Putting patients first

John Schofield on the Health and Social Care Act and more

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December 2013
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President's Address

Putting our patients first

Reflecting on the year as it comes to a close, and my first eight months as President, I am gratified at how much we have achieved in such a difficult period. This year has been particularly challenging for some hospital consultants and specialists, but I hope has also been rewarding for the majority.

We have been contacted by many of you during 2013, and I hope that the team have provided valuable assistance, making some of the issues you have faced easier to overcome. The phrase ‘thank you, you’ve been so supportive’ is one that the Overton office have heard many times in 2013 and I can say that I am really delighted that we have been able to continue to stand up for our members so effectively in these difficult times.

There have been many issues of note this year, particularly the Francis and Berwick reports, the Keogh report, debates around 7-day services, consultant contract negotiations, proposed changes to the clinical excellence award system, and pensions. We have been hard at work representing your views and campaigning on these issues as we know you care about them deeply. It is for this reason that HCSA exists, to not only represent its members when needed but also to take its members views to a wider audience, to gain support for those views and ultimately influence the outcome of decisions which affect us all. With that in mind, I have set myself and the Association ambitious goals for 2014, which support our objective of winning greater influence, improving services, developing the consultants’ role and growing our presence. As you read the roundup of the year on page 3, you will see that we have already made great strides towards achieving these goals. But we still need to do more, particularly in developing our local networks within hospitals and increasing our membership.

So, in 2014 there will be a strong focus on recruiting local hospital representatives, with the development of training and support information and an opportunity for all these representatives to come together and find out more about how they can grow their role. Local representatives are crucial to the development of HCSA, and I would like to thank all local and national representatives for the part they have played in making HCSA a success in 2013. We act as the patients’ advocate, and our role in ensuring high quality standards of care must not be underestimated. It sometimes puts us in a difficult position, but we must continue to keep putting our patients first. No Christmas address would be complete without talking about New Year’s resolutions, so I have one for all of you. If each one of you recruited just one new member to HCSA in 2014, we would be even stronger and more able to influence the decisions that are so vital in shaping the future of our role. Thank you all once again for your support this year and I hope you all enjoy a peaceful and joyous festive season.

John Schofield

Welcome

A very warm welcome to new hospital representatives: Mr Harish Parmar, Consultant Orthopaedic Surgeon at Queen Elizabeth Hospital, Welwyn Garden City and Dr Paul Cooper, Consultant Anaesthetist at Balfour Hospital, Orkney Islands.

Vacancies remain in other areas, so if you are interested in becoming a hospital representative or joining the HCSA council please get in touch with the Overton office.

We were deeply sorry to hear of the death of Dr Katherine Bradley, an HCSA fellow and consultant psychiatrist in Berkshire. The family funeral was held on 9 December, and there will be a memorial service in Spring. Anyone wishing to get in contact to express their sympathy and condolences can do so through the HCSA office in Overton.
Meeting our challenges together

HCSA chief executive Eddie Saville looks back on a year when HCSA confidently met the challenges that members faced.

At the same time the South West Pay Cartel was looking to introduce wide-ranging changes to terms and conditions, simply as a result of geography. We joined forces with other organisations and campaigned hard to oppose regional pay. We reported on the issue of open referrals, which meant patients could be sent to the insurer’s choice of consultant, limiting patient choice. It was also around this time we had to react to the government’s proposals on pension tax changes that would see many of our members hit by new tax thresholds and lower allowances.

We soon then saw the publication of the Francis report into events at Mid Staffs, followed by the 209 recommendations therein. The issue of whistleblowing was high on the agenda, and the HCSA spoke out on the stresses that members experienced when whistleblowing became necessary. In spring we were involved in the revision of the NHS constitution, and have promoted its use in the workplace to ensure the NHS fulfils its pledges and commitments.

In April the HCSA launched its three year strategic plan. The plan set out our vision, values, principles and objectives for the Association in the years to come.

Our vision:
“The doctor’s advocate and the trade union of choice for consultants and specialists”

Our values and principles:
- Strong leadership
- Integrity
- Fairness
- Responsiveness
- Quality

Our objectives:
“Winning greater influence, improving services, growing our presence, developing the consultants role”

This plan will see us continue to build and grow. To support this, we increased our communications capacity by creating a new role of head of communications and web services, this enhanced our communication strategy and began the process of updating our web site.

We surveyed our members on the government’s proposals to change the consultant contract and make changes to the CEA system. The efforts of the joint union campaign against regional pay began to pay off as a number of trusts in the South West began to withdraw from the cartel. The NH5 staff survey results were released which showed a mixed bag of results, some good and some very worrying - in particular the findings on bullying, harassment and staff shortages. We called on Trusts to take these findings seriously, work in real partnership with consultants and specialists and to listen and take note of what they had to say. We also for the first time attended the Women’s TUC Conference, known as the “annual parliament of women,” and successfully moved a motion on the effects regional pay has on women.

