FROM THE CCHMS

Action plan for "Achieving a Balance"

The general election caused a hiatus in the progress of *Hospital Medical Staffing: Achieving a Balance*, but the chairman of the Central Committee for Hospital Medical Services told the committee on 24 September that he expected an implementation report to be approved by the steering group on 1 October. This would not be a consultative document but would be given a wide distribution, including to regional committees for hospital medical services, and would be discussed by the Joint Consultants Committee on 27 October and the CCHMS on 3 December.

A great deal of work had gone on during the summer months to reach this stage, Mr A P J Ross said. The group negotiating the intermediate level service grade had met seven times and the technical subgroup ten times. The steering group would remain in existence for 10 years to monitor the package as a whole and to make changes where appropriate. Mr Ross reminded the committee that the bids for the 55 new consultant posts for 1988-9 should be submitted by 31 October. Forty five new posts had already been released (1 August, p 343); 22 of these were in general medicine, 14 in general surgery, and nine in orthopaedics.

The tripartite group between the JCC, the DHSS, and the Committee of Vice Chancellors and Principals had also met to discuss how the Joint Planning Advisory Committee could be modified to deal with registrars; it will continue to deal with senior registrars. It was proposed, Mr Ross said, that the profession's representatives should be increased from seven to 11—two from the CCHMS and two from the Hospital Junior Staff Committee. The academic and research representatives should be increased from four to six and the CVCP should have an additional member. If the steering group's report was adopted the committee would work in a slightly different way. It would decide within each specialty the total number of registrars required from United Kingdom graduates for career registrars and honorary registrars. It would allocate a quota for NHS registrars to each region and this quota would go to the regional manpower committee. It would also allocate a quota of honorary registrar posts to be funded by the University Grants Committee and a number for the Association of Medical Research Charities which would not be specific to particular specialties.

It had been proposed that all registrars' contracts would be held at regional level, though the administration of some aspects might remain at district level.

On the intermediate level service grade, which the CCHMS chairman emphasised would have no repercussions on any other grade, a memorandum would go to the review body explaining how the grade differed from career and training grades. The steering group had proposed that payment should be a flat rate for a four hour session. There would be a basic salary for 10 sessions with a facility to do up to three additional sessions and one additional temporary session. Agreement had not been reached on an appropriate salary and evidence would be submitted to the review body.

If the report was approved Mr Ross foresaw people in the grade working, for example, in outpatient departments of ophthalmology and dermatology, doing shift work in accident and emergency departments, and doing on call commitments in acute specialties provided that they were working substantially the whole of the time while on duty. There would be a slow release of people to the grade—with a limit of 10% of the total number of consultants at the end of 10 years. So there would be 200 a year in the first five years.

The associate specialist grade was not part of the exercise, but the revised criteria for the grade, which have been approved by the JCC, would, Mr Ross said, be included as an annexe to the final report. It had been proposed that the facility of early retirement should be extended to associate specialists and that up to 100 posts in the intermediate level service grade should be reserved for associate specialists; otherwise, appointments to the grade would be by open competition.

As there would be an increase in the number of senior house officers and the time spent in the grade would be longer the steering group has proposed that their incremental scale should be lengthened.

It has been proposed that career guidance for junior doctors should be more formalised and the name of the consultant primarily responsible would be included in the junior doctor's job description.

Mr Ross said that it was proposed that regional manpower committees should be asked to draw up a blueprint for regional health authorities by 30 September 1989 on how the "safety net" procedure would work in their regions. This is the mechanism to ensure that staff to support consultants in the acute specialties would not be reduced below a minimum number at an intermediate level of experience. A subcommittee of the Central Manpower Committee and the department would monitor the "safety net" procedure centrally.

"A slow steady progress towards achieving a balance within ten years" was the fundamental principle in the new document, if approved, as it was in the original report from the steering group, according to the chairman of the JCC, Mr A H Grabham. There had inevitably been disagreements in trying to bring together so many conflicting interests, but he believed that there would be no radical changes and that sufficient protection had been built in for the ordinary regional consultant.

Strengthening links with regional manpower committees

Regional manpower committees will have an enhanced role if the report is approved, and the CCHMS has approved proposals for strengthening the links between the regional committees and the Central Manpower Committee, whose task is "to advise the health department for England and Wales of measures to implement the manpower policies for the development of hospital and dental staffing, agreed between the department and the profession's representatives, aiming so far as possible at the setting of regional and national staffing targets."

