

Cooperation & Competition Panel: Inquiry on NHS consultants working non-contracted hours for other providers of NHS-funded services

Second Submission of Spire Healthcare Group

1 Introduction and Executive Summary

- 1.1 The Co-operation & Competition Panel ("CCP") has been commissioned by the Department of Health ("DH") and Monitor to carry out a study of the restrictions placed on consultants in relation to the non-contracted hours they can work for other healthcare service providers in the provision of NHS-funded services. Accordingly, it asked respondents, including Spire, for submissions and evidence on which the CCP might base its recommendations.
- 1.2 Spire submitted a paper on 8 May 2009 setting out its views in detail, attaching evidence to support its submissions and requesting that the CCP:
- (a) Conclude that the restrictions on consultants' use of non-contracted hours is contrary to the Principles and Rules for Cooperation and Competition ("PRCC") unless specifically justified on objective patient safety grounds;
 - (b) Make clear recommendations that NHS Trusts should desist from placing restrictions on their consultants, whether overtly, by implied threats or moral pressure; and
 - (c) Confirm that NHS consultants are free to participate in the tender process for IS bidders in so far as is necessary for those bidders to provide full information to commissioners.
- 1.3 The CCP has published two discussion papers, summarising the evidence submitted to date and setting out its preliminary view, as an interim step towards its final report. The CCP have again asked respondents for submissions containing new information, or pointing to alternative interpretations of the evidence provided to the CCP.
- 1.4 In this paper Spire makes further submissions with reference to certain elements of the CCP's preliminary analysis. Where we have commented on a particular element, we have repeated the relevant sections of the CCP's analysis (in italics) for ease of reference.

2 Discussion Paper 1

Paragraphs 5-8:

- 2.1 *"We are also considering the possible application of Principle 2 of the Principles and Rules. This states: Providers and commissioners must co-operate to ensure that the patient experience is of a seamless health service, regardless of organisational boundaries, and to ensure service continuity and sustainability...[i]t is not clear to us that Principle 2, whilst broad in its application, obliges providers and commissioners to cooperate to ensure that patients have a choice of providers of the same service. However, we would welcome submissions on this issue."*
- 2.2 It is Spire's view the concept of continuity of care relates as much to the ongoing availability of the consultants for follow up treatment as it does to a seamless care pathway. If this is undermined by a failure of providers to cooperate over making available NHS consultants, then this would appear to breach Principle 2 of

the PRCC.

- 2.3 Spire considers that restrictions placed on consultants' use of non-contracted hours for independent sector ("IS") providers have the effect of undermining continuity of care by leaving IS providers with no alternative but to use medical staff sourced from outside of the local area or from overseas who (as a result) do not have knowledge of and are not integrated into the local NHS.
- 2.4 As we detailed in our first submission, the government's now-withdrawn "additionality" policy, which applied to the Phase 1 ISTC contracts, made it extremely difficult for IS providers to provide NHS services effectively and there were real concerns expressed about continuity of care as overseas teams were only deployed on short term contracts and were unfamiliar with local NHS processes.

Paragraph 9:

