Hillier: I make the comment that it is Kafkaesque that the clinical commissioning group will be commissioning services and making its own decisions in April, but it will be forced by a decision of a previous body to go through a tendering process, potentially. It is very odd.

Sir David Nicholson: As I say, I cannot comment on that, but I will pursue it.

Q58 Jackie Doyle-Price: I am interested in interested in exploring what this Report tells us in terms of going forward, given where we are. Sir David, you have been honest enough in the past to concede that there are just not enough good managers in the NHS. That is brought out in the Report, because we hear that only 41% of consultants feel they are engaged in supporting the trust’s objectives. What are your reflections on that?

Sir David Nicholson: I think the responses that you have in the Report reflect how the NHS is at the moment. Think about it from a consultant’s perspective: if you are a gastroenterologist, a cardiac surgeon or whatever, and you have spent your whole life training and organising to be a gastroenterologist, a cardiac surgeon or whatever, when you work in a hospital, all you are interested in is getting great service for your patients. It is very interesting that consultants’ relationships with their clinical managers are much better than with their other managers, so if you are a cardiac surgeon, who is committed to cardiac surgery and focused on that, you can have good discussions with your clinical manager, who may cover the whole of surgery because some things may be of interest to all surgeons, such as the operation of theatres—you can absolutely see that that is a big thing—but you may be less interested in the corporate objectives of your organisation. That is what is shown here.

It can be questioned whether that really matters in the sense that, as long as you are providing great services for patients and working with your colleagues, does it really matter if you do not sign up to your individual organisation’s vision for the future or whatever? I would say that it does, but for most surgeons, and for most patients, I guess that it does not really matter as long as they are providing great services for those individuals. On the issue of signing up to corporate goals—it is interesting that 41% see themselves as working well with managers in that way—the local managers tend to be the representatives of the corporate goals in those circumstances, so you can see that those two things would work together. I think that is where we are.

If you look internationally—the relationship between clinical people and professional managers is not just a problem for the NHS—in some organisations it is fantastic and works really well, and you can see examples of that here, but in others it does not. That is to do with the culture of the organisation, the way they manage, the ethos and the quality of the people—all those things. The way that you resolve those issues, to be absolutely honest, is not to have an even more refined consultant contract, but to improve the quality of people who run our organisations. That is not just a quick fix; you cannot suddenly produce a whole set of new people to do it. In fact, many of the existing people, with help and development, can improve the way they do it. That is certainly the focus of our activities at the moment.

Q59 Jackie Doyle-Price: We could have a long discussion on the arrogance of medical professionals. The way you satisfy yourself that they are delivering good service is through regular appraisals and performance management, but there is no evidence here that that is happening across the board. What is your reflection on that? Would you like to see more appraisals? We discussed job plans earlier, but it is not enough for consultants to have them; they need to be measured to see whether they are delivering against the thing, too.

Sir David Nicholson: The fundamental place where all of this comes together is in the appraisal—not just doing it, but the quality of it as well. It is the time when the organisation sits down with the individual, and that individual says, “What support, help, tools and resources do I need from the organisation?” The organisation then says, “This is what we expect in terms of delivery for you.” There is no—

Q60 Chair: That is the theory. You are the head of the NHS, so why are you not translating that into practice?

Sir David Nicholson: It is very difficult to do—it is incredibly difficult to do. If you look at any organisation of this scale and complexity, it is very difficult to do. In some places—

Q61 Chair: I don’t agree with you, Sir David. The exchange over the last five minutes with Jackie—honestly, in any public or private sector organisation, one of the jobs of the leader is to get everybody pulling in the same direction. What comes out of the Report is that people are not pulling the same direction. It does not matter whether they are clinicians or not; they have got to feel part of a whole, and if your managers are not doing that, they are failing. That is the feeling that we, as performance management gurus around this table, are frustrated by.

Sir David Nicholson: I do not think that all of them are failing. Hospitals are providing some fantastic services—

Chair: You have got too much that is poor.

Q62 Fiona Mactaggart: Is that because of what you have been doing, or in spite of that?

Sir David Nicholson: Well, first, since 2003 in particular we have been trying to give individual organisations and trusts more freedom over their own affairs. There has been the whole thing with foundation trusts being developed to be accountable locally, not to Whitehall through me. At the moment, nearly 70% of all acute activity is run through foundation trusts, not directly managed from Whitehall in that sense, so we have been creating the environment for people. From the centre, from the start of the leadership council through the development of the leadership academy, we have put literally thousands of clinical staff through education, training and support. We have created a faculty of
Q63 Jackie Doyle-Price: You mentioned accountability. We have exchanged words about my local trust before, where the accountability spectacularly failed. We ought to have mechanisms in place for performance management, but that has become less crucial, quite honestly. This whole field and exchange feel very much producer led, to be frank. It is a matter of how we get to a culture that puts the patient first. I feel the debate is going the right way, certainly from the move we had before, but then I come to a hearing like this and I get profoundly depressed again. Because we are still talking about box ticking that X% have got job plans, even though they are not being delivered. How are we going to facilitate the cultural change that puts the patients at the heart of things without having real emphasis on delivering appraisals and performance management for all NHS personnel?

Sir David Nicholson: In a sense, that is exactly the point that Bruce was talking about earlier. We need to focus on outcomes, not on inputs. The more we can shift the NHS around identifying great outcomes, and then the whole organisation being designed around delivering them, the better it will be. That is what we have started to do in the Commissioning Board by developing the guidance for this year, in terms of the planning guidance for the NHS. It is all about outcomes; it is all about that. Orientating people to do that is relatively simple but absolutely vital, because that is what will shift the system in favour of patients.

Q64 Jackie Doyle-Price: Do you think—Sir Bruce might have something to say about this—that more emphasis on monitoring performance of consultants might have been relevant in the context of Mid Staffs and other trusts that have been singled out as underperforming?

Sir Bruce Keogh: I do. I think there are two bits of that. I may have said this to the Committee before, and I apologise if I am repeating myself, but I think it is the duty of every health care professional, particularly doctors, to be able to describe what they do and define how they do it. That is a professional, moral and social duty. If you can’t do that, you have forfeited some of your professionalism. I think that has got to be brought into the appraisal: “This is what I do. These are my results. This is where I think you have that kind of information, it should be in the public domain as well. That has to be the direction of travel. There is a second point. All sorts of things went wrong in Mid Staffordshire, but one was that that simple principle was adhered to. Furthermore, I don’t think the structures, culture and mechanisms in the trust allowed the trust board to know what was good and what was bad and what was going on. You are absolutely right to couple those two questions.

Q65 Chair: How are you going to do it in future with foundation trusts all local? That’s what you want. How are you going to do it—go from the theory to the practice? The one thing you have said, which I think everybody here has welcomed, is that you will publish consultants’ performance. How are you going to get that performance culture, so that we start seeing the value for our massive investment? Given that foundations trusts are independent and localised, how are you going to do that?

Sir Bruce Keogh: There is a couple of things. First, there is a massive cultural issue: people have to recognise the importance and professionalism of it. Unless we get to that place it will be more difficult. One thing that is helping towards that is revalidation, which you may be familiar with. Every year a doctor is meant to have an appraisal and then on a five-yearly cycle those appraisals are reassessed. So, whether somebody is up to scratch and keeping up to date. The General Medical Council, as the independent regulator of doctors, will then determine whether that individual is fit to carry on. I have had discussions with some commissioners who are keen to see the results of individual practitioners in the hospitals from whom they purchase services made available to them and published by trusts. We have asked the committee that awards clinical excellence awards to ensure that activity and outcome data are included in the applications for the awards. I do not think there is any one thing we can do, but there is a number of different things we can put in place to keep the pressure on.

Q66 Ian Swales: Building on Jackie’s questions, I would like to explore a bit more about the relationship—a power balance going on, where on one side you have managers, who even Sir David says need upgrading, and on the other side, you have often very experienced professionals backed by, some would say, the most powerful trade union in the country. All the time, they have to work on a basis that is not always well defined. I would like to pick up a couple of examples from the Report. The first is in paragraph 17, which says that “most trusts continue to use locally agreed rates of pay well above defined contractual rates to secure extra work from consultants.” Can you say more about what you think is going on there and what we can do about it?

Dean Royle: I think it is the point I made earlier. First, when we talk about managers in this context, most of the managers who manage consultants are consultants: they are clinical directors who have a clinical work load and want to remain clinically active with patients. In that context, there has been a general move about having more clinical leadership in organisations and less general management. In that context, we have been investing more in the training and development of leaders, building up over the medium term. There is something about not just...
assuming that a manager is a non-clinician; in fact, the vast majority of our managers hold some form of clinical qualification.

On the particular issue about the rates that are being paid, it is a point I was making before. A standard consultant works 10 sessions—10 programmed activities—a morning and an afternoon, five days a week. The average that we have them working is something like 11.5. At 10 programmed sessions, that is 40 hours; at 11, that is 44 hours. The maximum we can work them is 48 hours a week because of the working time directive. There is a whole host of work that goes on, within those contractual rates, that we are doing over and above the 10-rate. Occasionally, for waiting list initiatives and other uses, people use consultants for a one-off—asking them to come in on a Saturday morning or to work late to an additional list. As we have said before, when you do that, you are competing: you are asking, “Will you come and work for us rather than do the same work for the private sector, which may pay you more?”

Q67 Ian Swales: That leads me to my other question. A short section on page 21 talks about private work. According to the data, 40% of consultants are doing private work. Do you know how much private work people are doing and what sort of money they are earning? To what extent does that affect the 10 sessions that they are programmed to work for the NHS?

Dean Royles: On the particular issue that we have in the contract, one of the reasons that we wanted to get people to do more NHS work was that before people do any private work at all, they have to offer to the NHS an additional session. In some cases, the NHS may say, “That’s fine. The activities that we have are going okay.” In other cases, the NHS will take them up on that, before they go and do private work.

Q68 Ian Swales: So they have to do 11 sessions of NHS work before they are allowed to do any private work?

Dean Royles: They have to offer to do the additional session.

Q69 Ian Swales: How does that fit with the 48 hours a week, if they are working for somebody else part of the week?

Dean Royles: Most contracts—the employment contract that we have with them—will say that if they do additional work over and above that, they need to declare that, bearing in mind that private work may range from a couple of hours on a Saturday morning to something more. Those consultants do not necessarily all work the full programme of activities. Some people would be working part-time and doing private work as well.

Q70 Ian Swales: That was my other question. Do you pay people on that basis? If people are not offering the 10 sessions a week, do they get pro rata of the contractual pay?

Dean Royles: We have some consultants who will not work the full 10 sessions; they may work part-time. One of the issues, in terms of the number of consultants we have coming through medical school, is that we have an increasing feminisation of the work force. People are wanting to take time out of work for families and may not want to work full-time. We have to respond to that with flexible ways of working.

Q71 Ian Swales: I understand that, but I am thinking of the well-respected surgeon who has loads of private work and is probably a platinum holder of clinical excellence or whatever, and is not doing 10 sessions a week. Are there any of those people around?

Dean Royles: These are people employed by individual organisations with a contract for an individual trust.

Q72 Ian Swales: If people are doing private work for part of their core time, is their pay affected?

Dean Royles: I am sorry, but I do not understand the concept. Bruce may be able to help.

Q73 Ian Swales: All right, let me put it another way. If they are not doing 10 sessions a week, their pay is affected pro rata, including any excellence awards and everything else—true or false? Does anybody know?

Dean Royles: If they are working part-time, they get part-time pay.

Amyas Morse: Do they get a full excellence award?

David Moon: They get part of a share.

Q74 Ian Swales: It is probably overstating to talk about being held to ransom, but it feels to me as though because of a shortage of consultants, the fact that they can name their price for working a Saturday morning and 40% of them are doing private work—no doubt, quite a bit of that is in NHS resources—the power balance is not right. Furthermore, I have had personal experience in the past six months of a consultant telling me I had to go private to have a procedure, but I got it done on the NHS somewhere else. There is an element of people using the NHS to push their own private businesses. Are you aware of that going on?