Also in April we saw a change in the leadership of the HCSA with Dr. Umesh Udeshi completing his term of office as president and Dr. John Schofield elected to a three year presidential term. Prof. Ross Welch was elected as the new chair of the executive. At the same time the HCSA attended its first meeting of the NHS Staff Council as we took our observer seat.

The House of Lords were to decide on a key section of the Health and Social Care Act relating specifically to competition. The HCSA like many other organisations and trade unions had argued that mandatory competition risked the fragmentation of NHS services, and an amendment was tabled. However the Lords went on to defeat the amendment.

As the Francis report continued to be in the spotlight, the HCSA formed part of a high level TUC delegation that met with Robert Francis. Around that time we were able to renew our local trade union recognition agreement with Cardiff and Vale University Health Board, which gave us full negotiating rights alongside all other NHS unions within the Health Board.

Our Council meeting in April welcomed Dean Royles, leader of NH5 Employers who gave a keynote speech. In July we marked the 65th Birthday of the NHS attending a rally in Manchester; with our Council member Ahmed Sadiq giving a keynote speech to those in attendance. We also commented on the introduction of surgical league tables and updated members on the tripartite working review, which the HCSA are engaged with via our seat on the wider Social Partnership Forum. In September we were again active at the TUC congress, successfully moving and seconding motions on whistleblowing and the future of the NHS.

It was also the 65th anniversary of the HCSA this year and we were able to give a brief history of the Association which we will continue to research for our archives. Whilst we were celebrating our 65th birthday, meetings were taking place far away in Washington DC. The occasion was the opening of negotiations on a free trade agreement between the United States and the European Union. The Transatlantic Trade and Investment Partnership (TTIP) could be the biggest bilateral trade deal ever negotiated and could profoundly affect the future of the NHS. The year is finishing as it started with the key issue for us being the ongoing negotiations on the consultant contract. Though not directly involved in the detail of negotiations we will make our members views known.

Set out above are just some of the collective regional and national issues that the HCSA has been involved with. These are all ongoing matters and we continue to keep a watching brief on these and the many other issues which affect HCSA members. However, added to all of this is the day to day work that we do for members in the workplace. Supporting and representing members individually and collectively on contract disputes, bullying and harassment issues, disciplinary cases, grievances, TUPE problems, job plan disputes, discrimination at work and much more. For me and the excellent team of staff at the HCSA it has been a busy year - one where we have achieved many of our objectives.

Finally, just last month we strengthened our staffing numbers, giving us more staff in the field to support members and organise locally. So as we go into the New Year we renew those objectives; to grow our hospital based representation, to recruit more members and retain our existing members by improving our service. Above all continuing to be the voice of our members.
Good for doctors, good for the NHS and good for the HCSA

In a wide-ranging 'state of the union' address HCSA president John Schofield told the association's national council that the Health and Social Care Act had ushered in a new era for the NHS.

NHS England, the central managerial body of the NHS, has been separated from Public Health England, which has become part of the Civil Service while within NHS England, the establishment of Area Teams and Clinical Commissioning Groups has been completed, and from 1 April 2013 the formation of Strategic Clinical Networks replaced the pre-existing various clinical networks.

A new medical education structure, the Local Education and Training Boards, and new research structure, the Academic Health Science Networks and Local Clinical Research Networks are being born, often co-terminous, and divided into around 15 regions in England.

Sir Bruce Keogh has launched the clinical senates, councils and assemblies and these groups will have many functions but will be involved in service reconfigurations, urgent care reviews, horizon scanning and the process of ‘derogation’, where trusts will not be allowed to supply services unless they can demonstrate compliance with certain requirements.

“Some of our members are involved in clinical leadership in these new organisations, but for many it is a bewildering new world in which we are all having to re-learn the rules of engagement” he said.

Speaking out

The Berwick report, following on from the exhaustive recommendations of the Francis report, gave all professionals in healthcare a practical approach to dealing with system failures highlighted in Mid Staffordshire, but obviously not exclusive to that area.

“It is important” he said, “that we reflect on the conclusions and help build systems which do not allow any repetition of the appalling standards of care which were highlighted in these reports.”

“It is our duty as doctors to evolve better systems and to speak out when we witness poor practice.”

The new Chief Inspector of Hospitals, Professor Sir Mike Richards, was leading the CQC to produce a more robust quality assurance framework system for our hospitals, and was committed to extending the patient focus and involvement in inspection.