- 2.5 *"We are also considering whether restrictions on consultants' use of their non-contracted hours might breach Principle 3 of the Principles and Rules insofar as commissioners might discriminate in favour of those organisations able to secure the clinical services of consultants. We would also welcome submissions on this issue."*
- 2.6 Spire is aware of NHS commissioners evidencing discrimination in favour of NHS providers able to secure clinical services of consultants. One such example is Spire Bristol Hospital's unsuccessful bid in respect of a recent tender by South West Specialised Commissioning Group (the "Commissioning Group") for the provision of bariatric surgery to NHS patients.
- 2.7 Whilst the feedback was fairly limited, the Commissioning Group acknowledged that Spire had submitted a good bid, which was also reflected in the fact that Spire progressed to the final round of evaluation. The tender, however, was awarded to North Bristol NHS Trust.
- 2.8 One of the categories in which Spire was evaluated was "Clinical Standards", for which Spire Bristol was awarded a score of 1.5, being mid way between 'compliant with shortcomings' and 'satisfactory'. Spire was told that the only significant factor contributing to this low score was the perceived risk to the Commissioning Group as a result of Spire not employing the medical and surgical staff and concluded that the availability of consultants to undertake the work could not be guaranteed. It is of note that no other concerns were raised in respect of Spire's clinical standards.
- 2.9 Despite our reiteration that Spire currently successfully undertakes Bariatric activity for the NHS and the fact that we have an agreement in place with the surgical team to undertake such surgery, the score was not changed. The comparatively high weighting (21.05%) given to this category had a significant effect on Spire's overall score.
- 2.10 For the same reasons given for the "Clinical Standards" category, Spire was awarded a score of 1.5 for the "Clinical Multi-disciplinary team" category. Again, the high weighting (18.95%) attributed to this category significantly effected Spire's overall score.
- 2.11 We believe that the Trust in this case was awarded a significantly higher score than Spire based on the fact that the Trust employs consultants and believe that this was the single most significant factor which depressed Spire's overall score. It is certainly noteworthy that, of twelve bidders under the South West bariatrics

tender (six IS providers and six NHS providers), all six of the NHS bidders were awarded contracts as a result of the tender and none were awarded to IS providers. It is our view that the tender was not necessarily awarded on the basis of quality standards and believe that the clinical criteria were applied in a way which favoured the NHS.

- 2.12 Whilst we have no reason to suspect this was the case in the Bristol example, a commissioner could have legitimate concerns about the security of consultant supply in the event that it was suspected that an employing Trust (especially if competing in the tender) would take action to restrict Spire's access to consultants.
- 2.13 In these circumstances we consider that it would be a legitimate function of the PCT as commissioner to take measures in the procurement to ensure that such restriction did not occur. Such measures could include, for example, requiring the bidding Trusts to confirm that no direct or indirect restrictions have been placed or will be placed on the use of non contracted hours by consultants. This would go some way towards levelling the playing field and removing the deliverability concern over IS bids, thus achieving a fairer and more robust tender. We consider that guidance from the CCP on this point might well encourage more robust PCT commissioning practices and as result better commissioning.

Paragraph 26

- 2.14 *"At the time the [Consultant] contract was originally negotiated in 2003, public policy in relation to securing a plurality of providers of NHS-funded services ad not developed to the point it has today..."*
- 2.15 Spire believes that the policy of using IS providers to deliver NHS funded care was contemplated in the NHS Plan in 2000 and the so-called "concordat" between the Department of Health ("DH") and the Independent Healthcare Association in the same year.
- 2.16 By 2003, the DOH had clearly articulated the policy of Growing Capacity through use of the IS. The policy was sufficiently developed for it to have been well-understood that providers were contracting with NHS consultants in their non-contracted hours.
- 2.17 It is our view that public policy in relation to plurality of providers for NHS-funded services was clearly in the contemplation of those negotiating the 2003 consultant contract.
- 2.18 Further, and as detailed in our first submission, the HR Framework for ISTC Treatment Centres, the consultant contract terms and conditions and the Code of Conduct for Private Practice expressly permit consultants to engage in 'private practice'. That term is drafted so as to include the treatment of NHS patients under private arrangements.

Paragraph 44:

- 2.19 *"We have been told that NHS employing Trusts have provided training and benefits to consultants over a significant period of time, and exercise a significant degree of control over the consultant resource. Taken together, and taking account in particular of the reputational need for consultants to maintain their NHS appointments, our preliminary view is that these factors could indicate that the availability of consultants' time is different in nature to the availability of other highly skilled professionals. The factors outlined above could be seen as de facto restrictions on the availability of consultants. We would welcome*

submissions on this point."

