

THE ENGLISH NATIONAL HEALTH SERVICE: A PROFILE OF DEVELOPMENTS AND PLANS FOR THE WORKFORCE

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THE BRITISH NATIONAL HEALTH SERVICE

The British National Health Service (NHS) is a system that is virtually 100% free at the point of service. The fundamental structure lies within the broader Departments of Health of England, Northern Ireland, Scotland and Wales respectively, each with an NHS Executive (England) or equivalent. The English Executive has a central body (in Leeds) and eight Regional Offices. The NHS Regions have populations between 5 and 8.5 million. Within NHS Regions the overview of health needs and the commissioning / purchasing of health care is currently in the domain of Health Authorities, but this is being partially devolved at a rapid pace to Primary Care Groups (PCGs) with populations of anything between 300,000 and 900,000. Primary care is largely provided by partnerships of general practitioners (GPs) and multiprofessional teams, in semi-autonomous practices funded by the NHS. Increasing numbers of GPs are now opting for salaried positions, working for GP partnerships or other NHS organisations or new “direct access” clinics which are often funded independently. Secondary and tertiary care, and community care, are delivered through hospitals and services managed by NHS Trusts, commissioned, to some extent directed, and closely performance-managed by Health Authorities and Regional Offices. The excellent paper prepared for this conference by Professor Alan Maynard gives a fuller and more precise picture of many aspects of the NHS in the year 2000.

Alan Maynard's paper (see pages 243-258) has attached tables, particularly Tables 1 and 2, which give an insight into the NHS workforce statistics. Attached to this paper are Tables 1 to 4 which provide some expanded information on those figures. It should be emphasised that the tables below refer exclusively to the figures within England. The overall picture is very similar in Northern Ireland and Wales, but Scotland has a significantly greater staffing and funding level per capita.

THE NHS PLAN (www.nhs.uk/nhsplan)

Following a period of intense consultation, overt and covert, and vigorous exploration of new health and social policy, July 2000 saw the publication of a powerfully directive game plan for “the new NHS”. Unusually, it was accompanied by a dramatic commitment to increase in resource ... “growth by one half in cash terms and one third in real terms in just five years”. The Plan as published applies to England specifically, not the UK as a whole, but very similar directions of movement of policy are now likely to follow in Wales, Scotland and Northern Ireland. The Executive Summary of the NHS Plan is extracted and reproduced as Appendix 1.

Investment in staff is clearly of particular relevance to this conference, but other features are notable as context:

- criticisms of “old fashioned demarcations between staff and barriers between services”
- new hard measures to set and deliver national standards; building on the recent introduction of formal “clinical governance” ie. quality assurance systems embedded and transparent in all NHS organisations, new national bodies will include ...
 - ◆ a National Institute for Clinical Excellence (NICE), building on experience of Cochrane collaborations and quality assurance methodology
 - ◆ a Commission for Health Improvement (CHI) to “police” the system (developmentally, it is claimed)
 - ◆ more formal contracts for more GPs
 - ◆ barring new NHS consultants from private work in their first few years (seven is suggested)
 - ◆ extension of flexibility of roles and skills mix especially but not exclusively of nurses and midwives

A HEALTH SERVICE OF ALL THE TALENTS: DEVELOPING THE NHS WORKFORCE

(www.doh.gov.uk/wfprconsult)

Judy Hargadon and Martin Staniforth (participants in this conference) had hinted at revolution a few months previous to the publication of the definitive NHS Plan, in a provocative consultation document, familiarly known as the workforce planning review. The Executive Summary, reproduced here as Appendix 2, identified many other key issues which were to reappear in The NHS Plan.

CHANGES FOR NHS DOCTORS

(Section 8 of The NHS Plan; www.doh.gov.uk/wfprconsult)

This serves as an effective summary of policy and intention regarding the size and nature of the NHS medical workforce of the future. Some ancillary notes may be helpful to readers unfamiliar with UK systems (paragraph numbers refer to those in the document, Appendix 3):

- 8.2 Reference to faster growth of GPs indicates the widely predicted need for more doctors to be involved in primary care, particularly given the increasing trend towards part-time and flexible working for a number of demographic reasons.
- 8.3 The “red book” referred to in several places is effectively a complex and politically sensitive memorandum of agreements and contracts between “independent” GP contractors and the NHS.