“At the TUC conference, our Chief Executive Eddie Saville called on Mike Richards to take on a role ensuring that clinicians and others can speak out safely when necessary to preserve standards of patient care and I am pleased to report that Mike has agreed to take this on as an important part of his remit.”

John Schofield said that whistle blowing had proved a punitive, arduous and adversarial task for NHS staff, and HCSA members had often suffered serious consequences when raising legitimate concerns.

“We need to achieve an open culture, a willingness to hear constructive criticism and react accordingly to improve services, as advocated by Francis,” he said.

“Consultants and specialists need to be in the vanguard in promoting high standards of care, and must not fear persecution for identifying failings in the current system.”

Strengthening the HCSA

Urging the council to consider opening membership up to specialist registrars – consultants in waiting – he said that for the HCSA to prosper the association must tap into their enthusiasm and provide them with a reason to join.

“We currently offer membership to those within two years of CCT; but this has always seemed an arbitrary cut off.”

“With the rules revision currently underway, I urge you to consider whether we should open membership to all specialist registrars, preserving what we do well for existing consultant and specialists, but building a powerbase of young, spirited professionals who represent the consultants of the future.”

“After all, they are already specialists! Our plans to expand the number of regional officers, and their remit, will give us the capacity to provide support to those in the transition to consultant or senior specialist status.”

“The HCSA has a justifiably excellent reputation in representing members in difficulty, and this is one of the main reasons that many of our members join us. With the issue of revalidation looming for many consultants, this is an important area for us to become active in,” he said.

“My commitment to developing these aspects of our Association, and so we are currently in the process of recruiting two additional part time regional officers, allowing us to provide enhanced services to our members. These officers will also be able to help with recruitment and provide support to council members in furthering the aims of the Association. We hope to appoint a lead regional officer to help with the administration of this expanded cohort.”

John Schofield told council while the HCSA was some way from the goal to provide a focus in every hospital he was committed to finding a way to have a local representative in all hospitals.

“It does not seem to be impossible to achieve, I need to find out from you what it will take to get to this goal and together we can do this. It builds strength and resilience into the organisation, and allows us to support more members, so rather than an increase in membership per se, I have chosen this as my personal goal,” he said.

He continued: “We are a professional association first and foremost, but we are..."
also a union affiliated with the TUC. It is an important part of our heritage, and offers us one way to achieve more influence which benefits our members. At the same time, we need to seek other ways to exert influence by direct interaction with ministers, political parties and the Department of Health.”

“I am very pleased that we now have a probationary seat on the Staff Council, and that Eddie Saville has been re-elected to sit on the TUC General Council.”

“Alan Shrank would have been proud of this moment, and it marks an important step in the development of the HCSA”

Consultant contract

“As well as our attendance at the TUC conference this year, we were pleased to be invited to a meeting in January, hosted by the Health Minister which launched the discussion about a new consultant contract, looking particularly at seven day working and consultant remuneration including CEAs.

“We were able to voice our opinions based on a survey monkey poll which many of you participated in. This showed a high level of dissatisfaction with the current system, and a desire to move to better ways of working. Following this meeting, Heads of Terms for a new consultant contract were developed, and I hope we will have the opportunity to discuss these in greater detail later today.

“At a previous meeting we agreed our strategic goals as now laid out in the strategy document and published in The Hospital Consultant and Specialist. These enable us to re-invent and move the Association forward in the 21st century, whilst maintaining our core values and history.”

“I commend them to you and would add that the power of youth should not be underestimated, tempered with the necessity of experience.

John Schofield proclaimed HCSA was the doctors advocate with strength in solidarity, strength in purpose and strength in numbers.

“So, 65 years on, I think we need to re-invigorate the HCSA for the modern NHS. It is important that doctors stand together. This Association is good for doctors and good for the NHS, but most of all, good for patients. Long may it flourish.”

Dr Chris Khoo reports on the Competition Commission investigation

In November the Office of Fair Trading made a market investigation reference to the Competition Commission (CC) in April 2012 under the provisions of the Enterprise Act (2002) regarding the supply or acquisition of privately funded healthcare services in the UK “to decide whether any feature, or combination of features, of each relevant market prevents, restricts or distorts competition in connection with the supply or acquisition of any goods or services in the United Kingdom or a part of the United Kingdom”

Provisional Findings

The CC notified its provisional findings on 28 August. They found that, at a national level, both private hospital ownership and the provision of private medical insurance are highly concentrated. The five main hospital groups account for 70% of privately funded healthcare revenues in the UK, whilst the four largest Private Medical Insurers account for approximately 87% of UK insurance premium revenue, with the two largest alone accounting for 65%. The provision of consultant services is highly fragmented, and most consultants working on a stand-alone or small group basis.