The constitution of the Central Manpower Committee will be amended so that where the seven representatives elected by the CCHMS are

Dr A P J Ross (left), a consultant surgeon in Winchester, was re-elected unopposed to chair the CCHMS for the 1987-8 session. Mr J R A Chawner (centre), a consultant obstetrician in Bangor, and Dr E B Lewis (right), a consultant anaesthetist in Hythe, were re-elected unopposed as deputy chairmen and will chair the general purposes subcommittee and the negotiating subcommittee, respectively.

This report was prepared by LINDA BEECHAM, assistant editor, *BMJ*.

not regional manpower committee chairmen the chairmen from the appropriate regions will be appointed to the full clinical side of the Central Manpower Committee. The remaining seats on the clinical side will be filled by chairmen from those regions who do not have a representative among the seven from the CCHMS.

Continued concern at "Project 2000"

The CCHMS continues to be concerned about the proposals for nurse education in *Project 2000* from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. Though agreeing that there is a need to improve nursing as a career in order to attract and retain people in the profession, the committee thinks that nursing skills are best learnt in an apprentice type environment. Members saw it as essential that student nurses should continue to work under supervision on the wards because caring for patients was part of the attraction of a career in nursing and that motivating factor should be maintained. Part time opportunities needed to be improved by changing the current inflexible working practices and inconvenient rotas. The committee believed that salary levels needed to be improved and that specialist nurses should receive greater financial recognition.

The chairman reported that the interregional secretariat, which services a group of regional chairmen and regional general managers, was conducting an in depth randomised survey into why nurses were leaving the profession.

Cervical cytology

The CCHMS and the JCC have welcomed the recommendations from an intercollegiate working party for an effective and efficient cervical cytology screening service (1 August, p 343), but the committee was concerned about the question of who was the responsible doctor, arguing that it was not clear what the precise nature and extent of the responsibility was. Clarification has been sought as to who holds responsibility at each stage of the screening procedure and on the position of clinical medical officers.

Mr J R A Chawner thought that the person who took the test should be responsible for following it through, and he hoped that the administration would be tightened up. Several members spoke of the inadequacy of record keeping, and the JCC chairman said that the individual consultant who may have requested a test would not have the facilities to ensure that the test was done. The health authority had a responsibility to see that machinery was available to ensure that the tests were done and the results reported.

The president, Mr David Bolt, who also chairs the General Medical Council's professional conduct committee, said that in his view if a doctor thought it important enough to order a test he would be regarded as negligent in law if he did not follow the procedure through.

The general purposes subcommittee will look into the whole question of responsibility for investigations in this context.

BRIEFLY . . .

- Dr W J Appleyard and Dr Marion Miles (chairman of the paediatric subcommittee) will represent the CCHMS on the working party set up to implement the recommendations of the Child Health Forum.
- Dr E R S Hooper, chairman of the CCHMS defence trust, has been coopted to the committee; the chairman will invite a representative of the regional medical officers to join the CCHMS, and he has also invited Dr Caroline Marriott, consultant psychiatrist in Belfast, to fill a casual vacancy.
- The DHSS and representatives of the NHS have welcomed the profession's proposals for a professional review machinery to deal with those senior hospital doctors who persistently fail to honour their contractual commitments; the department is preparing a draft circular on an informal mechanism.
- Meanwhile discussions have continued with the department on ways of making disciplinary procedures quicker and more efficient.
- The department is to write to regional general managers spelling out the legal position about attendance at consultant advisory appointments committees. The constitution of the committees is statutory and the attendance of any other officer—for example, a district general manager—can only be at the invitation of the majority of committee members. Members were advised to refuse to start the work of the committee if the membership was unacceptable to them.

Milage allowances and crown cars

After agreement was reached in the General Whitley Council on a crown car scheme for NHS employees a revised offer was made to the CCHMS in July on a scheme for hospital doctors. The proposal is that employing authorities would operate *local* schemes to provide vehicles to their employees through contract hire arrangements. Instead of providing his or her own car and being reimbursed for NHS milage at a rate which includes an element for running and petrol, a doctor would be allocated a leased vehicle, receive reimbursement for NHS petrol costs, and pay a charge per mile for his or her personal milage.