- 8.10 An undue proportion of referrals to the General Medical Council for performance failure arise from single handed practices, and several mechanisms will now pressure those in those circumstances – apart from isolated and rural areas – to work collaboratively.
- 8.13 The funding mechanisms for most trainees in the hospital service in England is a 50% contribution to basic salary through an educational budget managed by Regional Postgraduate Deans, the remaining 50% of basic salary and overtime being contributed by the Trust. This recognises the dual commitment to education and training on the one hand and service and care of patients on the other. Some very junior doctors and those in Public Health and those with part-time contracts are more fully funded, often 100%, and a range of schemes operate across the UK as a whole. The Scottish model of 100% funding of all training contracts through the training budget is being envisaged, and it is this which is implied by the last sentence, “the government will centrally fund all specialist registrar posts....”. This managed contribution of these posts through Deans acting to the standards and requirements of Colleges and the NHS Executive has proved effective in raising and maintaining standards following the ‘Calman Reforms’.
- 8.17 Career grade doctors, not in training and not in consultant posts, are termed staff doctors or staff grades or associate specialists, and the concept of a new “specialist grade” was proposed at one stage in the Workforce Planning Review. This would be a doctor appropriately qualified with a Certificate of Completion of Specialist Training (CCST), who would, as in Europe or post Boards in the United States, be able to practise independently as a specialist or within a managed team in a department, while not carrying the expected experience or management role of the classic NHS “consultant”. The proposal has proved unpopular with hospital consultants and those training for the position.
- 8.18 *et seq* ... These paragraphs suggest a new discipline in regard to the expectations of the NHS from consultants under contract, particularly as in 8.23 and 8.24 with the reference to tight regulations regarding work outside the NHS for those employed by the NHS.
- 8.27 An overhaul of the senior house officer (SHO) grade, which occupies the average trainee from the end of his “internship” as a pre-registration house officer to his entry into higher specialist training as a specialist registrar (SpR), is seen by all to be overdue. Many of these posts are of good quality, and some are in excellent programmes, but many meet neither of those criteria. There is considerable interest in early SHO posts becoming explicitly part of general professional training for 1 year or perhaps longer, moving into foundation programmes which are explicitly linked to and relate to programmes leading to a CCST, or occasionally into general practice. Many of those entering into general practice would be expected to engage in general professional training programmes to a greater extent, or one might see the evolution of a foundation programme specifically generalist in nature.

This is very much unfinished business and will provide the new wave of activity for 2001.

In other recent documents there has been much discussion in regard to the prediction of needs for various species of doctor as expressed by the service and focussed centrally, and the Workforce Planning Review and The NHS Plan both envisage an increased commitment to integrated all-health-professional planning, both locally and centrally. An interesting innovation is the thought that this should be handled within care-plans for particular categories of illness or patient, for example, coronary care, cancer, mental health, or diabetes. The mechanics of such care-based planning has yet to be exposed and discussed. In the meantime the workforce advisory groups at all levels are attempting to improve the effectiveness of their needs analysis and workforce predictions.

Apology

We apologise to our colleagues that due to illness and through circumstances quite beyond anyone's control, the preparation of this paper was delayed and could not be commenced until Monday 6 November. It is for this reason that the briefing has had to be in the nature of hard data and, in the main, extracts from published documents. It is hoped that this will provide enough of a picture to be useful for discussion by participants.

APPENDIX 1: THE NHS PLAN - EXECUTIVE SUMMARY

This is a Plan for investment in the NHS with sustained increases in funding. This is a Plan for reform with far reaching changes across the NHS. The purpose and vision of this NHS Plan is to give the people of Britain a health service fit for the 21st century: a health service designed around the patient. The NHS has delivered major improvements in health but it falls short of the standards patients expect and staff want to provide.

Public consultation for the Plan showed that the public wanted to see:

- more and better paid staff using new ways of working;
- reduced waiting times and high quality care centred on patients; and
- improvements in local hospitals and surgeries.