In their study they proposed 7 “Theories of Harm” (ToH) including ToH4: a PMI may have buyer power over individual consultants, and ToH6: there may be information asymmetries and limited information available to patients (as well as GPs and possibly PMIs) and ToH7: there may be vertical linkages that lead to significant harm to competition.

They received many complaints about the conduct of the PMIs in their dealings with consultants (a high proportion relating to Bupa). Many were from consultants, but there were also many from policyholders. Trade bodies and some hospital operators supported these concerns. They found that the two largest PMIs at least, Bupa and AXA PPP, have buyer power in relation to consultants, but did not think this affected competition, for example, by leading to a shortage of consultants in private practice or to a reduction in innovation or quality of consultant services. They based this on an estimate of 22,000 consultants in private practice (page 253, para 7.5a).

Possible “Remedies”

The CC has also published a Notice of possible remedies on measures which could improve competition, including requiring operators to sell hospitals in areas where they derive significant market power from the ownership of local clusters: a ban on some incentive schemes; prevention of ‘tying or bundling’ when an operator might respond to a loss of business in one area by raising prices nationally; possible entry enhancing measures; and the provision of better information on prices and quality for patients.
Responses
In September 2013 private hospital operators, BMI Healthcare Limited (BMI), HCA International Limited (HCA) and Spire Healthcare Group (Spire) applied successfully to the Competition Appeal Tribunal (CAT) seeking judicial review of the CC’s interim statement, casting doubt on the validity of the process (with regard to the handling and use of confidential information).

In November, the Chief Executive of the Private Patients’ Forum, Don Grocott, wrote to the Competition Commission casting doubt on the validity of the figure of 22,000 consultants in private practice, as used by the CC to determine that the market is not under threat. He drew the CC’s attention to the National Audit Office Report (February 2013) “Managing NHS Consultants” whose surveys showed that in 2000, 16,349 consultants undertook private practice and in 2012 the figure was 15,754. However as the overall number of consultants has increased, the proportion of consultants in private practice has decreased from 67% in 2000 to 39% in 2012. The Western Provident Association’s figures accord with this; they have approximately 14,000 recognised consultant providers. The NAO states that 97% of NHS consultants are now on the 2003 contract, which has succeeded in the aim of focussing consultant activity within the NHS.

Professional Indemnity
A current survey of consultants has shown that there is now less incentive to enter or undertake private practice in the face of rising indemnity and administrative costs, and falling, contractually-imposed, PMI reimbursements. In responding to concerns about indemnity (page 253 para 7.5c) the CC acknowledges that the cost of obtaining professional indemnity can be significant.

“However, many consultants have small-scale private practices suggesting that the cost of professional indemnity insurance is not a significant barrier, since even small scale private practice appears to be viable.” This is not correct; small-scale private practice in specialties such as Obstetrics and Neurosurgery is not financially viable.

A recently appointed consultant’s response
A recently appointed consultant ophthalmologist had to agree terms and conditions and accept an imposed fee schedule in order to be recognised. These specified significantly lower reimbursements than for established consultants. He now has a majority self-pay practice, limited in general to non-BUPA patients.

He states that the restriction the large PMIs have imposed effectively restricts his working in the market, as their fee schedule does not adequately address his medical indemnity and administration costs. The imposition of a reduced-fee schedule disadvantages him compared with those already in the market, and this is anti-competitive. The schedule does not allow adequate margins for forward investment in innovative technology.

The PMI term “fee approved” suggests that those not approved are of low quality when approval is in fact based on low price. Therefore, imposed fee reductions for new consultants distort the market.

http://tinyurl.com/mts9geu

Established consultants
Established consultants are also affected. BUPA has reduced reimbursements for procedures by up to 60% and unilaterally introduced exclusions, and both of these impose shortfalls on subscribers.

FIFO concerns
The Federation of Independent Practitioner Organisations has made further representations to the CC, drawing attention to:

● BUPA’s threat to derecognise consultants on the sole basis of billing in top 10%
● Reminding the CC that it already recognises that derecognition by a majority PMI disrupts the whole of a consultant’s practice.
● PMIs, and especially BUPAs:
  – Interference in referral pathways and clinical management of patients
  – Unfair incentivisation
  – e.g. allowing partner premiums to perform outpatient diagnostic tests in private facilities and bill for them, while others have to refer to recognised hospitals.
  – Offering increased commission to intermediaries to sell specific policies (eg open referral schemes).

The consequences of derecognition of a hospital or hospital group, which affect all consultants with practicing privileges, whether or not they have been personally targeted, is an example of vertical influence (ToH 7).

