THE PENSION TRAP

WHAT YOU NEED TO KNOW… AND WHY THE TAPER MUST GO: P10-15

JOURNAL OF HCSA: THE PROFESSIONAL ASSOCIATION AND TRADE UNION FOR HOSPITAL DOCTORS
The piecemeal reduction of SPA time for Consultants is a symptom of the financial pressures faced by Trusts, but the long-term impact on medical staff, training and ultimately patient care is an unacceptable consequence.

The NHS at national level – aside from the honourable exception of Wales, where 3 SPAs forms the standard job plan – is making a disastrous error by turning a blind eye to this rampant erosion.

Part of the blame for the assault on SPA time lies in the 2003 Consultants Contract, where the wording accepted by the BMA stated only that the split "should typically" include an average of 7.5 PAs for direct clinical care and 2.5 PAs for SPAs.

We know that increasingly this split is far from typical. In fact, 1.5 or even 1.0 SPAs is the new norm. In some Trusts individual doctors are asked to bid for more than 1.0 SPAs against a list of "approved" activities. If they are unsuccessful then they must shoehorn everything necessary for GMC revalidation, general CPD, and teaching and basic service provision into a handful of hours. Ever greater statutory and mandatory training to meet governance targets place further pressure on non-clinical time.

Yet SPAs are a vital component of professional development, let alone the revalidation process, for which 1.5 SPAs is the baseline stated by the Academy of Medical Royal Colleges.

Less-than-full-time Consultants are often additionally penalised by having the core SPA pro-rated down further by Trusts, in direct opposition to the Consultants Contract and Academy of Royal Colleges recommendation, which is again in order to allow doctors to maintain revalidation requirements.

The Academy assessment on SPAs is extremely clear, stating: "A contract that includes only 1.5 SPAs and 8.5 Programmed Activities would have no time at all for other SPA work such as teaching, training, re-

When is a vacancy not a vacancy? Unfortunately, there’s no witty punchline here.

The truth is we do not know the real scale of rota gaps in our hospitals and community teams. The 10 per cent published rate, and much worse in certain specialties, is undoubtedly the tip of the iceberg: a point confirmed by HCSA members.

Vacancies are being hidden from view both because of the way in which they are measured – through job adverts – and through the systematic exploitation by many Trusts and the NHS nationally of staff goodwill.

We know that for HCSA members and
search, service development, clinical governance, contribution to management etc.

“It is unthinkable that a consultant could be employed with absolutely no involvement in management, if only attendance at departmental meetings, reading and responding to messages from management etc. Similarly, it is difficult to envisage a post that never involves any teaching or training of any sort.

“A post that does not permit any involvement in service development or clinical governance would be contrary to our concept of the consultant role. From this it follows that 1.5 SPAs in total would be inadequate and that the original recommendation in the Consultant Contract of 2.5 SPAs as typical seems reasonable.”

How deceitful it then is for NHS Improvement to state in job planning guidance to Trusts that the AMRC calls for 1 to 1.5 SPAs for revalidation – a grand lie made worse in an accompanying bullet-point list of “core activities” covered by this basic allocation, several of which the Academy explicitly says cannot feasibly be included.

The annualisation of contracts and the introduction of inadequate e-job planning tools such as Allocate inject a touch of the bizarre, with some members reporting fractions of time earmarked for supportive or learning activities squeezed into their working patterns – sometimes barely enough to log in to a computer and gather one’s thoughts. Many doctors now carry out vital activities in their own time.

The squeeze on SPAs is yet another example of professionalism, and the quality of care, being sacrificed in the scramble to plug rota gaps and meet financial targets.

Hospital doctors as a profession have both an individual and a collective responsibility to push back against this virulent trend. At a local level this means working as individuals and collectively in teams to diarise the work that is being done outside of the allocated time – and what is not being done at all. HCSA nationally continues to press for increased SPA time.

We want to see national standards implemented, and the NHS Improvement guidelines rewritten to reflect the need for 2.5 SPAs as core.

The aspirations of the Long-Term Plan, if they are to have any chance of succeeding, will only be met through the increased involvement of medical staff in service design. That requires SPA time. We shall be making this point loud and clear.

their colleagues, shortages of medical and support staff represent the biggest barrier to delivering patient care.

A number of factors are now threatening to bring this house of cards tumbling down. The pensions system crisis is driving hospital Consultants to drop PAs or additional shifts. Even putting the pensions situation to one side, years of pay restraint at a national level and HR policies which undermine the profession’s morale and wellbeing mean there is little left in the goodwill pot, and increasing numbers wish to go less than full time, cut back their PAs to a core 10, or simply leave.

We are seeing an NHS running on empty, and a government and in particu-
In Brief

ALL EYES ON MAJOR PUBLIC PENSION RULING

HCSA is watching closely court cases brought by the Fire Brigades Union and judges over the fairness of their 2015 pension schemes.

The government has announced its intention to appeal a Court ruling that the scheme, in particular transition arrangements for some older members, was discriminatory on the grounds of age, race and equal pay in relation to changes to their pension.

Only when the legal process is exhausted will the impact on this and all other public sector schemes, including the NHS scheme, become clear, although the government has estimated that a remedy could cost up to £4 billion extra per year.

CHEERS AT QUEEN VIC AS HCSA SEALS RECOGNITION

Doctors in the South-East received a boost recently when Queen Victoria Hospital East Grinstead became the latest Trust to formally recognise HCSA to negotiate collectively on behalf of local members.

National Officer Stuart Denness said it was a moment of "empowerment" for doctors in HCSA.

"Being locally recognised means being able to represent members in the LNC arena, which acts as the collective voice in the workplace and is where positions on doctors’ terms and conditions are agreed," he said. "It remains vitally important to win new members to HCSA in order to obtain local recognition at all NHS Trusts."

Forum aims to place members in driving seat

East Midlands negotiators unite to champion best conditions

East Midlands doctors are joining forces for the launch of a new HCSA forum aimed at raising workplace standards across the region.

Specially trained local negotiators will meet at the inaugural event in a part of England where the Association continues to go from strength to strength.

In the past two years the Association has won collective negotiating rights for members at University Hospitals Leicester, Northamptonshire General, Derby and Burton, Sherwood Forest and Nottingham University Trusts.

The new forum aims to share the best policies for doctors in the region, East Midlands HCSA National Officer Andrew Jordan explains.

"Human resources departments share their policy ideas with each other all the time, some of which are detrimental to doctors. Our aim is to do the same, but from the hospital doctors’ perspective," he says.

"We are trying to make sure that we have the best policies and practices in place. The new forum will enable our workplace negotiators to pursue evidenced local policies which implement best practice from our staff-side point of view.

"On a wide range of policy areas – whether that be leave, job planning, or CEAs – we want to promote consistent good-quality practices across the region, rather than it being one-way traffic at management’s behest."

