

Response from Anonymous #3

9 July 2009

RE: Restrictions on Consultants' Use of Their Non-Contracted Hours

Response to Discussion Paper No.2 and Notice of Possible Policy Recommendations

Thank you for inviting submissions in respect of your enquiry.

I am writing as an individual and as a practicing consultant surgeon [X].

I am a full time NHS consultant and in addition have a private practice treating insured and self-pay patients. I also see and treat a very small number of NHS patients through the NHS-ECN [extended choice network] scheme [X]. In addition I am an equity partner, and am involved in a managerial capacity, with [X].

I would urge the committee to consider the benefits of allowing clinicians' engagement in the business management with independent providers of NHS work [*option 1: CCP guidance document, section 7c*]

Healthcare in the UK is unique insofar as the only credible career route for a practicing secondary care clinician is within the NHS and to be employed by an NHS Trust. No other professional person in the UK is subject to such a restriction. The NHS represents a monopolistic employer and whilst the option of total private practice remains an option, it is in practice unrealistic other than for the very few.

It is artificial to dislocate clinical, operational [business] and strategic functions. For any sustainable competitive business model all aspects need to be intertwined to create a package that is unique and attractive to the consumer. To say that clinicians can only contribute to clinical management is regressive and only serves to perpetuate the status quo. In other countries many senior clinicians are actively involved in the business of creating health services. This is denied to most in the UK.

This current NHS model is monolithic and from many clinicians' perspectives, including my own, represents a difficult environment from which to innovate.

Within the NHS status quo, the view is of consultants as a commodity and most of us practice within a 'command and control' managerial culture. Surgeons are viewed as technicians to meet targets with little regard to the broad context. This means in practice that whilst many clinicians have ideas, many that we are using already in our private practices, we cannot influence our NHS practices. This might include clinical coding and pricing, software that we use to track our private patients and how we organize our administrative and secretarial functions.

To dislocate clinicians from the core business function of healthcare is to stifle entrepreneurial innovation and to further perpetuate the status quo. The consequence of this will be to further disengage and demotivate clinicians from the innovation of NHS services.

Healthcare systems in Europe and the USA are experiencing unsustainable pressures that require bold innovation rather than incremental change. A necessary requirement is to allow the full experience and ability of clinicians to be involved in this transformation. Clinicians ought and deserve to be involved in this. We have a deep and wide understanding of healthcare both at a micro and macro level. We understand the failings of incumbent systems: we have to make them work. To deny consultants any involvement in management with the private [NHS] sector, subject to formal declarations of interest, and the avoidance of

obvious conflicts, is surely to stifle the very innovation that is needed at this critical time. This cannot be in the national interest.

If, in the longer term, the private [NHS] sector is successful in creating effective value added services there is a risk of unintended consequences. If the only choice for a clinician interested in the management of NHS business is to remain within the NHS versus resigning and working full time for a private provider there is a small risk of losing clinicians to the private sector over time. This is not likely to be a significant near term risk but with time it may be. It is possible that the clinicians most likely to leave will those experienced clinicians, mid career, who have the clinical and financial confidence to move. These clinicians will have a significant capability and are likely to be those for whom the NHS Trusts would be least advised to lose.

It is of note that in other countries the clinicians working in the state run public sector are often relatively inexperienced clinicians or academics affiliated with Universities. As clinicians become more experienced, confident and financially secure, they seek greater autonomy. In the UK this has not been the case. Clinicians with sizeable non-NHS Trust practices remain employed and this benefits the wider NHS through their clinical experience, teaching, training, mentoring, etc.

It is surely for the NHS to provide the opportunity and incentives to retain clinicians' interest. In several of your submissions Trusts have sought to restrict 'their' clinicians from engaging in non-NHS management activities in their non-contracted hours. This indicates clearly the lack of opportunity and incentivisation to thrive within the NHS. Were this not the case clinicians would not be drawn to the private sector interested in providing NHS services.

In conclusion; I would urge strongly that the CCP support bold innovation and the entrepreneurialism that is needed in healthcare in the coming decade. I would strongly urge the committee to take 'the risk' that by allowing clinicians the opportunity to innovate in the private [NHS] sector by taking a broad strategic role this may provide the credible plurality of provision that is required for genuine patient choice. In doing so it may actually encourage Trusts to make full use of the senior clinicians who work with them. If these objectives could even be partially met this decision would be in the broad public interest.