DHSS/JCC Manpower Initiative

"Hospital Medical Staffing: Achieving a Balance"

Foreword

This is not a report in the accepted sense. It contains no detailed analysis or argumentation. The problems we have been examining are not new. They have bedevilled the National Health Service for more than 25 years. In a sense, too much has been said about them and too little has been done. That is why our proposals are different—not just in the way they are presented—but different in that they set achievable goals and spell out how these are to be reached. We believe we have devised a realistic and integrated package of measures which can start to work immediately and which, in a controlled and gradual way, will bring the staffing structure into balance over the next 10 years. This is in the interests of patients and doctors alike.

We believe that our proposals would achieve

- **for patients, the prospect of a continuing improvement in standards of medical care.**
- **for health authorities and their local professional advisers, a greater flexibility to match hospital staffing to local circumstances and to the differing needs of the various specialties.**
- **for junior doctors, a far greater assurance of progression to a secure career post without lengthening the time spent in training.**
- **for senior doctors, an assurance that there will not be unacceptable changes to the nature of consultant work.**

In contrast, if no action is taken we foresee increasing difficulty in staffing services and insecurity and deteriorating career prospects for junior doctors.

The recommendations are in terms that are suitable for application in England. Some modifications will be necessary to adapt them to the distinct and differing needs of Scotland, Wales, and Northern Ireland. The other Health Departments strongly endorse the principles underlying these proposals and intend to consult separately with their appropriate professional and service interests in the best way of achieving these objectives in their own countries.

We therefore ask you to give our proposals your urgent and careful consideration. We would stress that these are integrated proposals, which must be seen as a package. While we hope that few will dissent from the general tenor of our recommendations, we would welcome comment.

The problem is urgent. Action must start soon.

(Signed)
Barney Hayhoe for the UK Health Ministers
Anthony H Grabham for the Joint Consultants Committee
Gordon Roberts for regional health authority chairmen

Introduction

In October 1985, the Minister of State for Health, Mr Barney Hayhoe, invited the Joint Consultants Committee (JCC) through its chairman, Mr A H Grabham, to join him in discussions about hospital medical staffing.

Also involved in the talks, as constituent bodies of the JCC, were representatives of the royal colleges and of the Central Committee for Hospital Medical Services and the Hospital Junior Staff Committee of the BMA. Sir Gordon Roberts (chairman of Oxford Regional Health Authority) was asked to represent regional health authority chairmen. The group included the Chief Medical Officer of the Department of Health and Social Security, the chairman of the NHS Management Board, and officials of each of the UK Health Departments. A full list of members of the group is given on p 148.

The group met six times between January and July 1986, with detailed work being remitted to a number of technical sessions. This document is the result. It comprises a series of integrated recommendations, first in summary form and then in detail, aimed at bringing the hospital medical staffing structure into balance.

The group will reconvene at the end of September, as a steering group for implementation. It would be helpful to receive comments before that date, but the group will be prepared to receive comments up to the end of November 1986. These should be sent to Mr J C Dobson, DHSS, Eileen House, Elephant and Castle, London SE1 6EF. The Scottish Home and Health Department, the Northern Ireland Department of Health and Social Services, and the Welsh Office will be calling separately for comments on this document.

Summary of recommendations

(1) A boost to the existing rate of *consultant expansion*, especially in the acute specialties, and including:

a limited period of central funding for additional new consultant posts in general medicine and related specialties and in general surgery and traumatic and orthopaedic surgery;

the conversion to consultant of senior registrar posts identified as surplus to training requirements;

a review of the registrar staffing of consultant firms, to take place prior to each impending consultant retirement, with a view to converting a registrar post to a consultant post wherever this would be appropriate on service grounds.

(2) A scheme to allow early retirement in the interests of removing promotion blockages; and arrangements to facilitate *partial retirement* of consultants over 60 to release funds for new consultant appointments.

(3) Continuation of the *review of senior registrar numbers* by the Joint Planning Advisory Committee, which is relating the number of senior registrar posts required to expected consultant level vacancies.