- 2.20 Spire concurs with the CCP's preliminary view that factors such as the training and benefits provided by the NHS to consultants, together with the reputational need for consultants to maintain NHS appointments, constitute de facto restrictions on the availability of consultants. This reinforces the control of the Trusts over the consultants which are key inputs need by Spire to compete for NHS funded work.
- 2.21 In many local markets NHS consultants are the only source of supply of this specialist manpower. The utilisation by Spire of NHS consultants in their non-contracted hours is the only meaningful way to give effect to the government's policy of patient Choice. As set out in detail in our first submission, consultants are essential inputs in enabling patient Choice, and access to consultants is needed both by NHS Trusts and IS providers in order to compete effectively for NHS work. The effect of restrictions would therefore restrict or distort this competition and thus reduce the prospect of patient choice and a plural market.

3 Discussion Paper 2

Paragraph 52

- 3.1 *"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 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."*
- 3.2 We agree that there are clear advantages to patients and the NHS in maximising consultant involvement in the delivery of private healthcare to NHS patients. We note that the CCP recognises the importance of consultant involvement in clinical management, however we consider that consultant involvement in certain operational management aspects of service delivery are also critically important. For example, a consultant might assist with evaluating new equipment or designing care pathways, or might provide expert support in liaising with an NHS commissioner.
- 3.3 We would oppose any legitimising of restraints on consultants' action in this area. We have received legal advice to the effect that consultants are free to assist IS providers who tender for NHS funded work in a variety of ways - clinical, technical and commercial. This is subject always to their professional and ethical duties. We see no justification for drawing an arbitrary line between "pure clinical" activity and "ancillary" activities since there is no apparent justification for this in the consultant contract itself and in any event any such distinction would be impossible to define and police in practice. Trusts are of course generally able to access this sort of help from their employed consultants and so taking steps to prevent this for IS providers would disrupt any level playing field and put consultants in a position where they are unable to make a full contribution to the move towards plurality and competition. There would also be a potential conflict with their contractual duty to avoid acts or omissions which diminish the resources available to the NHS.
- 3.4 However, in the event the CCP is minded to support a Trust's ability to impose

restrictions in this area we would suggest that any restriction should be limited to a consultant's involvement in the commercial or financial management of a service or a bid to provide a service. A consultant should be free to provide any other support to an IS provider, including involvement in the clinical or operational aspects of a service or bid to provide an NHS funded service.

- 3.5 We would draw to the CCP's attention that it would be helpful to obtain specific clarification that a consultant is entitled to provide details (including personal details and details of clinical expertise and outcomes) for inclusion in an IS provider's bid to provide NHS services. NHS tenders universally require such details to be included, and if consultant co-operation in this regard was prohibited (as argued by some NHS employers) IS providers could effectively be prevented from bidding for NHS work. It would also be helpful to clarify the extent to which consultants can participate in other aspects of a bid, for example assisting in preparing the Clinical and Operational sections of a bid document, or attending meetings with the commissioner during the tender process.

Paragraph 59

- 3.6 *"A number of submissions 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."*
- 3.7 Patient safety is, rightly, the key concern of both NHS and IS healthcare providers. It is in everyone's interests that consultants and other healthcare professionals adopt safe systems of working, including in relation to their working hours and shift patterns.
- 3.8 There is of course a risk that in allowing consultants to do any private practice consultants could work excessive and dangerous hours. This risk, however, is mitigated by the consultants having to agree their private sessions with their employing Trust as part of their job plan, and is further mitigated by consultants individually and as a class wishing to maintain their clinical reputation and to provide the best standards of care for their patients.
- 3.9 Spire's experience is that Trusts have rarely, if ever, raised genuine patient safety issues with us in relation to consultants' non-contracted hours. Rather, the issue of working time has on occasion been used as a convenient screen behind which to advance a Trust's commercial or political agenda. For example, we are aware of examples where Trusts have agreed private activity as part of a consultant's job plan but have sought to use working time as a basis for objecting to consultants doing NHS funded work in those agreed hours, even though the Trust would have been quite happy if the payor in those same hours was an insurance company or other private source rather than the NHS.
- 3.10 In agreeing a consultant's job plan we consider that an employing Trust should only give consideration to issues of patient and employee safety. This is the position underlying the Phase 2 ISTC HR Framework (which technically only applies to certain centrally procured ISTC Schemes). If a Trust wishes to deny a consultant the right to a particular proposed change in his or her job plan the Trust, acting reasonably, should be required to provide objective and evidence-based reasons why the proposal would prejudice patient or employee safety and should be obliged to work with the consultant to find a solution allowing the consultant to undertake his/her private sessions in a way that does not infringe employee or patient safety. It should be made quite clear to Trusts that they have

