Minimum service levels in event of strike action: hospital services in England, Scotland and Wales: HCSA response

Department of Health and Social Care consultation
Submitted by email 14.11.23

HCSA – the hospital doctors' union is a trade union and professional association representing all grades of hospital doctors across the UK.

Consultation questions

1. **To what extent do you agree or disagree that current arrangements are sufficient in providing cover for essential services?**

- Strongly agree

Please explain your position and provide any supporting evidence (maximum 250 words).

HCSA – the hospital doctors' union, is a professional association and trade union representing hospital doctors at every grade. Hospital doctors are professionals who dedicate their whole working lives to their patients. Their top priority will always be to ensure that their patients are safe. It is on behalf of these professionals that we respond to this consultation.

The longstanding system of derogations is appropriate in providing continuity in service without impinging upon the democratic right to withdraw labour. The implementation of the broader Minimum Service Levels Act and regulations will have a detrimental impact on industrial relations and place an unnecessary additional bureaucratic burden on both employers and trade unions in the NHS.

The consultation impact assessment provided by DHSC also acknowledges the threat to the right to strike: "*Given the fact that the services subject to MSLs are to be determined by Secondary Legislation, there remains a number of uncertainties around (a) the extent to which the policy would restrict the right to strike, (b) the relationship between the ability to strike and the strength of workers' ability to bargain on terms and conditions of employment through collective bargaining,*

and (c) the value workers place on collective bargaining relating to terms and conditions of employment."[1]

The current system minimises bureaucracy for employers and unions. HCSA junior doctors have withdrawn their labour on 25 days of 2023. In advance of and during strike periods, HCSA senior leadership has met with NHS England frequently on a national basis to monitor the impact and respond to any unforeseen incidents. HCSA maintained a 24/7 phoneline as an emergency response mechanism were a decision required on exempting employees from strike at short notice. On only one single occasion has NHS England requested we provide a derogation, and after consideration HCSA agreed to the derogation.

Joint Local Negotiating Committees, where unions meet in partnership with employers, have also played a key role in identifying local solutions to provide cover for emergency care. HCSA senior doctors have provided cover for junior doctors on strike days in hospitals and for BMA consultants during their strike periods. Recently, when BMA senior doctors took action, an arrangement to provide Christmas day cover was implemented. On most occasions, HCSA provided more than the required 14 days' notice of strike to allow employers additional time to prepare.

We therefore object to the accompanying narrative of this question that suggests on occasions where derogations have not been agreed, unions hold the entire responsibility. In fact, too often employers have been responsible for inadequate planning ahead of strike days, leading to a last-minute rush to cancel services. Our experience of short staffing issues on strike days shows a tendency for their occurrence in the very same hospitals where there are chronic systemic issues and often inadequate leadership. Improved staffing and governance all year round would correct this. MSLs are not a proportionate response to the small number of instances cited where derogations were not agreed in good time. Indeed, we have concerns about the ability of the very same Trusts to carry out the planning required to agree an MSL.

The NHS waiting list for elective treatment in England has tripled since 2013 to 7.77million[2]. The Health Foundation estimates that strikes have added 210,000 to the waiting list; significant and deeply troubling for patients whose cases have been delayed, but a far less statistically significant factor according to the Health Foundation than "avoidable failures including a decade of underinvestment in the NHS, a failure to address chronic staff shortages and the longstanding neglect of social care."[3] A preferable approach would be to treat the root causes that have left staff feeling they have no option but to withdraw their labour.

Despite our principled objections to a proposal that we feel overextends, HCSA will nonetheless engage in this consultation in good faith and seek to highlight the logistical issues that arise.

[1] Department of Health and Social Care, *MSLs in event of strike action: hospital services - impact assessment*
[2] NHS England, Referral to treatment waiting times
[3]Health Foundation, NHS waiting list

2. **To what extent do you agree or disagree with the proposal to introduce minimum service levels during strike action to achieve this aim?**

- Strongly disagree

Please explain your position and provide any supporting evidence (maximum 500 words).

HCSA rejects the implication from this question that the most essential services have not been provided under the existing derogation system. We reiterate our point that local solutions have been found and more readily where there has been effective management and adequate staffing levels.