In part the NHS is failing to deliver because over the years it has been underfunded. In particular there have been too few doctors and nurses and other key staff to carry out all the treatments required. But there have been other underlying problems as well. The NHS is a 1940s system operating in a 21st century world. It has:

- a lack of national standards;
- old-fashioned demarcations between staff and barriers between services;
- a lack of clear incentives and levers to improve performance; and
- over-centralisation and disempowered patients.

These systematic problems, which date from 1948 when the NHS was formed, are tackled by this Plan. It has examined other forms of funding healthcare – and found them wanting. The systems used by other countries do not provide a route to better healthcare. The principles of the NHS are sound but its practices need to change.

The March 2000 Budget settlement means that the NHS will grow by one half in cash terms and by one third in real terms in just five years. This will fund extra investment in NHS facilities...

- 7,000 extra beds in hospitals and intermediate care;
- over 100 new hospitals by 2010 and 500 new one-stop primary care centres;
- over 3,000 GP premises modernised and 250 new scanners;
- clean wards – overseen by ‘modern matrons’ – and better hospital food; and
- modern information technology systems in every hospital and GP surgery.

...and investment in staff:

- 7,500 more consultants and 2,000 more GPs;
- 20,000 extra nurses and 6,500 extra therapists;
- 1,000 more medical school places; and
- childcare support for NHS staff with 100 on-site nurseries.

But investment has to be accompanied by reform. The NHS has to be redesigned around the needs of the patient. Local hospitals cannot be run from Whitehall. There will be a new relationship

between the Department of Health and the NHS to enshrine the trust that patients have in frontline staff. The principles of subsidiarity will apply. A new system of earned autonomy will devolve power from the centre to the local health service as modernisation takes hold.

The Department of Health will set national standards, matched by regular inspection of all local health bodies by the Commission for Health Improvement. A more streamlined centre will merge the posts of Permanent Secretary and Chief Executive creating one post which will be appointed in the autumn.

The National Institute for Clinical Excellence will ensure that cost effective drugs like those for cancer are not dependent on where you live. A Modernisation Agency will be set up to spread best practice.

Local NHS organisations that perform well for patients will get more freedom to run their own affairs. There will also be a £500 million performance fund. But the Government will intervene more rapidly in those parts of the NHS that fail their patients.

For the first time social services and the NHS will come together with new agreements to pool resources. There will be new Care Trusts to commission health and social care in a single organisation. This will help prevent patients – particularly old people – falling in the cracks between the two services or being left in hospital when they could be safely in their own home.

For the first time there will be modern contracts for both GPs and hospital doctors. NHS doctors work hard for the NHS. But the contracts under which they work are outdated. There will be a big extension of quality-based contracts for GPs in general, and for single-handed practices in particular. The number of consultants entitled to additional discretionary payments will rise from half to two-thirds but in return they will be expected to increase their productivity while working for the NHS. Newly qualified consultants will not be able to do private work for perhaps seven years.

For the first time nurses and other staff not just in some places, but everywhere will have greater opportunity to extend their roles. By 2004 over half of them will be able to prescribe medicines. £280 million is being set aside over the next three years to develop the skills of staff. All support staff will have an Individual Learning Account worth £150 per year. The number of nurse consultants will increase to 1,000 and a new role of consultant therapist will be introduced. A new Leadership Centre will be set up to develop a new generation of managerial and clinical leaders, including modern matrons with authority to get the basics right on the ward.

For the first time patients will have a real say in the NHS. They will have new powers and more influence over the way the NHS works:

- letters about an individual patient's care will be copied to the patient;
- better information will help patients choose a GP;
- patient advocates and advisers will be set up in every hospital;
- proper redress when operations are cancelled on the day they are due to take place; and
- patients' surveys and forums to help services become more patient-centred.

For the first time there will be a concordat with private providers of healthcare to enable the NHS to make better use of facilities in private hospitals – where this provides value for money and maintains standards of patient care. NHS care will remain free at the point of delivery – whoever provides it.

These far reaching reforms to the service will result in direct improvements for patients.

