FROM THE JCC

Anxieties about consultant expansion progress

An expansion of the consultant grade is one of the bulwarks of the package agreed by the health departments, the National Health Service, and the Joint Consultants Committee in *Hospital Medical Staffing: Achieving a Balance: Plan for Action*.[1] Ministers had given a written assurance that every effort would be made to ensure that the 2% consultant expansion would be maintained and there were to be 100 new additional consultant posts over the next two years.

At its meeting last week, however, the Joint Consultants Committee heard reports that the 2% expansion was unlikely to be met in some regions. In some districts the posts in the pump priming exercise had been allocated and agreed but not funded.

The chairman, Sir Anthony Grabham, told the meeting at the Royal College of Surgeons on 19 January that "if consultant expansion is not implemented then the package will be doomed to fail."

In some places, the president of the Royal College of Surgeons, Mr I P Todd, said, junior staff were being withdrawn and no arrangements were being made to take up the workload. Dr Joy Edelman feared that district health authorities were using *Achieving a Balance* as a means to save money. In the North East Thames region consultants had been told that early retirement would not be allowed.

The committee agreed to tell the chief medical officer of its concern later in the day and chairmen of regional manpower committees have been asked to gather information on their regions' plans for the future.

Joint monitoring group

A machinery for continuous and regular review was built into *Plan for Action*, and the JCC has agreed the remit and composition of a joint monitoring group.

The remit of the group will be:

"To monitor the evolution of the hospital staffing structure, and to advise the steering group for implementation of any significant deviations from the *Plan for Action*.

"To review and update as required the statistical projections in the *Plan for Action* in the light of later information and experience of the new arrangements.

"To advise health departments through the steering group for implementation and its technical subgroup on (*a*) limits on the number of early retirements to be available in each specialty in England and Wales (and on any specialties to be excluded on manpower grounds); (*b*) senior house officer ceilings for the English regions; (*c*) the rate of release of staff grade posts in England and Wales and quotas of these posts for the English regions."

The membership will be the chairman of the Central Manpower Committee; the chairmen of the three CMC medical subcommittees and of the dental subcommittee; the chairman of the JCC; one representative each from the Central Committee for Hospital Medical Services, the conference of royal colleges, and the Hospital Junior Staff Committee; the head of the DHSS medical manpower division and two further DHSS representatives; one representative from Wales; one regional specialist in community medicine; and one representative of academic and research interests.

Planning registrar numbers

There has been one meeting of the Joint Planning Advisory Committee, whose remit and membership have been expanded to examine the number and distribution of registrar posts. Its first task will be to determine its advice on the total number of career registrars, including those with National Health Service and honorary contracts, required in each specialty to balance with numbers of senior registrar posts and expected consultant vacancies (see figure). It will also advise on the number of posts to be set aside for part time training.

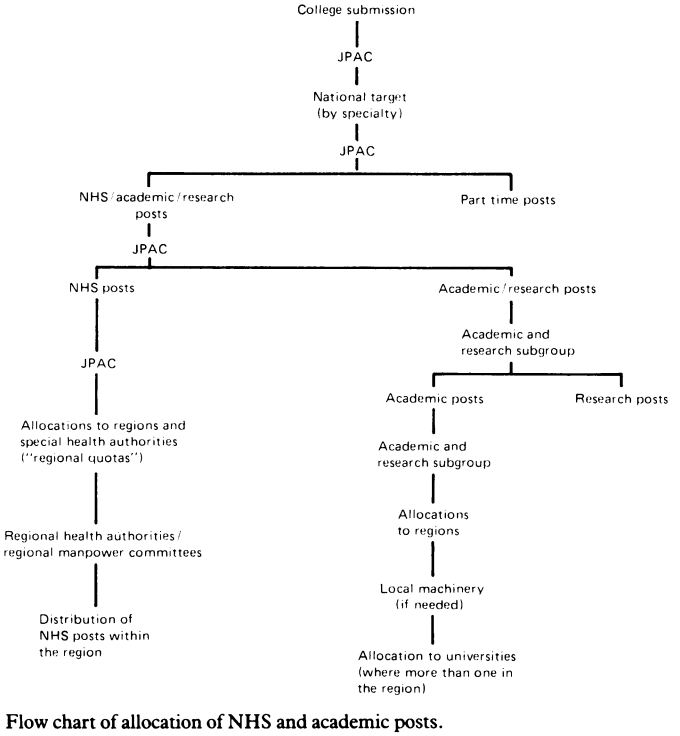
Distribution of NHS career registrar posts within regions will be for the regional health authority advised by the regional manpower committee. Distribution of academic posts will be done by the university in regions with one medical school; for regions with more than one medical school appropriate machinery will need to be agreed locally. An academic and research subgroup will be set up to advise on the regional quotas of academic posts with honorary clinical status.