We find the terminology within this question to be problematic, for example "hospitals will treat people as they would on a non-strike day". It is not clear whether this refers to the treatment a patient could expect to have on a non-strike weekday, or whether a non-strike weekend level is appropriate. In the impact assessment, the description is of 'a higher level of service than has been provided during some recent strikes.' There are already excellent examples of how goodwill agreements can provide a service akin to a weekend, which includes those who are in-patients and those awaiting discharge. Similarly, while 'emergency' care is easily understood by the medical community as life-threatening illnesses or accidents requiring immediate treatment, 'urgent' care is not always clear and can vary greatly depending on specialty. To exemplify the broad definition, we note that NHS England defines 'urgent care' as follows: "Urgent care involves any non-life-threatening illness or injury needing urgent attention which might be dealt with by phone consultation through the NHS111 Clinical Assessment Service, pharmacy advice, out-of-hours GP appointments, and/or referral to an urgent treatment centre (UTC)".[4]

Without much more detailed clarification by specialty, our concern is that Trusts will err on the side of caution in order to ensure they have satisfied the provisions of the secondary legislation – and face legal action over their interpretation of an MSL if a patient is found to have been harmed. The broadest interpretation of the terms would lead to a situation where virtually no NHS clinician will in practice be permitted to exercise their democratic right to strike. There is an accompanying risk of creating unrealistic expectations from the public that they will be seen as usual on strike days, leading to many more patient complaints for Trusts to deal with.

It is also clear that 'continuity of access to essential service' is not necessarily always available on non-strike days. See the example of Nottingham University Trust, who declared a critical incident on 30th October 2023, a non-strike day, reporting 220 people in A&E and 120 waiting to be admitted to a ward.[5]

The impact assessment emphasises the intention for MSLs to create more "*certainty, clarity and consistency*" for patients and staff on which services will run on strike days. The proposals in their current form are instead likely to lead to a situation where a huge amount of work consulting on and processing work notices is undertaken in an extremely tight timescale, with variations from employers on work notices allowed up until 4 days before the strike. It is likely that certainty and

[4] NHS England, 'About urgent and emergency care'; https://www.england.nhs.uk/urgent-emergency-care
[5] BBC News, 'Critical incident declared at Nottingham hospitals', https://www.bbc.co.uk/news/uk-england-nottinghamshire-67276033

clarity on staffing and services running will only be available at the very last minute ahead of the strike.

The impact assessment also highlights the possibility that the implementation of MSLs leads to prolonged and protracted strikes: *"Implementing MSLs could increase tensions between unions and health service employers. This may result in more adverse impacts in the long term, such as an increased frequency of strikes for each dispute"*. We would suggest that this is not a possibility, but a certainty. The perception that Government preference is to curtail the right to strike rather than address root causes will only intensify ongoing disputes.

3. **To what extent do you agree or disagree with the proposal to introduce minimum service levels during strike action for in-patients already receiving hospital care?**

- Strongly disagree

Please explain your position and provide any supporting evidence (maximum 250 words).

We are once again concerned by imprecision in language. When we consulted our membership of hospital doctors on this question, many highlighted that inpatients do not receive the same level of care on each day of the week. Treatment varies depending on local systems and by department.

For example, a member working in psychiatry told us that there is typically only a single doctor, the Senior House Officer, on site for in-patients at the weekend. On weekdays, there are ward rounds and a full medical team. If the latter were the expectation, it would entirely prevent strike participation from staff in in-patient mental health, which is clearly an infringement on civil liberties and the democratic right to strike.

A further concern is the large number of inpatients who are "medically fit for discharge" and not receiving treatment. This makes the calculation of medics required to provide a minimum service level more complex.

Other members pointed to the status quo in their Trusts on strike days, where inpatients have been seen as per priority – similar to in the case of weekends, bank holidays or a night service. HCSA is strongly opposed to maintaining services beyond emergency cover on strike days and opposes the inclusion of any service beyond this in this legislation.

4. **To what extent do you agree or disagree with the proposal to introduce minimum service levels during strike action for existing patients requiring urgent elective treatment? For example priority 1 or priority 2 elective surgery lists, dialysis, elective caesarean, or induction of labour?**

- Strongly disagree

Please explain your position and provide any supporting evidence (maximum 250 words).

Priority 1 surgery lists relate to emergency procedures which must always be delivered and have been throughout ongoing industrial action of doctors. Similarly, time critical interventions such as inductions and elective caesareans could also be considered emergencies and have been delivered on strike days.

However, we strongly object to the inclusion of priority 2 procedures. The Royal College of Surgeons indicates these surgeries can safely wait for up to four weeks. There is no safety argument for their inclusion in MSLs.