Concerns and Consequences
● PMI market power over consultants will lead to uniform consultation and procedure prices, destroying competition in the market.
● The sustainability of independent consultant practice is threatened.
● Policyholders are suffering from the lack of transparency about their policies.
  – The CC said “companies like Bupa need to ensure that they communicate better with policyholders about what their premiums entitle them to.”
  – Currently, policyholders do not know what their PMIs reimburse for each procedure: if it is right that hospitals and consultants should provide clarity, PMIs should also do so.
● Policyholders should have the right to “top up” from the level of remuneration purchased to support choice.

CC Annotated Issues Statement, February 2013 “It is not evident to us that patients are disadvantaged by top-up fees if they know about them in advance and if this would allow them to choose the consultant they prefer. Allowing such fees might provide greater patient choice.”

Policyholders should have the right to portability: the ability to use their benefits with the clinician of choice, without being restricted to the PMI’s chosen provider.

FIFO is concerned that the private medical sector may be heading towards an irreversible market outcome unless the CC imposes remedies to ensure the proper function of the market.

Outcome
The Competition Commission is required to publish its final report by 3 April 2014, and consultation on previous work and the Provisional Findings Notification of 28 August 2013 closed in September 2013.

HCSA were among a group of organisations who jointly sent a letter to The Times following the interim report into the Competition Commission’s investigation into private healthcare.

The text of the letter and list of signatories is on the HCSA website
The secretary of state writes...

Jeremy Hunt’s message to NHS staff, 22 November 2013

This week was a major milestone for the NHS, with our final response to the Francis report. It comes on the back of a challenging year of unprecedented scrutiny and transparency. It has not been easy, but I am confident the result will be a profound change in culture that will make our NHS the safest health system in the world.

So I wanted to write personally to all NHS staff to explain some changes that I agonised over for a long time on the incredibly important issue of making it easier for you to speak out if you encounter poor care.

For the first time, there will be an explicit Professional Duty of Candour in both General Medical Council and Nursing and Midwifery Council regulations which makes it clear that if there is any avoidable, unintended or unexpected harm, doctors and nurses have a professional duty to tell the patient and their organisation (and doing so will give some protection if there is a subsequent professional misconduct case).

For all staff, I also need to make sure your bosses encourage rather than discourage you from speaking out if you become aware that any patient is not receiving the safe and compassionate care they deserve. So for the first time hospitals everywhere will have an incentive to report suspected harm quickly and openly, or risk losing some of their protection against successful litigation claims. Of course, I hope no hospital ever finds themselves in that situation, but I want Boards to send out a clear message to everyone: if in doubt, report it.

Another big change is something we have learned from the airline industry, where safety is paramount, and that is the need to report ‘near misses.’ These are occasions when no harm actually happened, but a mistake was made which meant it might have. It is as important to report near misses as it is actual harm because, as President Obama’s safety expert Professor Don Berwick says, every organisation must become a learning organisation when it comes to patient safety.

One of the most inspiring people I have met this year is Helene Donnelly, a nurse in A&E, who faced bullying and harassment when she spoke out about poor care at Mid Staffordshire. The whole of the NHS needs a culture of openness and transparency, whereby reporting and acting on problems becomes the norm and the need for whistle-blowers would vanish - but we have a long way to go to get to this. So all organisations should have systems in place for staff to report concerns anonymously if they do not want to tell their line manager.

Also remember that to support you in raising concerns, the Department of Health funds a free telephone helpline offering free, impartial and confidential advice to staff who wish to raise concerns, but are not sure how or what protections they have in law when they do. The helpline number is 08000 724 725.

Finally, I want to thank you for your efforts in the busy run up to winter. Last week I was on the frontline at the Acute Medical Unit at King’s (thanks to Vanessa and her team for looking after me so well - and Linda for showing me how to make an NHS bed to her high standards).

I was struck by two things: just how much pressure everyone is under in the run up to winter. And secondly how challenging it is for hard-working staff when problems in the NHS are hitting the headlines so frequently. Our NHS is doing nearly one million more operations every year on broadly the same budget. It is an incredible achievement - only possible because so many people are working so hard for patients. So let me finish with a big thank you again to everyone.

HCSA responds...

The HCSA has always supported the highest standards of patient care, and welcomes the Secretary of State’s response to the Francis Report on Stafford hospital. Patients and families had received appalling care: the official reports detailed between 400 and 1,200 unnecessary deaths between 2005 and 2009, receptionists made clinical decisions, and nurses failed to respond to basic needs. “Cruelty became the norm and no one noticed,” said Jeremy Hunt, the Health Secretary. “The NHS is a moral being or it is nothing.”