HCSA, working in partnership with the BMA, is pursuing various issues on behalf of members at East Midlands Trusts, including plans for a regional locum pay cap and aiding recruitment and retention to SAS grades by putting annual leave rights on a par with Consultants.

Andrew explains that, wherever possible, HCSA adopts a constructive approach.

"This is not about us being diametrically opposed to management, it is us trying to promote the best policies that work for staff – to ensure policies function rather than adopting proposals that look good on paper but don’t work in practice," he says.

"It means HCSA negotiators will be able to tell them: ‘If you do this you are making a mistake, you’re not where other local Trusts are on this’."
Pressure for reform grows amid doctor pension crisis

HCSA mounts lobbying campaign with call for Treasury to scrap damaging ‘taper’

CSA has issued a call for urgent reform of the pension taxation system to avert a growing crisis in NHS care.

The impact of the UK’s tortuous pensions tax regime on hospital doctors has been laid bare in recent months as HCSA, employers and other medical organisations highlight the damaging implications for staffing and patient care.

A rising tide of evidence has ensured that the issue is being raised in Parliament by a cross-section of MPs. A Westminster Hall debate led by Paul Masterton MP, who cited HCSA data on the damaging impact, forced Health Minister Jackie Doyle-Price to concede that the issue was “driving behaviour within the NHS in a way that could potentially cause us difficulties in terms of delivering our overall commitments.”

Thousands more medics are expected to receive unexpected tax bills this year as a result of the complex system of tapers and thresholds which has a particularly harsh impact on public-sector defined benefit schemes.

Amid a growing climate of fear and confusion within the profession, leading many hospital doctors to cut back on additional clinics or eyeing early retirement, HCSA continues to campaign for Treasury action in the run-up to the significant Spending Review expected this autumn.

HCSA Pensions subgroup chair Dr John West warned: “The impenetrable pension tax reforms of tapers, triggers and annual allowances mean that hospital doctors are playing a game of financial Russian roulette where taking an extra shift to meet the healthcare needs of patients and employers could land them with an unexpected tax bill in the tens of thousands at the year’s end.

“The predictable result is that more and more doctors are avoiding the stress, risk and confusion altogether by adopting a cautious approach. We know that for some, this is the final straw that is pushing them to leave the service.”

The Association has organised meetings with senior politicians to press the issue and has written to the Treasury Select Committee to ask it to mount an inquiry into the impact of the “taper” on NHS staff and other public-sector workers.

As well as continuing to lobby politicians, the Treasury and employers, the Association has established as a top priority the need to ensure a greater awareness around the issues involved – and to ensure that people do not needlessly fear or fall into “the pensions trap”.

MORE ON PAGES 10-15 ➔

New leadership team takes reins

A new all-woman leadership team took the reins at HCSA following their endorsement at Spring Council and AGM.

New President Consultant Anaesthetist Dr Claudia Paoloni (pictured, left), who contributes her first column in this edition, is joined by Chair Dr Cindy Horst (right) for three-year terms.

Both had previously served lengthy periods on the Executive, most recently as Chair and Honorary Secretary respectively.

Three new Executive members were also co-opted from among the Council in recognition of new responsibilities facing HCSA.

The appointment of Junior Doctor Emma Cox, Dr Harish Parmar, and Dr Mukesh Chugh was welcomed at the event in Bristol.

Praise for pay probe progress

HCSA President Dr Claudia Paoloni has praised the Gender Pay Gap in Medicine review for “not just acknowledging the problem but investigating practical ways to implement real change.”

Dr Paoloni was speaking after the release of interim findings from the review, led by Professor Jane Dacre. HCSA is one of the core stakeholders taking part alongside the Medical Women’s Federation and British Medical Federation.

The headline gender pay gap figure revealed by the initial phase of research is 17 per cent – meaning male medics earn £1.17 for every £1 earned by women. The causes for this are complex and relate in part to variations between male and female-dominated specialisms and access to training and progression as a result of parenthood.

Prof Dacre said the review aimed to help “identify and understand the main contributors to the gap, and to explore ways to reduce it.”
HCSA lodges 5.1% call to ‘be bold’

Association delegation warns DDRB review body vacancies, morale and retention risk stability of NHS services

CSA has urged a minimum 5.1 per cent pay rise for all grades and sent a firm message that professional confidence in the DDRB review body is at rock bottom.

In an oral session in March, interim Chief Executive Joe Chattin urged the DDRB to "be bold" in both their recommendations and in standing up for them after last year’s decision by the Westminster government to ignore their findings.

HCSA’s stance was based on member research which revealed a majority of members still believe the DDRB has an important role to play.

Nearly 1,000 members responded to our call for detailed information and views.

Evidence from HCSA members was revealing, with the top barriers to their ability to carry out their job identified as lack of investment in services (over 50%), availability of beds (45%), lack of medical staff (43%), and lack of support staff (41%).

One in five respondents had made definite plans to leave the NHS earlier than previously expected, with one member summing up the current level of morale thus: "Show me the exit and I’ll take it. Been a consultant for 17.5 years and not planning to stay a day longer than I have to."

The Association warned the DDRB: "Taken together, the results produce an extremely concerning picture of low morale, which in turn is resulting in counter-productive outcomes around the motivation to work additional hours, career intentions, and herald an ever-worsening workforce vacancy crisis, with a knock-on impact on productivity, finances and continuity of NHS services."

"There is a pressing urgency across all grades not just to tread water in terms of remuneration but to actively reverse the damaging impact of real-terms pay decline and pensions taxation changes over the past 10 years."

A doctor was robbed at knifepoint in The Royal Oldham Hospital car park in March in a terrifying attack, adding to a string of reports raising questions over the safety of grounds after dark.

The robbery – the third of its kind at the hospital – prompted management to increase security patrols.

However, the Royal Oldham is not alone. In Nottingham, junior doctors working late shifts have reported safety concerns after a prowler was reported to have leapt out and confronted one medic.

Similar reports and fears have been echoed at hospitals across the winter months over poor lighting, remote parking spaces, or lack of security staff.

While the evenings are now longer and lighter, HCSA is still urging members to raise any concerns they have on the issue with their Hospital Representative or National Officer.

Some sites have already adopted a progressive attitude towards safety. Steps taken include ensuring that those finishing shifts after dark or in the early morning have parking spaces reserved near to the main building.

Other sites have laid on extra security personnel, escorts, or improved CCTV and lighting.

If you or your colleagues have any concerns over hospital grounds safety, HCSA’s team of National Officers are here to help.

The local landscape has become a crucial battleground on terms and conditions with national standards often in the firing line for Trusts seeking to squeeze budgets.

One person who understands the ongoing struggles at a local level is Dr Bernie Borgstein, a Consultant paediatrician and LNC co-chair at Imperial College Healthcare Trust. CEA, rota gaps, and catering facilities are all near the top of the agenda.

