

Study on consultants' non-contracted hours

Discussion Paper No.2: Initial assessment of the presence and effect of restrictions on consultants' use of their non-contracted hours

Introduction

1. The Department of Health and Monitor have requested that the Cooperation and Competition Panel (CCP) carry out a study of restrictions placed on consultants in relation to the non-contracted hours that they can work for other healthcare service providers. The focus of the CCP's study, in line with its remit, is restrictions placed on the non-contracted hours NHS consultants can work for other providers of NHS-funded healthcare services.
2. The concept of patient choice for acute elective care and other healthcare services relies on there being a plurality of providers that patients can access. Consultants using their non-contracted hours to work for alternative providers of NHS-funded services is one means by which a plurality of provision, and patient choice, can be facilitated. Restrictions on consultants' ability to work for other providers of NHS-funded services may, as a result, constrain patient choice. Further, restrictions on consultants' ability to work for other providers of NHS-funded services may also constrain the ability of commissioners to establish new services outside of an acute setting that require the services of consultants. The purpose of this study is to assess whether there are restrictions that may be having this effect and to provide to provide guidance to NHS service providers on the application of the Principles and Rules for Cooperation and Competition (PRCC) to such restrictions.
3. The CCP commenced the study on 14 April 2009 with a call for submissions by interested individuals and organisations. Around 60 responses were received in response to this call for submissions, including 32 from NHS and Foundation Trusts, 7 from groups representing consultants, 6 from PCT groups, 5 from independent sector providers and 4 from employer organisations. Non-confidential versions of these submissions have been placed on the CCP's website at www.ccp-panel.org.uk.
4. The CCP is now publishing two discussion papers as an interim step towards its final report. These papers, based on the initial submissions referred to above as well as further information requested by the CCP, summarise the evidence thus far and set out the CCP's preliminary views. In publishing these papers the CCP hopes to elicit further responses that may contain additional new information, or point to alternative interpretations of the evidence provided to the CCP.
5. The first discussion paper provides a summary and preliminary analysis of the restrictions which the CCP has been told effect consultants' use of their non-contracted hours. In particular, it summarises the relevant provisions of the consultants' contract and discusses the duty of fidelity that employees owe to their employers. It also examines the *de facto* restrictions on consultants arising from established links between NHS employing Trusts and consultants.

6. This second discussion paper sets out the evidence submitted to the CCP regarding the nature of the various restrictions that Trusts are placing on consultants' use of their non-contracted hours, and provides an initial assessment of the benefits and costs of these restrictions.
7. We also plan to publish a short paper in the coming weeks which addresses the form of guidance that might be issued by the CCP in the event that it were to conclude that restrictions on consultants' use of their non-contracted hours were inconsistent with the Principles and Rules.
8. The CCP welcomes further submissions in response to these two papers. These should be made to the CCP (nch@ccpanel.gsi.gov.uk) by 26th June 2009 to ensure that they can be taken into account in the CCP's advice and recommendations. The study is due for completion by 28 August 2009.

Overview of this paper

9. This paper provides an initial assessment of the presence and effect of restrictions on consultants' use of their non-contracted working hours. It sets out:
- evidence provided to the CCP on the nature, effectiveness and rationale for restrictions placed on consultants' use of their non-contracted working hours by NHS Trusts;
 - a framework for considering the effect of restrictions on consultants' use of their non-contracted working hours that encompasses both benefits and costs;
 - a discussion of the benefits arising from restrictions on consultants' use of their non-contracted working hours; and
 - a discussion of the costs arising from restrictions on consultants' use of their non-contracted working hours.

Restrictions on consultants' use of their non-contracted hours

10. The accompanying discussion paper provides a summary and preliminary analysis of the restrictions arising from the consultant contract and elsewhere which the CCP has been told might affect consultants' use of their non-contracted hours.¹ In the paragraphs below we identify restrictions that Trusts have individually sought to place on consultants.