Sir Bruce Keogh: I hear anecdotal stories of that. Can I be absolutely clear that from a professional standpoint I regard it as utterly abhorrent behaviour?

Chair: But it happens.

Ian Swales: It has happened to me in the past six months.

Q75 Chair: It happens. It seems to me that you are not living in the real world, Sir Bruce.

Sir Bruce Keogh: I live in the real world all right. Don’t be mistaken about that.

Q76 Chair: It has happened to a lot of the people who come and see me. It happens.

Sir Bruce Keogh: I am not denying that it happens; I am saying that professionally, as the most senior doctor in the NHS, I regard it as utterly abhorrent.

Q77 Chair: So what are you going to do about it? I think that all of us round this table agree that it is abhorrent. You are running the NHS, so what are you going to do about it?
Sir Bruce Keogh: You know, the vast majority of consultants do not behave like that.

Q78 Chair: It happens too often for that.
Sir Bruce Keogh: I look forward to the evidence.

Q79 Ian Swales: My final question on this is if consultants are doing private work in NHS facilities, to what extent do you make a full cost recovery of the facilities that they are using?
Dean Royle: Many consultants will do their private activity through another organisation that will lease back such things as operating theatres. It will vary from organisation to organisation where they use that capacity. Where they are using NHS facilities, it is normally through a parent organisation, not individual consultants.
Ian Swales: To be clear, this is all about value for money. We are all focused on making sure we get the best value.

Q80 Stephen Barclay: Could you clarify what Professor Don Berwick’s role is? He is a world-leading authority on patient safety and he advised President Obama. What, Sir David, is his role in the NHS?
Sir David Nicholson: He has been commissioned to give us advice about how we can make the NHS culture zero-tolerant for patient safety.

Q81 Stephen Barclay: Is he someone whose judgment is to be trusted?
Sir David Nicholson: He is a fantastic health leader.

Q82 Stephen Barclay: In his 2008 report, Professor Berwick said that the consultant contract, “paradoxically deprofessionalised doctors, as well as enriching them”. Do you agree with his assessment?
Sir David Nicholson: This was part of the debate around the 2003 contract. It was a debate around whether you pay people and expect them to deliver what they professionally think is the right thing to do or whether you just try to organise their time managerially. The argument at the time was very clear—that the consultant contract, as it was described, was putting too much managerial power and control in the consultant contract. I think that it was the right thing to do.

Q83 Stephen Barclay: Do you agree with his assessment, or do you not agree with his assessment?
Sir David Nicholson: I think the danger is there, but we took the judgment in 2003 that the arrangements for the consultant contract overall were the right thing to do.

Q84 Stephen Barclay: Overall you don’t agree with his assessment.
Sir David Nicholson: Well—

Q85 Stephen Barclay: It is not a trick question. A world-leading authority was brought in. How much did his report cost?
Sir David Nicholson: I did not commission it.

Q86 Stephen Barclay: Can we have a note on how much it cost?
Sir David Nicholson: Just because he is a world-leader doesn’t mean I have to agree with everything that he says.

Q87 Stephen Barclay: Absolutely; hence my question, Sir David. I didn’t say you were under a duty to agree. I just said, “Did you agree or not?” I am still at a loss as to whether you did.
Sir David Nicholson: The people who negotiated the contract in 2003 had a set of judgments to make about where they went with that particular contract, and the judgment was that at that particular time, given the expansion, having more managerial control over it was the right thing to do; and I think that was right.

Q88 Stephen Barclay: Professor Berwick also talked in 2008 about the culture and made some scathing recommendations about the culture, which your deputy, David Flory, described as a caricature. Do you think Mr Flory was right in that assessment?
Sir David Nicholson: I think you are now trying to rerun the Mid Staffordshire inquiry, aren’t you?

Q89 Stephen Barclay: No, I am not. I am trying to get a sense of this person we have just brought in, who made a comment on what is exactly germane to today’s hearing—the consultant contract—and who talked about the culture, which is germane to consultants, and what the culture pertaining to consultants is. Both are absolutely within the scope, so could I ask the question again, please: do you think Mr Flory was correct when dismissing Professor Berwick’s comments about culture?
Sir David Nicholson: I do not think he dismissed the comments that Don Berwick made about culture. Cultures are really important for the NHS. It is a complex area. There are different cultures in different organisations. There are different cultures even in different wards, and we know that the right kind of culture is much more likely to deliver better services for patients. Being critical about the culture and wanting to improve it is the right thing to do, but to caricature the whole of the NHS culture in one way or another—I think David Flory would be right to say you shouldn’t caricature it.

Q90 Stephen Barclay: You say he didn’t dismiss it, but the question talked about the shame and blame culture and the answer was, “I think that the three statements, which you’ve highlighted, are quite outrageous”, which sounds to me like he is dismissing the comments. I am trying to get a sense of why we have just hired someone—Professor Berwick—whose report in 2008 you didn’t see, and Mr Flory didn’t see even though it was central to his role, and that we’ve paid for, and whose judgment, it seems, was probably wrong in 2008, according to senior people in the Department of Health. Now, five years later, we’ve hired him to advise the Department.
Sir David Nicholson: When we did “High quality care for all”, which is what you are referring to, we came to the conclusion that quality was not the organising principle of the NHS, that the culture of
the NHS at that particular time was not in the best place it could possibly be and that we had to do a whole series of things to improve it. That’s what we have been doing since then.

Q91 Stephen Barclay: Did you sign off on that report when it was published?

Sir David Nicholson: “High quality care for all”? Indeed, Ara Darzi said I was a kind of co-writer of it; I was absolutely involved in all of that work, and the analysis that went before, and the reason why we did it.

Q92 Stephen Barclay: How could you be the co-author, sign it off, be involved in the analysis, and not see the reports that fed into it?

Sir David Nicholson: There were literally hundreds and hundreds and hundreds of reports that were done as part of that.

Q93 Stephen Barclay: From world-leading experts like Professor Berwick?

Sir David Nicholson: Experts on all sorts of different things. There were three particular ones that were identified, as I said at the inquiry, that I hadn’t seen at the time, but the implications of them—the importance of service change, transformation, the way in which Don Berwick identifies you change culture and improve services—I absolutely signed up to.

Q94 Jackie Doyle-Price: Sir David, what are your reflections on the most important ingredients for a good culture that will deliver good care for patients?

Sir David Nicholson: This is a really important question. Of course. If I can describe it by comparing it with what a bad culture might look like, if you think about a conversation between a middle manager and a clinician about people waiting in accident and emergency departments, which is often where people come, a bad culture is the middle manager saying to the consultant, “Get that patient sorted out, because if we don’t we won’t deliver the four-hour target.” That seems to me a bad culture, and we need to name it as such. A good culture says, “Can we sit down and talk about our patients? Can we see how we can give them the best possible experience and outcome? Let’s work out what we do.”

That, in a nutshell, is the difference between a good and a bad culture. You will see both of those operating in the NHS. Right from my beginning in this job, I used the phrase—I don’t know whether I invented it or not—“The worst thing we can do is hit the target and miss the point.” That is the fundamental belief that has taken me through all the changes that I tried to lead in the NHS over the last few years.

Q95 Jackie Doyle-Price: That’s right, but it is still quite a processy way of answering. Let me run this by you. These are the ingredients I always see as being crucial to a good culture: good leadership with strong accountability, good staff of high quality who are empowered and managed, and good management of complaints when things go wrong. Am I missing anything?

Sir David Nicholson: All those are really important ingredients of a good culture. I would add transparency and the ability for individual staff members to speak up about issues and make things happen and change.

Chair: Okay, Amyas and Austin, and then I am tying things up and moving on to the issue of gagging clauses.

Q96 Amyas Morse: One thing to say on the record is that in our fieldwork, nobody mentioned the fact that there was a union dispute. It may have been a factor, but we saw no evidence of that effectively whatsoever. It is important to put that on record. Secondly, I would like to hear a little bit about whether you accept our comment in paragraph 2.8 that over half of trusts did not think that the clinical directors had enough time or resources to look after their clinical staff properly.

Finally, to return to the discussion that has been going on with Sir David about the need to develop and raise the quality of non-clinical managers, we got a strong impression from the workshops that there is quite a lot of no-go area. I am not saying this to score points; I am really interested in how we are going to get managers not to be reluctant to tangle with clinical staff and to feel that we have a much more joined-up culture. Will that simply be a matter of having more clinical people, as I heard you say? I genuinely do not know the pathway for that.

Dean Royle: Can I pick up on the industrial action? Although it may not have been mentioned, it was certainly happening. I want you to understand the sort of thing that was going on at the time. At that time, we were asking every organisation who they expected to be at work, what services were being run, how we were going to reform services and what protection we had. All through the run-up and the follow-up, we got managers and clinicians involved in that activity.

The point I was making was that at the time we were doing this—did they have time and effort, and all those sorts of things—the Report makes it clear that they did not feel that they had enough support staff. It is incredibly difficult for organisations that are constantly trying to become more efficient and reduce the number of managerial and administrative staff, when we know that those can be helpful support for our clinicians.

Sir David Nicholson: There is a point in all this, and I think it is about the way in which you use your clinical staff. We are finding this particularly with clinical commissioning groups. If, as a clinical leader, you think your job is to do a load of management, you are probably wrong. What we have found in places that work really well is that the clinical leaders focus on the clinical activities and leave the managerial stuff to others. My experience of dealing with clinical directors is that very often they want to do everything, because they feel responsible for everything. Learning to delegate is an important part of it.

On the second part of your question, there is no short cut to this. This is about—

Amyas Morse: So you recognise it is an issue?

Sir David Nicholson: I recognise it is an issue. On the particular point that you make, all this falls down
if the consultants do not feel part of the corporate objectives of the organisation. If the corporate objectives are essentially a reflection of what people are saying nationally, you can see why you would not get buy-in. Where you do not get buy-in, you get that difference between doctors and managers, because at the top level they are not aligned. That is why it is important for organisations, as they start to think about how to focus their attention on outcomes, to get buy-in at the top level. That is how you will get real change.

Chair: Having just said that you understand why a clinician would focus on his speciality and not have a buy-in, that is an interesting answer.

Q97 Austin Mitchell: It makes me worried. Your answers here and there make me feel that you are being too deferential to consultants. We were told, as mere Back Benchers, that the 2002 contract, which was negotiated so generously, would allow hospitals to use consultants more efficiently and effectively, yet that does not seem to have happened. In northern Lincolnshire, there was a proposal to have them in the emergency ward so people could be quickly diagnosed as they came in and either sent home or taken up to a ward and treated. Paragraph 1.24 says that only 34% of trusts stated that the contract helped them increase the provision of service for patients. Why is that? Is it because consultants are too powerful in hospitals, or did the trusts not try?

Dean Royles: When looking at productivity and efficiency, it is quite difficult in terms of looking at consultants.

Q98 Austin Mitchell: No, you are looking at service to patients.

Dean Royles: Yes, but just this weekend, for example, there was something on TV about a bunch of nurse practitioners in one of our hospitals who were seeing patients. The patients were coming in to the organisation, being seen by nurse practitioners and being discharged, or if they stayed in hospital, they stayed for less time. To me, that seems an efficient use of money; but it would have reduced consultant productivity, because the consultant was not seeing those patients.

Part of the issue is that when you look at a report like this, you are looking at a unidisciplinary issue, consultants, when we are used to working in a multidisciplinary environment: how do we use the entire health care team? How do we use our health care scientists, allied health professionals and nursing staff? That is where the whole thing comes together.

Does the consultant contract on its own improve patient care? It goes some way towards it, because it is about how we deploy and use our entire work force. I agree that once you have buy-in and good management and supervision for those staff, it is better.

Q99 Austin Mitchell: So the consultants have not been too powerful in the hospitals to stop the improvement in the service to patients that was expected to arise from the 2002 contract.

Dean Royles: I don’t know what you mean by—

Q100 Austin Mitchell: Well, have they been too powerful, or have they not?