(4) Arrangements to *relate the numbers of graduates of UK medical schools entering registrar posts* to the number of senior registrar

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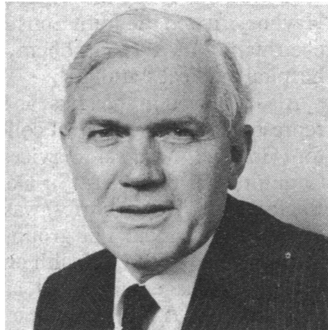
posts and thereby, in turn, to the number of consultant level opportunities.

(5) A steady reduction, in some specialties, in the total number of registrar posts in the light of the number of posts required for training future consultants and the likely training requirements of overseas doctors. This would be achieved largely by means of the *review of registrar posts* described under (1) above.

Membership of working group

Mr Barney Hayhoe.



Mr Anthony H Grabham.

Health Departments

Mr Barney Hayhoe, Minister of State for Health
Sir Donald Acheson, Chief Medical Officer, DHSS
Mr Victor Paige, chairman of NHS Management Board*
Dr Diana Walford, Senior Principal Medical Officer, Medical Manpower and Education Division, DHSS
Mr Charles Dobson, Principal, Medical Manpower and Education Division, DHSS
Dr Graham Scott, Deputy Chief Medical Officer, Scottish Home and Health Department
(Alternate: Dr Basil Slater)
Dr Gareth Crompton, Chief Medical Officer, Welsh Office
(Alternate: Dr Gwyn Penrhyn-Jones)
Dr Clifford Hall, Principal Medical Officer, DHSS (Northern Ireland)

Joint Consultants Committee

Mr Anthony Grabham, chairman, Joint Consultants Committee (JCC)
Sir Geoffrey Slaney, vice chairman, Joint Consultants Committee
Dr Maurice Burrows, vice chairman, Joint Consultants Committee and chairman, Central Committee for Hospital Medical Services (CCHMS)
Sir Raymond Hoffenberg, president, Royal College of Physicians
(Alternate: Sir Malcolm Macnaughton, president, Royal College of Obstetricians and Gynaecologists)
Mr Alexander P Ross, CCHMS
Dr Peter Hawker, chairman, Hospital Junior Staff Committee (HJSC)
Dr Bernard Crump, HJSC
Dr Angus Ford, Scottish JCC
Frank Wells, undersecretary (Hospital Services Division), British Medical Association
(Alternate: Miss Sally Watson)

Regional health authority chairmen

Sir Gordon Roberts, chairman, Oxford Regional Health Authority

*Till 3 June 1986

(6) A *small increase* in the number *of senior house officer posts* to allow for adequate breadth of training at this level.

(7) Introduction of a *new non-training intermediate level service grade*—possibly a modification of the hospital practitioner grade*—with entry directly from SHO, which would be advertisable subject to strict regional manpower control and central monitoring.

(8) *Newly appointed consultants* in the acute specialties to accept a greater direct involvement in patient care and in the direct supervision and training of their junior staff. This would be subject to the important proviso that staffing in support of consultants in acute specialties should not be reduced below a minimum number at an intermediate level of experience (the "safety net").

(9) Local assessment of the needs of those now in the training grades who seem *unlikely to make further career progress*.

(10) Detailed planning of medical manpower posts within this centrally agreed framework to be the responsibility of regional and district health authorities, with appropriate professional, educational, and university advice. Health authorities would be accountable to the Secretary of State for the discharge of these responsibilities, in the normal way. *Our group would also monitor the effect* of these proposals and amend them where necessary in the light of experience.

(11) *A long term aim of reducing the length of time* spent in the registrar and senior registrar grades to the point at which the two grades could be combined into a single higher training grade.

(12) *Implementation of these proposals* to begin on 1 January 1987.

Recommendations in detail

These recommendations are set out as they would apply in England. The starting position in Scotland is somewhat different and it will be for the Scottish Home and Health Department in discussion with the Scottish Joint Consultants Committee and health boards to determine how best to achieve the same objectives. In addition, some modifications would be needed to adapt the proposals to the particular circumstances of Wales and Northern Ireland and the Welsh Office and DHSS Northern Ireland will be consulting their appropriate professional and service interests on this.