Types of restrictions placed on consultants

11. The following paragraphs set out evidence that has been received from Trusts, consultants and others on restrictions on consultants' use of their non-contracted working hours. These examples are not held out as being representative of most Trusts in England, rather they allow us to assess the various individual restrictions that have been observed. The different restrictions are categorised in terms of explicit restrictions and measures designed to discourage consultants from working for other providers of healthcare services. Differences in the scope of various restrictions are then discussed.
12. The purpose of setting out this material is not to draw attention to the behaviour of individual Trusts, but to ensure that our assessment of the benefits and costs of these restrictions is firmly grounded in actual practice rather than any theoretical consideration of the issue. We further note that the purpose of this study is to draw general conclusions that can inform our advice rather than raise issues of compliance with the Principles and Rules in relation to individual Trusts.

¹The restrictions and permissions that are examined may also relate to the use of non contracted hours to treat fee paying patients in private and NHS hospitals, however the scope of this Inquiry and the evidence received is restricted to the effect on NHS funded services including those of the Trust which employs the consultant.

Explicit restrictions on consultants' use of their non-contracted working hours

13. A range of mechanisms have been identified to the CCP as used by Trusts to explicitly restrict consultants' ability to work their non-contracted hours for other providers of NHS-funded services.

- a. Four Trusts² [X³] informing their consultants that they will not be allowed to work non-contracted hours for other providers of NHS-funded healthcare services on either certain specified programs (eg the Extended Choice Network), or in some cases, under any arrangement.
- b. Two Trusts [X] refusing individual requests to work non-contracted hours for another healthcare service provider.⁴
- c. A Trust [X] writing to consultants to tell them that by accepting employment from the Trust, all employees have made a covenant that they will not co-operate with any third party to enable them to secure any service provision which would consequently be lost to the hospital.
- d. Three Trusts [X] contacting independent sector providers to inform them that they are not prepared to 'release' their consultants to work non-contracted hours either generally or for that provider.
- e. A Trust [X] asking a consultant to sign a letter promising not to undertake non-contracted hours work for another provider. The consultant is informed that failure to sign the letter will be deemed to be gross misconduct since it is considered to be a reasonable request.

Measures to discourage consultants from using their non-contracted hours to work for other providers of NHS-funded services

14. A number of mechanisms have also been identified to the CCP during the study whereby a Trust seeks to discourage its consultants from working for other providers of NHS-funded services, but does not explicitly ban them from doing so. These include:

- a. Three Trusts [X] writing to all consultants explaining that working non-contracted hours for a competitor *might* put them in a conflict of interest with their employer.
- b. Three Trusts [X] writing to their consultants to tell them that any reduction in patient numbers that occurs as a result of their working non-contracted hours for another provider would risk causing redundancies amongst medical staff.

²As stated these examples are not held out as being representative of most Trusts in England.

³The X symbol indicates that we have excised material, such as the name of an organisation, from this discussion paper so as to preserve the confidentiality of certain material provided to the CCP.

⁴In one case the Trust takes legal advice on its options for dealing with the consultant, including whether the Trust can discipline the consultant, sack the consultant, withdraw the consultant from clinical excellence awards, make the consultant redundant or move the consultant to an alternative position within his specialty.

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- c. Three Trusts [X] writing to their consultants to urge them to recognise that, whilst they would be within their rights to work non-contracted hours for another provider, this would endanger the Trust's plans to build new medical facilities.
- d. Nine Trusts [X] telling consultants that they have a duty to ask for permission from their Chief Executive before agreeing to work non-contracted hours for another provider. In these cases the Trust often indicates that it will make a decision based on the material impact on the income and business of the Trust. Consultants from two of these Trusts [X] told us that restrictions were in place on any work that "compromised activity at the Trust".
- e. A Trust [X] asks whether consultants have any interest in working non-contracted hours on the Extended Choice Network. Some consultants told us that they believed that such a confirmation would have a negative impact on their career progression and chances of receiving a clinical excellence award.

