

## Response from Gloucestershire Hospitals NHS Foundation Trust

10 July 2009

We welcome the opportunity to comment on this issue which has attracted considerable interest internally and externally. Our Medical Staff Committee generally take the view (whilst individuals/groups within may not share this entirely) that colleagues should not do this work and look to the Trust to express their perspective on this. To date, this has been to express a similar view without an overt expression of sanctions. Clearly all parties would welcome clarity on how this issue will be resolved going forward so it does not have a disproportionate effect on the Trust. Whilst commenting on the 'restrictions' proposed as discussion points, I would make the general observation that we start from the fundamental principle that we do not believe our employees should be able to work in a directly competitive capacity to the Trust, with a clear distinction between providing services to a competitor for which the Trust is not in competition, compared to one where it is and for where the patients could have ended up with the Trust. With reference to the issue as to whether any restrictions become enshrined in the Consultant contract, then clearly it would be helpful for all sides to have this clarity.

In terms of representing our position more specifically;

1. The principle of consultants working for a competitor in settings that do not offer comprehensive care and is likely to select relatively low risk patients, will inevitably skew costs to us as a provider. The Trust bears significant overheads generally and significantly in relation to issues such as training, CNST, appraisal etc. Whilst the tariff for services delivered internally will reflect those overheads, the tariff earned externally will have more of an element of pure profit attached to it and without an amendment to the tariff to reflect these differences, a level playing field is not created.
2. In terms of low risk cases, we cite the example of the Consultants with contracts at the Trust operating on patients in a local private hospital via the 'Choose and Book' scheme. The patients are being anaesthetised by Trust anaesthetists and whilst we have no numbers (and therefore it is difficult to quantify), this is an example of a purified group of patients of low risk. Inevitably, the greater number of low risk patients extracted from ourselves increases the number of high risk, low return patients for the Trust. By their nature these cases are complex and more likely to require extensive preoperative work up. The implications for our average waiting times are obvious and force the Trust into a non-competitive position.
3. In addition, we may witness a trend of consultants requesting part time contracts to increase their activity in the private sector, thereby increasing this imbalance between the educational/training costs borne by the Trust and the direct return. Whilst all enlightened employers are expected to deal fairly with flexible working requests, these are primarily designed to deal with carer responsibilities, typically associated with paternal/maternal duties, as opposed to the freedom offered by the consultant contract to go and earn additional money in private settings which actively seek to compete with the Trust. The Trust would need to be confident in setting out that approval or otherwise for these requests is driven by the patient need first and foremost and the capacity of the Trust to organise itself to deal with demand on its services.
4. Concerns have been raised by various Trusts in relation to EWTD and in particular the safety aspects of consultants working excessive hours in private practice. There is the clear safety issue of consultants returning to the Trust and potentially making errors in addition to errors being made in the private setting which the Trust has to rectify. The whole question of liability may prove to be significant and tortuous to unravel. Whereas the culture of healthcare provision has not historically been about

apportioning blame or liability, this may become a feature of future relationships between organisations who share resource.

5. Competition surely has to be about having the best staff, sourcing, appointing, developing and retaining them. It would be bizarre to countenance the argument that failing to offer these high value resources to a competitor - for free – limits their fair entry to the market place. This market place is also open to them to find, appoint and retain staff at their own cost.
6. We are already seeing consultants band together to form limited liability partnerships (LLP), which incorporate wholly owned subsidiaries to deal with NHS work. To date it may be argued that it has been to the mutual benefit of Trusts and these groups who have thus far elected not to tender for aspects of care that may create a competitive situation. Whilst this situation endures and the individuals concerned in the management of these ventures pledge that they would not allow conflicts of interest to develop, it will require some complex policing and regulation to ensure continuance of such a situation and doesn't remain dependent upon individual goodwill, however genuine this is (and there has been no reason to doubt it). This can only be exacerbated by the increase in part time work whereby the ultimate question of allegiance and who is the primary employer in these instances may be severely tested over time.
7. There may be certain examples where it is cited that the Trust does not have the capacity to do the work and therefore this does not create a competitive situation. Applying the non-contracted hours ruling implies that the work for another organisation would have to be done at weekends and in late evenings. We have considerable spare capacity at these times and could increase our throughput if Consultants were prepared to utilise this time. In reality, they utilise contracted hours. Policing of this will require an extra and inefficient recourse to no obvious benefit of the patient.

Regards

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