Dean Royles: What the report says is that in terms of the objectives and what this was trying to achieve at the time—remember the context of the time—

Chair: Why don’t you answer the question? We have read the Report.

Dean Royles: Yes, but the context at the time was that we were haemorrhaging staff. We could not recruit consultant staff, so pay review body after pay review body was giving inflationary increases. This was an opportunity to pay up front and bring people in. As a result, we have a disproportionate number of newer consultants coming into the work force, as opposed to more experienced consultants. Over time, as they work and become experienced, we get much better value, but this was up-front cost for long-term benefit.

In that context, what the report is saying is that those objectives were either partly or wholly delivered.

Q101 Austin Mitchell: One more question. In that case, if it has been solidly proven, it will be very difficult to realise the ambition of a 24/7, seven-day-a-week hospital service. The consultants’ contract states that they only work from 7 am to 7 pm and they will not work at weekends, presumably so that they can play golf. If you are going to realise a 24/7 use of hospitals and facilities, you will have to stuff their mouths with gold, won’t you?

Sir David Nicholson: There are examples of poor consultants around; there is no doubt about that. We have all seen them, and I have managed hospitals so I have seen the worst of it. But fundamentally, consultants are there to provide services for patients, and they do it fantastically well. According to the Report, they work out of hours for little or no extra pay. They all do more hours—

Austin Mitchell: They are paid a higher rate.

Sir David Nicholson: Even with that, they work far longer than their contracted hours. The vast majority of them are very dedicated. Having said all of that, in order to take the service forward over the next few years, it is clear that the consultant contract provides obstacles to doing the kinds of things that Sir Bruce does, and making sure that we get seven-day services so we can improve hospital mortality, outcomes and the rest of it. It needs to be more flexible, and that is why we are involved in the negotiations with the BMA about how we can get a contract that will take us to the next level, which is all about outcomes and improving services for patients across the whole of the working week.

Q102 Justin Tomlinson: I have been listening patiently to this, but there is something I have picked up on. Can you qualify what you meant when you said that you were haemorrhaging staff pre-2003? Was that actually the case? Were we seeing a fall in the number of consultants?

Dean Royles: Across the entire work force, we were struggling to recruit staff. If you recall, at the time, there was the NHS Plan, which said that the public wanted more staff, working differently and paid more. That was effectively the ambition behind what we were trying to do at the time. Various targets were set
in terms of increasing the size of the consultant and nursing work force. At the time, most people said that those targets were overambitious on what we could achieve.

Q103 Justin Tomlinson: Specifically on consultants, the graph in figure 5 on page 22 does not show a fall in the number of consultants—or a haemorrhaging, which was the word used.

Richard Douglas: That is right. We were looking to grow significantly. It was not a matter of countering significant reductions; we were looking to grow significantly the number we had.

Q104 Justin Tomlinson: What was said was that the number of consultants was haemorrhaging. I am struggling to understand. Formerly, I owned my own business, and if I had a 27% uplift, I think would probably just have chosen to increase the number of consultants by 27%, and I would have had much greater confidence in the improvement in outcomes. We are trying to get 24/7 operating. What worries me is that this was a once-in-a-lifetime opportunity. You do not often come to the table with a big pot of gold that allows you to say, “Right, let’s broker some changes here. If you are more flexible in your working arrangements, we have got a very generous 27% uplift in pay. We expect something.” It just seems to me that we have given the money without necessarily getting those changes. I would be surprised if we were in a position to go back and broker a deal with such a strong arm ever again.

Richard Douglas: In terms of the earnings growth figure, in the four years running up to that contract, consultant earnings were increasing by about 4.9% a year above inflation. The year we introduced the contract, they increased by 12%. For the four years after that contract, they increased about 1.3% above inflation. If you look at the period around pay growth, during the three years before the year of the contract, the average growth was about 4.9%. If you look at the year of the contract and the subsequent three years, the average growth in earnings was lower than that, overall.

Q105 Mr Jackson: We are not talking about growth in earnings, we are talking about numbers of consultants.

Richard Douglas: The point was made about how you would use the money, as well.

Q106 Mr Jackson: No. Mr Royles used the word “haemorrhaging.” In the graph in figure 5 on page 22, the full-time equivalent is 22,188. It has gone up to 26,341 in the period before the pay review and the uplift of pay. That is not haemorrhaging.

Justin Tomlinson: That is exactly what is confusing me.

Q107 Mr Jackson: Mr Royles, maybe you would like to nuance your answer to my colleagues about haemorrhaging. I think you are trying to muddy the water by saying “Lots of staff were worried about the NHS then”, or “We could not recruit staff”—but we are not talking about that. It is all very interesting, but we are talking about consultants. They were not haemorrhaging, and they certainly were not haemorrhaging after their 27% pay rise. Maybe you want to rephrase your answer to my colleagues.

David Moon: For the record, the rate of growth in full-time consultants was actually higher before the new contracts than it was directly after. The rate of growth in full-time consultants between 2000 and 2003 was 5.9% per annum. Between 2003 and 2006, it dropped to 5.1%. They were definitely not haemorrhaging staff.

Q108 Justin Tomlinson: This is crucial, because at that point you sat around brokering the deal. Had you been right, and you had been haemorrhaging staff, and we had seen the graph that showed that the figure was growing, we could have accepted the argument that it was value for money because we were keen to get those outcomes. It seems that staffing was not the problem. Therefore the question is, what did we get for that 27%? We probably did get things—you have given evidence of that—but I am not convinced that we got enough.

Dean Royles: I go back to the report, and I apologise if the use of the word “haemorrhaging” was wrong. My recollection at the time was that we had rising waiting lists and we were struggling to recruit staff in many areas across the work force. That was one of the things we were trying to correct.

Q109 Mr Jackson: Let us clarify this, because you are possibly inadvertently misleading the Committee. You can see the facts in front of you on page 22. We were not haemorrhaging. The trajectory was increasing recruitment and it was increasing faster, in terms of the number of full-time equivalent head count, in the four years before—the period during the Wanless committee review and the Health Select Committee review—than it was after. So please do not try to mislead the Committee. We are talking about consultants’ pay and remuneration, not the general picture of employment practices and recruitment in the health service.

Q110 Chair: We will leave that. I will ask some final questions, then we will move on. Are pay increments still linked to years of service, rather than performance?

Dean Royles: Yes. The norm in the consultant contract is that an increment would be paid. There are circumstances in which you can withhold that under the current contracts.

Q111 Chair: So even after this big pay rise and after there is supposed to be some performance management, pay increments are still linked to years of service.

Dean Royles: Yes, and that was intended in the contract.

Q112 Chair: Can I ask what the average sickness absence rate is among consultants?

Dean Royles: I do not know what it is off-hand. My recollection is that medical work force sickness
Chair: The figure I have got is 10.7 days in the NHS as a whole, compared with 9.7 in the public sector as a whole and 6.4 in the private sector. So it is worse. Have you got that, Mr Douglas?

Richard Douglas: I have not, but we can come back to the Committee with a number.

Chair: By 2020, according to the Centre for Workforce Intelligence, we will have 60% more consultants trained—accepting that it takes time—which could cost £2.2 billion. Do you expect them all to be in jobs, or is it a generation of wannabe consultants?

Sir Bruce Keogh: My expectation is that they will all be in jobs.

Chair: With the money that you know will be available for the NHS?

Sir David Nicholson: At the moment, we have not got a clear strategy about how we will take the NHS forward in the next period of austerity. We have a view up until the end of 2014–15, and we have to think about what the NHS might look like after then. My general approach to it, if you look at the development of health care that we have had over the last three or four years, is to shift resources from the infrastructure—the overheads of the NHS—into clinical services. We have managed to increase the number of doctors—

Chair: You want people out of hospitals, in the community.

Sir David Nicholson: We would expect that. We would also expect consultants’ jobs to change significantly. We would see far more community cardiologists and far more consultants working out, supporting general practice in the community.

Stephen Barclay: It is quite a revelation that you do not have a view beyond 2015. That does not say much for long-term planning.

Sir David Nicholson: We have not done the spending review, yet, so we have not been through all the process.

Chair: This is the problem: it is all so short term. I want to keep going on these questions. Steve, do you mind if I keep going? Otherwise, we will never get to the end.

There is an assumption that consultants are available all over the place. We know that 86% of trainees end up working in the area where they are trained. There are areas where there is a massive shortage of consultants. One, dare I say it—I know I always bring it up—is my local hospital trust. What are you doing about that? We have just had yet another lousy report on our A and E, and one reason for that is that we do not have the consultants we need—they all work in central London in the teaching hospitals—and we do not have the registrar staff we need. Some 50% of my registrars are locums at the moment. What are you doing? You are training all these guys, and they have this fantastic contract, but they are not in the areas where we need them.

Dean Royles: One of the things that has just been established is the new organisation Health Education England, which is looking at the sort of work force planning that we need to have done in the future.

Chair: What are you going to do to get people to go to work in these places? If it is true that 86% of trainees end up working in the area where they trained, what are you doing? You are running this service. What are you doing to make sure that this precious resource, which it has taken us however many years to train, goes and works in the areas we need it, such as Barking and Dagenham? Jackie would probably say the same about her local hospitals.

Dean Royles: Some of this goes into long-term planning, so—

Chair: No, it doesn’t. It needs action.

Jackie Doyle-Price: It is not about that; it is about why I would choose to work in Barking rather than Cambridgeshire. That is the question.

Dean Royles: That is the question that individual organisations—Health Education England and the local education training boards—are trying to do. Can you get people at schools interested in working in particular areas? That is what I mean by long-term planning. You can go and see the sorts of places where people can go and work.

Chair: This is just waffle, with respect, Mr Royles.

Jackie Doyle-Price: If I am a consultant, I can work where I want to. Why would I choose to work in Barking, where I am going to struggle to understand half my patients, frankly, rather than Cambridgeshire, where you have a different class of patient? [Interruption.] That is the truth.

Dean Royles: That is a big ask for a number of organisations, but they work incredibly hard at looking at how they can develop services to attract in consultants, who can bring juniors in, so that juniors come and stay because they can see services developing over a period of time.

Chair: We want you to “do”. It is not going to get any better. The other thing on consultancies is that you have got them in the wrong jobs. What about A and E or geriatrics? A statistic I got showed that, in 2011, it was not possible to fill 50% of trainee posts in geriatric medicine, but everybody is getting older and needs it more. There is a lack of applicants. What are you going to do about that? What are you doing about it? The main message from us is “Don’t think, just do”.

Chris Heaton-Harris: We want them to think.

Chair: Okay. Think and do.

Mr Jackson: Is there a possibility to use the clinical excellence awards as a mechanism to direct consultants into less glamorous, more prosaic disciplines, such as geriatrics, as the Chair said, or other fields that have perhaps not attracted talented
consultants hitherto? Rather than just chucking money at them, try to focus it in a planned way.

Dean Royles: The evidence we gave the doctors and dentists review body, which was looking at this, is that there should be much more local discretion in how clinical excellence awards are awarded, rather than the basis of national—

Q124 Mr Jackson: That is a different thing. That is about fellow clinicians, who happen to be hospital managers, stuffing people’s mouths with money to keep them quiet. I am not talking about that; I am talking about someone at what would have been the strategic health authority level—obviously this is not going to happen now—or Department of Health level saying, “In West Sussex, Eastbourne, Brighton and Hove, we need more geriatricians. We will give enhanced clinical excellence awards if that could happen.” In that way, we could direct a strategy to get better outcomes.

Dean Royles: There is provision in the existing contract: we would call them recruitment and retention premia. It is the money that will draw and attract people in, and that can be used to pay additional premiums to people.

Q125 Ian Swales: I am amazed at what you just said. Surely it is quite wrong to talk about clinical excellence awards being localised and used for local problems. My sense of that is that it is peer-group reviewed, nationally recognised excellence—surely that is what the awards are about. They are not about filling a vacancy in Brighton, or somewhere, and saying, “By the way, you are now clinically excellent, because we have got a vacancy.” You are not proposing that, are you?

Dean Royles: I think that was your colleague’s suggestion.

