

## Response from Paul Conley

10 July 2009

I am writing this submission to the CCP in my capacity as an NHS GP who firmly believes in shifting care from hospital to a community setting wherever it is possible and clinically safe. I am also part of a large group of GPs in Hampshire who have bid for services in conjunction with Circle (partly because our local consultants had been prevented from working with us by their acute trust).

We should start from the perspective of the patients, many of whom no longer see acute trusts as their first choice facility to access specialist expertise. This trend has accelerated since the publicity afforded to Maidstone and South Stafford Hospitals. Overwhelmingly they tell us they want services delivered locally.

Who should provide these services? Surely the answer is that they will require a mix of skills, from both generalists and specialists, with medical, nursing and social care expertise. The appropriate organisation to provide services could take many forms. Acute Trusts currently have the consultant expertise, although it could be argued that they have little experience of population management and delivering care closer to patients. Acute trusts have huge incentives to maintain the status quo: they only get paid under choose and book when patients arrive at the hospital or at a satellite community hospital and are generally not interested in removing potentially unnecessary (but revenue generating) steps in the clinical pathway.

Groups of GPs have a good understanding of how to manage patients in the community but need the active participation of consultants for reasons of clinical governance, mentoring and for access to the experience that only consultants can provide. We have tried to work with acute trusts to provide us with local consultant resource but have either been flatly refused or been allowed to access consultants at above market rates, making community-based services uneconomic.

Many of the NHS contracts now being put out to tender are increasingly long-term and are based on managing populations "at risk", rather than on a per capita basis. In this immature market, we as new providers may seek to limit our supplier cost risk, by seeking to align long-term incentives, sometimes including joint ventures and other equity participation schemes. One of the ways we can succeed in this regard is to have shared ownership of such services, so that all clinicians and managers share in the risks and rewards. Recent evidence published by the Nuffield Trust argues that operational efficiency can be significantly increased where clinicians have some ownership of the business. If you think like an owner, you develop your business.

Restricting the ability of consultants to participate in such financial arrangements will increase risk to new providers, thereby stifling the development of this emerging market, leaving all but the lowest value services firmly in the hands of the acute trusts. Innovation will be strangled at birth by the incumbent acute trusts.

Most GPs in the UK are independent providers operating under the NHS umbrella and are free to engage in equity participation with any number of companies. We may own shares in nursing homes, drug companies, private niche providers of pathology services or shares in publicly listed secondary care providers. Any potential conflict of interest is managed by disclosure of our interests. Consultants should be likewise free to supply their skills to new provider organisations and should not be shackled by being unable to participate in the equity of these organisations.

Similarly, I believe that consultants should not be restricted from a managerial/strategic role in any new organisation that we may wish to form with them; this direct involvement is often specifically sought by NHS commissioning bodies in order to ensure long-term quality and governance. Innovation will surely flow

from both primary care and secondary care intimately involved in designing and delivering high quality clinical services, and ensuring spread of best practice. Placing managerial/strategic restrictions on consultants involved with new care organisations will encourage monopolistic behaviour by acute trusts, to the detriment of patient care.