Scope of the restrictions placed on consultants

15. Most commonly, a Trust will restrict its consultants from working for independent sector providers of NHS-funded services. However, the restrictions employed by Trusts may also affect consultants working for other NHS organisations providing NHS funded services. Two Trusts [X] told us that such restrictions would prevent consultants from working non-contracted hours for services commissioned by practice-based commissioners. [X] PCT also told us that it was concerned that restrictions would inhibit the ability of practice based commissioners to commission services. In addition a consultant wrote to us to explain that his employing Trust [X] placed restrictions on consultants working for a nearby charity [X].
16. The scope of a restriction may vary in that it may only apply:
 - a. to non-contracted hours work on a particular program (eg choose and book); or
 - b. to non-contracted hours work involving patients in a particular geographic area.
17. For example, in [X] we understand the local Acute Trusts are willing to allow consultants to work non-contracted hours on certain initiatives (eg local initiatives to reduce waiting lists), but not others (eg [X] – an initiative commissioned by [X] PCTs and operated by [X] aimed at creating additional capacity and providing patients in the area with more choice).
18. Similarly, we were provided with evidence of Trusts restricting their consultants from working non-contracted hours for independent providers of NHS-funded services to patients within their catchment area. In each case, the Trust explained that only this activity was in competition with the Trust. The Trusts would grant permission to consultants to work non-contracted hours for the same provider, in the same scheme, providing they could be assured that the consultant will not treat patients that would otherwise choose to be treated at the Trust.
19. Finally, there are cases where the restriction relates to the role that the consultant may have with an alternative provider. For example, at least five Trusts [X] have told their consultants that while working their non-contracted hours in non-management roles would probably not represent a conflict of interest, any management role would represent a conflict and the

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consultant would be in breach of its duty of fidelity and this would consequently be potentially incompatible with continued employment by the Trust.

20. This aspect to the restriction highlights the fact there are a number of roles that a consultant might occupy in work for an alternative service provider, including straightforward clinical activities, advice on tendering for NHS contracts, a management role in an alternative healthcare service provider, and a shareholder or financial investor in an alternative healthcare service provider.

Rationales for the imposition of a restriction

21. In all we received submissions, either from or about, 59 individual Trusts. Of these, 38 Trusts appeared to place some form of restriction on their consultants' use of their non-contracted hours (including the various forms of discouragement previously discussed in paragraph 16). A further 16 Trusts did not apply restrictions on their consultants' use of their non-contracted hours, while the situation in relation to the remaining 5 Trusts was not clear. Various rationales were advanced for the imposition of restrictions on consultants' use of their non-contracted hours. These included:

- a. to prevent the Trust losing volume and revenue to a competing provider of NHS-funded services (explicitly stated in 11 cases);
- b. to protect patient (and employee) safety (explicitly stated in 8 cases);
- c. to prevent distortions to competition or anti-competitive behaviour (explicitly stated in 8 cases), by:
 - i. eliminating the possible incentive of a consultant (who might gain personally from the success of the independent provider) from referring patients for NHS-funded treatment at the independent provider, rather than at the Trust;
 - ii. eliminating the possible incentive for a consultant (who might gain personally from the success of the independent provider) to use confidential information obtained within their role at a Trust when working on an independent providers bid for NHS tender;
 - iii. eliminating the possible incentive for a consultant (who might gain personally from the success of the independent provider) to facilitate collusion between the Trust and an independent provider;
- d. to compensate for other 'level playing field' issues, (explicitly stated in 2 cases); and
- e. to bring the NHS into line with other professions and industries (explicitly stated in 2 cases).