Government plans to improve NHS safety include:

- Removing indemnity cover from hospitals which mislead or conceal information (and being responsible for their own damages and costs, which currently cost the NHS litigation authority £1.2bn a year).
- NHS trusts will have to publish nursing staffing ratios in each ward, and will be subject to immediate CQC inspection if they fail to meet the guidelines.
- An explicit Professional Duty of Candour in both General Medical Council and Nursing and Midwifery Council regulations which make it a professional duty to tell the patient and their organisation if there is any avoidable, unintended or unexpected harm. Wilful malpractice will lead to a prison sentence.
- A return to the practice of having the name of the consultant, and now also the nurse, on every patient’s bed.
- Making “failed NHS Managers” subject to a new “fit and proper person” test before they are allowed to resume work.

The Secretary of State said that the speed with which health professionals admit to serious mistakes will be a mitigating factor in any conduct hearing into their behaviour.

The Royal College of Nursing’s safe ratio is one nurse to eight patients, but this ratio will not be mandatory, though the National Quality Board, working with the Chief Nursing Officer will advise on staffing ratios for safe and effective care. NICE (The National Institute for Health and Care Excellence) will also be involved, taking into consideration the size and specialty of the ward facility and patient factors, such as age and the need for care.

A separate report on patient safety in the NHS by Professor Don Berwick, a former US presidential adviser, recognised however that “fear is toxic to both safety and improvement. To address these issues the system must recognise with clarity and courage the need for wide systemic change and abandon blame as a tool and trust the goodwill and good intentions of the staff.”

The lessons from the airline industry are that whilst safety is paramount, it is a responsibility of the whole system, and is not best achieved by pinning the blame solely on individuals. The Foundation Trust Network has drawn attention to the balance recommended by Francis between learning and openness one hand and blame and recrimination on the other. “Medicine is a messy, difficult job to do” said Glenda Cooper, writing in the Telegraph the day after the Commons statement, and HCSA members are all part of a caring profession.

Hard pressed and dedicated carers willingly and effectively deliver the best care, but we do need to work within a caring and supportive environment to be able to achieve the ideals which drive us.
The introduction of shared parental leave
Time off for fathers and partners to
The creation of new rights to time off and
Better paid leave for adopters
The extension of the right to request

Spotlight on equality legislation
By Annette Mansell-Green
The Single Equality Act was introduced in 2010 giving us a strong and coherent piece of legislation that expanded previous protection from just covering sex, race and disability to prohibit age, gender reassignment, sexual orientation and religion or belief discrimination too. The Public Sector Equality Duty was introduced and the Equality and Human Rights Commission was established with stronger powers of investigation and a role in holding government to account.

The government appear to be intent on dismantling our equality infrastructure. Indeed the coalition government’s equality strategy Building a Fairer Britain states “The Government’s new approach to tackling inequality (is) one that moves away from treating people as groups or ‘equality strands’ and instead recognises that we are a nation of 62 million individuals.”

On April 25th 2013 the Enterprise and Regulatory Reform Act 2013 received royal assent and as a result the following equality legislation has been repealed:

Third Party Harassment Protection - this made an employer liable for repeated racist, sexist, homophobic or other prejudice-based harassment of staff by third parties like patients or patient’s relatives etc., where the employer failed to take reasonable steps to protect them.

The Government stated that there was no real need for this protection. The HCSA knows that this is far from the case and I am sure that many of you have personal knowledge of this happening either to yourselves or colleagues.

Statutory Discrimination Questionnaires - this allowed employees who believed that they have suffered discrimination to seek information from their employer.

This has proved to be an extremely useful and effective tool in avoiding full tribunal claims and facilitating early settlement of claims. Without sufficient information it is often impossible to prove discrimination so this is regarded as a move that will prevent many individuals from gaining access to real justice.

On 15 May 2012 the Home Secretary announced that there would be a wide ranging review of the Public Sector Equality Duty as part of the ‘Red Tape Challenge’. The general duty, which only came into force in April 2011, should “eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010. Advance equality of opportunity between people who share a protected characteristic and those who do not and foster good relations between people who share protected characteristics and those who do not.” There are also specific duties around the publication of information and objectives.

One of the main objectives of the review is to examine the effectiveness of the Duty taking into account the devolved administrations. It is difficult to see how meaningful this will be after less than two years of operation. It is clear that some of the fundamental aspects of the Duty are under threat which could again weaken the opportunities of people with currently protected characteristics.

The public sector equality duty has been significant in stopping or delaying cuts in public services where they have a disproportionate impact on vulnerable groups and in mainstreaming equality into decision making by public authorities.

A review of the role, duties and powers of the Equality and Human Rights Commission has seen their budget cut from £70 million in 2007 to core funding of only £17 million by 2015 with a 70% reduction in staff and the closure of regional offices.

These changes are significant and will have a substantial impact on individuals pursuing discrimination claims.