Patients will see waiting times for treatment cut as extra staff are recruited:

- by 2004 patients will be able to have a GP appointment within 48 hours and there will be up to 1,000 specialist GPs taking referrals from fellow GPs;
- long waits in accident and emergency departments will be ended; and
- by the end of 2005 the maximum waiting time for an outpatient appointment will be three months and for inpatients, six months.

The treatment of cancer, heart disease and mental health services – the conditions that kill and affect most people will improve with:

- a big expansion in cancer screening programmes;
- an end to the postcode lottery in the prescribing of cancer drugs;
- rapid access chest pain clinics across the country by 2003;
- shorter waits for heart operations; and
- 335 mental health teams to provide an immediate response to crises.

Older people use the NHS more than any other group. This Plan will provide them with both better and new services:

- national standards for caring for older people to ensure that ageism is not tolerated;
- breast screening to cover all women aged 65 to 70 years;
- personal care plans for elderly people and their carers;
- nursing care in nursing homes to become free; and
- by 2004 a £900 million package of new intermediate care services to allow older people to live more independent lives.

The NHS Plan will bring health improvements across the board for patients but for the first time there will also be a national inequalities target. To help achieve this we will:

- increase and improve primary care in deprived areas;
- introduce screening programmes for women and children;
- step up smoking cessation services; and
- improve the diet of young children by making fruit freely available in schools for 4-6 year olds.

The NHS Plan will require investment and reform to make it work. But the funding is there to support change and it is backed by the key organisations in the NHS. There is a new national alliance behind a reformed, patient-centred NHS. These are the most fundamental and far reaching reforms the NHS has seen since 1948.

APPENDIX 2: A HEALTH SERVICE OF ALL THE TALENTS: DEVELOPING THE NHS WORKFORCE CONSULTATION DOCUMENT ON THE REVIEW OF WORKFORCE PLANNING

Executive summary

Nearly 1 million people work for the NHS. We spend some £2 billion a year on supporting training and education for clinical staff – and more money is spent locally on staff development and training. We need to make sure that we plan and develop the NHS workforce, and use our investment in it, to deliver the best, most effective, care for patients. Because caring for people is what the NHS is all about.

This report stems from long-standing concerns about the way in which the NHS educates, trains and uses its staff. Its proposals and recommendations – which are summarised below – are wide-ranging and radical. But at their heart is a simple theme – that the NHS workforce, whose commitment no-one can doubt, needs to be transformed in order to provide the sort of care which will be needed in the future. The emphasis needs to be on:

- *team working* across professional and organisational boundaries;
- *flexible working* to make the best use of the range of skills and knowledge which staff have;
- *streamlined workforce planning and development* which stems from the needs of patients not of professionals;
- *maximising the contribution of all staff to patient care*, doing away with barriers which say only doctors or nurses can provide particular types of care;
- *modernising education and training* to ensure that staff are equipped with the skills they need to work in a complex, changing NHS;
- *developing new, more flexible, careers* for staff of all professions and none; and
- *expanding the workforce* to meet future demands.

And we need to do this not just because it is the right thing to do but because it will provide patients with the care they have the right to expect. Care which is delivered quickly, by skilled professionals, who listen to them and provide the best possible treatment and care.

The NHS has dedicated, hard-working staff. We need more of them. The Government is committed to expanding the NHS by expanding the number of doctors, nurses and other health professionals. But alongside expansion must come reform, to change the way staff work, the way they are trained and how they are educated. Realising the potential of all NHS staff is our aim. We want a health service of all the talents.

The proposals and recommendations in this report, which is published for consultation, are aimed at helping to deliver the workforce the NHS now needs.

What are we trying to achieve?

Chapters 1 and 2 of the report set out briefly the reasons why the current workforce planning arrangements need to be changed in order to deliver the workforce which the modernised NHS requires.

Where are we now?

Chapters 3 and 4 of the report describe the current arrangements for workforce planning and the problems which need to be tackled. In particular current arrangements are not:

- built around service needs and the skills required to deliver them;
- well integrated with service and financial planning;
- holistic in their approach, looking across primary, secondary and tertiary care or across staff groups;
- responsive to service changes and developments; and
- supportive of multi-disciplinary training, education and working.