HCSA has been recognised by the Trust for the past two years to negotiate on behalf of members’ collective interests. Dr Borgstein says the Trust has been positive about HCSA involvement, while on areas of disagreement “the support of the union is absolutely crucial.”

Robbery puts car park safety in spotlight

The Trust is more responsive to a co-ordinated approach from us together with the unions rather than to individual approaches,” she explains.

Successes have included negotiating for the abandonment of plans for doctors with higher CEA awards to reapply, but other areas such as the approach to rota gaps and the implementation of a new acting down policy have been harder nuts to crack. Art of the challenge lies in getting managers to acknowledge "significant and dangerous" gaps, Dr Borgstein says.

The Association has supported the Junior Doctor Forum with sponsorship, and has worked with JD reps for action.

‘Support of the
HCSA also reiterated its call for an early retirement task force involving the NHS, Department of Health and Social Care, and medical unions to "explore and seek better evidence around early retirement."

Our other key recommendations included the promotion of 2.5 SPAs as standard in order to boost clinical productivity and innovation against the backdrop of the NHS Long-Term Plan, amid evidence that the new norm is now well below that figure.

HCSA also urged the establishment of a review into possible barriers to progression facing black and minority ethnic medical staff, modelled on the Dacre Gender Pay Gap Review.

The DDRB is scheduled to finalise its report in May, with the publication date – and response – then in the hands of the Department of Health and Social Care and national governments.

HCSA's full submission is available via www.hcsa.com.

Keen golfers are being sought to swing their clubs in a revived HCSA Golf Tournament which will take place near Coventry in late summer.

The contest has restarted after an eight-year break, with players vying for The Stephen Charkham Trophy.

Stephen Charkham joined HCSA in 1974 and became its Chief Executive in 1988. He retired in July 1999 and passed away two months later.

His wife Anne donated the Trophy and the first tournament took place in 2001.

HCSA past president and Fellow Dr John Chandy explained that the aim is to widen knowledge of the Association: "Fellows, staff, active and retired members are encouraged to attend and to bring a guest non-member."

The golf tournament will take place on Sunday 1st September 2019, starting at 1.30pm, at Coventry Golf Club, St Martins Road, Finham, Coventry CV3 6RJ. A Premier Inn (Postcode: CV3 6VB) is available close to the course for those who wish to stay overnight.

The cost per person for 18 holes of golf and a two-course meal is £40 – application form on page 22.

PLAYERS SOUGHT FOR REVIVED GOLF CONTEST

HCSA is helping hospital doctors in a bid to secure a satisfactory outcome at Dudley Group NHS Foundation Trust over complaints of systemic bullying and mismanagement.

The issue came to light after Consultants wrote an anonymous letter voicing no confidence in the regime.

However a long-awaited report into the matter by management lawyers Capsticks has not yet materialised, while a summary in March exonerated the Trust.

HCSA National Officer Rob Quick has branded the report a “whitewash”, and the Association plans to seek a fully independent inquiry into the complaints.

DUDLEY TRUST REVIEW BRANDED ‘WHITENESS’
Members and non-members alike came together for HCSA’s 70th anniversary conference Hospital Doctors: What Does the Future Hold? in October to discuss the many issues facing the profession and hear expert speakers give their view.

Interim Chief Executive Joe Chattin updated delegates on the latest developments in long-running consultant contract talks, while a panel of speakers discussed the implications for hospital doctors on medical gross negligence manslaughter — including hearing from Dr Cicely Cunningham (right), an HCSA member who is Doctors Association UK lead on their #LearnNotBlame campaign.

Further sessions focused on the challenges facing doctors in the realms of IT and a presentation of the in-depth findings of a joint study between Dr Kevin Teoh and Dr Atir Khan into the links between consultant burnout, lack of autonomy and workplace stress.

HCSA’s team of National Officers led breakout sessions on a range of areas.

Trades Union Congress deputy general secretary Paul Nowak also delivered anniversary greetings, underlining the importance of HCSA’s affiliation to the umbrella organisation.

70th anniversary conference puts down marker for the future

The less than glorious history of NHS IT and computer systems has created an epic and battle-scarred landscape, claiming the heads of commissioners, beggars and knaves alike (or external consultants and contractors, as the latter two are better known), writes Richard Bagley.

It feels like not a week goes by without a fresh call from the Secretary of State urging the NHS to enter the 21st century, get “app-ified” — or at least to use emails rather than faxes.

The scale and depth of the problem was underlined when news of the latest apparent white elephant hit the headlines in April, the Care Quality Commission pulling out of a project to link 12,000 computers across five organisations. It launched a stinging broadside at a host of failures as it left.

But if the national bodies can’t manage to pull their systems together, let alone Trusts and the myriad NHS organisations locally, where does that leave the foot soldiers — the front-line clinical staff.

To Dr Kit Latham, a junior doctor whose experience of dire NHS IT systems has created an obsession with making things better for medics, it’s not just important for hospital doctors to take back control, it’s essential. And we should be demanding it.

“Around 43 per cent of all clinical time is spent on what’s called non-productive data entry — something that ‘doesn’t move the story forward’ for the patient but is either the inputting of data or the copying of it from one place to another,” he says.

“This also includes the time spent logging in, and the time spent waiting for a computer. This is a shocking statistic.”

Doctors across the land will
It’s time for we doctors to control our IT destiny

Dr Kit Latham sets out the case for medics to halt the technology train and jump on

be familiar with having to use multiple disconnected systems to carry out their clinical work. But Dr Latham explains the facts which underline why a new system is no silver bullet.

“A fairly robust finding, from both here and America, is that when implemented electronic patient records typically, but also prescribing systems, will slow doctors down. And not by a small amount, by about 30 per cent typically,” he says.

“It’s known as the productivity paradox of digital health – this is increasingly recognised as a very important issue.”

Dr Latham believes doctors themselves are key to winning the battle against poorly designed technology, which is part of the reason he co-founded the Doctors’ Digital Collective with likeminded colleagues across the UK. He is also CEO of DrFocused, a software company which aims to bring the experiences and views of frontline medics to the fore in technical developments. And he is scathing about the tone of some of the companies pitching to build clinical systems.

“When people talk about health technology in the media, this is a common refrain: ‘All of the problems in the health system can be solved if we just… if we just…’. That healthcare can be solved if only we can get rid of those pesky clinicians and replace them with this technological utopia.”

He cites one such advocate of health tech, who suggested “A lot of money is wasted on manpower.”

Dr Latham says: “Now to me, money that is spent on manpower in the health system is the opposite of waste, particularly when it’s spent on clinical care.”

The challenge is to devise technology that removes barriers to care. And, according to US research, failure to do so doesn’t just slow medics down, it makes them ill.

Dr Latham cites the work of Robert Wachter, who conducted a 2011 UK government review into technology in the healthcare system.