The negotiators have found several aspects of the offer unsatisfactory. Employing authorities would decide whether or not to make an offer of a crown car on grounds of economic viability. The authority would have to take into consideration the requirements of the individual post and post holder in allocating the size of the vehicle, but the decision would be at its discretion, subject to a maximum size of 1800cc. Doctors would be able to choose a large vehicle on the condition that they met the additional costs. Existing regular users who turned down the offer of a crown car would be entitled to continue to be reimbursed at regular user milage rates but new appointees who turned down the offer would be reimbursed at the public transport rate. Thus future consultants would be financially penalised for opting out of the crown car scheme. The option of regular and essential users would disappear.

The CCHMS is concerned that local schemes might vary from region to region and from district to district, and the negotiators have raised other issues with the department, including the need for guidance on insurance cover for personal and private practice use (cover for NHS use is carried by the crown); the question of taxation, particularly in relation to payment for home to hospital milage; and the mechanism for claiming reimbursement and verifying milages.

The negotiating subcommittee chairman, Dr E B Lewis, disapproved of the use of duress by the department, who, he claimed, did not understand how consultants worked and the fact that they needed to be continually available. He hoped to be able to achieve no detriment for existing consultants and would continue to pursue the outstanding points at issue. The subject has caused disquiet in several regional committees, and Dr Lewis said that "a question and answer" guidance would be prepared for consultants. Milage rates had still not been updated from 1 July 1986, and updating was conditional on accepting the rest of the package; even then the government had made no promise about a date.

Reducing junior doctors' hours of work

The CCHMS is to join with the HJSC in a joint approach to the DHSS to seek a revised circular on hours of work which would contain the following principles.

- Reactivation of district hours of work working parties to review rotas more onerous than one in three in the hard pressed specialties
- A ban on rotas more onerous than one in three for those first on call in the hard pressed specialties in the absence of variation orders
- Payment at standard rate for prospective cover by all juniors on rotas of one in three or more onerous
- A reminder of paragraph 20 of the terms and conditions of service*
- Regular returns to the DHSS of information from district working parties on rota reductions.

*"It is recommended that, in the assessment of contracts, a minimum of 88 hours per week of assured periods of off duty, including freedom from on call liability, should be made available to practitioners, always provided that the needs of patients permit."

General purposes subcommittee

Dr W J Appleyard (Canterbury)*
Dr J M Cundy (Bromley)*
Dr Joy Edelman (London)*
Dr J A Ford (Glasgow)
Mr L P Harvey (Rugby)*
Dr J P Lee-Potter (Poole)*
Mr R T Marcus (Stratford upon Avon)*

Negotiating subcommittee

Mr D A Aitken (Sheffield)
Dr W J Appleyard (Canterbury)
Dr J M Cundy (Bromley)
Dr Joy Edelman (London)
Mr L P Harvey (Rugby)
Dr J P Lee-Potter (Poole)
Mr Tom McFarlane (Manchester)
Mr R T Marcus (Stratford upon Avon)

The negotiating subcommittee also includes the chairman and deputy chairmen of the CCHMS (ex officio) and representatives of the Scottish CHMS, Welsh CHMS, Joint Consultants Committee, associate specialists subcommittee, Medical Academic Staff Committee, and the British Dental Association, with observers from the Northern Ireland CHMS, the Central Committee for Community Medicine and Community Health, and the Hospital Junior Staff Committee.

The chairman and deputy chairmen serve ex-officio on the general purposes subcommittee; they also serve on the Joint Consultants Committee, together with those members whose names are marked with an asterisk.

Dangers of increased alcohol consumption

Though the general purposes subcommittee had made no objection to the government's recent proposals to reform the licensing hours by allowing longer opening times, several members of the CCHMS warned of the dangers. According to Professor R G Priest, chairman of the psychiatric subcommittee, the government had not heeded the profession's advice on the risks of increased consumption. There was a link between availability and morbidity, and alcoholism was increasing, particularly among women. The government was implying that there had been no change in Scotland, where the opening hours had been extended, but there were many variables in assessing the consequences. If the reforms had been coupled with stronger measures to curb consumption they might have been more acceptable to the Royal College of Physicians and the Royal College of Psychiatrists, which, he was sure, would oppose the reforms.

In Dr J M Cundy's view hospital casualty departments were taking the strain of the effects of increased alcohol consumption. Of the 450 people injured by assault and attending Lewisham Hospital in the past three years alcohol had been found to be the provoking factor in 60% of them.