What changes need to be made?

In order to improve the present arrangements the review makes a number of proposals and recommendations covering four key areas. While some of its recommendations are firm and can, subject to consultation, be taken forward quickly, others will require more debate and discussion to agree the way forward.

Greater integration, more flexibility

The review recognises that current workforce planning and development arrangements inhibit the development of multi-professional planning and have not supported the creative use of staff skills. It stresses the need for:

- greater integration of workforce planning and development with service and financial planning;
- more flexible deployment of staff to maximise the use of their skills and abilities.

It then makes a number of proposals to help achieve these aims, including:

- Workforce planning and development to be aligned with service planning at local level through the Health Improvement Programme (HImP).
- Workforce plans to be developed on a multi-disciplinary basis, focusing on services to be delivered and looking across primary, secondary and tertiary care.
- The establishment of a National Workforce Development Board, supported by Care Group Workforce Development Boards, to be responsible for ensuring the proper integration of workforce issues with service development taking account of skill-mix changes and research and development findings. It should incorporate the work of existing uni-professional groups.
- The merger of education and training levies to provide an integrated funding stream.
- Central action to co-ordinate work on skill-mix changes and the development of new types of healthcare worker.

Better management ownership, clearer roles and responsibilities

The review concludes that effective workforce planning and development requires greater clarity about responsibilities, proper management and clear systems of performance management. At employer level it is the responsibility of each NHS Trust or other local employer to develop workforce plans for their organisation and be held to account for their delivery. While these local plans provide a major input to national workforce planning they are not sufficient on their own. First, the NHS is not only the employer of healthcare professionals, and second, the time horizon for local planning is necessarily limited compared with, say, the time required to train doctors. The review recommends that:

- NHS Trust Chief Executives ensure workforce plans are developed for their organisation.
- Health Authority Chief Executives are accountable for preparing workforce plans to support local HImPs.

Workforce Development Confederations are established to bring together NHS and other employers of healthcare staff to:

- ensure coherence across their area and that all staffing requirements are identified;
- provide information to support central planning for basic professional training;
- contract for NHS-funded education; and
- provide a focus for developing local HR strategies where appropriate.

These would replace current education consortia and take over relevant functions from Local Medical Workforce Advisory Groups.

- The establishment of sub-groups of the National Workforce Development Board to look across the board at future undergraduate and postgraduate training requirements in the light of information drawn from Confederations and Care Group Workforce Development Boards.
- NHS Executive Regional Offices to have a strengthened performance management role to ensure the delivery of local and confederation plans.
- The appointment of Directors of Workforce Development in each Regional Office, to whom postgraduate deans and others would report.
- A comprehensive review of information requirements to support workforce planning.

Improved training, education and regulation

The review recognises the need to build on, and develop, partnership working with those providing training and education for the NHS workforce and with the relevant regulatory bodies. Education providers should be fully involved in developing workforce plans in local health economies, contributing their knowledge and expertise. It is also important that the NHS works with higher education providers and regulatory bodies to improve the flexibility of basic and post-basic training programmes, facilitating career shifts during and after training. Some of the more detailed proposals include:

- The development of training and education arrangements for staff which are genuinely multi-professional and provide greater scope for switching training paths without staff having to start their training afresh.
- Building on the changes in the nursing strategy Making a Difference to develop wider entry routes into nurse and other professional training, and working with higher education.
- Providers to design appropriate training for new types of healthcare worker.
- Addressing contract price variations for NHS-funded education and developing longer-term contracts with education providers.
- Placing a clear responsibility on individual employers and Workforce Development Confederations, to establish good quality clinical placements, and to establish Specialist Registrar posts, supported by more flexible funding arrangements for such posts.
- Ensuring that accreditation is not withdrawn from medical and dental training posts without a proper discussion of service and other related issues.

- A new relationship between the NHS and clinical staff whose education it funds under which if staff commit to working to the NHS for a fixed period the NHS would commit to employing them for that time subject to satisfactory performance.
- Reviewing the private sector's contribution to education and training.