Wachter has written “about the increased levels of doctor burnout that are seen in the US that are directly attributed to the electronic patient records that doctors have to use,” Dr Latham says.

Wachter refers to a scenario familiar to many doctors: “Windows 95-style screens, drop-down menus, data input by typing, and navigation by point and click.”

“These antiquated user interfaces are astonishingly difficult to navigate, clinical information vital for care decisions is sometimes entombed dozens of clicks beneath user-facing pages of the patient’s chart.”

Dr Latham says: “It’s completely obscene all that time that is wasted in a massively resource-strapped healthcare system. We can get that back if we improve the user experience for doctors.

“Too much has happened to us and not with us as clinicians. If we want to be more in control of the tools that we use, we should demand that we are more in control of the tools that we use.”

So how can doctors follow through on his call to “take back control”?

“My advice to doctors would be that the person who is the Chief Clinical Information Officer in your Trust needs to be you, or you need to be encouraging them to look at the massive benefits that can be had by freeing up all that wasted clinical time,” he says.

But it doesn’t stop there. The use of technology “that increasingly determine the way that we practise as doctors” must also be confronted head on, Dr Latham argues. “Things like how our rotas are administered, which determine how much annual leave we have or how frequently we can take it. Things like how our jobs are apportioned.

“There are off-the-shelf packages that can be used for rostering. The problem is, not many of them can accommodate the complexities of the various contracts with hard and soft constraints in them.

“Rostering is something we need to get right, and something that unions need to have a really big hand in.”
Hospital doctors’ pensions have hit the headlines since the start of the year with a growing body of evidence underlining the damaging impact on care of the current tax regime.

Suddenly, hospital doctors, senior nurses and NHS managers are finding they face a big financial issue over the withdrawal of tax relief on their pension contributions. It is impacting on the health service because the extra taxation charges act as a deterrent to taking on more work for fear of falling into a pension trap – becoming entangled in the complex web of thresholds and tapering that accompany the annual allowance and which make work effectively unpaid or even loss-making.

HCSA has described this as Russian roulette, and it is delivery of effective patient care and the NHS who are the ultimate victims.

The Association has received a constant stream of reports from aggrieved members who have received unexpected hefty tax bills, often triggered by additional management duties or having worked extra shifts to help hospitals meet patient care needs.

This situation is clearly unsustainable – in terms of the choices which hospital doctors are being forced to make about work in a strained NHS system, and in terms of the knock-on impact on patient care.

Although HCSA as a doctors’ trade union is unable to give individual financial advice, that does not stop us from taking a firm position on the current situation facing our members.

Key problem areas include:
- The “cliff edge” of the £110,000 “threshold income,” which is seeing doctors facing unexpected bills after, for instance, taking on extra non-pensionable shifts to assist employers
- The similar perverse impact of a normal annual incremental pay step, taking a promotion, career progression, working more PAs or additional responsibilities
- The way additional pensionable pay within a tax year impacts on the calculation of a hospital doctors’ “pension input amount”, which can trigger sizeable tax bills for breaching annual allowances
- The difficulty of predicting a breach of any thresholds until after the event: leading many hospital doctors to adopt an extra cautious approach to agreeing to additional shifts
- The pension lifetime allowance ceiling, which among other factors is causing some more experienced hospital doctors, and senior NHS managers, to consider the exit.

All of this has created a rapidly unfolding crisis which, while NHS Employers, politicians, and member organisations are raising the alarm, the Treasury seems content to allow unabated.

One limited measure has been taken to alleviate the problem of surprise tax bills, most notably the extension of “scheme pays,” whereby, if asked, the NHS Pension scheme will pay the costs, with an interest charge, of tax bills triggered across the three schemes – 1995, 2008 and 2015.

To date, this is the sole move on the issue, but many doctors are reluctant to take it up – perhaps because the interest on “scheme pays” appears high and will reduce a doctors’ eventual pension. Certainly the advice of an independent expert in NHS pensions is required to assess whether it would be the best path.

In the political arena HCSA is pressing the Treasury Select Committee to mount an investigation into the disastrous impact of the taper for NHS doctors. We are also engaging with a range of parliamentarians, including providing briefings for a recent Westminster Hall debate secured by Paul Masterton MP, and individual journalists, to ensure that the issue is highlighted in Westminster, and uncover the depths of the problems the NHS pension trap is causing.
Specialist knowledge and experience to help medical professionals...

We are independent financial advisers with the specialist knowledge and experience to help medical professionals with their complex financial needs and circumstances – from calculating a tapered annual allowance to protecting against a lifetime allowance tax charge.

Whether or not you are part of the NHS pension scheme, we can help you plan for retirement. We can forecast how much money you’ll need to achieve your retirement goals, and whether you’re on track. If there is a shortfall, we could recommend other ways to get back on track – from postponing retirement a few years to making additional savings in a personal pension or creating an investment strategy that puts your money to work for you.

We help many medical professionals to structure their finances tax-efficiently and take advantage of all of the available tax allowances. This could include simple options such as paying into an ISA and making the most of a spouse’s tax allowances, or more complex tax-efficient investments. We also specialise in helping medical professionals manage NHS pension tax charges.
DO I NEED TO WORRY?
You may be affected by the taper if your “threshold income” in a given tax year is more than £110,000.
You will not be affected by the taper at all if it is less than £110,000.
But, even if you are unaffected by the taper, if your pensionable earnings have increased or you have bought additional years for your pension, this may in turn increase the “pension input amount” used to calculate your annual allowance liabilities. This could leave you facing a tax bill if the value between the start and end of the year across your pension schemes has risen by more than £40,000.

WHAT IS ‘THRESHOLD INCOME’?
To establish it, you need to work out your “net income” – your taxable income from all sources less certain tax reliefs (not Gift Aid, however).

WHAT IS ‘ADJUSTED INCOME’?
For NHS hospital doctors, this is where complications really start, and the advice of an NHS Pension specialist may be required.
If you breach the £110,000 “threshold income”, the “adjusted income” is used to determine whether your annual allowance will be tapered.
It is calculated by totalling your “net income” (see above), the pensions input amount (the “paper” growth of your pension schemes over the year), and a few other elements.
One complication hospital doctors will face is calculating their pension input amount, which is not the amount paid in as shown on your payslip.
It is based on the paper growth, which for the NHS Pension scheme is via a formula linked to your pensionable salary.
An extra pay point or promotion, for instance, can result in surprisingly large growth – pushing “adjusted income” over the £150,000 threshold for the tax taper.

NAVIGATING THE MAZE

Will your ‘threshold income’ this tax year be over £110,000?

Will your ‘adjusted income’ this tax year be over £150,000?

Have you received a pensionable salary rise this year?

You may be at higher risk of a bill for breaching £40k Annual Allowance

Your Annual Allowance will be subject to the tax taper and you risk a bill

There is no doubt that amongst all coffee room conversation topics the taxation of pension contributions is one of the most commonly discussed amongst hospital consultants.