We again raise our concerns about the use of the term 'urgent elective treatment'. Far greater clarity is required in the final legislation. An example from psychiatry is for emergency patients who are prescribed electroconvulsive therapy (ECT). Even in emergency cases, in the Trust in question this treatment is only provided twice per week and not at the weekends. A decision would need to be made about whether ECT should go ahead on strike days. HCSA's view is that there should be no MSLs for any elective treatment beyond emergency treatment on strike days.

5. **To what extent do you agree or disagree with the proposal to introduce minimum service levels during strike action for existing patients needing emergency, critical or urgent assessments, diagnostics or treatment? This does not include routine procedures like knee or hip replacements.**

- Strongly disagree

Please explain your position and provide any supporting evidence (maximum 250 words).

Again, we would highlight that for successful implementation, there will need to be definitions provided for all the terminology used. We agree that emergency and critical services should continue on strike days, as they have thus far. We understand emergency services by the NHS England definition, "Emergency care involves life-threatening illnesses or accidents which require immediate treatment from the ambulance service (via 999) and an emergency department (A&E)."[6] We also agree with provision of intensive care on strike days. We understand intensive care as defined by NHS England as follows, "Intensive care units (ICUs) are specialist hospital wards that provide treatment and monitoring for people who are very ill." [7] However, 'critical care' is not so precisely defined and while also used interchangeably with 'intensive care', is not used exclusively in this way.

We strongly object to inclusion of 'urgent' care. The accompanying text in the consultation particularly highlights cancer and cardiac pathways as those which should be covered by MSLs as 'urgent'. These areas are indeed those of serious concern to patients and clinicians. Yet the catch-all term 'urgent' goes far beyond these specialties and can be interpreted to include assessment and treatment of minor injuries such as those that could be treated in a pharmacy.

[6] NHS England, 'About urgent and emergency care'; https://www.england.nhs.uk/urgent-emergency-care
[7] NHS England, 'Intensive Care' https://www.nhs.uk/conditions/intensive-care/

Even within cancer and cardiology services, the urgency of diagnostics and treatment plans varies vastly. The proposal as it stands could prevent any cardiologists or oncologists from striking altogether, when in reality, an 'urgent' case may require treatment within three months rather than within hours or days. Similarly, the vast majority of those on waiting lists for diagnosis are there on a precautionary basis and a delay of a few days for diagnosis will have very little impact on prognosis.

6. **To what extent do you agree or disagree with the proposal to introduce minimum service levels during strike action for new patients presenting to the hospital requiring unplanned assessment, diagnostics and/or treatment?**

- Strongly disagree

Please explain your position and provide any supporting evidence (maximum 250 words).

Again, we disagree with broad terminology which could require any new patient to be diagnosed or treated. We reiterate our position that emergency procedures must be provided on strike days, and that this has been achieved in all strikes thus far via status quo derogation system. A triage system has and should always be in place that identifies the emergency patients who must be treated on strike days. We reiterate our concern that this terminology will encourage Trusts to take the widest possible interpretation and therefore extremely limit the right to strike.

We also would caution that this language could encourage the public to show up on strike days, creating unrealistic expectations for Trusts to handle and the potential of system overload.

7. **To what extent to you agree or disagree with allowing local clinicians to determine whether their patients fall under the categories for MSL outlined in the principles listed above during strike action?**

- Neither agree nor disagree

Please explain your position and provide any supporting evidence (maximum 250 words)

The question of where the duty lies to determine in which cases an MSL applies is very problematic. The implication of the proposal is that the Trust will be responsible for assigning the role of risk assessing and categorising patient cases. This will then provide basis for consultation with unions on the MSL required. Clearly, the role of assessing and categorising patients must sit with clinicians who have the requisite knowledge and experience to carry it out safely. We strongly object to this role being carried out by non-medical managers, who would not be able to adequately assess patient cases. However, we are concerned in the case of a doctors' strike this could represent a conflict of interest for medical managers assigned the task.

We are also concerned that this approach could result in disciplinary and Fitness to Practice investigations against our members, were a patient safety incident to arise on a strike day, where a medic had been responsible for determining the use of MSLs. Furthermore, we can see that carrying out this assessment will create an additional burden on our members in an already overstretched and under resourced NHS.

The status quo thus far has been that many local decisions on which services can and cannot run on strike days have been taken through the pre-established machinery of Joint Local Negotiation

Committees. However, as HCSA highlights in our submission to the consultation on the draft Code of Practice, as we do not have representatives on all of these committees this would not be an appropriate mechanism in its current form.

We have highlighted throughout our response that the very vague terminology in this proposal is likely to lead to the broadest interpretation by Trusts, which in turn will significantly weaken the ability of our members to exercise their right to strike.

