

30 June 2009

Mr. Andrew Taylor,  
Chief Executive  
NHS Panel for Cooperation and Competition  
1 Horse Guards Road  
London  
SW1A 2HQ

Dear Andrew

## **Non-Contracted Hours**

Thank you for inviting the NHS Partners Network to comment on the Panel's Notice of Possible Recommendations on NHS Consultants' use of non-contracted hours.

### ***Background***

The NHSPN represents a broad range of independent sector providers of care to the NHS. Our members include major hospital groups, ISTC providers, primary and community care providers and diagnostics companies. Membership encompasses both not-for profit and commercial organisations.

### ***The Co-operation and Competition Objective***

The starting point for the NHSPN is that the primary competition objective is to secure an available supply of consultants to deliver services to NHS patients. Restrictions - whether direct or indirect – imposed by NHS employers on the use by Consultants of their non-contracted hours have the potential significantly to restrict this supply. In so doing, such restrictions reduce choice, increase cost, and are therefore detrimental to the primary competition objective, as well as being inimical to patients' choice of consultant, and the wider interests of taxpayers.

If permitted, such restrictions would significantly increase the cost of market entry, and render untenable the position of some potential participants in the market for the delivery of clinical services to the NHS. In summary, this would massively favour NHS incumbent providers, and ossify NHS service provision.

We do not believe that there is any countervailing *practical* argument in favour of such restrictions. We acknowledge that there is an argument in favour of such restrictions, but this only stands up by (a) ignoring completely the co-operation and competition objective referred to above, and (b) deploying the nineteenth century common law doctrine of master/servant 'fidelity', which we suggest has no direct application in this area (and which the consultant contract provisions relating to private practice demonstrate have been superseded, certainly in relation to non-contracted hours).

At a practical level, there are already examples of the damage caused by attempts by NHS employers to impose such restrictions. Conversely, it has proved hard to identify any specific examples of ways in which allowing Trusts to restrict consultants in these ways might produce genuine benefits for patients or for the wider NHS.

## ***Possible Recommendations***

### *7.a and 7.b*

We therefore believe that the right course for the Panel to take would be to adopt the two prohibitions contained in paragraphs 7 (a) and 7(b) of the Notice of possible recommendations, thus clearly banning both direct and indirect restrictions on consultants' use of their non-contracted hours. We note that this would not affect the existing requirement within the contract that consultants first offer hours back to their NHS employer.

### *7.c*

We note the inclusion in the paper of a possible additional approach (paragraph 7 c (i), (ii) and (iii)), which seek to reflect the distinction that might be drawn in respect of the role of consultants in the strategic management of, preparation of tender bids for, or shareholding in a potential provider of services to the NHS.

Whilst we believe that there should be a single limitation on a consultant's ability to operate as a 'primary tenderer' (see below) we believe that attempting to draw a distinction between clinical work on the one hand, and strategic, management or governance work on the other is unnecessary and

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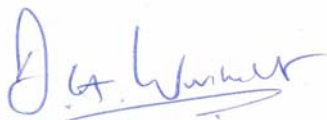
unhelpful. It also flies in the face of a major initiative being undertaken across both the NHS and the independent sector, the engagement and involvement of clinicians (per Professor Lord Darzi's review). To establish a workable code of practice based on such a spectrum of participation by consultants will be extremely difficult.

It is in our view better to rely on the simple proposition that an employed consultant cannot operate as a 'primary tenderer' in a tender in which his NHS employer is participating. That consultant may, however, (provided he adheres to the usual and normal contractual position on commercial confidentiality, and protection of business secrets) be a component part of the resource structure of a third party's service offering, even if that third party by so doing competes with the consultant's employer.

Finally, we think it would be sensible if the Panel were able to issue guidance to commissioners of NHS services to the effect that a private sector bidder should not be marked down on a tender because the consultants it proposes to use are NHS consultants working their non-contracted hours.

We would be happy to discuss this letter with you at any time if that would assist the Panel in reaching a conclusion, or in framing the statement of a concluded position.

Yours sincerely,

A handwritten signature in blue ink, appearing to read 'D. Worskett', with a horizontal line underneath the name.

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David Worskett  
Director  
NHS Partners Network