(1) Consultant expansion

The present rate of expansion of about 2% a year should be maintained, and in addition would be enhanced by:

(1.1) A PUMP PRIMING SCHEME IN ACUTE SPECIALTIES

(1.1.1) Central funding would be set aside for 50 new consultant posts each in general medicine and related specialties and in general surgery/traumatic and orthopaedic surgery. Provision would be made for the funding of the basic salary costs of each post (including employer's superannuation and national insurance contributions) and for an additional £15 000 a year towards related expenses.

(1.1.2) Regional health authorities (RHAs) and special health authorities (SHAs) would be invited to submit bids for these posts over a two year period (1987-8 to 1988-9). A successful bid would need to demonstrate that the post would be genuinely additional to existing short term plans for consultant expansion; that it could be accommodated within existing facilities; that any additional revenue

*This recommendation will not affect the existing hospital practitioner grade.

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costs, over and above the central funding, would be constrained within available resources; and that the consultant appointment would be expected to lead to a significant improvement in patient services.

(1.1.3) Funding would be earmarked for three years and then built into authorities' baseline revenue allocations.

(1.1.4) Authorities would be asked to monitor the service and cost effects of the new appointments.

(1.2) REPLACEMENT OF SENIOR REGISTRAR POSTS BY CONSULTANT POSTS

The DHSS, advised by the Joint Planning Advisory Committee (JAPC), will be bringing the number of senior registrar posts into line with consultant opportunities, by allocating appropriate quotas of senior registrar posts to regions. Posts surplus to regions' allocated quotas which carry an important service commitment should, wherever possible, be converted to consultant posts.

(1.3) REPLACEMENT OF REGISTRAR POSTS BY CONSULTANT POSTS

Whenever a consultant in a firm with a registrar nears retirement the relevant health authorities would review the service need for the registrar post and, on the advice of the regional manpower committee, decide whether it should be retained as a registrar post, converted to a consultant post, be replaced in some other way, or be closed without replacement (but see paragraph (8) below).

(2) **Early retirement and partial retirement**

Promotion blockages could be further relieved by (*a*) a scheme to permit early retirement of some consultants and (*b*) arrangements to facilitate existing options for consultants over 60 to retire from half the sessions worked, thereby releasing salary support for new consultant appointments.

(2.1) EARLY RETIREMENT

(2.1.1) A new scheme would be introduced to encourage early retirement to facilitate the proposed changes to the hospital staffing structure in all specialties.

(2.1.2) The decision to offer early retirement would be for management but such retirements would be entirely voluntary. There would be an overall national limit on the numbers involved; this would be related to the numbers required to relieve immediate promotion blockages, but would also take into account the need to maintain a steady rate of consultant vacancies in the future. The scheme would be subject to central review.

(2.1.3) Benefits would be similar to those available to other staff groups under the provisions of HM(62)49—very broadly, enhancement of lump sum and pension to what would have been payable on normal retirement at age 65.

(2.2) PARTIAL RETIREMENT AT AGE 60

It is already possible for a consultant with agreement of his employing authority to retire from some of his sessions at age 60 or over and to draw his lump sum and pension (subject to the normal rules of abatement), while earning a salary for his retained sessions and accruing a small additional pension and lump sum on final retirement. For a consultant on the top point of the salary scale with a merit award, the salary released by relinquishing half his sessions would go a considerable way to paying for a new young consultant who could share with him existing facilities and junior staff.

(3) **Senior registrar posts**

The review of senior registrar numbers by the Joint Planning Advisory Committee (see paragraph (1.2) above) will continue.

(4) **Registrar posts**

There is a pressing need to relate the number of graduates of UK medical schools entering the registrar grade to the expected number of senior registrar—and hence consultant—opportunities. To this end we propose division of existing registrar posts into regional and district registrar posts as follows:

(4.1) Registrar posts would be divided into regional registrar posts (with contracts held at region) for doctors who are eligible to seek a consultant career in this country*; and district registrar posts (with contracts held at district) for training overseas graduates. All such posts would be good quality training posts, with educational approval from the relevant royal college or faculty.

(4.2) A central body—similar in function to the Joint Planning Advisory Committee but with a membership which adequately reflected the crucial service input of the registrar grade as well as its training and educational function—would be asked to advise the DHSS on quotas for regional registrar posts, by region and by specialty. It would not be the function of this body to advise on the numbers of district registrar posts.