Dr Peter Hawker believed that the position in Scotland had been confused by a reduction in the amount of disposable income (because of the recession), which, coupled with increased availability was the major cause of increased consumption. As a gastroenterologist he saw the consequences of increased consumption.

Putting the opposite view, Dr E B Lewis declared that there was no evidence that opening hours had anything to do with consumption. He believed that there had been a lot of scaremongering and recalled seeing many more people the worse for alcohol years ago.

Measures to check the use of locums

The committee has recommended that a working party of representatives of the JCC and the DHSS should be set up to review the use of locum agencies by health authorities. There had been several reports of possible risk to patient safety when junior doctors were hired at short notice. The committee hoped that such a working party would consider the following points.

- Locum agencies should be licensed as nursing agencies were required to be under the Nurses Agency Act 1957
- The rates paid by health authorities to locum agencies should be limited
- Regional health authorities should be encouraged to establish their own locum banks
- NHS locum rates should be reviewed.

BMA meets insurers on medical reports

The BMA met the Association of British Insurers on 22 September to discuss medical reports for insurance purposes. At the annual representative meeting the BMA decided to advise doctors that they should refuse to complete a medical report for insurance purposes unless they were satisfied that the following criteria were met:

(*i*) That written consent has been given.

(*ii*) That a separate copy of the consent is provided for the retention of the reporting doctor.

(*iii*) That the consent form incorporates a form of words which is acceptable to the BMA council.

(*iv*) That requests for medical information comes from the company's chief medical officer and be returned only to him.

The BMA, represented by members of the central ethical committee, put the following points to the Association of British Insurers, which agreed to consider them.

That doctors should be free to show applicants completed medical reports before these are sent to insurance companies.

That the doctor must be assured that the patient has given valid consent in writing and that the patient fully understands the nature and extent of the information being sought.

That questions about an individual's human immunodeficiency virus (HIV) state should be addressed to the applicant and that insurance companies should not ask doctors to speculate about their patients' lifestyles.

The BMA's representatives also made the point that they saw the question about HIV counselling and testing now recommended by the Association of British Insurers as confusing the information that insurance companies received. The question suggested by the insurers' association is:

"Have you ever (*a*) been counselled or medically advised in connection with AIDS or any sexually transmitted disease; (*b*) had an AIDS blood test—if so please give details, dates, and results."

The BMA believes that people who could best be described as the "worried well" would need to answer yes to questions on counselling and that could result in companies drawing wrong and damaging conclusions about an applicant's health.

Improved fees for local authority work

The BMA has negotiated improved fees for work done by doctors for local authorities and police authorities. The changes affect work done directly for local authorities or done under collaborative arrangements. Some examples of the increases are given here along with a list of relevant BMA leaflets containing full details of the changes. Members can obtain these leaflets from their local association offices.

The rate for a consultant session (normally one and a half to two and a half hours) under the collaborative arrangements will be £51, retrospective to 1 April 1987; a new item of service fee equivalent to a sessional rate of one hour or less has been introduced, retrospective to 1 October 1985.

General practitioners' reports—for example, to support priority housing or telephones for the blind—will attract a fee of £11.20. The list of forms for adoption and fostering has been expanded to include extra forms recently recommended by the British Agencies for Adoption and Fostering.

A revised milage rate for work done directly for local authorities has been negotiated retrospective to 1 April 1987; this will be 35.8p a mile.

Increased rates for police work will operate from 1 July 1987; the initial day call out fee for police surgeons will rise from £17.80 to £19 at the lower rate, and from £24 to £25.70 at the higher rate; the annual availability fee will go up to £1440.

The relevant BMA fees leaflets are:

- "Work under the collaborative arrangements" (namely, work for local authorities by district health authorities) FS23
- "Visiting medical officers to establishments maintained by local authorities" FS24
- "Doctors assisting local authorities" (including part time occupational health work) FS25
- "Medical referees at crematoria" FS26
- "Police surgeons" FS27
- "Home Office appointed pathologists" FS28
- "Coroners' analytical work" (fees payable under section 25 of the Coroners' Act 1887) FS29
- "Coroners' work: reports" (fees payable under section 25 of Coroners' Act 1887) FS30

Correction

Fate of ARM motions

When we published the list of motions submitted to the annual representative meeting but referred to a craft conference (25 July, p 282) the following motion from Northampton was omitted. It was referred to the senior staffs conference but was not reached: "That we wish to express our concern at the continuing decline in the basic consultant salary in relation to those of comparable responsibility outside the profession."

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