8. **If MSL regulations are introduced for hospital services, which types of employers should be specified to follow these regulations during strike action?**

- No employers should be specified by MSL regulations

Please explain your position and provide any supporting evidence (maximum 250 words).

HCSA strongly disagrees with MSL regulations specifying that employers must follow MSLs. There are effective pre-existing mechanisms in place in the majority of Trusts that are far less burdensome bureaucratically for employers and unions.

9. **To what extent do you agree or disagree that MSLs should not include community-based health services?**

- Strongly agree

Please explain your position and provide any supporting evidence (maximum 250 words).

HCSA strongly disagrees with MSL regulations specifying that employers must follow MSLs. There are effective pre-existing mechanisms in place in the majority of Trusts that are far less burdensome bureaucratically for employers and unions.

10. **Do you think there is an alternative option to introducing MSLs in hospitals, to ensure continuity of access to essential services and protect patients from risks to life and life-changing harm during strike action?**

- Yes

Please explain your position and provide any supporting evidence (maximum 250 words).

There are effective pre-existing mechanisms in place in the majority of Trusts that are far less burdensome bureaucratically for employers and unions and do not interfere with democratic rights.

We must also emphasise the important role Government should play in proactively resolving disputes instead of legislating out of them. While the ongoing dispute is about pay, HCSA has highlighted at every opportunity that pay is also a tool for staff retention and recruitment. Investment in workforce is crucial in reducing waiting lists. As cited in the previous response, the Health Foundation demonstrate that the impact of strikes on waiting lists has been minimal compared to other factors.

HCSA has also highlighted in previous responses the failings from some employers to make the necessary plans for service levels in advance of strike days. More rigorous enforcement and guidance from NHS England could support this.

HCSA would also like to caution that it is dangerous to introduce this sweeping reform at pace with very little planning and no trial. We will highlight below our grave concerns regarding the scant detail and questionable analysis in the government's impact assessment. We are equally disturbed by the lack of detail in the previous consultations on Code of Practice and Work Notices. Far from improving continuity of care, we foresee a scenario where implementation is disastrous, leading to widespread uncertainty and inevitable patient safety issues.

Trade union experience

1. **Has your trade union called industrial action in any NHS hospital since December 2022?**

- Yes

2. **Provide an estimate for the total number of hours spent by your trade union officials to work with local hospital managers and national authorities such as NHS England, to ensure essential health services remained available during the most recent strike action your union was involved in.**

This includes but is not limited to discussions on special arrangements like derogations. Select the closest range.

- Under 25 hours

3. **Considering the proposal for a hospital MSL and the draft code of practice on reasonable steps trade unions should undertake, how do you anticipate the time commitment for your union officials to take these reasonable steps will compare to the time currently spent working with NHS trusts or health boards in preparation for industrial action?**

- More time-intensive than the time currently spent preparing for industrial action

Please explain your position and provide any supporting evidence (maximum 250 words).

HCSA is of the view that the impact assessment grossly underestimates the time demands for both unions and employers, which in turn leads to entirely inaccurate financial costings. The impact assessment acknowledges "There is low confidence and high uncertainty in the evidence base to robustly monetise impacts." We are extremely concerned about legislating on this basis.

In the familiarisation costs, the consultation notes "in practice some unions may have more or less depending on their size". For a relatively small union such as HCSA, setting up the systems that will

enable us to comply with proposed legislation would require a far larger proportion of our total resources. HCSA therefore asks that proportionality for smaller unions is considered.

The impact assessment estimates two officers per region plus two senior national officers would apply four days each to a familiarisation process, which already appears very minimal. Yet it overlooks entirely the input of administrative and communications departments in familiarisation. Four days would be a wholly inadequate time period to review existing systems and implement new processes required. This would instead take several weeks.

The proposed code states that 'prior to any ballot for industrial action, the union should have ensured that its membership data is accurate and up to date'. HCSA feels this differs significantly from the principle in 226A of TULRC, which states unions must provide information that is "as accurate as is reasonably practicable in the light of the information in the possession of the union at the time." We have already outlined our concerns in our response to the consultation on code of practice and highlighted that as it stands, compliance is impossible. However, the time-resource of any increase in a union's responsibilities to maintain accurate records also needs to be factored into this assessment.