Effectiveness of NCH Restrictions

22. The evidence that we have seen to date does not indicate that explicit restrictions on consultants' use of their non-contracted hours are ineffective in that they are ignored or bypassed by consultants. We have been informed of a number of cases [X] where consultants withdrew their offer to work non-contracted hours for an alternative provider as a result of a restriction that was imposed by their Trust. We have also been informed of a case [X] in which the consultant had resigned from his Trust to work for a competing healthcare provider as a result of being unable to overcome the restrictions imposed by the Trust.
23. There are, however, examples of consultants collectively resisting the imposition of these restrictions. For example, a consultant from [X] told us that a Trust withdrew a restriction on working for a competing healthcare service provider when a large group of consultants specialising in a particular area [X] wrote a letter asking the Chief Executive to reconsider.
24. The evidence regarding the effectiveness of measures designed to discourage consultants from using their non-contracted hours to work for other healthcare providers is less clear. In some cases a discouragement has been sufficient to effectively restrict individual consultants (eg [X] in which a consultant was unwilling to ask permission from the Chief Executive of his employing Trust), or [X] may effectively discourage enough consultants to force a provider to post no capacity on the Choose and Book system for certain specialties.
25. In other cases consultants have submitted that their Trust has tried to discourage them from working in non-contracted hours for competing providers but they have yet to enforce this by forcing the consultant to give up existing commitments to work non-contracted hours for competing providers.
26. Thus some Trusts are unwilling, for now, to go beyond a strategy of discouraging consultants. Nevertheless in some cases this is sufficient to effectively restrict consultants' use of their non-contracted hours.

Framework for assessing the net effect of restrictions on consultants' use of their non-contracted hours

27. The framework used by the CCP to assess whether NCH Restrictions are consistent with the Principles and Rules (particularly Principle 4, Rule 2: Providers, referrers and commissioners of NHS services must not restrict choice via collusive behaviour or any other action) is a cost-benefit framework. That is, where the CCP identifies behaviour that is inconsistent with the relevant Principles and Rules, it seeks to identify whether the costs of the restrictions that would otherwise be in breach of the Principles and Rules are outweighed by any associated benefits.⁵
28. Consistent with this, the following two parts of this discussion paper first consider the possible costs of these restrictions and then the possible benefits of restrictions on consultants' use of their non-contracted hours.

⁵This is broadly consistent with the analytical framework which would generally apply under the Competition Act or Article 81 EC which involves assessing countervailing efficiencies once it has been established that a restriction gives rise to competition concerns.

Costs of restrictions on consultants' use of their non-contracted hours

29. For patients and/or taxpayers to be disadvantaged by restrictions on consultants' use of their non-contracted hours a number of conditions need to be satisfied:
- first, the restrictions on consultants' use of their non-contracted hours need to be effective in influencing consultants' behaviour;
 - second, potential providers of NHS-funded healthcare services are prevented, delayed or otherwise impeded in providing services as a result of these restrictions; and
 - finally, the lack of entry by these new providers of healthcare services imposes a cost on patients and/or taxpayers, for example, in the form of reduced choice, quality of service or efficiency.

Effectiveness of restrictions on consultants' use of their non-contracted hours

30. As discussed in paragraph 24, explicit restrictions imposed by individual Trusts appear to be effective in preventing consultants from working their non-contracted hours for competing service providers. The situation in relation to measures designed to discourage, rather than prohibit, consultants from working non-contracted hours for competing service providers is, as discussed in paragraphs 26 to 28, less clear. In the following section we assess the impact of effective restrictions, whether they happen to be an explicit ban or a discouragement.

Impact of restrictions on potential providers of healthcare services

31. As identified in paragraph 23, many of the Trusts making submissions told us that they imposed restrictions on consultants' use of their non-contracted hours so as to prevent the Trust losing volume and revenue to a competing provider of NHS-funded services. In this respect the intended effect of the restriction is clear. In this section, we review the evidence of the actual impact that these restrictions have on the ability of alternative providers to provide services. We consider, first, restrictions on consultants providing clinical services, and second, restrictions on consultants providing management services and capital.

Effect of NCH Restrictions on the provision of clinical services by consultants

32. For restrictions on consultants' use of their non-contracted hours to impact on new service providers, these new service providers must be reliant on access to locally based NHS consultants and unable to access sufficient, suitable consultants or specialists from elsewhere. Evidence on this issue has come in two forms. First, evidence of the availability and suitability of alternative non-NHS consultants. Second, evidence of the actual effect on new service providers of the restrictions that we have observed.