The topic is so complex that even financial professionals struggle with it. Accountants often have a very limited understanding and will exclude any pensions advice. As a result, coffee room talk often leaves Consultants more confused and in some cases has resulted in rash decisions. Trainee doctors too are beginning to wonder about the best way to build their pension.

HCSA is not able to give financial advice and cannot assist with individual queries. We are, though, concerned by the lack of easily digestible information available.
The three big words in pension taxation are lifetime allowance, annual allowance and tapered annual allowance. This article...
Dr Bernhard Heidemann breaks down some of the pension system complexities

concentrates on the latter two.

**THE ANNUAL ALLOWANCE**
The annual allowance (AA) is the amount of pension contributions, called the pension input amount (PIA), on which you are allowed to claim tax relief. This is set at £40,000 per annum. If the PIA exceeds this amount it then becomes your duty to declare this to HMRC and pay any tax recovery charge associated. However, this is not necessarily a straightforward calculation.

Part of the challenge lies in the way hospital doctors’ PIA is calculated: it is not a simple case of taking your monetary contributions, but relates to the notional “increase” in your pension between the start and end of the tax year. This can cause particular problems for doctors whose pensionable income increases during the year, whether due to a promotion, pay progression or an increase in hours.

At this point “carry forward” can provide some breathing room, but involves some complex calculations. Carry forward means that you are allowed to use any unused annual allowance from the preceding three years to reduce your tax liability in the current year.

**THE TAPER**
The next – and perhaps most notorious – level of complexity is the so-called taper. For every £2 of income above £150,000 per annum, your annual allowance will be reduced by £1, from £40,000 down to a floor of £10,000. This floor is hit if your total income is £210,000 or greater. Complicating this further is the way in which your net income is calculated. A common misconception is that only your pensionable income is used in this calculation when in fact all of your taxable income is used, including private earnings, dividends, interest etc.

As long as this is below the threshold income of £110,000, you will not be subject to a tapered annual allowance. But if you exceed £110,000, “adjusted income” will be calculated which consists of your total taxable income plus your PIA. If your adjusted income is above £150,000 then the taper is triggered.

It is this complex maze which is now causing so much trouble for hospital doctors, and impacting on patient care. If you think you are affected by this or are unsure, you should seek assistance from a financial advisor with specialist knowledge in this area.

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**Have you increased your hours?**

- **NO**

**Have you purchased additional years for your pension?**

- **NO**

**“Pension input amount” from all sources less than £40k? If so, all clear**

Will NHS Pensions tell me if they think I’ve breached the annual allowance limit?

They will send a pensions savings statement if they calculate that a scheme member’s “pension input amount” breaches the standard £40,000 annual allowance (if your allowance is tapered then you may not receive an automatic statement at all). They say this will be dispatched by 6th October following the relevant tax year provided the necessary information has been received from employers by 6th July. If it is not, then they say a pensions savings statement will be dispatched three months after receipt of the necessary information. If you have other retirement savings this will of course not provide a full picture.

Is there a deadline for electing for ‘scheme pays’?

Yes – and unfortunately it is 31st July – so you would need to notify NHS Pensions that you wish to activate the facility prior to having a final statement of your tax liabilities.

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**The topic is so complex that even financial professionals struggle with it**
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The bottom line is that there is currently a culture of fear within the profession and a dearth of information for worried doctors. And ultimately it is patient care that suffers.

Some doctors have taken the matter into their own hands by pulling out of the NHS scheme, changing their working patterns or exiting the profession altogether. Withdrawal from the scheme has its own risks: not least the removal of partner pension rights and the life assurance and death-in-service benefits.

To avoid this some doctors are dipping in and out of the NHS Pension scheme in what has been termed the "hokey cokey".

In places medical staff have negotiated individual deals with Trusts by which they are paid in lieu of pension contributions – again a step which should not be sought without expert personalised advice.

All in, the situation is nothing short of chaos.

Ultimately, the root cause is the Treasury’s tortuous method of reducing tax relief for high earners. While it is unlikely that it will loosen its grip on the value of this tax pot, a growing alliance, of which HCSA is part, is arguing for reform, in the first instance the abolition of the taper. This would strip out one element of the current pensions trap.

Other public-sector pension schemes have adopted different mechanisms which, if adopted for hospital doctors, would return a modicum of individual choice.

Members of the Universities Superannuation Scheme, for instance, are allowed to specify the earnings they wish to see pensionable – with no impact on lump sum death benefits. Such a mechanism would be beneficial to many doctors in removing the tax "cliff edge".

There is also a strong case for a better service and swifter information from NHS Pensions, and urgency from Trusts, to provide the information required to supply pension value statements in good time.

At the end of the day, given its reliance on hospital doctors working extra shifts to paper over the vacancy gaps, it makes no sense for the NHS to maintain a system which effectively incentivises reductions in workload – a fact not lost on NHS Employers and the Department of Health and Social Care.

That is why pressure for change needs to continue on every front to ensure the government acts to end this perverse system, but also that it does not replace the current regime with something equally as bad – or worse.

Looking back at your time as president, what are the highlights that stand out?

I think the most significant highlight was finally achieving national recognition for collective bargaining with NHS Employers and government. This was something that so many previous presidents and executive members had pursued for so many years that I feel really privileged to have been in post when it came to fruition.

It has been followed by two years of tortuous negotiating on a new consultant contract, which to be honest is not much further forward. The employers’ side have very clear aims and objectives, principally that of not spending anything more on medical salaries, but also to remove the Consultant opt-out clause on elective out of standard hours working in the pursuit of a seven-day normal working week. We have battled hard to secure protections for staff from management bullying and manipulation. Although the employers and the BMA reached agreement on local CEAs, we did not and we are still very much of the opinion that the interim scheme, and the performance-related pay scheme that will replace it from 2021, is a very bad deal not just for the Consultants of today but for those doctors currently in training who will soon face the new system.
It has been very pleasing since we achieved national bargaining rights for all grades of hospital doctors to see how many Trusts have signed formal recognition deals with us, allowing the Association to negotiate collectively on behalf of members at a local level. This will become even more crucial if NHS Employers get their way on future contracts, as nearly all aspects would then be open to local variation in pay and terms.

Many Trusts have already begun the process of establishing revised Joint Local Negotiating Committees to include representatives of the BMA, HCSA and non-unionised doctors of all grades. Other employers are more hesitant, often because of inaccurate claims that Local Negotiating Committees, the democratic mechanism for all medical staff, are a “BMA-only” body. This is something that our legal advisers have said is contrary to trade union law.

Elsewhere, HCSA and the BMA do co-operate successfully, underlining what can be achieved when we work together to represent the common interests of medical staff. It is to my regret, therefore, that the BMA maintains its position of separate negotiations at a national level.