Staff numbers and career pathways

The review recognises that England has fewer doctors per head than many other Western countries. Although staff numbers are not the only factor here – there are issues about how efficiently and effectively staff work – there is a need for more staff. While not centrally concerned with workforce numbers the report recommends a review of the longer-term requirements for all professional staff.

The report recognises the need for clear and flexible career structures and pathways for staff, which reflect the changing ways in which staff, will wish, and need, to work in future. Much work has already been done, or is in hand, in this area, particularly for nurses, therapists and scientists but the report believes more needs to be done. In the medical and dental fields it believes there will be an increasing need for hospital services to be delivered by fully trained doctors and dentists. It proposes that:

- The number of fully trained doctors and dentists will need to increase but this will need to be accompanied by changes in the way in which they work. This could be achieved through changes to consultant contracts and job plans but serious consideration should also be given to establishing a specialist grade which would be staffed by fully trained doctors who would work alongside, but not under the clinical supervision of, consultants and be appropriately remunerated.
- Steps should be taken to provide a proper career structure for staff employed as non-consultant career grades (eg. staff grades, associate specialists and other Trust-specific grades), which will see them providing a valuable and valued role within the hospital and community health services.
- The SHO grade should be reformed with the aim of providing better and broader educational experience and a reduction in inappropriate workload.
- Improved career counselling and support arrangements should be developed for doctors in training and other staff, particularly in the early stages of their careers.
- Action should be taken to enable Specialist Registrars and consultants to retrain in another specialty if they wish to without requiring them to start from scratch.
- There should be a fundamental review of the primary care workforce.

Implementation

The review recommends that a properly resourced implementation team be put in place to ensure delivery of the changes it recommends.

APPENDIX 3: THE NHS PLAN - CHANGES FOR NHS DOCTORS

Summary

- expansion of medical students, specialist registrars, consultants and GPs
- further expansion to follow
- move to new quality-based contracts for GPs
- new arrangements for single-handed practices
- new contract for consultants
- extra rewards for consultants tied to NHS service

Introduction

8.1 Doctors working in primary care and in hospitals work hard for their patients. Both their commitment and skill is highly valued. We have some of the finest doctors in the world. The NHS has to value its doctors by investing more in their skills and their efforts for patients. But the contractual arrangements for GPs and consultants stem from 1948. They are based on arrangements that in important respects are not relevant to today's world. In partnership with doctors and their representatives now is the time to make changes to help deliver the improvements in this Plan.

Family doctors

8.2 Our family doctors are a real source of strength for the NHS. As a result of the changes in this Plan we will have strengthened GP services still further:

- There will be 2,000 more GPs and 450 more GPs in training by 2004. This will just be a start – faster growth of the number of GPs will need to continue beyond 2004.
- There will be a bigger role for GPs in shaping local services, as more become specialist GPs, as PCTs become universal and as new care trusts, incorporating social services as well as health services, come on stream.
- Pressure on GP services will be eased as nurses and other community staff together with a new generation of graduate primary care mental health workers take on more tasks.
- Up to 3,000 family doctors' premises including 500 new primary care centres will benefit from a £1 billion investment programme by 2004.
- GPs will be helped with their continuing professional development through earmarked funds.
- NHS occupational health services will be extended to cover family doctors.

8.3 The development of primary care services is key to the modernisation of the NHS. However, we need to modernise the relationship between the NHS and GPs, building on what is already good. The current GP contract - the 'red book' - has often worked well, but it gives greater emphasis to the number of patients on a GP's list and the quantity of services provided rather than the quality of them. Too often it has been an obstacle to GPs who have wanted to develop services tailored to the needs of their own local population.

8.4 Family doctors are also looking for better and more flexible ways of working. For example, some GPs want to spend at least part of their career as salaried doctors rather than independent contractors. A significant number want to restructure their practices, perhaps to develop new

services by using their staff in new ways or co-operating with other practices in offering care across a local community.

8.5 Since 1998 an increasing number of GPs have been working to a different type of contract - the Personal Medical Services (PMS) contract - instead of working to a standard national contract. Personal Medical Services pays GPs on the basis of meeting set quality standards and the particular needs of their local population. For example, if an area had a particularly high level of heart disease the PMS contract could set targets for ensuring that local people at risk were identified and prescribed appropriate treatment.