Availability and suitability of alternative sources of consultants

33. In seeking evidence for this study, we asked NHS organisations and others for their views on the availability of alternative consultants to conduct the work that certain NHS consultants were restricted from undertaking. The responses were as follows.

34. South West SHA told us that from an independent sector provider's perspective, access to NHS consultants is regarded as vital in order for them to compete effectively. East of England SHA told us that in its view it is hard to see, at this time how non-NHS providers could attract clinical resource (consultants) in sufficient quantity should their ability to use non-contracted hours be removed. A Trust in a semi-rural area [X] told us that an independent provider of NHS services would have no alternative sources of consultants if it were unable to agree terms for the non-contracted hours of consultants working at the Trust.
35. An independent sector provider [X] submitted that in many cases where it encountered restrictions on consultants' use of their non-contracted hours there were still enough co-operative Trusts in the area for it to access sufficient consultants for its business. As such, at present, the effect of these restrictions were somewhat mitigated. However, it also submitted that the number of restrictions would increase if the Department of Health or Monitor were to endorse their use as this would remove much of the uncertainty which at present discouraged some Trusts from imposing such restrictions. The British Medical Association (BMA) also told us that it is concerned that the number of Trusts that apply restrictions will grow if the existing restrictions are seen to be supported.
36. Another independent sector provider [X] told us that it had considered various alternative sources of consultants (eg overseas specialists⁶) but found none of them to be viable under the NHS tariff other than using consultants with available non-contracted hours. In particular, it noted that the volumes and patient mix from NHS Choices were currently insufficient to attract full-time consultants. It also noted that it had difficulty recruiting newly qualified consultants (CCT⁷ holders) since they were unlikely to receive the same level of support or mixture of cases that they would expect in an incumbent Trust. In addition they told us that the consultants that they do employ cannot be stretched across cases as they are in the NHS since there is no junior support team in the independent sector.⁸
37. Two independent sector providers [X] and [X] identified problems of service continuity and emergency availability as limiting the geographic area from which it could recruit consultants with non-contracted hours. They explained that this meant that for them, recruiting consultants from more than a [X] minute drive-time was not a feasible strategy.
38. More generally, the availability of newly qualified consultants to new service providers will vary over time and specialty depending on the degree to which training intakes have created a pool of consultants who might be available to undertake this work.⁹ The 2007 census conducted by the Royal College of Physicians noted that "there appears to be increasing concern amongst

⁶Outside the UK, specialist doctors are not generally known as consultants. We therefore label this group as overseas specialist doctors.

⁷Certificate of Completion of Training

⁸We were told by [X] that: "The NHS is required to comply with Standards for Better Health, and medical care can be delivered by an employed junior team under the supervision of an employed Consultant. The independent sector, by contrast, is regulated by the Care Quality Commission; and the National Minimum Standards mandate that all care is delivered directly by Consultants who meet stringent practicing privilege requirements (mainly as independent contractors)". As such, junior doctors cannot be used to mitigate the restriction on access to consultants.

⁹Changes in demand for consultants will also affect the availability of alternative consultants, for example new technologies may reduce or perhaps increase the need for certain specialists.

senior trainees that sufficient consultant posts may not be available for those emerging from training but at present there is no evidence to support this". However, it goes on to suggest that a 'bulge' in the consultant workforce may be approaching. "In a steady state workforce the number of trainees in each specialty should be approximately one sixth of the number of consultants (since training typically takes five years and consultants are in post for more than 30 years). The number of trainees currently in training substantially exceeds this ratio."