Structurally, HCSA has increased the numbers of our extremely able National Officers (NOs), enhancing the individual member support we provide. We are also implementing changes to backroom hardware and software with a greater focus on organising and communication. The fruits of this will become increasingly visible to members.

In order to meet the challenges of recognition and increase our campaigning capacity we have grown our Policy committee, which has led campaigns such as around the case of Hadiza Bawa-Garba and Gross Negligence Manslaughter and is currently very active around the inequalities of the pension scheme. We will continue to run these campaigns, supported where needed by research to ensure we reflect members’ thinking – we fundamentally wish to be evidence-based and confident in representing these views to employers and all the “arm’s length” NHS organisations that affect clinical decision-making.

One of the greatest delights has been the rapid growth in trainee numbers in the HCSA and we are starting to get them involved in Council...
and Executive as they are our future. We want many, many more trainee members and hope our current members will play a part in this.

We reached our 70th anniversary last October and held a very successful conference at the Royal College of Physicians, combined with an anniversary dinner. Two senior BMA officers joined us, and we very much hope it signals the start of a new phase in our relationship.

HAS YOUR TERM AS PRESIDENT CHANGED YOUR VIEW OF HCSA’S ROLE AS AN ORGANISATION?
When I took up the presidency, I was determined that the views we presented as a professional association should be member-based, not the thoughts of a small group who held office or held representative positions. The willingness of so many members to share their opinions has confirmed my hope that we were a representative association.

My experience of most committee work, both inside and outside the NHS, had led me to believe that plans were often made not as a result of wide consultation, as this made things too complex, but through poor decisions by less-than-well-informed small groups. I was very pleased to see that the HCSA was not like that.

DID ANYTHING COME AS A SURPRISE OVER YOUR THREE YEARS IN THE ROLE?
How quickly trainees joined us when we changed the rules! More, please!

IS THERE ANYTHING YOU WISH YOU COULD HAVE ACHIEVED BUT HAVEN’T?
I am very sad that we have not achieved a better working relationship with the BMA. We have had good interactions with their senior team, but their complicated representative structure makes it almost impossible to get things changed easily and quickly.

Two heads are usually better than one, and I am absolutely certain that we represent a different core group to the BMA and that those individuals a) need representation at the top tables and b) have a legitimate voice that needs to be heard.

WHAT FUTURE DO YOU SEE FOR HCSA IN YEARS TO COME?
If we can get the trainees in in large numbers, and we can keep them as members as they become seniors, then the HCSA has a great future. Numbers matter and the more you have, the more influence you can have both locally and nationally.

DO YOU THINK THE MAIN CHALLENGES FACING HOSPITAL DOCTORS HAVE CHANGED OVER THE PAST FEW YEARS?
Hugely! The NHS is no longer primarily a care provider but a business. This is devastating for patient care which is why most of us went into the profession. Doctors at all grades, but particularly Consultants, spend far too much time trying to control the overzealous management culture when they should be doing what they have trained for.

This is driving hospital doctors to leave the profession. With almost 20 per cent of medical students not completing two years of foundation training before they leave the profession or the country, combined with the huge exodus of seniors leaving early – often burnt out, bruised and damaged by the daily fight to maintain standards – I do have serious concerns for those left behind, too young to retire and too old to really consider a change of direction.

WHAT WILL YOUR INVOLVEMENT BE IN HCSA WHEN YOUR TERM AS PRESIDENT ENDS?
I will become the “immediate past president”! As such I will still sit on the Executive committee and involve myself with the running of the Association. I hope to continue being useful to the association and its members. Most of all I hope to support our most excellent new president.

HAVE YOU GOT A MESSAGE FOR YOUR SUCCESSOR AS PRESIDENT, AND IS THERE ANYTHING YOU’D LIKE TO SAY TO MEMBERS?
I think the best advice I can give Claudia is simply to do your best. As HCSA’s first female president, I hope she will use the platform to bring support to and further the progression of women in medicine.

To members, my message is simple: get others to join, get involved as a local hospital rep, by standing for Council, in surveys – but whatever else, participate in your HCSA.
Independent practitioners have faced new challenges in the past year as they feel the outcome of The Competition and Markets Authority’s investigation into the private healthcare market.

Its conclusion, that patients considering private healthcare were not being given enough information to understand and compare their options, led to recommendations that have created a complex new reporting landscape for doctors practising in the sector.

HCSA is part of FIPO, the Federation of Independent Practitioner Organisations, which has been working actively with this agenda. FIPO’s Charter upholds the highest standards of private care, but there have been concerns across the profession about the practicality of the CMA’s remedies.

A central plank of the CMA’s 2014 Order required all UK Consultants undertaking private activity to submit information to the Private Healthcare Information Network, which will publish hospital and Consultant data with the aim of “empowering patients to make better informed choices.”

The competition watchdog intended that patients should be aware of the cost and quality of private activity, and proposed specific “remedies” that would enforce its view.

The CMA’s fee remedy aimed to see all Consultants publish charges from April 2019, although close to the deadline only 5,100 had provided consultation fees and 3,500 a procedure fee.

Meanwhile the Order outlined 11 outcome measures that must be reported by hospitals and individual Consultants as part of the CMA’s information remedy:

- Volumes of procedures undertaken
- Average lengths of stay
- Infection rates
- Readmission rates
- Revision surgery rates
- Mortality rates
- Unplanned patient transfers, including to the NHS
- Patient satisfaction
- Information from registries and audits
- Procedure-specific measures of improvement in health outcomes
- Frequency of adverse events.

PHIN has enabled individual Consultants to sign off their data as accurate online via its Consultant Portal (portal.phin.org.uk/consultants), to which all Private Practice Consultants have been invited. The portal also allows Consultants to upload profile information, including special interests.

The nature of the quality “outcomes” prescribed by the CMA means that those performing surgical procedures have been the initial target. As the April deadline approached, around 2,150 Consultants had approved their data, raising questions over the planned publication date.

All private practitioners must now also comply with two further requirements of the CMA Order by sending out pre-consultation letters, and following up with a “Treatment/Tests” letter if any additional investigations or treatment have been advised.

The information required is tightly defined, and a summarised version is reproduced below.

1. Submit fee and outcomes data to the Private Health Information Network (PHIN)
2. Sign off on the data as published on the PHIN Consultants Portal ((portal.phin.org.uk/consultants)
3. Send a pre-consultation letter to all patients informing them:
   - The initial consultation fee
   - The follow-up consultation fee
   - Whether the Consultant has any financial interests in the hospital or clinic, or any equipment
   - The Consultant must list all private medical insurers who recognise them
   - The letter should remind insured patients to check the terms of their policies, especially regarding the type and level of outpatient cover
   - The patient should be directed to the PHIN website for quality information.
4. If any additional investigations or treatment have been advised, the patient must be provided with a further letter informing them:
   - The reason for the further tests or treatment
   - An estimate of the cumulative charges
although private hospital operators are required by the order to provide consultants with a pro-forma letter which can be personalised.