The chairman emphasised that the committee would provide indicative allocations only. It would look at each specialty in turn and then work out a formula for calculating the quotas.

Sir Anthony Grabham reported that the Central Manpower Committee had met and appointed its subcommittees. A circular had been issued on early and partial retirement (23 January, p 305) and evidence had been given to the review body on the new staff grade; a report was expected shortly.

Access to records

As a condition of the removal of manual medical records from the Access to Personal Files Act the



Flow chart of allocation of NHS and academic posts.

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

department of health had asked the profession to consider how patients could be given more information. At a recent meeting representatives of the JCC had assured the department that consultants were in favour of patients having as much information as possible but they favoured a voluntary code of good practice rather than a legal requirement for consultants to give full access to manual records. It would, the chairman said, be damaging for some patients to have complete access. Discussions will continue with the department.

Under the Data Protection Act patients are entitled to see their computerised medical records. The JCC, however, is unhappy about the draft code of confidentiality because this delegates responsibility for preserving the confidentiality of personal health information to a "qualified health professional," a definition that includes those without a professional code of ethics. The committee has asked the DHSS to reissue the policy stated by the minister for health in 1980 that although medical records were the property of the Secretary of State, doctors were the custodians and carried responsibility for safeguarding the confidentiality of records. The JCC will discuss the matter with Sir Douglas Black, chairman of the Interprofessional Working Group, which drew up the code.

Steering group on undergraduate medical education

A steering group has been set up to bring together the national agencies with an interest in medical education. Chaired by Mr Michael Partridge, second permanent secretary at the DHSS, the group will consider how the current arrangements for undergraduate medical education can be improved to ensure that the policies and programmes of the bodies concerned are properly coordinated and directed.

The decision to set up a group arose from a meeting in November 1987 when the permanent secretaries of the DHSS and the Department of Education and Science, the chief medical officers of the DHSS and the Scottish Home and Health Department, the chairman of the University Grants Committee, the president of the General Medical Council, the chairman of the Committee of Vice Chancellors and Principals, and a regional health authority chairman discussed the effects of changes in the NHS and higher education on medical teaching and the need for improved information systems.

Planning medical manpower

The personnel director of the NHS Management Board, Mr Peter Wormald, is to chair a working group of NHS managers and planners from a variety of disciplines to assess the demands for doctors. The group, which will report in six months, will "consider methods for planning medical manpower, in particular methods of assessing future demand for medical staff, both regionally and nationally, taking account of NHS service planning and the planning of other manpower groups, and with particular reference to the NHS strategic planning process." The secretariat will be provided by the DHSS.

Overseas medical students

The committee has considered a proposal from the Joint Conference of Provincial and Metropolitan Deans that the medical schools should be permitted to increase the proportion of overseas students in the medical school intake, currently about 5%, by 5%. This could mean up to 200 additional students a year in the United Kingdom. Since 1981 universities have been required to charge full cost fees for overseas students and there is a financial advantage in admitting more overseas students since the marginal cost to them of an additional student is much less than the fee income received. The deans have pointed out that only in medicine are there such strict controls on educational opportunities for overseas students in the United Kingdom.