Ian Swales: It was his idea, but I am saying is that actually what you want?

Dean Royles: The evidence that we gave is that there should be more local discretion on how those are used.

Q126 Mr Jackson: No, I think Mr Swales and I are agreeing on this, but just in a different way. [Interruption.] It is a loveless marriage—we know there is going to be a divorce. What we are both trying to get to is that it should not be a stop-gap, in terms of run-of-the-mill management. It should be about clinical excellence, and in that respect it can be used nationally to direct health service management locally, which is slightly different to just firefighting. That is where I am coming from. What do you think?

Dean Royles: In terms of recruitment, there is provision that we can use recruitment premia to be able to do those sorts of things if it is about attracting people in. Sometimes there is a shortage in specialties, and it is not just the money that we are looking at, but in terms of clinical excellence awards, you are quite right, in terms of looking at the excellence. Part of the recommendation is that whereas at the moment we get something like 40% of people getting local excellence awards, the doctors’ and dentist’s review body said that that should be more like 25% of people.

Q127 Ian Swales: Exactly—in fact, wasn’t it 60%?

Dean Royles: Including the national, it is 60%, yes.

Q128 Ian Swales: Can you say on the record that you think those local problems should be dealt with through the mechanisms of recruitment and retention that you already have, and not by playing around with the clinical excellence system? Is that what you are saying?

Dean Royles: It depends on the question you are asking me, in terms of—

Q129 Ian Swales: I am saying that you don’t use the clinical excellence system—you don’t bastardise it by saying, “You happen to be clinically excellent because you are in an area where we are short.”

Sir David Nicholson: Absolutely. Clinical excellence at national level should reflect on where the clinical excellence is through peer review and all the rest of it, and at local level similarly. The way you deal with the problem of geography is through recruitment and retention. However, on the clinical excellence awards locally, there is an argument for thinking about the way in which you distribute them between the individual specialties. So if you think about geriatrics—care of the elderly, older people—you could see exactly how, at a local level, you might, within your clinical excellence award system, shift it towards rewarding people who are going into older people’s care.

Q130 Chair: Well, Sir David, come and run the hospital in Barking and Dagenham and get us both our A and E consultants that we haven’t got, and get us the geriatrics that aren’t even being trained.

Sir David Nicholson: Is that a job offer?

Chair: We are going to move on to the next element of the hearing, but what I felt really strongly is that this is too theoretical.

Q131 Fiona Mactaggart: Before anyone leaves, I want to ask a question that links the two issues. I was looking at the Francis report, and the second recommendation is about how we manage the NHS. It is very clear. “The NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done. This requires: A common set of core values and standards shared throughout the system”—I am not sure that that is what we have been hearing in how the system is managed at the moment—“Leadership at all levels...committed to and capable of involving all staff with those values and standards; A system which recognises and applies the values of transparency, honesty and candour; Freely available, useful, reliable and full information on attainment of the values and standards; A tool or methodology such as a cultural barometer to measure the cultural health of all parts of the system.”

That is a very different picture of management from the picture of management we have been discussing, frankly. We have been discussing a management picture that seems to owe more to Tesco than to this kind of values-based management, which Francis rightly pointed out is essential to changing the NHS
into something better. I am anxious that, in this description of how you manage consultants, we have not had any reflection of a values-based culture, more transparency or safety first, which are the kind of things that pilots—I know them well, because many of them live in Slough—have to do as part of air safety training. It seems to me that one of the messages of Francis is that that has to be the way the NHS works, so that there is mutual accountability. How does that fit in with what we have just been hearing? It does not seem to at all.

Sir David Nicholson: I agree with everything that you have just said. That is why, when I was asked by Ara Darzi some time ago about whether we should have an NHS constitution and if so, what should be in it, I developed the NHS constitution. The core principles of the NHS, which are set out in the NHS constitution, and the values within it, are exactly in the place that you have just described. At the time of Francis, we were much more in a culture that was putting focus and content around fragmentation, not bringing people together. It is really important that we do that sort of thing. That is why we are talking about changing the way in which the consultant contract is done, so that we can put that into it right from the beginning. I absolutely agree with you. That is why we are developing leadership programmes across the NHS. That is why we are bringing more clinicians into leadership. That is why we want to bring a common purpose. One of the issues for me about the 2005–06 NHS was that there was no sense of common purpose in the NHS. We have been working over the past 18 months in particular to build a sense of common purpose across the NHS—

Q132 Fiona Mactaggart: What is the common purpose?

Sir David Nicholson: It is about putting patients absolutely at the centre. That is exactly what we are trying to do with the organisations that we are building and the systems and processes that we are trying to put into place at the moment, in order to support and help that culture being developed.

Q133 Fiona Mactaggart: How do you effect that? If, for example, you are writing a consultant’s contract, do you put in that contract that that consultant has a duty of candour— I think that that is implied by the recommendations of the Francis report—in relation to patient care and that they have a duty to report it? And who do they report it to?

Sir David Nicholson: Yes.

Q134 Fiona Mactaggart: Where? That is the question.

Sir David Nicholson: We have accepted that there should be a duty of candour. This year, in front of all the development of the Francis report, we have put a duty of candour in the contracts of service for organisations, so that every CCG, NHS trust and foundation trust has a duty of candour written into their contract. That is not enough; you need to—

Q135 Fiona Mactaggart: But they are breaking it at the moment with their gagging clauses, are they not?

Sir David Nicholson: We are going to talk about that in a while.

Chair: Now.

Sir David Nicholson: Okay. This thing about openness and candour is a critical part of when you make change happen. It is something that, right from the beginning of my career, I—

Q136 Fiona Mactaggart: Sir David, the reason why I am frustrated is that you are saying it now, because you know that we are getting on to gagging clauses. Almost nobody—to some extent Sir Bruce has—has said this up until now in our earlier sessions. I do not think that the duty of candour that you are saying is at the heart of everything has been at the heart of your responses on the consultants’ contract.

Sir David Nicholson: And if we are going to discuss the Francis report—in relation to patient care and that they have a duty to report it, so I did talk about it earlier, in response to the kind of culture that we want to develop in the NHS. I talked about the ability to raise issues and do all of that, so I did talk about it earlier.

Q137 Fiona Mactaggart: A wee bit, but how are you going to do it? I see no route map. You are not about changing the culture of this organisation. What is the route map to get from this organisation that we all hoped had a culture of candour, but actually does not, we discover? It is very obvious that it does not. It is issuing gagging clauses on hundreds of people.

Sir David Nicholson: Are we going to develop that now?

Chair: Go on.

Sir David Nicholson: It seems to me that in any kind of change, it is really important that you enable people to speak out about the change and the impact that that has, particularly, for us in the NHS, on patients. This is not something that I have recently discovered or whatever. I have consistently, throughout my career, argued the case for people being open and whistleblowing. Indeed, right at the beginning of my career, I was a whistleblower myself, if you want me to talk about all that. It has been an important part of what I have been doing. That is why I wrote to the service in 2007 and 2011 setting out what our expectations are around all that. That is why we introduced it into the contract in 2010. That is why we changed the NHS constitution recently to support and help whistleblowers. That is why we have set up the whistleblower helpline. It is a very important part of the change that we want to make.

In terms of being balanced and clear about where we are at the moment, we have the NHS staff survey, which is the largest staff survey of its type in the world: 160,000 people have been involved in it. It gives you a balanced picture about where we are in the NHS at the moment, and it is not one extreme or the other. For example, my trust encourages staff to report errors, near misses and incidents. In 2006, 76% of staff said that they felt they could do that; in 2012, 86% of staff thought they could do that. That is a big change in a staff survey over that period. That does not reflect the kind of picture that is sometimes described—but it is not enough. That 86% needs to be much more and it needs to be spread across all organisations across the NHS. You can never stop
supporting and developing this idea. I am absolutely committed to doing it, and I have throughout my NHS career.

Q138 Stephen Barclay: In terms of the open culture, can you clarify whether Martin Yeates was subject to a gagging clause?

Sir David Nicholson: The position around Martin Yeates was that he stood aside when the inquiry started.

Q139 Stephen Barclay: I just want to know whether the contract had a gagging clause.

Sir David Nicholson: I will just explain the position around Martin Yeates.

Q140 Chair: Can you tell us all who Martin Yeates is?

Sir David Nicholson: He was the chief executive at Mid Staffordshire and he stood aside. The board of the foundation trust commissioned a report from a gentleman called Peter Garland on whether he should stand for disciplinary action. The Garland report said that he should and that he had a case to answer; the board itself decided that he should not and that he should leave. He left with six months’ pay in lieu of notice. I do not know whether he had a confidentiality clause; that was not available for me to look at. What we do know is that he made a statement for the inquiry. He did not appear at the inquiry, because of his health problems.

Q141 Stephen Barclay: Probably busy skiing. You just said you did not know.

Sir David Nicholson: As I sit here at the moment, I cannot recall whether I have seen one or not. It would not have gone to me as a matter of principle.

Q142 Stephen Barclay: In your evidence to the Health Committee, you made a point of saying how keen you are to intervene if there is even a hint of a gagging clause. This is a very high-profile case. Why have you not bothered to ask whether there was a gagging clause?

Sir David Nicholson: Because he made a statement to the inquiry. He has made a full and public statement covering all those issues to the inquiry. It is not safe to assume in those circumstances that he was not in any way gagged.

Q143 Stephen Barclay: I asked the Health Minister in my Adjournment debate two weeks ago—actually, my colleague, the hon. Member for Bracknell, put the question—and he said, “I shall endeavour to write to my hon. Friend to clarify.” We have not had any response. Why is there such a delay in clarifying what is a fairly basic point: whether Mr Yeates had a gag when he left?

Sir David Nicholson: All I am saying is, whether he had one or he hadn’t, he did make a full statement to the inquiry on what happened. I can only assume from that, whatever it was he had, he interpreted it as enabling him to make that statement and he did make it.

Q144 Stephen Barclay: Under the rules, the trust would have been under a duty to make a submission to the Department of Health.

Sir David Nicholson: No, they would make a submission to Monitor.

Q145 Stephen Barclay: So have you discussed with Monitor whether the submission included any gagging clause?

Sir David Nicholson: To Martin Yeates? I have recently had some in relation to Alder Hey brought to my attention. I have written to Monitor, asking for its judgment on that. As for Martin Yeates, I haven’t, largely because he has actually made his statement.

Q146 Chair: Wouldn’t Treasury know?

Marius Gallaher: Only if the case came to us. We do not look at gagging or disclosure clauses on those cases. We only look at the value-for-money angle of a particular case, if it is above the statutory or contractual arrangement.

Q147 Chair: Every contract that is signed off that has more in it than is statutory would come to you.

Marius Gallaher: Should come to us.

Q148 Chair: So you should have seen Yeates’ contract.

Sir David Nicholson: My understanding is that it did not have more than his legal entitlement, so it would not have gone to the Treasury.

Marius Gallaher: If it is within his entitlement, it would not be referred to the Treasury.

Sir David Nicholson: The Secretary of State at the time then wrote to the trust and said that he thought they should reconsider and go through a proper disciplinary procedure, so that everything could be open, and the trust refused.

Q149 Stephen Barclay: It is very odd that, the question having been put in the Chamber two weeks ago, we are still in the dark as to whether Mr Yeates was subject to a gagging clause. Could we have a note? Could you liaise with whichever stakeholders you need to liaise with? Could the Committee have a note?

Chair: Within a week.

Stephen Barclay:—within a week, on whether Mr Yeates was gagged?

Can I turn to the appointment of Barbara Hakin? It was a senior appointment. Was the Secretary of State told before it was made public?

Sir David Nicholson: No, he wasn’t. For all the appointments on the Commissioning Board—indeed, Barbara Hakin’s original appointment to the Commissioning Board—Ministers were not notified before the appointments were confirmed. My understanding is that none of the arm’s length bodies confirm with Ministers before they make announcements to their directors. Clearly the chief executives are different, because they are subject to ministerial scrutiny, but not in Barbara’s case.