39. In addition to problems with the availability of non-NHS consultants, there are also potential issues associated with their suitability to provide NHS-funded services. The BMA submitted that when independent providers were prevented, by the terms of their ISTC contract, from employing NHS staff¹⁰ in phase 1 of the ISTC programme (in what was known as the policy of 'additionality') they had to recruit consultants or specialists from elsewhere, and it was concerned about the effect this might have had on ISTC outcomes. It noted that "it is worth bearing in mind that doctors with less NHS experience may not deliver the same standard of care as NHS consultants and that this can have serious consequences both clinically and financially". Similarly the Royal College of Physicians submitted that in their view "there is a disparity in the competencies of UK trained doctors and non-UK trained doctors such that we cannot be sure the quality of clinical service provided by other providers using non-UK trained staff is adequate".
40. The House of Commons Health Committee report on phase 1 of the ISTC programme reported in 2006 that the policy of additionality had been seen by many as having an adverse effect on the quality of care. It reported that this was blamed by some on the necessary use of foreign-trained clinicians who, unlike the many foreign trained doctors already working in the NHS, had not been integrated into the system over a long period of time. By contrast, the newly arrived clinicians had no experience of working in the UK or in the NHS. It reported concerns that they might be unfamiliar with processes within the NHS, surgical techniques or equipment and might have language problems. It reported that a small number came to the UK to work for a weekend or a few weeks and were therefore unable to follow-up, or even be aware of, complications. However, most witnesses agreed that the evidence was not available to compare clinical standards in NHS organisations and NHS-funded ISTCs.¹¹
41. In its response to the House of Commons report, the Department of Health stated that the policy of additionality had encouraged ISTCs to increase capacity whilst preserving NHS clinical skills. However, it added that additionality had made integration more difficult and that as a result too many ISTCs were poorly integrated into the NHS. This lack of integration had limited the flow of innovation and best practice between the independent sector and the NHS. The Department explained that a relaxation of the additionality rules in phase 2 of the ISTC programme would be introduced in order to bring about greater professional integration.
42. These views on the additionality policy would appear to suggest that while there are other consultants outside the NHS (eg overseas specialist doctors) that could potentially be recruited

¹⁰Healthcare professionals who were working in the NHS or who had worked in the NHS in the last 6 months

¹¹The Healthcare Commission conclusion in its review of ISTCs offers reassurance about the quality of services provided and that patients surveyed rated services highly. However, they noted that there are still too many gaps in the data to consistently compare the quality of care with that of the NHS.

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to undertake work for new service providers, there may well be quality related disadvantages to relying on these consultants. This would appear to be consistent with the relaxation of the additionality rules for phase 2 of the ISTC programme.

43. In addition, we were told by [X] that providers employing specialist doctors from overseas will incur additional expenses since the provider may have to pay a considerable cost for mentoring, language classes, relocation and any induction training that is required. [X] told us that during phase 1 of the ISTC programme when the additionality rule was in place the cost of employing consultants from outside the NHS increased costs by [X] per cent and [X] per cent in certain cases. They also suggested there was a greater turnover of such consultants as they often wanted to return home within a year or two. In other cases they moved on to work in the NHS.

Evidence of effect on new service providers of observed restrictions on consultants' use of their non-contracted hours

44. The following paragraphs set out the effect on the ability of new service providers to provide services as a result of restrictions on consultants' use of their non-contracted hours .
45. An independent sector provider [X] told us that restrictions on consultants' use of their non-contracted hours prevented it from offering capacity on the Extended Choice Network in [X], and as a result, patients in these areas have less choice of provider. It also told us that it had to withdraw from the Extended Choice Network in other cases as a result of a lack of access to consultants.
46. A consultant from [X] told us that his practice had been prevented from establishing an NHS-funded [X] practice at the local independent sector [X] hospital as a result of restrictions imposed by the local Trust. A number of consultants from the same Trust noted that while refusing to allow consultants to work on ECN cases, the Trust would sub-contract to private providers at "tariff minus 10%". The 10 per cent is apparently retained by the Trust to cover administration costs.
47. [X] told us that it had been unable to offer certain specialties of ECN work in [X] and [X] as a result of the restrictions put in place by the Foundation Trusts in those areas. It also reported that in the past restrictions on consultants' use of their non-contracted hours meant that it had been unable to tender for central NHS contracts, smaller local spot purchase work¹² and PCT contracts.
48. We also received a submission from an independent sector provider [X] stating that it had withdrawn from a bid for a [X] contract because the [X] Trust and the [X] Trust had both denied access to their consultants.
49. In one case a PCT [X] was in the process of commissioning a contract for [X] services worth more than £[X]. An independent provider in the area was in talks to take on the contract but withdrew. The PCT submitted that the reason for the withdrawal was that the provider could not

¹²Spot purchase work is work contracted out to independent providers at a market rate. For example this may be used to reduce waiting lists or to cover whilst a facility is being renovated.