Crisis in NHS hospitals

The JCC chairman has asked the Secretary of State for Social Services to meet him and his deputy chairmen, Mr I P Todd and Mr A P J Ross, to discuss the current crisis in the hospital sector. Last month the presidents of the Royal College of Physicians, the Royal College of Surgeons, and the Royal College of Obstetricians and Gynaecologists issued a joint statement (12 December 1987, p 1505) and met the Secretary of State, Mr John Moore, earlier this month (23 January, p 306). The committee was told that the chairman of the BMA council had also met Mr Moore and that the CCHMS was conducting a survey into the conditions in the acute sector, which would be published.

The DHSS has consulted the other United Kingdom health departments and the English regional health authorities, who have supported the proposal subject to certain safeguards.

Professor D Shaw told the committee that the deans believed that most overseas students would leave the United Kingdom after they had completed their preregistration house officer year or their postgraduate training. Furthermore, overseas students attracted between £8000 and £10 000 a year and the extra money would enable more teachers to be appointed.

Despite these assurances the JCC decided to tell the chief medical officer of its concern that the proposals would have implications for the overall manpower figures, would be an additional burden on teaching resources, and would affect the existing medical student establishment.

Under the immigration rules an overseas student who comes to the United Kingdom to study medicine is permitted to do his or her preregistration year in this country and is entitled to a further permit free period of four years for postgraduate training. The JCC was concerned that after that length of time the Home Office would be reluctant to send the doctor home against his or her will. This could upset the manpower figures.

According to Dr G H Hall, the Advisory Committee on Medical Manpower Planning believed that the proposal would necessitate a reduction of 2% in the intake of British medical students.

Reference

1 United Kingdom Health Departments, Joint Consultants Committee, chairmen of regional health authorities. *Hospital medical staffing: achieving a balance: plan for action*. London: DHSS, 1987.

Private practice in the NHS in Scotland

Two years ago the Department of Health produced a handbook on the management of private practice in the health service in England and Wales.[1] A similar handbook has now been issued by the Scottish Home and Health Department.[2] According to the department there has been "an apparent lack of awareness of control procedures" by some health board staff and a failure to follow guidelines about collecting income from private patients.

The handbook emphasises that a patient must be identified as NHS or private from the outset and that the consultant with primary responsibility for the patient should ensure that this is done. The use of standard admission, records, and referral forms which differentiate between NHS and private patients would help the procedure. The guidelines advise that all inpatients and outpatients are legally entitled to change their status during the course of stay in hospital or at a subsequent outpatient visit, but private patients who revert to NHS status must take their place appropriate to clinical priority on waiting lists, etc. Diagnostic and service departments should maintain registers of work done for private patients and notify the records department of the treatment given. Undertakings to pay hospital charges should be obtained from patients before admission or treatment except in emergencies, and health boards are being urged to seek deposits equivalent to the full estimated cost of the hospital charge which will be payable.

References

1 Department of Health and Social Security. *Health services management. Private practice in health service hospitals*. London: DHSS, 1986. (HC(86)4.)

2 Scottish Home and Health Department. *Management of private practice in NHS hospitals*. Edinburgh: SHHD, 1987. (1987(GEN)25.)

New mental health committee

The BMA council has agreed that the mental health group and the mental health group committee should be wound up and replaced by a mental health committee. This new committee would deal with matters relating to all aspects of mental health, reporting direct to the council.

The chairman will be an ex-officio member of council and the membership will be:

Two members working in psychiatry nominated directly by the council.

Two members nominated by the GMSC; one by the CCHMS; one by the CCCMCH; one by the HJSC.

One prison medical officer nominated by the civil service medical officers group.

The chairman of the psychiatric subcommittee of the CCHMS (ex-officio).

One observer from the Royal College of Psychiatrists and one from the Department of Health.

Not more than four coopted members to ensure sufficient representation from those specialties not otherwise represented.