Q150 Stephen Barclay: That reflects the legislation—paragraph 3 of schedule 1 says that your
appointment, as the first one, is made by the Secretary of State—but is it not odd that the appointment of the deputy chief executive of a body spending £12 billion, the second or third most senior person in the NHS, is made without even mentioning it to the Secretary of State for Health?

Sir David Nicholson: Barbara Hakin is a very talented female clinician, who has spent half her life working as a clinician, and for the rest of her working life, she was involved in management. She is a member of my board and accountable to me at the moment. As you may know, two of my directors have left, both recruited by the private sector, and I needed a short-term interim arrangement to enable me to carry the organisation forward and to make the kind of decisions that we need to make on a day-to-day basis. I offered the job to Barbara on an interim basis, which she accepted.

Q151 Stephen Barclay: So who is in charge? You or the Minister? It is fair to say that you are in charge, then?

Sir David Nicholson: I made an interim appointment of a really top-class manager, who was already working for the board.

Q152 Chair: Did you know that she was being investigated by the GMC when you appointed her?

Sir David Nicholson: I knew that she had been referred to the GMC.

Q153 Chair: So you knew that she was being investigated by the GMC?

Sir David Nicholson: Yes.

Q154 Chair: And you didn’t think it would be appropriate to wait until the investigation was completed, particularly in the current climate?

Sir David Nicholson: I have to make operational decisions about how we can best organise ourselves in the very short term. I cannot wait for the GMC’s processes to go through. I had to make a decision there and then.

Q155 Chair: But in the current climate, when she is being investigated for reportedly sitting on somebody who was trying to talk about patient care and had concerns about patient care, when she was allegedly bullying and preventing this person from being open, in a climate where we want candour, when all those allegations were still around, you still thought it was appropriate to put her in? I do not know how many people work in the NHS. I think everybody is replaceable—we are all replaceable around this table—but you felt that it was appropriate to appoint her before the GMC had come to a conclusion.

Sir David Nicholson: I should say that in the particular case you are describing, allegations were made to me about the bullying of the East Midlands Strategic Health Authority; I immediately instituted an independent inquiry into that. The inquiry, which went through all of it in detail, concluded that Barbara, in particular, was exonerated from all of that, and that was the background in which I was working. She has been referred to the GMC and they are making their judgments at the moment about what to do.

Q156 Chair: When are they expecting to come to a conclusion?

Sir David Nicholson: I have no idea.

Q157 Chair: Why didn’t you ask them? If I were doing an appointment of that nature and I knew that somebody had a disciplinary hanging over their head, A, I would talk to them to find out what the timing was and, B, I would wait that little bit longer to see whether they agreed with your judgment.

Sir David Nicholson: First, it is not a disciplinary. Secondly, she was already appointed. She already works for the Commissioning Board. She has been responsible—

Q158 Chair: Yes, but you promoted her.

Sir David Nicholson: It’s not promotion. She gets no extra money. No extra anything.

Q159 Chair: You promoted her in a job.

Sir David Nicholson: It’s takes on more responsibility for no extra money and as an interim—

Q160 Chair: It seems odd. It is part of being in touch. Out there, there is a lot of angst and a lot of anxiety about whether managers in the NHS, of whom you are at the top of the tree, really understand the importance of candour and listening to what patients say about patient care. Here is an opportunity for you to demonstrate that just by holding back from making an appointment until she has been cleared or otherwise from the allegations from the GMC. You chose not to and that just seems bizarre.

Sir David Nicholson: Operationally, the individual, part of whose job she will be taking over, is leaving imminently. So I had to make a judgment. There was no one else in my view around who could do that job as well as she could. I did not want to hold against her the fact that that was happening. I think she’ll make a great job of it.

Q161 Stephen Barclay: Does it not show a certain disregard for the opinion of the Secretary of State that you don’t even discuss it?

Sir David Nicholson: No, not at all. I have the highest regard for the Secretary of State.

Q162 Stephen Barclay: So high that you don’t even mention it to him. Could I ask about judicial mediation? Is it still the case that there is only one case of judicial mediation in the NHS?

Sir David Nicholson: When I spoke to the Health Select Committee it was the only one that I had ever come across.

Q163 Stephen Barclay: Have you come across any others?

Sir David Nicholson: I have not yet, but no doubt I will do over the next few weeks as we ask people around what is happening and get the information in.
But what we have done now, of course, is close that particular loophole. As I said—

Q164 Stephen Barclay: You did in response to my parliamentary question. That was only last week that it was closed. You said that you would ask around. You said when you appeared before the Health Select Committee that you already had asked around. So are you doing any further asking around?
Sir David Nicholson: We need to do it much more formally.

Q165 Stephen Barclay: Have you written to all NHS bodies and organisations asking for the record that they are required to keep of judicial mediation payments?
Sir David Nicholson: No, I haven’t yet.

Q166 Stephen Barclay: Why not?
Sir David Nicholson: I will do it, in time—
Stephen Barclay: Right.
Sir David Nicholson: As soon as I possibly can.

Q167 Stephen Barclay: So when you first heard of this payment outside the rules—potentially within the rules, but it did not go to the Department of Health or the Treasury—did you not think, “Well, I need to check whether there are any others and write to the NHS bodies and organisations concerned”?
Sir David Nicholson: No, I genuinely did not. I was led to believe that judicial mediation was a choice that organisations and individuals would have and that it would be backed by a court order. In that sense, organisations like my own had little involvement in it. It was subsequently, when I investigated the issue, that I found that it was absolutely possible to bring it within the governance arrangements that we now have and we have done it immediately.

Q168 Stephen Barclay: Would it be possible for a judicial mediation payment to be made on a case which the Treasury had turned down for a special severance payment?
Sir David Nicholson: It is theoretically possible. From what you have said I think it is theoretically possible.

Q169 Stephen Barclay: How? You are responsible for the system. How?
Sir David Nicholson: Because the governance arrangements that were set in place were to deal with compromise agreements between health bodies and individuals. They were not set up to deal with judicial mediation. You could argue that it should have been but it wasn’t.

Q170 Stephen Barclay: So someone can go to the Treasury to try to pay someone off, be told it’s not value for money, go away and enter into a voluntary agreement through judicial mediation to pay them off, and attach a gagging clause to that. That is what you are saying.
Sir David Nicholson: I am just saying it is theoretically possible. I don’t know of anybody but it is theoretically possible.

Chair: Sorry, I am a bit lost in this, Stephen. I know you are more expert. I want to get something clear. My understanding is that any agreement outside the rules has to go to Treasury. My further understanding, looking at the guidance that has been issued, is that, even if you use the mechanism of judicial mediation, you still have to go to Treasury.

Stephen Barclay: No.

Q171 Chair: Well, I’ve got something that says, “Treasury approval is necessary in all cases involving severance payments.” Is that right? I am getting a yes there.

Marius Gallaher: Yes, if it’s outside the contract.

Q172 Chair: It also says, “Judicial mediation may still be used in such cases but Treasury approval is recommended to be sought.”

Marius Gallaher: Correct.

Stephen Barclay: So it’s not, is it, Sir David? The answer to my parliamentary question sets that out.
Chair: That’s what guidance says, Steve.

Q173 Stephen Barclay: Let’s ask the accounting officer. Did the Gary Walker payment get signed off by the Treasury?
Sir David Nicholson: No.
Stephen Barclay: No, it didn’t.

Q174 Chair: But should it have done, under the rules?
Richard Douglas: I think what you quoted, Chair, is that it is recommended that Treasury approval should be sought. That is not then a requirement. There was an absolute requirement on everything else that Treasury approval was required for it.

Q175 Chair: It is pretty strong this. “Treasury approval” and “judicial mediation”. I am quoting from what I think is the guidance for employers. Am I right? Just tell me if I am wrong about this, because I wrote it out and might have got it wrong. “Treasury approval is necessary in all cases involving severance payments.” I have then put dot, dot, dot. “Judicial mediation may still be used in such cases.” So everybody knew about this judicial mediation. “But Treasury approval is recommended to be sought...so that the mediation can be completed and finalised on the day.”

Richard Douglas: My understanding of the situation as it was until very recently was that there was not a requirement to go to the Treasury in the case of judicial mediation.

Q176 Chair: All I am doing is quoting from your own guidance.

Marius Gallaher: The Treasury’s view is that if it is outside the contract—any payments outside the contract—even if it is agreed in a judicial mediation, it is not valid. The Treasury would not approve, because it is not value for money, unless there is some other case.

Q177 Chair: So they should have got Treasury approval, then.
Marius Gallaher: Yes, if it is outside their contract.

Q178 Chair: Yes. I will quote from “Managing Public Money”, the other document. “It is important to ensure that Treasury approval is sought before any offers, whether oral or in writing, are made.” That is what I understand judicial mediation to be all about. Is that right?
Marius Gallaher: Yes, that is the guidance and I stand by it.

Q179 Chair: Let’s read it again. “It is important to ensure that Treasury approval is sought before any offers, whether oral or in writing, are made.” One is left saying, “Why not?” Why didn’t it happen?
Dean Royles: Can I help with a bit of background? It might be helpful for context. The Treasury guidance has been around for a number of years, but it was only relatively recently, in the past five or six years or so, that there was a view that that also applied. If you look at that guidance it is written that “Departments must”. There was a question about whether the guidance applied to the broader public sector.

Q180 Chair: Mr Royles, could I just say to you that we have had all accounting officers up in front of us? We have been told by the Cabinet Secretary, Head of the Civil Service and everybody that the one document they make everybody read is “Managing Public Money”. Right? The role of this Committee is to ensure that you have read it and you stick to it. In “Managing Public Money”—it is not old guidance—it says clearly, and has been confirmed by our Treasury official today, that you have got to get the bloody Treasury approval, but you did not. Why not?
Richard Douglas: My understanding was that the guidance did not clearly require Treasury approval in those cases, and that was something that had been clarified with the Treasury.

Q181 Chair: Is that right, Treasury?
Marius Gallaher: Well, I understand that in the case of judicial mediation there was a misapprehension of what it meant. We thought that it was the stamp of a judge, when, in fact, it was not. It was just mediation.

Q182 Stephen Barclay: That is the crux: judicial mediation is a voluntary agreement. If it was a payment made by employment tribunal, there is no discretion: you have to pay it, so there is no discretion and no requirement for approval. The point about judicial mediation is that it is a judge shutting between two rooms and it is a voluntary agreement.

To quote from last week, when I raised this in a parliamentary question: “To ask the Secretary of State for Health under what circumstances payments made from the NHS budget as a result of judicial mediation require his approval and the approval of the Chancellor?”, the answer was, “Approval has not hitherto been required by the Chancellor, or the Secretary of State for Health for special severance payments made as a result of judicial mediation. However, as of 11 March 2013”—last Monday—“approval will be required by both the Department of Health and HM Treasury”.

What we have is, in essence, a serious loophole in the rules where people can be paid without seeking Department of Health or Treasury approval. That is correct, is it not, Sir David? You are nodding your head, so I take that as agreement.

There is a then a clear conflict of interest. There are question marks over whether Barbara Hakin was involved in one such conflict of interest because Gary Walker was paid through judicial mediation and it is unclear what role the SHA had in that.

It is also unclear how many such payments have been made because while you said to the Health Committee that you asked around, you have not actually asked the bodies formally and, for the two years that I have been raising this issue with you on this Committee, you have constantly told me that there is no problem. The figures that you gave us of £15 million on special severance payments are obviously inaccurate because they do not include these payments, and it is further unclear whether any judicial mediation payments have been made to people who have tried for approval from the Treasury but had that turned down. With respect, you are responsible for the system, and it seems that we have a serious problem with the system in place.

Sir David Nicholson: Undoubtedly, when it was brought to my attention that judicial mediation had been used for Gary Walker, and that, as part of that, it did not require to go to the Department or the Treasury—

Q183 Chair: Steve, I know you are saying this, but I do not accept it. It says in the guidance that “Treasury approval is necessary in all cases involving severance payments. Judicial mediation may still be used in such cases but Treasury approval is recommended to be sought”. That is pretty strong guidance; in all the years that I have been around Government guidance, that is pretty obvious to me. Then, the other bit in “Managing Public Money” makes it completely clear. I do not think that there is a gap; they just did not do it.
Sir David Nicholson: As I was saying, I did not know what it was until it was brought to my attention.