(4.3) In calculating the quotas of regional registrar posts, an allowance would be made for normal wastage—for example, emigration, health, educational, or personal reasons for leaving the grade—and adequate provision would be made for part time training.

(4.4) The intention in calculating the regional quotas would be to allow, wherever possible, for at least one regional registrar post in each of the acute specialties in each district; and the local allocation of quotas within the region should also take this into account.

(4.5) Regional health authorities acting on the advice of their medical manpower and education committees, with appropriate university representation, would be asked to identify suitable posts or rotations up to the quota allocated in each specialty. Rotations should include experience in both teaching and non-teaching hospitals—where this is practicable and consistent with the principle of paragraph (4.4)—and good existing rotations of this kind should not be disturbed.

(4.6) Most regional registrars could expect to spend around three years in the grade. However all doctors would have to complete at least two years in the regional registrar grade before appointment to senior registrar posts.

(4.7) All registrar posts not identified as regional registrar posts would be designated district registrar posts, and contracts would continue to be held at district level. As these posts became vacant, they would be reserved for overseas graduates in training.

(4.8) While doctors seeking training in research methods might normally be expected to acquire this before entering the registrar grade, there would be provision for a number of clinical research posts with honorary registrar contracts within the regional registrar quotas. District health authorities would not grant honorary contracts at registrar level.

(5) **Reduction in registrar posts**

(5.1) As well as limiting the number of regional registrar posts in each specialty, there is a need, in some specialties, to reduce the total number of registrar posts, subject to the training requirements of overseas doctors. Wherever possible, this should be achieved by conversion of a registrar post to a consultant post (but see paragraph (8) below).

*To conform with European Community law, EC doctors would have (as now) equal access to these posts.

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(5.2) The time to make any reductions in the registrar establishment of a consultant firm would be on the retirement of one of the consultants, following a local review of service needs, and on the advice of the regional manpower committee (as described in paragraph (1.3) above).

(5.3) As an exception to this rule, a registrar post which consistently failed to attract suitable applicants could be reviewed, on the advice of the regional manpower committee, other than at the time of a consultant retirement, with a view to closing the post and to providing the service in another way.

(6) SHO grade

(6.1) Training at SHO level should provide an opportunity for:

(6.1.1) a period of appropriate general professional training, in which doctors have the opportunity to obtain experience of a variety of disciplines before making their choice of specialty, and

(6.1.2) some basic training in the specialty of their choice.

We would not wish our manpower proposals to change the overall nature of training in this grade.

(6.2) We therefore propose that all SHOs should receive formal careers counselling shortly after entering the grade and regularly thereafter. At the appropriate stage, SHOs would start applying for regional registrar posts (see paragraph (4.1)). Those unsuccessful in the competition for regional registrar posts in their chosen specialty should receive further careers counselling with a view to changing their specialty. Some additional experience at SHO level in a new specialty might then be needed before applying for a regional registrar post in the new specialty. As part of these arrangements it may be necessary to consider a lengthening of the incremental payscale for SHOs.

(6.3) To accommodate the necessary breadth of training at this level (see above), we also propose that the SHO "ceilings" should be lifted to allow a modest increase in the number of SHO posts in each region. This might amount to an annual increase of around five posts per region over 10 years.

(7) Non-training support grades

(7.1) A new intermediate level service grade would be introduced, with strict regional manpower controls and central monitoring to prevent its use either at the expense of new consulant appointments, or at the expense of doctors with the aptitude and willingness to train as consultants. These controls would ensure that the size of this grade would increase only gradually over time and that, even in the longer term, the numbers in the grade would not exceed 10% of the numbers of consultants.