In June 2016, FIPO appealed against the CMA's initial Order and lost – but it has continued to work closely with PHIN to try to ensure that patient choice does not suffer from an oversimplification of the complexities of medical care.

As one FIPO director noted, “Choosing your Consultant isn’t the same as choosing to buy tomatoes from Waitrose, Sainsbury's or Lidl based only on price.”

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Seeking – and finding – that ‘something else’

Dr Paul Cooper explains his life-changing decision to up sticks and take a job in idyllic Orkney

As you grow old, you lose interest in sex, your friends drift away and your children often ignore you. There are other advantages of course, but these are the outstanding ones,” noted politician Richard Needham.

But what do you do about work?

You might be the departmental sage, offering your experiences to anyone who asks. You’ve climbed as much of the greasy pole locally and/or nationally as you want or are able, and can use your wisdom as influence with colleagues and your organisation.

Or not, as the case may be.

Having done what you are doing for more than 20 years, you need to do something else. You might take up fly-fishing, playing the clarinet or learn Esperanto. Of course, these things aren’t mutually exclusive – none, or all, of them could apply.

In my case, my wife is an enthusiastic knitter/spinner/weaver and as a result Orkney became a regular holiday destination. On one visit I struck up a conversation in the pub with a local anaesthetist. Several months later, I was being interviewed for my third consultant post.

I went from a multi-site Trust with 25-plus anaesthetic colleagues to a Health Board where the total hospital consultant complement is 12.

Now I’m an obstetric, ENT, eyes, dental, gynae, trauma, and paediatric anaesthetist and, when required, neonatal resuscitator, major trauma stabiliser and ad-hoc intensivist.

Balfour hospital, with 49 beds, serves a population of about 22,000, with another 150,000-plus cruise-liner passengers and holidaymakers between March and October. And as the nearest “big” hospital is more than 200 miles away, we are the first port of call for anything that needs secondary care.

My “something else” is breeding sheep – a flock of Borerays, Britain’s rarest breed. I’ve learned about lambing, drenching and rooing. I can go on about fibre staple length and crimp. I’ve built and repaired drystone walls, drained and filled ponds and burns, seen the Northern Lights and built a polycrub (a wind-resistant cross between a polytunnel and a greenhouse).

I come to veterinary medicine late in life. Toxaemia of pregnancy in sheep isn’t the same as the human condition. Obstetrics which I learned viewed for my third consultant post.
all those years ago hanging round labour wards doesn't really help with lambing. Coamoxiclav is used to treat "jointill" (septic arthritis in lambs). With injections in sheep, you don't just think about hitting other anatomical things.

In many ways the day job in Orkney is also "something else".

Programmed activities aren't a good way to reflect unpredictable daytime work with frequent on-call and variable out-of-hours workload. Regardless of the hospital size, there are essential administrative roles and the individual burden can be higher than in bigger set-ups. And it's not straightforward to reflect all these demands in a job plan framework designed for largely predictable workload in bigger units.

The management approach to problems needs to be different as well. Clinical and management structures are very flat. It's easy to get to see the CEO, MD or relevant admin person and the hospital managers' office (we have just the one) is just along the corridor.

There is a different perspective on maintaining staffing and a safe rota when you live cheek-by-jowl with patients who may be your friends and neighbours and are very dependent on the service you provide. The nearest alternative is several hours and a flight away.

A 1-in-3 rota can restrict what you can do when on-call. But the journey to work takes 14-16 minutes – there are no permanent traffic lights in Orkney – regardless of time of day or night. Unless you get stuck behind a tractor.

Parking is close and free, so popping in to sort something doesn't take long. Night-time disturbance isn't frequent. Air ambulance retrievals, though, can mean being on-site for six to eight hours with the patient awaiting their arrival, or longer when we are stormbound.

Recruitment in Scotland, and in the north in particular, is difficult, with many posts vacant for more than six months and heavy use of locums. Terms and conditions are the same as "down south" – ie anywhere south of Wick – with the addition of a Distant Isles allowance, which is currently £1,194 per year for Orkney.

Travel to Orkney can be expensive – £300-400 per person from London. But that can be offset by much more affordable housing, while goods and services that don’t have to be transported here are relatively cheap.

We have no waiting list initiatives or private practice opportunities, though, if that is your thing.

We also don’t have an LNC (yet). But getting the views of your substantive colleagues – as of January that meant six of us – isn’t difficult. Issues can easily be raised, if not solved, by going and banging on someone's door.

HCSA has branded the NHS “a system in denial” following the release of annual NHS Staff Survey results showing rises in bullying and stress-related sickness among hospital staff.

Nearly four in 10 (39 per cent) of staff reported “feeling unwell due to work-related stress in the last 12 months”, up two percentage points, while more than half – 52 per cent – said they had gone to work sick in the past three months.

Over a quarter of staff had reported harassment, bullying or abuse from patients, relatives or the public in the past year, at 27 per cent, or from other staff, at 26 per cent – up one point.

Just as worryingly, less than half of staff (45 per cent, down one point) had reported their most recent experience of harassment, bullying or abuse.

HCSA has called for members to remain vigilant on this issue. Immediate past president Professor Ross Welch said of the figures: "It
it would now only be an “interim” plan which would aim to “get some steers”, but ultimately was dependent on the Treasury Spending Review scheduled for this autumn.

Questions had already mounted about the viability of the Long-Term Plan given widespread vacancies among medical and other clinical staff, and the fact that the budget on offer follows multiple years of NHS underfunding compared to historical averages, and cuts to public health budgets.

The National Audit Office warned that the Long-Term funding settlement did not cover key areas of health spending, such as education and public health, and risked being undermined by staff shortages.

The accompanying plan “provides a helpful indicator of the direction of travel,” it said, “but significant internal and external risks remain to making the plan happen.”

The NAO added that “previous funding boosts appear to have mostly been spent on dealing with current pressures rather than making the changes that are needed to put the NHS on a sustainable footing.”

Prof Welch noted: “The elephant in the room is a 20 per cent real-terms fall in medics’ pay which has seen morale collapse, made it hard to recruit, and left our most experienced doctors eyeing an early exit.”

Aside from vacancies and retention, HCSA is warning that the squeeze on SPA time will hamper Consultants’ ability to deliver the system changes envisaged, while the impact of the pensions tax system – which is again the preserve of the Treasury – is fuelling an ever worsening staffing crisis that could also critically undermine the Long-Term Plan.

Reflects a system in denial over the scale of the current workforce crisis, with a third of the hospital staff being made sick by work-related stress, and half feeling pressured into attending work despite being ill, risking patient safety.

“Equally disturbing are the findings around bullying, abuse and harassment, with a quarter of hospital staff affected but fewer than half reporting it.

“These figures are predictable but no less shocking for it – now the onus is on ministers and employers to act rather than leave these findings languishing on a spreadsheet.”