Q184 Chair: You are the accounting officer, Sir David.
Sir David Nicholson: As soon as it was brought to my attention, I did something about it.

Q185 Mr Jackson: On the broader point, clearly you have expressed a value judgment as to whether these sorts of arrangements are right or not. I think that it is pretty unambiguous, but, for argument’s sake—to play devil’s advocate—let us say that there is an opaque, grey area. What action have you taken up until now to try to address the issue of opacity: what is ultra vires and what is not? It is your responsibility to do that.
Sir David Nicholson: First, in 2007 I wrote to the service setting out what the arrangements are to be, which is for any of these payments, they had to go—this is not judicial mediation, by the way, they are excluded from that, but for other payments—to the remuneration committee of the organisation which
should first of all consider it. If it involved extra-
contractual payments or payments that were novel in
any way, that would then be referred to the
remuneration committee of the Strategic Health
Authority for their consideration, and they would look
at it, in those circumstances. If they felt it was worth
going ahead with, it would then be referred to the
Department of Health and the NHS financial
controller would go through those arrangements. If it
was accepted then it would go to the Treasury.

We put those positions in place in 2007. You can see,
through the figures during that—with I say that the
agreements that were made around the numbers were
what might come out of the local discussions? They
were not agreements in themselves, so they should not
assume that they got agreement for that. From 2007
onwards, you can see how, slowly but surely, we have
reduced the number of such payments going through
the system. There were over 200 in that year. We are
down to 44 in the last year.

In the last year, the Department of Health refused
more than half of all the proposals that came to it.
Over time, once we got the governance in place, we
then focused our attention on the decision making. So
we have squeezed the numbers right down. It is not
low enough yet, but it is coming down quite a lot. As
we have done that, we have tried to close the
arrangements and the loopholes and make sure we put
all the support and help for people in place. That is
where we are today.

Q186 Mr Jackson: Yes, but I think this speaks to a
more unhealthy, pernicious culture of paying people
off who might try and traduce working practices or
public policy in health. I am a bit concerned about the
integral role of the Strategic Health Authority in this.
Some of these people are whistleblowing about the
clinical frameworks that have been given to them by
the Strategic Health Authority, which is judge and
jury. My specific question has not been answered, as
to, for instance, what liaison you had with the
Treasury. We all think that the Treasury position is
pretty clear, but it is obvious that until last Monday it
was not clear at all.

Sir David Nicholson: We work very closely. The
people who do this sort of thing work very closely
with the Treasury around all of these sorts of things.
To reaffirm the point that you make, the guidance says
that these sorts of things should not be a soft option
“to avoid publicity, management action, disciplinary
process, unwelcome publicity or reputational
damage”. These are really important things which the
Department would absolutely uphold. In the
conversations with the Treasury, that is what they do,
irrespective of what happens at SHA or remuneration
committee level.

Q187 Chair: Can I just ask some questions of fact?
Then I think we want to move on.

The Secretary of State made the statement about
gagging clauses last week. Is that going to be applied
retrospectively? That is, all the people who have been
gagged—the 400, or whatever it is. Is that being
lifted?

Sir David Nicholson: We are working through what
all of that means, at the moment. If it means writing
to those individuals who have been involved in those,
explaining the arrangements that we have suggested,
then that is what we will do, if that is necessary.

Q188 Chair: So it will be applied retrospectively.
Sir David Nicholson: Yes.

Q189 Chair: Each of the cases that have been signed
off, those people, if they have a public interest issue,
can now raise it.

Sir David Nicholson: Absolutely. We have said—even
my letter in January 2012 to the service said—that
if you try and put these in, they are void anyway;
they have no application at all.

Q190 Fiona Mactaggart: Will people get jobs in the
NHS? It is a very serious question. If there is a
gagging clause against them—this is somewhere
where you ought to lead—and then you lift it, and
then they say something about the culture that they
were in, what are their prospects for future
employment? How are you going to protect them, in
terms of their future employment? Is there some
action you could take?

Sir David Nicholson: We need to do whatever is
necessary to protect them in those circumstances.

Q191 Stephen Barclay: What is the most senior
appointment you have made of someone who has
previously blown the whistle?

Sir David Nicholson: I have myself whistleblown.

Q192 Stephen Barclay: Yourself does not really
count. I mean, come on.

Sir David Nicholson: It counted to me quite a lot.

Q193 Stephen Barclay: You have hired a lot of
people in your time. You talked about being a chief
exec in the NHS for, I think, 35 years. I am talking
about leadership in terms of the role model you
provide and in terms of the culture. We have heard
lots of warm words about culture from you. What is
interesting is the behaviour and the example that you
set. Have you recently hired to a senior role someone
who has previously whistleblown to send that signal
to the rest of the NHS? Can you name a senior
appointment?

Sir David Nicholson: That is a quite a difficult bar
that you have given me there. I have appointed lots of
people who have been very outspoken in their views
and criticisms of the NHS over the years. Whether
those individuals were active whistleblowers and had
that as a name for themselves I do not know, but I
have never shied from appointing people who are
critical of the status quo and who are prepared to stand
up and say that.

Q194 Chair: Can I just ask a few more questions? Is
the gag on Gary Walker going to be removed?

Sir David Nicholson: It has been completely
removed.
Q195 Chair: Was it right for the trust’s lawyers to threaten Gary Walker before he appeared on—
Sir David Nicholson: It was completely wrong, and we told them that it was wrong.

Q196 Chair: What are you doing about that?
Sir David Nicholson: The Secretary of State wrote to the trust to say that they were completely wrong.

Q197 Chair: Then what? So you have written to them. They can ignore you.
Sir David Nicholson: They have now written to Gary Walker saying, “To be absolutely clear, you are completely free to talk about the circumstances around United Lincolnshire hospitals.”

Q198 Chair: Can I just ask two questions about private providers? First, if they make severance payments, do they have to be approved? If a private provider is providing an NHS service out of taxpayers’ money, do their severance payments have to be approved by you and the Treasury?
Sir David Nicholson: No.

Q199 Chair: So for example, when the Serco out-of-hours service, which the Committee is going to consider after the recess, parted company with some employees, do we know whether they were gagged and whether you would have allowed that?
Sir David Nicholson: It does not go through the Department.

Q200 Chair: As we are getting more and more providers—it is all taxpayer money—providing NHS services in the NHS, we do not see the difference between private and public. I do not. I went and had a hearing test at a GP surgery and it was a private provider. I want to know that, were they to complain, they would not be gagged.
Richard Douglas: We should make it absolutely clear in the contract with those providers that—

Q201 Chair: Are you?
Sir David Nicholson: Yes. The duty of candour is the same for them. My letter of January 2012 absolutely clearly sets out and underpins our approach to gagging clauses. We would expect all providers of NHS services to abide by that.

Q202 Chair: What about your own Department? What about whistleblowers in the Department itself or in the commissioning body?
Sir David Nicholson: The same applies.

Q203 Chair: So somebody can blow the whistle on you.
Sir David Nicholson: Absolutely. We would encourage them to.

Q204 Chair: Okay. In 2012–13 so far, how many compromise agreements have we had?
Richard Douglas: As of 11 March, 44 cases have been approved.

Q205 Chair: How much did they cost the taxpayer?
Richard Douglas: £1,319,335.

Q206 Stephen Barclay: How many had gags in them?
Richard Douglas: They should not have had gags in them, but—
Chair: They will have done, because they will have been done before the announcement last week.
Stephen Barclay: You do not know the proportion that do.
Dean Royles: The Department would not have known. When organisations are doing this, there are a number of legal processes. PIDA applies, and there is the ability to do compromise agreements, which was introduced as a way of saving money rather than going to employment tribunal cases. In addition to that, in terms of the arrangements, individual organisations that are making those severance payments would first of all need to get their own remuneration committee’s approval, usually with their audit approval. They would then need to refer that, in the case of a trust, to the strategic health authority for approval. If the strategic health authority approved it, they would send it to the Department. If the Department approved it as value for money, they would send it to the Treasury. In that process, people do not necessarily see that this is part of a compromise agreement. They are putting forward a case that this represents value for money that is tested. In addition to your legal requirements, you have got a—

Q207 Stephen Barclay: I am sorry, Mr Royles, but that is a very misleading answer. You know that we have had Frank Dobson’s 1999 guidance, we have had the 2004 guidance, Andrew Lansley put it in the NHS constitution and we have had PIDA. We have had all those things, and we can see that they have not worked. The reason why they have not worked, as I understand it, is because the legal risk is placed on the whistleblower. It is for the whistleblower to prove that they complied with PIDA. That legal risk has a chilling effect, coupled with the sense that they will not work in the NHS again, and that is why many people are reluctant to speak out.

With respect, Sir David, I have had this exchange with you for the past two years, where concerns have repeatedly been raised not about the legislation but about how it operates. You constantly say that there is a not a problem, and yet we now have the Secretary of State coming to the Chamber and saying, “Here’s a new announcement: we need to have a change.” Two weeks ago, the Health Minister said in the Adjournment debate, “Yes, we need a change.” Why have you been telling the Committee that there is no problem, when the Secretary of State and the Health Minister now tell us that we need a change?
Sir David Nicholson: We have a process, which has just been described. I have set out to the service on a number of occasions what our expectations are, most recently on 11 January 2012 in what I think is quite a strong letter, which states very clearly that “the compromise agreement should make clear the right to make a protected disclosure is not affected. It is unacceptable to require an employee not to make any ‘further’ complaint or grievance.” When people fill in
the Treasury guidance, they have to confirm that it is legal.

The point that you made was: in the environment in which we operate at the moment, is that enough? The conclusion we have come to is that no, it is not enough. What we need to do, on top of all the things that we have done, is to set out that not only must they comply with what I have said there, but they have to write in a particular type of wording that will enable absolute clarity to be brought to the position. I think we have strengthened it. It was a strong position, but I think it is stronger now because of that.

Q208 Stephen Barclay: But we do not know for the last years. In your evidence to the Health Committee you said, “Wherever I see it, or if I have a whiff of it…I immediately intervene”. And yet cases such as the Walker case were flagged to you some time ago—I do not want to pre-empt the evidence session tomorrow before the Health Committee—so it is very hard to support the idea that you intervened immediately when concerns were raised.

Sir David Nicholson: I intervened immediately when concerns were raised.

Q209 Stephen Barclay: When were they first raised?

Sir David Nicholson: When Gary Walker wrote to me setting out his concerns about the way he was being treated. He did not identify himself as a whistleblower at that moment in time, nor did he raise with me any issues of patient safety. Nevertheless, I immediately responded by commissioning an independent inquiry into the circumstances around there, which produced a report, the executive summary of which was published at the time. My understanding is that the SHA published the whole report last week.

Q210 Stephen Barclay: So Mr Walker did not suggest to you in his letter of 2009 that he should be regarded as a whistleblower.

Sir David Nicholson: No.

Q211 Stephen Barclay: And the media coverage of his case in the likes of Private Eye and elsewhere did not lead you to intervene either.

Sir David Nicholson: As I say, I intervened straight away by commissioning a report into what had happened. That report is in the public domain.

Q212 Stephen Barclay: But he was paid by judicial mediation, and you said you did not know anything about it. You intervened in the case and it was then paid by judicial mediation.

Sir David Nicholson: As soon as Gary Walker raised a set of issues with me, I intervened immediately. That is what I did.

Q213 Stephen Barclay: And then he was paid by judicial mediation.

Sir David Nicholson: I intervened immediately. Subsequently—because of course, as you know, he was dismissed for gross misconduct by the organisation that he worked for—the agreement was made through judicial mediation. That is all on the public record. But I did intervene immediately when a problem was identified.

