



HOSPITALS MANIFESTO 2017: **VIEW FROM THE WARDS**

A 2017 ELECTION MANIFESTO FOR 21ST CENTURY HOSPITAL
SERVICES & THE CLINICIANS DELIVERING THEM



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Much will be said and written about the NHS in coming weeks as we approach the 2017 General Election on 8th June.

This manifesto represents a call, from hospital doctors of all grades to every politician vying for a Westminster seat, to commit to common-sense policies on health services and the clinicians who deliver them.

Our current hospital workforce reports continuing low morale and high levels of stress and sickness.

Relentless pressures to meet targets and to squeeze more from the same or fewer members of staff threatens to have a disastrous outcome with an exodus of our most experienced hospital doctors into early retirement.

Illogical measures designed to cut costs in other parts of the

service have piled ever more pressure on hospitals.

Our hospital services are themselves underfunded and our hospital doctors are being stretched too thinly.

Yet we believe that as professionals we have a great deal to offer in delivering innovation and safeguards on our health services.

This manifesto reflects the belief that with proper long-term planning for funding, workforce matters and service structure, as well as a systematic focus on the well-being, workload and expertise of our clinical staff, health services need not suffer endless chaos.

Our message to politicians is: heed us, work with us, and in partnership we can build hospital services fit for the 21st century.

The Hospital Consultants & Specialists Association is calling for cross-party consensus on issues affecting hospital doctors and the hospitals where they work:

- 1. FUNDING** A HEALTH SERVICE FIT FOR FUTURE CHALLENGES
- 2. RETAINING** EXPERIENCED STAFF AND **RECRUITING** THE DOCTORS WE NEED
- 3. CARING** FOR THE CARERS TO DELIVER SAFE SERVICES
- 4. LONG-TERM PLANNING** FOR A STABLE 21ST CENTURY NHS





1.1 A national cross-party deal to agree a benchmark share of GDP to fund increases, from general taxation, for health and social care that reflects restructuring plans, projected demographic changes, and international standards within the OECD.

1.2 A review of the ongoing burden of private finance initiatives, which totals around £2bn a year, on hospital spending and procurement.

1.3 A reversal of social care funding reductions to reduce the pressure on the hospital network.

1.4 Reinstate control for public health and health education to NHS commissioners and restore funding as part of a concerted preventative approach to reduce pressures on our hospitals.



2.1 Guarantee the right to remain of essential NHS staff with EEA citizenship.

2.2 End the public-sector pay freeze and allow the pay review body true independence to establish salaries at a level it deems necessary to stabilise the NHS workforce.

2.3 Exempt NHS bodies from annual £1,000 penalty charges for hiring skilled non-EEA staff from abroad on Tier 2 visas.

1. **FUNDING** A HEALTH SERVICE FIT FOR FUTURE CHALLENGES

There is near consensus on both “sides of the fence” – employer and employee – that the current NHS funding settlement is insufficient. It remains well short of the additional £8 billion identified within the NHS Five Year Forward View – a figure itself based on never-before-seen efficiencies.

HCSA agrees with the Lords Committee on NHS Sustainability that it is possible with some accuracy to plan for the demographic demands facing the NHS.

A cross-party commitment to stabilise funding for the NHS as a proportion of GDP, from general taxation, tied to our call (point 4.1) to divorce health and social care planning from the electoral

cycle, would ease the sense of uncertainty and chaos affecting hospitals.

There has been too little focus on the multibillion-pound annual impact on health service budgets of PFI funding arrangements. Politicians must find the strength to revisit these deals.

Finally, downward funding for public health and social care have both a short and longer-term knock-on impact on front-line resources.

We believe that these cuts, in tandem with the transfer of public health responsibilities from the NHS to local authorities, are shortsighted, already impacting sexual health and weight-loss services, and must be reversed.

2. **RETAINING** EXPERIENCED STAFF AND **RECRUITING** THE DOCTORS WE NEED

HCSA sees current plans to increase training places for home-grown doctors as welcome, but our own research suggests that many experienced consultants are eyeing early retirement as stress levels rise across the service and real-term pay falls.

The issue of wages must be addressed, and by a properly independent pay review body.

Given existing vacancies

across the specialties, it is time to end uncertainty for thousands of EEA citizens working in our NHS with a guaranteed right to remain.

With around a quarter of existing specialist doctors also from non-EEA countries, the introduction of a Tier 2 visa penalty, which will cost NHS hospitals £1,000 per year per recruit, also appears perverse. The NHS should be exempt.

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3. CARING FOR THE CARERS TO DELIVER SAFE SERVICES

Within hospitals across England and in every speciality there are doctors working beyond their capacity to cover vacancies left unfilled.

Health Education England has published statistics showing that on average there is an 8 per cent shortfall in specialties across the country. That equates to 3,325 posts.

HCSA research shows that rising pressure to perform to targets in the face of ever tighter resources is one of the key drivers of stress and low morale amongst the clinical workforce.