no right to refuse a consultant the ability to undertake private sessions (including for NHS funded patients) on commercial, financial or other non-safety based grounds.

Paragraphs 65-67

- 3.11 *"A number of Trusts 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."*
- 3.12 We do not agree with this argument. For example, one issue identified by the Trust was the cost of training new doctors. However the costs of training new doctors are funded centrally by the DH via the Multi-Professional Education and Training (MPET) fund and not by the Trusts themselves. IS providers do not have access to the MPET fund or any similar fund and therefore we do not consider that an unfair cost disadvantage arises.
- 3.13 Other cost disadvantages identified by the Trusts are employment and pension costs. However, we consider that in reality the Trusts are in a privileged position in relation to these costs, and indeed receive state subsidies not available to IS providers. For example, the NHS has a monopoly on doctor training. It also provides the vast majority of training opportunities for nurses and other healthcare professionals in the United Kingdom. Any clinical professional wanting to work in the UK will have to spend a significant proportion of his or her career in the NHS. We note that this training is not funded by the Trusts but by state-funded training funds.
- 3.14 Further, the NHS Pension Scheme, which applies to virtually all NHS employees, is significantly underfunded, with the accumulation of funds (less benefits already paid out) being inadequate to pay for future liabilities. Unlike the IS, which is required to fully fund pension schemes, NHS benefits are, in effect, subsidised by future taxpayers who will be expected to pay for the shortfall, meaning that NHS employers have a state pension subsidy not available to the IS. Further, the NHS Pension Scheme is administered centrally by the NHS Business Services Authority without cost to the Trust, in contrast to the IS which suffers administration costs for its pension schemes. In other words, through underfunding and avoidance of administration costs, it costs an IS provider more than a Trust to offer this employment benefit to employees.
- 3.15 The net effect of the factors described in paragraphs 3.13 and 3.14 is that it is easier for the NHS to employ staff than it is for IS providers, and those staff are cheaper for the NHS to employ than their equivalent in the IS.
- 3.16 In addition, and as noted by the CCP, the IS suffer costs and other disadvantages relative to NHS Trusts, such as the obligation to pay corporation tax, VAT and Stamp Duty Land Tax, which place the IS at a competitive disadvantage to the NHS.
- 3.17 Further, the IS does not benefit from the other cost benefits available to Trusts, including:
- (a) the economies of scale achieved through collective purchasing power;
 - (b) the ability to access equity from the Exchequer at the National Loans Fund

rate, which is significantly lower than even a large and low risk private borrower; and

(c) centralised IT systems funded by the DH.

3.18 Spire rejects the argument that Trusts suffer an unfair cost disadvantage relative to the IS. Further, it rejects the implication that the differing costs of NHS Trusts and IS Providers justifies a restriction on the ability of consultants to use their non-contracted hours for other providers of NHS-funded services. It is our view that if the level playing field issue is to be addressed, that it should be dealt with through appropriate mechanisms such as the Fair Playing Field Advisory Group or through tariff adjustments (once the costs on both sides had been properly considered), and should not be used to justify a unilateral decision to place a restriction on consultants' use of non-contracted hours.

Spire Healthcare
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