Q214 Mr Jackson: On this specific issue, can we have a note on the breakdown of those 2012 figures between primary care trusts, foundation trusts and hospital trusts? That would be very helpful to the Committee.

Sir David Nicholson: I can tell you now. There were 75 NHS trusts, five strategic health authorities and 32 foundation trusts.

Q215 Mr Jackson: And primary care trusts?

Sir David Nicholson: There were no primary care trusts in 2012–13.

Q216 Mr Jackson: May I ask, in order to help us to understand the discrepancy, whether the Treasury could provide a note to us on: its interpretation of ultra vires payments, which they clearly are; what legal precedent there has been for recouping any moneys that were considered to be ultra vires; and what efforts it is making to liaise with the Department of Health following the ministerial statement last week to ensure that previous incidents are reviewed and that it does not happen going forward?

Marius Gallaher: We will provide a note.

Q217 Chair: One final question, and I am sorry to ask you, but this has been in the public domain, Sir David. There is an issue about whether or not you have been paid by the taxpayer for first-class travel on Fridays to go home to Birmingham. Is that true?

Sir David Nicholson: I have been paid for first-class travel.

Q218 Chair: You have. And how do you justify that?

Sir David Nicholson: In 2010, I was offered the job as chief executive of the NHS Commissioning Board by the Government. On top of that, I was also obviously going to continue as chief executive of the NHS, and I was going to be responsible for the management of the transition of the system. Those are three really big and significant jobs. In order to do my job, I have to travel around the country a lot and I have to stay away from home two or three nights a week. On average, I travel between 12 and 14 hours a week. It is simply impossible for me to do my job without being able to work during those hours in order to get value out of my time. I judged that the only way I could guarantee that was to have first-class travel during those periods so that I could guarantee that I could do that work. I have been open and transparent about it—I have published all the documents—and my employers completely understand why I do it. It is really important that I get out and about in the service. There is hardly a week that goes by when I do not visit a hospital or a community service—all those things—and that was the only way that I could guarantee my ability to do that work.

Q219 Chair: I think there are two issues. Some of us manage to work without having to be in first class, I have to say. In fact, train journeys are really good
places for most people to work. You do not have to be in first class. But I think the thing that raises eyebrows is that you are paid it to go home on a Friday.

Sir David Nicholson: The position in relation to my expenses and my working arrangements, which I agreed with the Department and the Cabinet Office in 2010, was that I would have three working bases—Birmingham, London and Leeds—and that my travel between those three would be paid for. That was the agreement I made at the time to enable me to do the three jobs that people asked me to do.

Q220 Chair: Well, at a time when we’re all in it together, I think you should reconsider whether it is appropriate that you travel first class.

Jackie Doyle-Price: I completely disagree with that. I think that it is entirely appropriate for you to travel first class and work. Can I just put that on the record?

Meg Hillier: Chair, if you have ever tried travelling second class on Virgin and tried to work on confidential papers—

Chair: I do.

Meg Hillier: There are some trains where you can travel second class at certain times of the day—I hope, Sir David, that you look at all options and perhaps you will clarify that—but there are some times, when the man who is running our health service has confidential papers, when there might be an argument for first-class travel.

Sir David Nicholson: When I go to my position on 1 April and I am doing just one of those jobs, I will be travelling standard class. I do not believe I require it after that period.

Q221 Stephen Barclay: Although it will be for Mr Walker to give evidence tomorrow, I just wanted to put on record that my understanding was that he expressly identified in his 2009 letter to you—in fact in the last paragraph—that he wanted to be regarded as a whistleblower.

Sir David Nicholson: As I say, I acted immediately. There had already been a review of the clinical safety in that hospital commissioned by the strategic health authority, which had found that the services for patients were safe, but that there were serious problems of clinical governance. As soon as I got that information, I instituted an independent inquiry into what was happening there. As I say, what they came up with is on the public record.

Chair: All right. Thank you very much indeed.

Written evidence from South West Whistleblowers Health Action Group

The South West Whistleblowers Health Action Group (SWWHAG) was formed in September 2011 by members of the public who have had good and bad experiences of using healthcare services.

Our members have a wide range of professional experience of working in healthcare, education, public and private sector service delivery, programme management, procurement, risk and change management, transport and media. Our skills and experience put us in an excellent position to constructively scrutinise the NHS.

Several of our members have personal experience of being the recipients of unsolicited disclosures over a number of years by consultant level doctors concerning allegations of unsafe care.

The implications for us have been the following:

— Distress caused by by these disclosures and the consultants’ evident inability to have them taken seriously and investigated by Medical Directors through established Whistleblowing Policies.

— Lack of trust and confidence in the Medical Profession, including the Royal Colleges and the professional regulator, the General Medical Council (GMC), for failing to deal with these issues in a fair, professional manner.

— Attempted victimisation and persecution by some NHS staff for asking questions which the consultants who disclosed information to us are too scared to ask. In the words of one this is because “they want to be able to continue to feed their children”. In the words of another, discussing whether a colleague should report a concern to the GMC “I doubt if our she will want to do that—she like most of us is scared.”

These are senior consultants, not junior doctors.

The implications for the NHS are:

— Reputational—public lack of trust and confidence in the services provided by medical professionals who are regarded as unable to meet their GMC duty to make patients their first concern through fear of Medical Directors and, ironically, the GMC.

— Financial—failure of clinical leaders to investigate concerns leads to avoidable expenditure on inquiries which would not be necessary if consultants’ concerns were taken seriously. For example the Bristol Histopathology Inquiry cost around £750,000. The Mid Staffordshire Inquiries cost considerably more.

In January 2013, BBC West’s Inside Out West Programme featured the unresolved concerns of doctors and patients about Bristol Histopathology services. An international cancer expert was shown some whistleblowing disclosures made by a consultant during the period 2007 to 2010 inclusive:
The expert commented as follows:

— “Where was management? Why wasn’t management sorting this out?”
— “There seems to be a degree of anarchy here emerging from these emails. Morale issues and threats of resignation. The language is diagnostic of an issue which has been neglected and allowed to fester. This would require urgent action as a manager. This is just not good enough.”
— “This really needs proper sorting. The patients need to get their voices heard in a meaningful way. They should be rattling the cages of these defensive medical practitioners.”

SWWHAG has a number of questions which we ask the Committee to consider putting to the NHS representatives on 18 March 2013:

1. In the NHS Structure effective from 1 April 2013 who is responsible for ensuring that the problems we describe above do not continue to occur? Who will be held accountable if they do occur?

2. How is the responsible person going to ensure that consultants have confidence that their concerns will be taken seriously by medical directors, without victimisation and having to resort to whistleblowing?

3. The Department of Health’s response to the 2001 Kennedy Report into Bristol paediatric cardiac surgery said:

“IMPROVING INFORMATION FOR DECISION MAKING AND STRENGTHENING THE MONITORING OF PERFORMANCE

We recognise that at the moment patients and clinicians do not always get the information they need. We are committed to the development of effective systems of monitoring clinical care through local audit and through national surveillance.

The introduction of electronic patient records by 2005 will act as the building block for the other information the NHS needs in order to monitor quality. In the meantime we are improving and making better use of Hospital Episode Statistics (HES) data, publishing headline performance indicators for health authorities and NHS Trusts and developing a series of high quality national clinical audits.

Our future programme of action will include:

— published data on the clinical performance of consultants and their units/teams for use by both clinicians and patients;
— by April 2004, publication of 30 day mortality rates for the previous two years for every cardiac surgeon in England, From April 2005 annual publication on a rolling three-year basis for each centre and for each cardiac surgeon;
— a co-ordinated approach to collecting data through the introduction of electronic patient records by 2005;
— better use of HES data by linking hospital data to Office for National Statistics (ONS) mortality data from April 2002;
— ‘star ratings’ to compare the performance of NHS organisations against national targets—through the CHI Office of Information on Health Care Performance from 2002;
— national audits in each of the clinical priority areas of The NHS Plan;
— a directory of clinical audit databases from 2002; and
— strengthening of the clinical coding function.”

(a) Why, nearly 12 years later does there seem to have been little or no progress in achieving many of these goals?

(b) How and when will they be delivered in the new NHS organisation?

(c) To what extent will NpIT enable these goals to be achieved? It is clear that until the Department of Health delivers on the commitments made after the Kennedy Inquiry, consultants and their patients will not have the data they need to monitor quality, safety, efficiency and value for money of services.

11 March 2013
Written evidence from NHS in England

I am writing to correct one specific point of detail following yesterday’s evidence session at the Public Accounts Committee, ahead of reviewing the uncorrected transcript. In response to a question from Stephen Barclay MP about Gary Walker, I said that when he initially wrote to me I thought he did not identify himself as a whistleblower. I have now had the opportunity to review the correspondence and would like to confirm that when Gary Walker wrote to me in July 2009, he did indeed ask to be considered as a whistleblower.

However, I would reassure you that the action I took at the time in response to Gary’s letter was appropriate. As I explained yesterday, I immediately commissioned a comprehensive independent investigation in to the allegations that had been made. The investigation was undertaken by a senior NHS manager (Neil Goodwin) and a senior Non-Executive (Susan Pyper). A summary of their report was published at the time and their full report has recently been put into the public domain.

Sir David Nicholson KCB CBE
NHS Chief Executive
18 March 2013

Written evidence from the Department of Health

Clarifications to the Transcript

Question 26

Q26 Chair: We obviously don’t agree. You aren’t answering the question. The only other thing to say of course is that the BMA has turned down the review anyway, so I don’t know what you will be negotiating with them.

Response from Dean Royles: Following consideration of the report (Review Body on Doctors’ and Dentists’ Remuneration: Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants Dec 2012—Cm8518) and subsequent related meetings, the BMA’s Consultants Committee agreed at its meeting on 7 March 2012, to participate in talks with a view to reaching Heads of Terms on future negotiations on the consultant contract and merit awards in England and Northern Ireland. The process is at an early stage but talks are progressing and an assessment of progress will be made at the end of May 2012.

Question 31

Bruce Keogh stated he had received an anonymised set of HSMR data from Dr Foster so was unable to say where England appeared in the international benchmarks. This was subsequently followed up by a letter from the Committee Clerk:

“The Committee would be grateful if you clarify whether or not you received correspondence from Sir Brian Jarman on this issue before the PAC hearing on 18 March and, if so, whether the data that Sir Brian provided had been anonymised.”

“In addition, could you please clarify whether The Department of Health owns any part of Dr Foster or its associated entities and if so why country specific data was not sought from an entity in which the Department has a financial stake?”

Response from Bruce Keogh: I did receive correspondence from Sir Brian Jarman before the PAC hearing. My reading of the slides he sent me to believe the data were anonymised, although on reviewing the slides since the Committee I acknowledge that one slide did provide the country code for England, which enabled data for England only to be identified, but not for any other country.

The Department of Health has a 49% holding in Dr Foster Intelligence Limited (the holding company of Dr Foster Ltd). Dr Foster Ltd trades with the NHS and the private sector on a fully commercial basis, independently of the Department, and its executive directors are given delegated authority to make most business decisions. If the Department wanted country specific data from Dr Foster, it would need to do so as a normal commercial transaction. Dr Foster Ltd does not own the Dr Foster Unit at Imperial College but there is a partnership agreement between Dr Foster Ltd and Imperial College, and as part of this agreement Imperial College is able to use the Dr Foster name.

Question 210

David Nicholson stated that in his 2009 letter Gary Walker did not identify himself as a whistleblower. This was subsequently corrected in a letter from David Nicholson to Margaret Hodge MP and Stephen Barclay MP the day after the evidence session.
Follow up notes to the Committee

Question 86

Q86 Stephen Barclay: Can we have a note on how much it [Don Berwick’s report] cost?

Response: The Chief Medical Officer at the time, Sir Liam Donaldson, commissioned the Institute for Healthcare Improvement (IHI) report in autumn 2007 as part of the NHS Next Stage Review. The IHI submitted the report, called *Achieving the Vision of Excellence in Quality: Recommendations for the English NHS System of Quality Improvement*, to the Chief Medical Officer on 31 January 2008. Professor Berwick was a member of the IHI team that produced the report and was at that time President and CEO of the IHI. The Department made payment of $162,500.00 to the IHI for this report.