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undertake the work at the NHS tariff level. We have seen evidence that the Trust [X] discourages consultants from working non-contracted hours for rival providers and thereby may increase the costs of those rival providers. We were told that it is suspected by some in the area that the withdrawal was partly a result of actions taken by the local Trust. Notably following the withdrawal the local Trust purchased a local independent provider unit so that it could provide the service itself.

50. A group of PCTs in [X] told us they had commissioned a scheme to create additional acute treatment capacity and to give patients a greater choice of provider. However the PCTs report that the independent sector provider has been unable to recruit a sufficient number of local consultants through using their non-contracted hours. The PCTs told us that the independent sector provider had advised them that [X] Acute Trusts in the area would not support consultants who wanted to work non-contracted hours in the scheme and accordingly the independent provider had to recruit additional overseas specialist doctors. The provider told us that in two specialties it had been able to recruit consultants from within the UK but outside [X], but the payment for travelling and accommodation fees substantially increased the cost of the service. The independent sector provider has continued to run the scheme. However, the Department of Health has confirmed to independent providers that any withdrawal by the provider would constitute a breach of the ISTC contract and would leave the provider liable.

Effect of restrictions on consultants' use of their non-contracted hours on the provision of management services and capital by consultants

51. As previously described, there are a number of cases where Trusts have sought to restrict the non-clinical roles that a consultant may have at an alternative provider. The most common example is that the Trust [X] restricts its consultants from taking on a management or strategic role at the alternative provider, while allowing them to provide clinical services. Similarly, some Trusts [X] restrict consultants from holding equity in the alternative provider or from participating in the tender process to win contracts for NHS-funded services.
52. We distinguish between the involvement of consultants in clinical management and in business and strategic management. We recognise the importance of clinical leadership and consultant involvement in clinical management, including clinical governance. However, the need for consultant involvement in business and strategic management and as financial investors is less clear. Some independent providers [X] have told us that consultants make better managers of health services. However, the majority of independent providers have attracted both equity and business managers without the need to recruit consultants into these roles in their non-contracted hours. These providers have demonstrated that alternatives are available and are commonly used by alternative providers.

Impact on patients and taxpayers as a result of impediments to entry by new service providers

53. Our analysis to date indicates that restrictions on consultants' use of their non-contracted hours are having an effect on alternative service providers ability to provide services, and thus acting to restrict patient choice.

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54. On the whole, on the evidence we have seen to date, we would not expect restrictions on consultants' use of their non-contracted hours that relate to a consultants' ability to work in strategic management roles at other service providers, or restrictions that relate to the provision of capital by consultants to these service providers to restrict the ability of new service providers to commence providing services. That is the evidence so far indicates that these types of restrictions do not impact on patient choice.
55. There is a further consideration as to whether restrictions on entry (and thus choice) are having an adverse effect on patients and/or taxpayers as a result of reducing competition. For entry *not* to increase competition it would require that the market was already as competitive as it can be. Given the early stages of patient choice and competition between service providers for NHS patients, we would expect that in the nearly every local market there would be scope for more competition should entrants be willing to provide it.
56. While we recognise that health services are in many ways different from the supply of other services, we would nevertheless expect increased patient choice and competition to provide:
- greater choice and convenience for patients;
 - greater pressure on service providers to increase quality;
 - greater innovation in service provision; and
 - more bidders for PCT contracts leading to improved services and better value for money.
57. However, for us to reach the view that these restrictions were having an adverse effect on patients and taxpayers, we would also need to conclude that any benefits arising from restrictions on consultants' use of their non-contracted hours did not outweigh the costs of these restrictions. Possible benefits from restrictions on consultants' use of their non-contracted hours are considered in the following paragraphs.