Secretary of State Matt Hancock has unveiled the latest bid to tackle IT woes in the form of NHSX, a new body which will scrutinise plans by all suppliers and commissioners.

NHSX will have a Chief Technology Officer, and will seek to uphold technical standards across different systems.

It will also be given the task of setting a national NHS cyber security policy – an issue which was placed in sharp focus by the 2017 Wannacry ransomware attack on the NHS, as well as concerns over the robustness of handheld apps.

NHSX will bring together staff from NHS England and the Department of Health and Social Care.

Chief Executive Matthew Gould described success as reducing the “crazy” amount of time spent inputting and accessing patient data.

The National Audit Office warned that the long shadow cast by the 2017 Wannacry ransomware attack on the NHS in Brief

THINK TANKS PUT £900m PRICE ON STAFFING BOOST

Health think tanks The King’s Fund, Nuffield Trust and The Health Foundation have issued a joint call for an extra £900 million for Health Education England to boost GP and nursing recruitment to the NHS.

Their report, which has little to say about hospital doctors, said the extra cash would be needed annually until 2023-4 – on top of the money already pledged by the government.

It envisages £250m for workforce development, £420m for cost-of-living grants for nurses, and £140m for other financial support for nursing, all with the aim of reducing vacancy rates from 12.5 per cent to five.

NHS Employers described the report as “well-considered”.

SQUEEZE ON AGENCY SPEND HITS THE BUFFERS

The squeeze on agency spending by NHS trusts appears to have hit the buffers – meeting an immovable object in the shape of the vacancies crisis and winter demand.

NHS improvement figures up to December revealed trusts overspent by £139 million against the agency savings target – up £26m on the same period in 2017-18.

NHSI notes: “Agency spend remains under control, but many vacancies are difficult to fill” in an acute sector under “extreme pressure.”

NEW A&E STANDARDS ON TRIAL IN 4-HOUR SHAKE-UP

A trial of new “A&E standards” to replace the four-hour waiting time target is being rolled out at 14 trusts in England. The current target has been widely missed for several years.

New A&E standards include: time before initial clinical assessment; time before emergency treatment for critically ill and injured patients; mean waiting time for all patients and strengthened reporting of trolley waits; and better use of same day emergency care.

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Chief Executive Matthew Gould described success as reducing the “crazy” amount of time spent inputting and accessing patient data.
And finally...

**DID MARVEL INSPIRE LATEST INSTALMENT OF NHS EPIC?**

One wonders how much thought the creatives gave before christening the latest quango born into the NHS family.

They are clearly running out of letters to place after the “NHS.” Or perhaps they are fans of Marvel Comics – after all, it has been a while since the last X-Men release.

Either way, a grand hospital doctors’ welcome to “NHSX”.

Secretary of State Matt “the App” Hancock has unveiled the new organisation in a bid to get to grips with the woeful NHS technology situation at a national level – the X presumably relating to experience rather than x-rated, although medics could be forgiven for speculating given their current technological encumbrances.

Hospital doctors will of course wish the new organisation well, and hope that it can ring the changes and free up clinical time.

To do so, it will need a backbone as robust as Marvel character Wolverine’s “Adamantium” spine (no relation to the ‘80s New Wave artist, apparently).

On the basis of a recent Department of Health press release trumpeting Mr Hancock’s call for the NHS to catch up with the mid-’90s – “Email must replace paper in the NHS” – it will undoubtedly have its work cut out.

**NO MAGIC BEANS**

Accountants’ dark arts can sometimes seem to make money exist in a kind of netherworld between two parallel dimensions, where the unreal becomes the real.

After all, who else could artificially extend the “expected life” of buildings to reduce the annual maintenance spend required on paper, thus saving money in the real world?

If this sounds like mumbo jumbo, that’s because it is. And it’s officially been outlawed. So dozens of Trusts left spellbound are now waking up to a possible £100 million hangover.

Which adds to uncertainties over how far “additional” government cash will really go after years of underfunding.

It’s also proof that, when it comes to paying for the NHS, there are no magic beans or golden eggs – only a sufficient real-world budget will do the trick.

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**2019 Golf Tournament**

**SUNDAY 1ST SEPTEMBER**

**COVENTRY GOLF CLUB**

See page 7 for full details

**Entry form**

The cost per person for 18 holes of golf and a two-course meal is £40. Cheque must be received by 30th August.

**Names:**

1.

2.

**Contact email:**

**Telephone number:**

I enclose a cheque for £40/£80 (please delete as appropriate)

*Please send this form with a cheque payable to Dr J Chandy to 27 Long Furlong, Rugby CV22 5QS by 30th August 2019. No refunds after closing date.*

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**Sudoku**

Difficulty: Medium

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**Solution**

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APPLICATION FORM 2018-19

Help build HCSA and save up to 100% on your fees next year. Find out more overleaf.

Title: 
Surname: 
Forenames: 
Male / Female: 
Qualifications: 
GMC No.: 
Year of Birth: 
Speciality: 
Year Qualified: 
Foundation/Training completion year (if applicable): 
Main Hospital: 
Trust/Board: 
Preferred Address: 
Post Code: 
E-mail: 
Contact Telephone No.: 
Grade:  
Consultant:  
SAS/Associate Specialist:  
Staff/Trust Grade:  
Core/Speciality Trainee:  
Foundation Years 1-2:  
Signature:  
Date:  

2018-19 Subscription rates:

- Full Annual: £290 per annum commencing October 1st 2018 (pro rata for first year of membership)
- Full Monthly: £24.50 per month
- Core/Speciality Trainee Annual: £110 per annum commencing October 1st 2018 (pro rata for first year)
- Core/Speciality Trainee Monthly: £9.50 per month
- Foundation Years 1-2 Annual: £105 per annum commencing October 1st 2018 (pro rata for first year)
- Foundation Years 1-2 Monthly: £8.50 per month

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

% Recruit by (if applicable)

Their membership number (if known)

Important - Please Note:
We are not normally in a position to provide personal representation over issues that have arisen prior to joining the HCSA.
Instruction to your bank or building society to pay by Direct Debit

HCSA
1 Kingsclere Road
Overton
BASINGSTOKE
Hampshire
RG25 3JA

Please fill the whole form using a ballpoint pen
Name(s) of account holders

Service user number: 997572
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 or building society.

Bank or building society account number: Branch sortcode:

Address

Post code

Signature
Date

Banks and building societies may not accept Direct Debit instructions for some types of accounts

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 organisation will notify you (normally 10 working days) in advance of your account being debited or as otherwise agreed. If you request the organisation 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 organisation 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 organisation 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 the organisation.

HCSA, Number One, Kingsclere Road, Overton, Basingstoke, Hampshire, RG25 3JA
T 01256 771777 F 01256 770999 E conspec@hcsa.com W www.hcsa.com