Question 113

Q113 Chair: The figure I have got is 10.7 days in the NHS as a whole, compared with 9.7 in the public sector as a whole and 6.4 in the private sector. So it is worse. Have you got that [average sickness absence rate among consultants], Mr Douglas?

Richard Douglas: I have not, but we can come back to the Committee with a number.

Response: The average rate for the 12 months ending 30 September 2012 was 4.2% for all staff, and 1.2% for consultants. Using the NHS Information Centre iView sickness absence and staff-in-post figures, and following the Cabinet Office Guidance by multiplying the calendar days by 225/365, the estimated average number of working days lost is 9.4 for all staff, and 2.6 for consultants.

Question 149

Q149 Stephen Barclay: It is very odd that, the question having been put in the Chamber two weeks ago, we are still in the dark as to whether Mr Yeates was subject to a gagging clause. Could we have a note? Could you liaise with whichever stakeholders you need to liaise with? Could the Committee have a note—

Chair: Within a week.

Stephen Barclay:—within a week, on whether Mr Yeates was gagged?

Response: Mid Staffordshire NHS Foundation Trust has confirmed that Martin Yeates did not receive any special severance payment when he left the Trust’s employment. He received no pension enhancements over and above his entitlement under the Pension Scheme, and did not receive any payment over and above his contractual and statutory entitlement. He was entitled to six month’s salary on notice of his resignation, which he received in lieu of notice. No Department of Health or HM Treasury approvals were required for the payment in lieu (PILON) made by the Trust to Mr Yeates. This payment was made in the context of a compromise agreement between the Trust and Mr Yeates, the terms of which are confidential between the parties, and therefore are not known to the Department of Health. However, we have been in contact with the Foundation Trust and they have undertaken to write to the Committee—and to the Department—by no later than Friday 5 April to confirm whether the terms included a confidentiality clause and if so whether that clause complied with the guidance on making protected disclosures. Foundation Trust Chief Executives are of course directly accountable to Parliament so if the Committee wish to discuss this in the meantime with the Trust they are able to contact them directly.

Compromise agreements or confidentiality clauses are a routine element in severance agreements across the public and private sectors, to ensure that both employers and staff have a clean break at the resolution of any dispute. However, it is absolutely critical that all staff working within the NHS feel able to speak out and raise concerns and that every NHS organisation takes concerns seriously and acts on them.

The Department of Health has consistently made clear to the NHS that local policies should prohibit the inclusion of confidentiality clauses that seek to prevent people speaking out on issues in the public interest. The Secretary of State announced earlier this month that in future, business cases proposing a special severance payment, which may be made under a compromise agreement, will only be supported where they include a specific clause stating that nothing within the agreement prevents the individual from speaking out on issues such as patient care and safety, or anything else in the wider public interest.

27 March 2013
Written evidence from the British Medical Association

Following the Public Accounts Committee’s recent oral evidence session on the management of hospital consultants, I write as chair of the BMA’s Consultants Committee to offer our thoughts on some of the issues highlighted in the session. I feel it necessary to provide clarity on a number of points that were discussed.

The Committee highlighted increases to consultant pay following the introduction of the current consultant contract in 2003, and stated that despite this increase in remuneration, consultant productivity had decreased. One of the main objectives of the contract was to recognise all of the unpaid work that consultants had previously been undertaking, and the increase to consultant remuneration was to reflect this.

Care should be taken when estimating productivity for consultants. The crude productivity statistics that are used reveal nothing about the quality of care provided and ignore the major changes in practice, such as technological advances and longer consultation times with patients. Additionally, the recent Nuffield Trust report: The Anatomy of Health Spending 2011–12: a review of NHS expenditure and labour productivity, shows that workforces with higher proportions of medically qualified staff are strongly associated with higher productivity. This suggests that the work consultants do improves productivity generally.

Job planning is integral to meeting the challenges faced by managers and consultants in delivering high quality care, especially in testing financial circumstances and amid organisational change. The Committee highlighted issues with job planning identified in the National Audit Office report, Managing NHS Hospital Consultants, published in February 2013. The BMA, and NHS Employers, have recognised for some time that job planning has been neglected in some areas where a small number of consultants still do not have job plans or an appropriate job planning process. We are actively working to address these outstanding issues. We worked jointly with NHS Employers to produce joint job planning guidance and are currently developing a joint training programme which emphasises the setting of appropriate objectives.

The Committee also discussed Clinical Excellence Awards. The BMA submitted extensive evidence to the Doctors’ and Dentists’ Review Body’s (DDRB) Review into Excellence Award Schemes for Consultants in 2010, stating that they encourage excellent performance and reward those providing the highest quality of clinical care and innovation across the NHS. The Committee will be aware that the publication of this report was considerably delayed and in the light of the Francis Report we feel that the context has now changed to such an extent that we cannot accept the report as written. However this should not be interpreted as a lack of willingness to engage in meaningful negotiations. Indeed, we are already engaged in talks with NHS Employers on a number of issues including pay scales, new excellence award schemes and facilitating appropriate consultant presence. These discussions are at an early stage and are being conducted in a without prejudice manner.

Dr Paul Flynn
Chair, Consultants Committee
28 March 2013

Written evidence from Gary Walker

I write regarding Sir David Nicholson’s evidence to the committee regarding my whistleblowing disclosures to him that he described at the meeting on 18 March 2013.

In summary, Sir David claimed, without hesitation, that I had not described myself as a whistleblower and that I had raised no concerns regarding patient safety. Both claims are untrue. Following my appearance at the Health Select Committee, Sir David then wrote to you the following day on 19 March 2013 to correct the whistleblowing aspect of his evidence. However, he did not, and I believe deliberately, correct his evidence regarding my raising concerns about patient safety. Sir David has not only misled the committee once, but continues to do so by not correcting his original statement.

I refer to the transcript of the meeting on 19 March 2013. In the context of whistleblowing the following questions were asked:

Q208 Stephen Barclay: But we do not know for the last years. In your evidence to the Health Committee you said, “Wherever I see it, or if I have a whiff of it…I immediately intervene”. And yet cases such as the Walker case were flagged to you some time ago—I do not want to pre-empt the evidence session tomorrow before the Health Committee—so it is very hard to support the idea that you intervened immediately when concerns were raised.

Sir David Nicholson: I intervened immediately when concerns were raised.

Q209 Stephen Barclay: When were they first raised?

Sir David Nicholson: When Gary Walker wrote to me setting out his concerns about the way he was being treated. He did not identify himself as a whistleblower at that moment in time, nor did he raise with me any issues of patient safety. Nevertheless, I immediately responded by commissioning an independent inquiry into the circumstances around there, which produced a report, the executive
summary of which was published at the time. My understanding is that the SHA published the whole report last week.

Q210 Stephen Barclay: So Mr Walker did not suggest to you in his letter of 2009 that he should be regarded as a whistleblower.

Sir David Nicholson: No.

Q221 Stephen Barclay: Although it will be for Mr Walker to give evidence tomorrow, I just wanted to put on record that my understanding was that he expressly identified in his 2009 letter to you—in fact in the last paragraph—that he wanted to be regarded as a whistleblower.

Sir David Nicholson: As I say, I acted immediately. There had already been a review of the clinical safety in that hospital commissioned by the strategic health authority, which had found that the services for patients were safe, but that there were serious problems of clinical governance. As soon as I got that information, I instituted an independent inquiry into what was happening there. As I say, what they came up with is on the public record.

Source: HC 1030-I, 18 March 2013 (emphasis added)

Sir David makes several claims with unequivocal assurance to the committee. All of these claims are untrue.

The first is that I “did not identify [myself] as a whistleblower” when I wrote to Sir David in July 2009. As can be seen from the transcript there is no doubt in Sir David’s evidence. His evidence, however, was untrue. Sir David accepted his statement was untrue when he wrote to the committee on 19 March 2013 to correct the evidence he gave. Sir David made this correction on the same day I gave evidence to the Health Select Committee in which I provided a copy of my letter to him of 22 July 2009. I attach it for information. Had I not proven Sir David to have misinformed the committee it is questionable whether he would have ever corrected the evidence he gave.

The second claim Sir David makes is that, without question, I did not raise any issues regarding patient safety. This again is untrue. I refer you to my letter to Sir David in which I discuss my concern for patient safety. However, in Sir David’s letter to you of 9 March 2013, he does not correct this point. In fact he states that he “immediately commissioned a comprehensive independent investigation in to the allegations that had been made”. This is not entirely true. A review was commissioned by Sir David. However it did not examine patient safety at all. Sir David’s claim that his action at the time was appropriate is inconsistent with the protected disclosure (whistleblowing) I made to him. In short, Sir David has not corrected the evidence he gave to the committee principally because he never examined patient safety.

Sir David claims that patient safety had been reviewed by the SHA and there were no problems. There are two issues with this claim. Firstly, the review by the SHA was prior to my letter to him in July 2009 and is therefore not a review into the protected disclosures I made to him. Secondly, the review was conducted by the SHA and it was the Chief Executive of that SHA I had raised concerns about. In no way could this review have been impartial.

At the committee Sir David states that his inquiry was on public record. In fact the report Sir David refers to (the Goodwin Report) commissioned in 2009 was made public only days before your committee meeting in March 2013. Sir David also stated the SHA published it. In fact it was the DH that published it because it was commissioned by Sir David personally.

Examination of this newly published report, will reveal that there are several key differences between what Sir David announced in October 2009 and what this until recently was secret.

The Goodwin report avoided any reference to patient safety and instead examined the bullying of one organisation (the SHA) over United Lincolnshire Hospital NHS Trust of which I was the CEO at the time. I think this is totally looking at the wrong, and less important aspect, of the case. It chose to focus on protecting members of the SHA instead of looking at the most urgent and important part of the problem—patient safety. I would have expected the chief executive of the NHS to be more concerned about our patients than any other side issue.

The report states that it found evidence of bullying and harassment but chose to rely its findings on written evidence of bullying and harassment. Not withstanding that it is nonsense to examine one organisation bullying another, particularly as I had only complained about the conduct of Dame Barbara Hakin, it is simply wrong to suggest that bullying and harassment only comes in written form. In October 2009, Sir David misled the public and Parliament regarding the outcome of the Goodwin report in which he claimed there was no evidence “whatsoever” of bullying or harassment. Indeed, Sir David then went on to recommend that those who had blown the whistle to him should be removed. It cannot escape your notice that not only Sir David’s actions were potentially unlawful, it is the opposite conduct expected of anyone in public office.

This is particularly relevant given the actual harm that came to staff and patients between December 2009 and March 2010 some of which were set out in my statement to the Health Select Committee and on public record.

The committee will also be aware from your questioning of Marius Gallaher from HM Treasury (Q174–177) that the payment made to gag me should have been authorised by HM Treasury. Sir David stated to the Health
Select Committee on 5 March 2013 that HM Treasury approval was not required and also that this was the first time he had heard of payments made via a Judicial Mediation process. In contrast to Sir David’s claim, the Department of Health specifically issued guidance in November 2010 (Chapter 5—Manual for Accounts 2010–11) setting out specific arrangements for the handling of Judicial Mediation claims. By his actions, Sir David has misinformed both the Health Select Committee and your committee about the DH and Treasury position regarding Judicial Mediation.

For a senior civil servant to be so blatantly deceptive makes a mockery of Parliament and its role to scrutinise the executive. To mislead and misinform on so many issues casts serious doubt on what else Sir David has told the committee with certainty that has in fact been false. But for my breaking my gagging order, appearance at the Health Select Committee and your questioning of the Treasury Officer, none of this would have come to light.

Further questions must be put to Sir David in order to ascertain what else he has not told the truth about and in this context I struggle to see how confidence or trust in this individual can remain.

I hope you will discuss this letter with Mr Dorrell to whom I have copied it, and agree what action needs to be taken to hold Sir David to account and ensure the safety of our NHS to treat patients.

16 April 2013