Response to the CCP consultation paper

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Overview

The 2003 consultant contract allows full time consultants to work non-contracted hours for non-NHS work providing they offer an addition PA to their primary employing Trust. Therefore Trusts should not be preventing consultants from doing extra work in the private sector. However the contract was not specifically addressing the issue of competition within the NHS, especially Foundation Trusts, which could then result in detriment to NHS FT patient services.

All NHS Trusts (Foundation or otherwise) exist for the benefit of patients and not for the benefit of those delivering the service. Whilst consultants occupy a privileged position in term s of their position in a Trust their freedoms must be compatible with Trusts remaining financially viable. The NHS has become a business as well as remaining a service. As such the contract between the employer and the employee (in this case the consultant) should be paramount and decisions relating to non-contracted hours should be at the employer's discretion. Trusts must be able to discuss with consultants potential conflicts of if they work for any other external body such as an ISTC.

In relation to ISTC's, a protocol already exists in relation to non-contracted hours and this should not be duplicated by further guidance.

Quality of Care and patient safety

The Foundation Trust network state the following
"The Panel will need to balance any potential reduction in patient choice from a decision not to allow the consultant to accept non-contracted hours employment elsewhere in a public interest test against the potential impact on the quality of care to NHS patients by a consultant working significantly longer hours than the 48 hours allowed in order to work non-contracted hours".

It is very difficult to see how choice per se increases quality of care in either sector given that the consultants delivering that care will have to be the same consultants. If quality of care was different that in itself, would be a governance issue.

On the other hand patient safety is influenced by many other factors, not least of which is the support provided by other specialty teams for inpatients who develop complications. The CCP should look very carefully at patient

safety issues when considering choice and ISTCs. Individual consultants must do the same

Continuing Professional Development:

All Trusts invest vast amounts of money in consultant training under their responsibility to continuously improve the knowledge and skills of consultant's staff (which also benefits the private sector). This is undertaken as part of the terms and conditions of service and in the interests of NHS patients.

These costs are not just direct costs such as travel expenses and subsistence but also involve opportunity and activity costs borne by the NHS Trust. If consultants were allowed to compete with their main employer it would certainly affect their willingness to invest in consultant training. Unless the ISTC also funded study leave and S code time they would be receiving a "free good" paid for out of NHS monies.

Consultant Loyalty (Duty of Fidelity)

At present there is an implied duty of fidelity to an employer within the consultant contract as there would be in any business environment. The view of foundation Trusts is as follows and is pivotal in the discussions regarding the establishment of a level playing field in terms of competion.

"Foundation trusts believe this (duty of fidelity) should be made an express duty, particularly as the forward NHS strategy following the next stage review will mean that clinical leadership becomes central to NHS activity. This will mean that increasingly consultants will play critical roles in decision making in their employing organisations and have access to strategic and commercially sensitive information. A clear commitment to fidelity to the employing organisations should be a reasonable exchange for this enhancement of organisational role and responsibility".

I can think of no other business situation where a key member of staff is allowed to work with the competition simply because they have time in which to do this. Equally important is that current restrictions on non-clinical activity should not be removed as consultants will have access to information that is commercially sensitive. Most foundation trusts differentiate between consultants taking on additional service provision and being involved in its management either by having a financial interest or shareholding in the private provider or determining policy. In such a case consultants must make a declaration of interests as there is clearly a potential conflict of interest.

Confidentiality

From an information governance perspective it is vital that confidentiality for both patients and the employer should be maintained and not threatened by any new guidance.

What happens in other non NHS businesses?

The key determinant of what happens in industry is the principle of conflict of interest. As a consequence restrictions are built into contracts of employment. Consultants have always had the freedom to choose who they work for and to agree the terms of their employment at the outset because historically there has not been a conflict of interest but two completely separate "markets". It might be argued that if Foundation Trusts want to attract the best consultants and those consultants want to work in other sectors for additional remuneration, that they may be able to negotiate an "exclusivity agreement" as also happens elsewhere.

How important is choice?

It has been stated many times (and repeatedly ignored) that what patients really want is a good local heath service, accessible and delivering high quality and safe patient care. Generally speaking they do not wish to travel long distances for this except when the services are highly specialised. There is no evidence that patients want to pick and choose and to have their health care fragmented by virtue of attending different hospitals for different health problems.

ISTCs have not shown that they can deliver a better quality of care at a lower price but they have been allowed to cherry pick those easier cases that make the most profit. For foundation Trusts to be able to complete on a level playing field and also make a profit some form of restriction to consultant activity is essential as most clinicians would regard themselves as free agents, which of course they were in the pre business planning NHS. This is no longer tenable when every FT is expected to work as a business and turn in a financial profit to re invest in heath care and new services. Without being able to do this, Trusts will stagnate and developments will cease, to the detriment of all patients.

Conclusion

The impending financial constraints will pose a major challenge for many NHS organisations including all acute Trusts. It is vital that the organisations that employ consultants in a full time capacity have the ability, if necessary, to prevent those consultant working in direct competition. I have particular concerns in terms of clinical leadership if consultants become increasingly independent, working only on a session basis for who ever pay the most. Without any forward planning and with little thought for service development the major contribution that consultants make, in terms of service development, will be lost.

Similarly, if ISTC's wish to employ consultants on a session basis they should also be responsible for the paying part of their pension, NI etc and CPD costs, including study leave expenses and paid ISTC time to attend courses. The same clinicians should not be involved in planning service delivery in the ISTC.