A major area entirely overlooked by the impact assessment is the consultation process. The draft code of practice, also in consultation, places a duty on the employer to consult with relevant unions prior to issuing a work notice to ascertain the work included and number of workers required. It is not clear what the mechanism for consultation will be (see following paragraph). If consultation was handled locally, in the event of a national strike, we could be engaged in local consultations with over 100 Trusts for every work notice, the vast majority in which we have no local rep (despite having national recognition for Consultant members), therefore requiring paid staff presence. It is impossible to determine the hours of staff time this would require without more detail on what the consultation entails. In effect, this would limit the time available for meaningful consultation on behalf of HCSA members and thereby deprive them of a legitimate and effective voice in a process aimed at curtailing their right to strike.

We would however expect the consultation process to be meaningful and legitimate, and therefore be held to legal requirements not dissimilar to the principles of redundancy consultation. This would include legal responsibilities for information sharing, to meet deadlines, a consultation mechanism and an appeal process such as the use of the Central Arbitration Committee. The HCSA view is that anything short of such meaningful consultation would be an unlawful sham and, thereby, render unlawful any subsequently imposed minimum service level.

The impact assessment outlines the costs for a single work notice, from one employer relating to one strike day under 'administrative costs'. Yet this presentation choice underplays the actual costs. In HCSA's junior doctors' strike of 2023, junior doctors across England have withdrawn their labour for 3 – 5 days in each instance across over 100 employers. This could represent 800 work notices to process for each instance of strike. It would further lengthen this process considerably were work notices to be provided in varying formats. Our position is that employers should be required to use a standardised spreadsheet format, along with accompanying narrative in a suitable standard format, and sector-agnostic templates to be included in guidance.

The impact assessment assumes it would take a union one day to process a work notice and notify all members at a regional level. While we feel this is a gross underestimation of how long it would

take, even on this basis it would be impossible for HCSA to process work notices for a national strike. The proposed code suggests an employer is permitted to make any variations to strike notices up to four calendar days prior to the strike. Within HCSA, compliance would require the appointment of a new team of staff working unsocial hours.

HCSA also objects to the duty relating to pickets. Any further steps than asking a member to explain their inclusion in a work notice, for instance providing local picket supervisors with lists of members of those on work notices, would represent an unreasonable and onerous task, as well as introducing an additional and unnecessary risk of data breaches involving special category data.

4. **Do you anticipate that your trade union will incur new costs, either one-time or recurring, in implementing the reasonable steps as outlined in the draft code of practice?**

- Yes

Please explain your position and provide any supporting evidence (maximum 250 words).

As outlined in detail above, we expect to incur huge additional staffing costs. This is likely to also be at the expense of other union activities.

The impact assessment assumes £15,000 of legal advice at familiarisation stage. No figure is put on additional unspecified legal costs related to legal challenges. Employment tribunals, damages claims and injunctions are extremely costly especially for a small union such as HCSA. This is particularly alarming in the case of a national strike, such as our ongoing junior doctor strike, where we must fulfil obligations working with hundreds of employers.

Public sector equality duty (PSED)

1. **Are there groups of people, such as (but not limited to) those with protected characteristics, who would benefit from the proposed introduction of minimum service levels in some or all hospital services?**

- No

2. **Which groups do you think will benefit and why?**

N/A

3. **Are there groups of people, such as (but not limited to) those with protected characteristics, who would be negatively affected by the proposed introduction of minimum service levels in some or all hospital services?**

- Yes

4. Which particular groups might be negatively affected and why?

Union members will be particularly negatively affected by restrictions on their right to strike. As outlined above, this is especially the case for those who work in specialties considered to fall under 'urgent' categories, who are therefore more likely to be impacted by work notices. MSL proposals will heighten anxiety for all union members, and even those not named on work notices may feel dissuaded from exercising their rights.

We can foresee some employers discriminating against union members by naming them on work notices more frequently than their peers. We therefore propose that unions are able to keep work notices on file "for a limited period" in order to allow unions to identify whether their members are being disproportionately selected for duty.

Hospital staff are more likely to be female. We are therefore extremely concerned by the disproportionate impact on women from introducing MSLs in hospital settings.[8] We could foresee this leading to legal challenge.

Black, Asian and minority ethnic doctors are already targeted by employers during strike action, for example HCSA has been concerned by scaremongering experienced by IMG doctors around the effect of strike on visas. We also know many doctors from equalities groups feel less secure in speaking up. Doctors already facing discrimination are therefore less likely to query any issues if named on work notice.

[8] NHS Digital, HCHS staff by gender and org Aug 22, https://digital.nhs.uk/supplementary-information/2022/hchs-staff-by-gender-and-organisation