

**Confidential**

Mr Andrew Taylor  
 Chief Executive  
 NHS Cooperation and Competition Panel  
 1 Horseguards Road  
 London  
 SW1A 2HQ

7<sup>th</sup> July 2009

Dear Mr Taylor,

**Restrictions on Consultants' Use of Their Non-Contracted Hours**  
 Response to Notice of Possible Policy Recommendations

We are writing on behalf and on the instruction of the Co-ordinating Committee of the Circle partnership. This is the leadership body of Circle, representing 1300 Consultants from all around the UK who are part of the largest partnership of clinicians in Europe. As so few submissions to the Cooperation and Competition Panel's Non-Contracted Hours (NCH) study have been from individual clinicians, we feel compelled to provide our unique perspective on this vitally important issue.

Our starting point is that our skills should be employed wherever most appropriate and that our primary responsibility is not to any individual institution, but rather to our patients. Consequently we strongly support the proposed recommendations included in 7(a) and 7(b) of the Panel's Possible Policy Recommendations which would bar existing NHS employers from imposing both direct and indirect restrictions on Consultants using their NCH to treat NHS patients wherever they choose to be treated. We believe that any limitations on NCH activities (including those set out in 7(c)) would effectively prevent many of us from participating in the emerging competitive market for treating NHS patients outside traditional NHS institutions. To support our view, we wish to explain why each of the three possible bases for restriction proposed by the Panel – financial interests, management responsibilities, and tender participation – undermine both clinical leadership and the development of a truly plural market for healthcare services.

### **1. The Role of Financial Incentives in the Healthcare Sector**

Every healthcare provider in the UK today offers financial incentives to Consultants. Whether in the form of cash bonuses, profit-sharing, equity, Clinical Excellence Awards, or final salary pension schemes, all providers use financial incentives to encourage Consultants to work at their facilities. Indeed as consultants we know that it is the NHS pensions more than anything else that discourages consultants from reducing their commitments to NHS trusts to provide clinical services elsewhere. That some of these incentives are aimed at increasing both quality and productivity within the NHS is explicitly recognised in Lord Darzi's 2008 final report of the NHS Next Stage Review, "High Quality Care for All". This states that Clinical Excellence Awards (the cost of which exceeds £220million p.a. plus the associated pension liability) would "become more conditional on clinical activity and quality indicators".

The General Medical Council already provide adequate guidance on the issues of financial interests and probity defining the circumstances requiring disclosure and the behaviour expected of practising doctors. To bar some incentives but not others (as 7(c)(iii) proposes) would be arbitrary and anti-competitive because it

deprives some providers of the means to attract Consultants to work with them. It is only fair, therefore, that all financial incentives be treated equally. Either the full array of incentives currently used should be permitted or none at all.

The issue of financial incentives has particular resonance for us. Circle is a partnership of more than 2000 Consultants, GPs, nurses, managers, porters, and cleaners, each of whom holds a small equity interest in our company. We believe that co-ownership encourages a level of engagement, accountability and productivity that allows us to deliver the very best care to our patients and the most value to those who pay for it. That this is the case was supported only last week by the highly respected Nuffield Trust in its publication *NHS Mutual* in which the authors report that “companies experience a productivity boost of four to five per cent when employee ownership is introduced, which is sustained over subsequent years” and that “employee ownership underpins and enhances the positive effect of staff participation schemes”.

Any restriction on NCH activities that arises from simply holding shares in an alternative provider such as Circle would seriously compromise our ability to provide both patients and commissioners with choice and value. To the extent that the Panel considers ownership to be relevant at all, the principles of transparency and declaration should apply. Just as shareholdings in pharmaceutical and medical device companies do not restrict Consultants from prescribing medicine or using equipment manufactured by such companies, neither should interests in alternative providers.

## **2. The Role of Consultants in Management**

To bar Consultants from serving in management roles for an alternative provider is significantly at odds with the increasing trend within the NHS to embrace clinical engagement and leadership. We believe that a distinction between clinical management and strategic management is a false one. The functions and responsibilities of a clinical manager operating in a modern healthcare setting are frequently influenced by strategic considerations (and vice versa), and as such cannot be distinguished in any meaningful way.

As Lord Darzi’s report *High Quality Care for All* made clear, inadequate clinical involvement in management and leadership roles has contributed to uneven quality and poor productivity levels within the NHS. That this is the case is in marked contrast to the situation in most other developed countries. As a result, the report advocated “a new emphasis on enabling NHS staff to lead and manage the organisations in which they work” and that financial remuneration would be used to “encourage and support clinical leadership of service delivery and innovation”.

It is only through the active engagement of clinicians in the management and delivery of healthcare services that the NHS can achieve meaningful, measurable improvements in care quality and productivity. Since it is clear that existing NHS institutions are being mandated to encourage and develop clinical leadership it would be unfair and surely anti-competitive effectively to exclude Circle and other new providers of care from doing the same as the pool of consultants with these skills is so small.

The fundamental concern should not be whether a Consultant can assume a management role in addition to his clinical duties. Rather, the focus should be whether a Consultant’s work at one provider poses a conflict of interest in relation to the Consultant’s work at another provider. In our view, a conflict only arises when a Consultant who holds management roles at two different providers has access to commercially sensitive information that compromises the interests of one of the providers. In these circumstances, we believe that it should be left to each provider to prove the conflict of interest and decide whether to allow the Consultant to serve in a managerial capacity. Ethical considerations, together with the Consultant’s obligation to

disclose the scope of his activities to all providers for whom he provides services, provide sufficient safeguards and transparency to ensure any conflicts are appropriately addressed.

And finally of course there can be absolutely no justifiable reason why a managerial role in one provider should prevent any clinician practicing clinical medicine at another provider.

### **3. Consultant Participation in Tender Bids**

The expertise and experience of Consultants are crucial to designing and bidding for NHS-tendered services, and most alternative providers simply could not participate in a tender process were they denied access to them. They certainly would be denied the ability to innovate and to bring best practice to designing clinical pathways for instance. Barring Consultant involvement in a tender would effectively limit the number of competitive bidders to one: the incumbent Trust. We recognise, of course, that there may be situations where a Consultant has access to his employing Trust's commercially sensitive information that could be misused as part of a tender bid by a competitor. However, this is true of all commercially sensitive information to which a Consultant has access (not just information that is relevant to a particular tender) and we believe that existing ethical, legal, and contractual obligations governing confidentiality and the protection of trade secrets provide a sufficiently robust deterrent to such misuse.

Particularly at the time when NHS management are finally being charged with embracing clinical leadership, to restrict clinicians from ownership and managerial roles in alternative providers would be profoundly anti-competitive and ultimately would limit rather than broaden the opportunities for meaningful patient choice.

Yours sincerely

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