8.6 In some PMS schemes all members of the healthcare team - doctors, nurses and other health professionals - work on a similar contract instead of the traditional arrangement where staff work for a self-employed GP. PMS also allows GPs, if they choose, to work on a salaried part-time or full-time basis.

8.7 This approach has brought a wide range of benefits. It has been used to develop new services for specific populations, such as ethnic minority communities, to attract doctors and nurses into deprived areas and to improve services for patients.

Case study of a PMS scheme in an area of deprivation

Until recently, the Pennywell area of Sunderland could not attract any GP practices to serve a population of approximately 13,500 people. Under PMS, the local NHS trust now employs a GP and fully integrated primary healthcare team to work in partnership with the community and other local agencies. People in this area of high need now have fast access to a wide range of primary care services. These include minor operations, drop in sessions, health promotion, asthma control and breast screening clinics.

Some services require no appointment. In others, appointments take place on the same day of asking and the average wait for an appointment is just one day. This shift to managed healthcare means a move away from reliance on emergency care. Some 2,300 accident and emergency attendances by patients registered with the Pennywell pilot took place in the year before it went into operation. That number has now fallen by 40%.

8.8 We will encourage a major expansion of PMS contracts. All the current pilot schemes that are successful will become permanent. By April 2002 we expect nearly a third of all GPs to be working to PMS contracts. And we expect the number to grow steadily over the next four years to form a majority of GPs. Salaried GPs will come to form a growing number of family doctors providing that is what they choose to do. We will make it easier to switch to a PMS contract by introducing a standard core contract to help cut bureaucracy. New entrants will, in the future, be able to make a more automatic switch into PMS without a lengthy pilot phase. The core contract will ensure basic

consistency on delivering key objectives such as access to primary care, national service framework standards, quality and clinical governance.

8.9 As we develop the core PMS contract we will work with GPs and their representatives to amend the national 'red book' contract. The revised national contract should reflect the emphasis on quality and improved outcomes inherent in the PMS approach. By 2004 both local PMS and national arrangements are set to operate within a single contractual framework that will meet the key principles and requirements of a modern NHS. This will be the most significant change to the way GPs work for the NHS since 1948.

Single-handed practices

8.10 It is particularly important to be able to confirm that single-handed practices are offering high standards, because although most single-handed GPs work hard and are committed to their patients, they tend to operate in relative clinical isolation. They do not have the ready support from colleagues enjoyed by GPs in larger practices. The current 'red book' contract is a particularly poor mechanism for protecting quality standards in these practices.

8.11 For this reason, new contractual quality standards will be introduced for single-handed practices. This will either be done through a negotiated change to the 'red book', or if this proves not to be possible, a new national PMS contract will be introduced into which all single-handed practices will be transferred by 2004. The role of primary care groups and primary care trusts in promoting and auditing clinical governance will also help reduce isolation and encourage co-operation between GPs.

Hospital doctors

8.12 Hospital doctors do a brilliant job for the NHS. Consultants are specialists whose expertise is highly valued by patients. As a result of the changes in this Plan by 2004 consultants working in the NHS will be benefiting from:

- a major investment in equipment, information technology and facilities; and
- a 30% expansion in consultant numbers with further increases in the pipeline as a result of expansion in medical school places and specialist registrar posts.

In the first instance this will help end single-handed consultants in hardpressed specialties.

8.13 But we intend to go further. As part of the Government's in principle commitment to major expansion of the consultant grade there will need to be a significant increase in the numbers of specialist registrars. One of the reasons that this has not happened in the past is that local NHS trusts have had to contribute part of the cost of specialist registrar posts. As a result there has been a large gap between the number of specialist registrar posts that have been planned for nationally and the number of posts that have actually been created locally. This will now change. From 2002 the Government will centrally fund all specialist registrar posts provided that agreement can be reached with the medical Royal Colleges and other bodies on curricula and criteria for training recognition.