(7.2) Detailed negotiation would be necessary but the grade would have the following features:

(7.2.1) a sessional (rather than unit of medical time style) contract, either part time or whole time;

(7.2.2.) entry would normally be directly from the SHO grade after a minimum of three years in the grade, which should include a period of appropriate general professional training as well as adequate training in the relevant specialty;

(7.2.3) appointment would be by competition to an advertised post, and would include a period of probation before final confirmation of the appointment;

(7.2.4) before a post could be first established, manpower approval would have to be obtained from the regional health authority advised by the regional manpower committee, on the basis of a district proposal setting out information on workload and on the intermediate level staffing otherwise available; the case would have to be made for an appointment at the intermediate level rather than at consultant level;

(7.2.5) provision would be made for continuing education for this grade;

(7.2.6) post holders would be eligible for personal regrading to associate specialist after an appropriate period of service in the grade, subject to the usual central manpower approval;

(7.2.7) they might exceptionally compete for regional registrar posts, but if successful would have to spend a minimum of two years in quota posts before being eligible to compete for senior registrar vacancies;

(7.2.8) use of the grade would be closely monitored by the JCC, the Central Manpower Committee, and the DHSS.

(7.3) We envisage little change to the associate specialist grade.

(7.4) As soon as the new grade became available, there would be no further paragraph 94 appointments of six sessions or more.* Doctors now holding such appointments would be allowed to remain in post under the terms of their existing contracts. They would, as now, be eligible to be considered for personal regrading as associate specialist, or would be free to compete for posts in the new intermediate service grade.

(8) The "safety net"

The changes in staffing levels implied by proposals 1-7 above would lead, in course of time, to a grade structure with more consultants and rather fewer junior doctors (or other support grades) per consultant. Newly appointed consultants would have a greater direct involvement in patient care, and would have more time for the supervision and training of their junior staff. However, staffing changes would be subject to the proviso that the number of intermediate level staff to support consultants in the major acute services should not be reduced below a minimum safe level for 24 hour emergency cover. The precise level of this safety net would need to be determined locally by the district health authority acting on professional advice (including that of the regional manpower committee); factors to be taken into account would include workload, case mix, suitability for cross cover between specialties, split site working, etc. Given the desirability of eliminating rotas more onerous than one in three, this implies that each district acute service should have three or four "intermediate level" doctors—that is, registrars, senior registrars, the more experienced SHOs, or doctors in the new intermediate service grade; this would wherever possible include at least one regional registrar.

(9) Overseas doctors

(9.1) Health authorities would be encouraged to make district registrar posts available for sponsorship schemes such as those now being set up by the Royal College of Obstetricians and Gynaecologists, the Royal College of Physicians, and the Royal College of Surgeons. Non-sponsored overseas doctors would also be free to compete for district registrar posts. Posts should be of equal training quality to regional registrar posts and all would need royal college or faculty educational approval. Wherever possible, regional and district registrars should be on the same rotation.

(9.2) Where a district registrar post failed consistently to attract suitable applicants the district health authority should, with the advice of the regional manpower committee, review the need for the post and consider the alternative ways of providing the service.

(9.3) The great majority of overseas doctors who enter the country in the future can be expected to leave after completing their four year period of postgraduate training. However, those who opted for an unpopular specialty could be eligible to take career posts provided that their prospective employers obtained work permits for them. Work permits can only be granted where the employer shows that no suitably qualified UK or European Community doctor has applied for the job.

(9.4) Health authorities, with professional advice, should review

*This recommendation is not intended to apply to general practitioner paragraph 94 appointments.

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the position of doctors now in the training grades who are judged unlikely to make any further career progress, and arrange for them to receive suitable careers counselling. Many of these are overseas doctors who entered the UK before 1 April 1985; they have the right to stay in the country and may wish to seek a career here. Sympathetic consideration should be given to their needs, and options might include

(9.4.1) retraining in another specialty or for general practice,

(9.4.2) appointment to the new intermediate service grade (when available),

(9.4.3) personal regrading to associate specialist,

(9.4.4) exceptionally, the grant of a five year rolling contract in respect of the post already held.

(10) **Local and central planning and controls**

(10.1) The new arrangements would require a close partnership between local and central planning. Health departments, with advice from the JCC and other central advisory bodies such as the Central Manpower Committee and the Joint Planning Advisory Committee (paragraph (1.2)), would be responsible for the overall framework for manpower planning; this would include:

(10.1.1) the allocation of regional quotas for training posts in the senior registrar and registrar grades (paragraphs (3) and (4.2)),

(10.1.2) monitoring the rate of consultant expansion (paragraph (1)), the reduction in the total number of registrar posts (paragraph (5)), and the use made of the new intermediate service grade (paragraph (7)).