Benefits of restrictions on consultants' use of their non-contracted hours

58. There are a number of possible benefits to patients and taxpayers in the list of rationales for imposing restrictions on consultants' use of their non-contracted hours noted in paragraph 23. These include: patient safety; preventing possible distortions to competition or anti-competitive behaviour; and compensating for other 'level playing field' issues. We discuss each of these possible benefits in turn below.

Patient safety

59. A number of submissions [38] suggested that by working for another provider in their non-contracted hours the consultant risked taking on an excessive workload. They suggested that by notifying the Trust of non-contracted work and then agreeing a job plan to incorporate such work, consultants can prevent situations in which they work an excessive number of hours and thus potentially endanger patient (and employee) safety.
60. This benefit arises from the restrictions contained in Schedule 9 of the contract, which requires consultants to inform their employing Trust of any Private Professional Services or Fee Paying

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Services and to agree a Job Plan annually in relation to this work as well as the overall restriction on the number of hours that may be worked by consultants.

Preventing distortions to competition or anti-competitive behaviour

61. Several submissions [38] suggested that restrictions on consultants' use of their non-contracted hours to work in a non-clinical role for another healthcare provider (eg as a manager or advisor on bidding for NHS contracts) would have the benefit of preventing collusion or competitive distortions.
62. For example, a consultant may have an incentive to treat patients at the provider where he/she works their non-contracted hours, rather than at the Trust if the consultant gains personally from the success of the independent provider. A further example is that where a consultant works on an independent providers' bid for an NHS tender there may be an incentive to use confidential management information (eg on costs), obtained within their role at the Trust, in order to win the tender.
63. Finally, a financial interest in an alternative provider of healthcare services may give a consultant a personal financial incentive to facilitate collusion between the provider and the consultant's employer Trust that will benefit the service provider rather than patients or taxpayers.
64. Restrictions that prevent consultants from having management positions, advising on bids for NHS contracts or having financial interests in competing providers of healthcare services, and to a lesser extent simply working for a competing service provider, would all assist in preventing these distortions to competition or anti-competitive behaviour.

Compensation for other 'level playing field' issues

65. A number of Trusts [38] submitted that the ability of the main employer to impose restrictions on consultants' use of their non-contracted hours was justified as it compensated the main employer for costs that would not be borne by the healthcare service providers for which consultants worked their non-contracted hours. This is a form of the 'level playing field' argument whereby different groups of healthcare service providers argue that they suffer an unfair cost disadvantage relative to other service providers.
66. The most common cost burdens identified by the Trusts included the following:
 - a. the cost of training of new consultants;
 - b. the cost of continuous personal development (including re-validation) for consultants;
 - c. the costs of consultants' employment leave; and
 - d. the contribution of costs to the consultants' pension scheme.
67. We note, however, that there are a number of other 'level playing field' arguments advanced by independent sector healthcare providers as to why they suffer cost or other disadvantages relative to NHS Trusts.

Bringing NHS consultants into line with other professions and industries

68. A number of submissions [8] argued that restrictions on consultants' working non-contracted hours for competing healthcare service providers brings the NHS into line with other professions and industries. However, in itself, this does not provide any benefit to patients or taxpayers. In the case of NHS consultants, we need to consider whether access to consultants by providers of new services (either by independent sector providers of NHS funded services or by other NHS organisations) is necessary for those services to be provided. This requires an analysis of the specific circumstances of the NHS rather than a comparison with the prevailing situation in other industries.

Next steps

69. In the next stage of this study will be to consider further submissions relating to the matters discussed in this paper, and in light of the evidence available to the CCP, weigh up the relevant benefits to patients and taxpayers arising from these restrictions and assess whether any such benefits outweigh the associated costs.