New rights for parents are due to be introduced via the Children and Families Bill 2013/14 which is currently at committee stage in the House of Lords. The main points of the Bill are:

- The introduction of shared parental leave and pay
- The creation of new rights to time off and pay for parents who have children via surrogacy
- Better paid leave for adopters
- Time off for fathers and partners to attend ante-natal appointments and time off for adopters to attend adoption appointments
- The extension of the right to request flexible working

The TUC along with other stakeholders are actively participating in all relevant consultations and where necessary active campaigns are taking place. The HCSA is playing a part in this work through its membership of the TUC General Council and participation in equality structures and consultation meetings.

It is vitally important that our member’s rights at work are protected and that we continue to ensure that all of our collective membership is treated fairly.

“The public sector equality duty has been significant in stopping or delaying cuts in public services”
Leading role

The Executive Committee of HCSA is the central committee of the ruling Council. Its main functions are the management of the business of the Association and the control and direction of the policy of the Association.

It consists of HCSA Council members elected by ballot at Council meetings and includes the elected national officers, the Chief Executive Officer and other elected members to ensure it, where possible, reflects a balanced representation of the various Constituencies and specialties of Members of the Association.

At the moment the Executive has two spaces that we would like to fill. The members of the committee at the moment include pathologists, radiologists, paediatricians, surgeons and anaesthetists. Most geographical constituencies of the UK are represented except for the North East, North West, Northern Ireland and Wales.

We would like to fill these spaces by ballot at the next Council of the HCSA on 12 April 2014 and would encourage nominations, including self-nomination, from any existing Council Member. Any Council member is eligible to stand from any area but in order to fill the aspirations of our association constitution we would particularly encourage nominations from other specialties and areas than already represented.

Executive has two subcommittees, Finance and Education and Standards. Meetings of Executive happen at least every two months. Our custom is to meet every month except August and December. Meetings are held on a Wednesday afternoon in central London, but move to a Thursday immediately before the two Council meetings each year. A very high attendance rate is essential although when necessary we facilitate teleconferencing when individuals cannot attend. Council members considering nomination should feel free to contact any of the existing executive members to discuss the role further.

Nominations must be received by 12 March 2014 by email or in writing to Sharon George, Business Manager, HCSA, 1 Kingsclere Road, Overton, Basingstoke, Hants, RG25 3JA (sgeorge@hcsa.com).

Ross Welch
Chair of Executive Committee

Bright innovations

Congratulations to Dr Kerri Jones who has been named as one of the top 50 brightest innovators in health by Health Service Journal (HSJ). The HSJ list recognises people whose contributions are making a tangible difference to patients, colleagues, the healthcare system or wider society and seeks to reflect the diversity of pioneering work and approaches across the healthcare system.

Dr Kerri Jones is consultant anaesthetist and associate medical director (innovation and improvement) at South Devon Healthcare Foundation Trust. She is the former national clinical adviser to the Department of Health Enhanced Recovery Programme, which focused on a new, evidence-based model of care that creates fitter patients who recover faster from major surgery.

The judging panel were impressed by her continuing improvement work in Torbay, which focuses on applying the model to non-surgical patients.

What the judges said: “A medic who does brilliant work locally. What she’s doing now is really innovative - she is taking enhanced recovery and applying it to medical patients. A local clinician delivering really good improvement work.”

The Executive Committee of the HCSA awarded Dr Tom Goodfellow, consultant radiologist at University Hospital of Coventry and Warwickshire, the ‘HCSA Medal for Outstanding Contribution’ to the Association.

Dr Umesh Udeshi made the presentation at the annual dinner and gave the short speech that follows:

Our colleague Tom Goodfellow served the HCSA and its members as County Chairman for ten years till 2012. He has an enviable track record of recruiting new members and helping colleagues in difficulty.

He was asked to chair the Education & Standards Committee in 2006 which he very ably did for 5 years. His success in that role was phenomenal. He led from the front and the committee tackled all the important issues of the day, deliberating on policy documents from a wide variety of sources including the GMC, the Department of Health, MTAS, Sir John Tooke, the NHS Employers and others too numerous to mention. He usually used his considerable writing talents to the great advantage of the HCSA in personally writing up the committee’s comments and deliberations in reports and responses.

Many of the documents that he wrote were accepted verbatim by the organisations they were submitted to and I remember the GMC lifted whole sections from our responses into one of their documents.

One of his major successes and of the HCSA was the HCSA response to the Tooke report which he crafted personally entitled “What’s in a name? The future role of the consultant”. This encapsulated our view of the future consultant career and has been used by many other bodies in their deliberations since. The Royal College of Obstetricians and Gynaecologists invited the HCSA to give evidence to their working party ‘Tomorrow’s Specialist’ based on that document.

More recently Tom has helped the Education & Standards Committee and the Executive and Council to update and re-write that document despite having finished his term of office as Chairman.