(10.2) Regional and district health authorities, with the advice of the regional manpower committee and local educational and university interests, would be responsible for detailed planning of medical manpower posts to meet local service and training needs within the framework determined centrally. Particular responsibilities would be:

(10.2.1) to determine the service need for additional consultant posts (paragraph (1)),

(10.2.2) to determine the minimum levels of support staff needed in the acute specialties for safe 24 hour emergency care (paragraph (8)),

(10.2.3) identifying high quality training posts (paragraphs (3), (4.5), and (4.7)), and

(10.2.4) determining the number of SHO posts needed in each specialty to accommodate the changes to the career structure arising from these proposals (paragraph (6)).

(10.3) Health authorities would be accountable for the discharge of these responsibilities to the Secretary of State, in the normal way. However, our group would also monitor the overall effect of these proposals so that they could be amended, as necessary, in the light of experience.

(11) **Unification of higher training**

The effect of these proposals would be to sharpen the distinction between training at SHO level—including a period of general professional training before final choice of specialisation—and training in the registrar and senior registrar grades—a period of training for the committed specialist. It may be possible in course of time to reduce the length of time spent in the registrar and senior registrar grades to the point at which they could be combined into a single higher training grade. In our judgment the present surplus in the registrar grade is so great that such a unification of the grades must necessarily remain a long term aim, but we recommend that health departments and professional and educational interests should work towards its achievement.

(12) **Implementation**

The need to start correcting the career imbalances is pressing. It is to be hoped that implementation of these proposals could begin by 1 January 1987.

Review body report and GPs' expenses

When the 1986 review body award was debated in the General Medical Services Committee concern was expressed about the reduced level of expenses. The point was made that some general practitioners and their accountants were not aware of the disadvantages to the profession in "netting out" expenses. The committee has, therefore, drawn the attention of local medical committees to the advice in *The Business of General Practice*.[1]

"The importance of recording your expenses fully, including those which have been directly reimbursed, cannot be overstated. Doctors who fail to to this, but 'net out' their figures, are responsible for a loss of income to the profession. Unfortunately, accountants sometimes fail to appreciate the point until their general practitioner clients explain it.

"The full wage of an ancillary should be shown in practice accounts as an expense, and the 70% reimbursement as income. Similarly with rent, the outgoing should show an expense, and the reimbursement as income. If the figures are shown net—that is, ignoring the staff salary and rent reimbursement, so that the accounts record only the 30% staff wage as an expense—the figures going to the review body will be distorted.

"The technical subcommittee will take the net 30% of staff wages, and deduct from that the 70% and the rent reimbursement. That will show a misleadingly low figure for that general practitioner's annual expenses, and if there are many similar cases the review body will give artificially low weight to the need for more payments towards expenses."

The 1986 annual report of the GMSC has a section on standardised practice accounts (appendix XIV).

1 General Medical Services Committee. *The business of general practice*. London: Medical Publications Ltd, 1983.

Local debates on primary care

The Minister for Health has urged community health councils to cooperate with health authorities and family practitioner committees towards a "common goal of better services for patients." Speaking to the councils' annual meeting on 3 July he asked them to generate "a genuine local debate" on the government's proposals on primary health care. CHCs had an important part to play in plans to introduce more consumer responsiveness into the NHS, he said.

NHS general managers

In a recent parliamentary written answer the Minister for Health reported that health authorities had made the following general manager appointments in the National Health Service.

NHS general managers

	Number
Regional general managers	
Doctors	1
Nurses	1
Administrators	9
Treasurers	1
Private sector	1*
Self employed	1*
District general managers	
Doctors	15
Nurses	5
National Health Service administrators	113
National Health Service treasurers	17
Private sector	18*
Public sector	4*
Armed Forces	12*
Self employed	3*
Overseas	1*
Unit general managers	
Doctors	97
Nurses	63
National Health Service administrators	322
National Health Service treasurers	6
Ambulance officer	2
Physicist/scientist	2
Works officers	2
Professions allied to medicine	4
Private sector	21*
Public sector	12*
Armed forces	9*
Self employed	1*
Overseas	1*

*Non National Health Service.

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