We believe that it is time for a proper, systematic assessment of the vacancies that exist in our hospitals and for a national strategy, tied to longer-term funding, with the goal of ending this damaging and potentially unsafe unofficial policy.

But this is not the only area where pressures are building in the system to the detriment of consultants and training grades, as well as standards of care.

A nationwide squeeze on Supporting Professional Activities time – time used by consultants to administer training, and maintain their own professional development – has seen the

national full-time standard of 10 hours out of 40 rapidly eroded by local hospital management. In some cases senior doctors have seen this fall to merely two hours a week.

This squeeze will have damaging consequences for current and future care, so we believe that a national standard must be enforced within Trusts locally.

Elsewhere in the hospital grade structure, SAS, Associate Specialist, and equivalent doctors have great potential to widen and enhance their skills through professional development. However, the 2014 Charter adopted nationally has yet to make real headway locally. Trusts should now implement its terms.

Finally, HCSA believes that the relentless pursuit of safety requires full freedom to speak up for all grades of hospital doctor in word and deed.

The career-ending threat hanging over Doctors in Training who whistleblow, in particular over safety concerns, looks set to end, but only through court action.

Policy-makers should not wait to enshrine robust, career-length statutory rights that protect doctors in training who speak out on safety.

3.1 Establish a new national body, comprised of NHS employers, trade unions and Health Education England, working in partnership to: establish minimum staffing levels and ratios; create a short-term, medium and long-term national workforce strategy to achieve fully staffed hospitals, specifically targeting those Trusts “running on empty” by spreading existing staff thinner rather than recruiting; and underpin a new national patient safety strategy.

3.2 Compulsory national standards improving and protecting Supporting Professional Activities – continuing professional development – time to ensure that our hospital doctors can update their specialist skills and have the time to train the doctors of tomorrow.

STAFFING: RUNNING ON EMPTY

	Staff in post	Shortfall
Small specialties	508	13%
A&E	1,509	13%
Acute Take	4,087	10%
Pathology & Lab	1,917	10%
Psychiatry	3,963	8%
Cancer Services	4,724	8%
Ophthalmology	1,026	7%
Other Medicine	4,393	6%
Surgery	7,302	6%
Anaesthetics & ICM	6,533	5%
Obsterics & Gynaecology	2,069	4%
Paediatrics & Paed Cardio	2,977	4%
ALL	41,557	8%

Source: HEE, DDRB 45th Report 2017

3.3 Bring in measures to implement the SAS Charter across the NHS in order to support and extend the skills of SAS, Staff, Specialty and Associate Specialist doctors.

3.4 Robust statutory rights and protection for Doctors in Training who whistleblow, lasting for the full extent of their career.



4.1 Establish an independent Royal Commission with a brief to end the financial cycle of NHS “boom and bust” and issue a detailed plan for how health and social care planning and finance can be separated from the “short-termism” of the electoral cycle.

4.2 Enshrine a robust gatekeeper role for clinicians in processes of service planning/restructuring to serve as a watchdog to ensure that patient care is not sacrificed by bad decisions based solely on financial imperatives.

4.3 Set up a start and finish group with the goal of building a modern, flexible workplace environment, drawing up policy for application in NHS hospitals to ensure we offer and get the best from trained doctors of all ethnicities and genders, and those with family or other commitments.



4. LONG-TERM **PLANNING** FOR A STABLE 21ST CENTURY NHS

NHS hospital services and workforces are left bruised and buffeted by the peaks and troughs of policy-making and initiatives which are aligned with the financial and ideological priorities of any given political tide.

This means that services are undergoing constant, expensive upheaval yet are rarely able to reach an end destination before the current switches flow in another direction.

Alongside a national body to oversee strategic aspects of workforce planning, as set out in point 3.1, HCSA believes that an independent Royal Commission should be established with a brief to end the “boom and bust” cycle that is so damaging to morale and stability and ultimately impacts on patient care.

It should have the remit of giving recommendations on how to divorce health and social care planning and finance insofar as possible from the electoral cycle.

Passing these issues over to an independent body with “teeth” would protect NHS planning and budgets from unexpected changes of tack, helping to build a stable bedrock on which to deliver services.

Indeed there has been worrying evidence from

those managing the current Sustainability and Transformation Plans that service delivery is low down their list of priorities when drawing up the shape of a future NHS.

HCSA therefore sees it as essential in assessing any similar plan that clinicians have a gatekeeper role in service planning and restructuring to ensure that medical and patient need and common sense are not overlooked in the race for financial savings.

Finally, in order to build a truly 21st century NHS, it must change culturally – embracing demographic and social changes affecting all workplaces such as the need for part-time working, particularly women, and family-friendly provision.

It is a tragic misuse of resources when bright and able minds are unable or unwilling to step up to senior grades.

A task and finish group, including employer and trade union representatives, to investigate the causes and draw up policy for implementation in our hospitals would be an important step forward in building a modern, flexible workplace for doctors to advance based solely on ability.

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The **professional** association and
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