He also served on the Executive Committee for 6 years and his wise counsel was very valuable to us all.

* Note: Dr Goodfellow is the first doctor to receive the medal. This medal is awarded by the Executive to those who are deemed to have made an outstanding contribution to the HCSA. It is not a regular award and only made in exceptional circumstances.
Executive Committee

President Dr. John Schofield
Chairman of Executive Professor Ross Welch
Immediate Past President Dr. Umesh Udeshi
Honorary Treasurer Dr. Mukhlis Madlom
Honorary Secretary Mr. Gervase Dawidew
Honorary Secretary Dr. Bernhard Heidemann
Honorary Secretary Dr. Claudia Paoloni
Chairman – Ed & Stan S-C Prof. Amir Mohsen
Independent Healthcare Mr. Christopher Khoo

Education & Standards Sub-Committee
Acting Chairman - Dr. Bernard Heidemann
Dr. Mukhlis Madlom Dr. C Morgan
Mr. Olanrewaju Sorinola Dr. Bernhard Heidemann
Dr. Umesh Udeshi Dr. Bernard Chang
Dr. Hiten Mehta Dr. Christopher Welch
Dr. T Goodfellow Dr. S Aryanayagam

Finance Sub-Committee
Chairman Dr. M.M. Madlom Dr. C Morgan
Mr. M.J. Kelly [Trustee] Dr. U. Udeshi
Mr. R.M.D. Tranter [Trustee] Dr. J. Schofield
Dr. R. Loveday [Trustee] Professor R. Welch
Dr. B. Heidemann

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Specialist Registrar National Representative
Vacancy

Non-Consultant Career Grade National Representative
Mr Anthony Victor Babu Bathula, MS; DNB; FRCS; Dip Lap Surg; MBA (Health Executive) victorbabu@gmail.com

HCSA contacts

HCSA Christmas opening hours
- Monday December 23rd – office closes at noon
- Tuesday December 24th – office closed
- Wednesday December 25th – office closed
- Thursday December 26th – office closed
- Friday December 27th – office closed
- Monday December 30th – office closed but Advice Direct and Voicemail monitored
- Tuesday December 31st – office closed but Advice Direct and Voicemail monitored
- Wednesday January 1st – office closed
Join the association

Hospital Consultants & Specialists Association
Number One, Kingsclere Road, Overton, Basingstoke, Hampshire, RG25 3JA
Tel: 01256 771777 Fax: 01256 770999 e-mail: conspec@hcsa.com website: www.hcsa.com

Membership Application 2013/14

Title | Surname | Forenames
---|---|---
Male/Female | Qualifications | GMC No

Speciality | Year Qualified | Year of Birth
---|---|---

Main Hospital

Preferred Mailing Address

Post Code | E-Mail
---|---

Contact Telephone Number

Grade: Consultant | Associate Specialist | Specialist Registrar | Within two years of CCT | Staff Grade/Trust Speciality Doctor
---|---|---|---|---

Signature | Date

IMPORTANT Please Note
We are not normally in a position to provide personal representation over issues that have arisen prior to joining the HCSA.

Please DO NOT fax or e-mail this application form - we need an original signature on the Direct Debit Mandate for your bank to authorise payments.

Current Subscription Rates
Annual - £225 per annum commencing 1 October 2013 | (pro rata for first year of membership)
---|---
Monthly - £19.50 per month | Please tick preferred payment choice

Please complete the Direct Debit Mandate overleaf and send it to the Overton Office address above.

Introduced by ____________________________ (If applicable)
Instruction to your bank or building society to pay by Direct Debit

Please fill in the whole form using a ball point pen and send it to:

HCSA  
1 Kingsclere Road  
Oxton  
BASINGSTOKE  
Hampshire  
RG25 3JA

Service user number  
9 9 7 5 7 2

Payment Reference (To be completed by HCSA)

Instruction to your bank or building society

Please pay The Hospital Consultants and Specialists Association Direct Debits from the account detailed in this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with The Hospital Consultants and Specialists Association and, if so, details will be passed electronically to my bank/building society.

Name(s) of account holder(s)

Bank/building society account number

Branch sort code

Name and full postal address of your bank or building society

To: The Manager  
Bank/building society

Address

Postcode

Signature(s)

Date

Banks and building societies may not accept Direct Debit Instructions for some types of account

This guarantee should be detached and retained by the payer.

The Direct Debit Guarantee

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits.
- If there are any changes to the amount, date or frequency of your Direct Debit, The Hospital Consultants and Specialists Association will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request The Hospital Consultants and Specialists Association to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit, by The Hospital Consultants and Specialists Association or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society.
  - If you receive a refund you are not entitled to, you must pay it back when The Hospital Consultants and Specialists Association asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.