8.14 In addition, as well as ensuring the creation of specialist registrar posts, the Department of Health will take action to help ensure that the appropriate number of consultant posts are

established in NHS trusts across the country. Drawing on national service frameworks, workforce plans will match the new standards of care with the numbers of staff required to implement them. NHS trusts will be performance managed against these standards.

8.15 So there will be a guarantee of more consultants and more future consultants too. There will also be a greater role for consultants in shaping local health services:

- hospital consultants will play a central role in the new local taskforces and modernisation boards that will advise on and oversee the implementation of this NHS Plan in all parts of the country
- strengthened forms of commissioning will draw more directly on the expertise of hospital consultants particularly when it comes to the regional commissioning of specialised tertiary services and in developing long-term service agreements with primary care groups and trusts
- radical new forms of clinically-led care will be piloted. In the first instance, pilots will be established to commission cancer services from the new cancer networks which span a number of individual NHS trusts.

8.16 Over the next decade there will be an unprecedented expansion in the number of consultants working in the NHS. It will be vital to ensure the NHS is getting the maximum contribution possible from both existing and new consultants.

8.17 Expansion on this scale also creates the opportunity to ensure that there is a clear career path for all senior doctors. We have examined two options here. The first would involve expanding the number of non consultant career grade doctors, often on trust specific contracts. This option would allow the NHS to get more fixed clinical sessions from senior doctors without competing with private practice, and it will be kept under review.

8.18 The second option is to make hospital care a consultant delivered service, where there is a clear career structure so that doctors have certainty about how they will progress and where contractual obligations to the NHS are unambiguous. It is this option that both the professions and the Government support in principle. Its implementation, however, will depend upon a new consultants' contract.

8.19 The national consultant contract is largely unchanged since 1948. Most consultants work very hard for the NHS and with tremendous commitment to the NHS. Many are working beyond their contractual commitments. But the way consultants are managed on the ground through their current contract is far from satisfactory. For instance, too few have proper job plans setting out their key objectives, tasks and responsibilities and when they are expected to carry out these duties. Even fewer have their performance regularly reviewed. The issue of consultants' private practice has remained a legacy of the 1948 settlement.

8.20 Consultants who make the biggest commitment to the NHS do not get the right rewards. In consultation with doctors and their representatives, we will, therefore, fundamentally overhaul the contract to reward and incentivise those who do most for the NHS.

8.21 As we have already agreed in principle with the British Medical Association, the new contract will make annual appraisal and effective job plans mandatory for all consultants. This process will

enable the professional and clinical needs of consultants to be identified and support clinical governance and revalidation. It must also ensure that NHS employers are able to manage the consultant workforce effectively in order to ensure the best use of their time and of the resources of the trust. Royal Colleges will be able to advise NHS trusts on, but not veto, the content of job descriptions for consultant posts. All consultants will have job plans specified by the employer linked to annual appraisal of their work.

8.22 Consideration has been given to 'buying out' the bulk of existing private practice nationally. However, careful analysis suggests this would be unlikely to work in practice: it would probably cost at least £700 million; the NHS would have to enter a bidding war with the private sector; it would seriously distort incentives; and it would be insensitive to local requirements. A different approach will therefore be taken.

8.23 At present, the consultants' contract requires them to work an ambiguous 'five to seven' fixed sessions a week. In future, existing consultants will, by default, be required contractually to undertake seven fixed sessions a week pro rata. Trusts will be able to fund extra, fixed consultant sessions on an as-needed basis, as at present. Assuming this condition and other aspects of the reformed consultant contract are being met, existing consultants will continue to be able to undertake private practice in their own time.

8.24 A move to a consultant-delivered service means that in future, newly qualified consultants will be contracted to work exclusively for the NHS for perhaps the first seven years of their career, providing eight fixed sessions, and more of the service delivery out of hours. In return we plan to increase the financial rewards to newly qualified consultants. Beyond this, the right to undertake private practice will depend on fulfilling job plan and NHS service requirements, including satisfactory appraisals. If agreement cannot be secured to these changes the Government will look to introduce a new specialist grade for newly qualified hospital specialists to secure similar objectives.

8.25 Over time we want to make clearer the advantages of making a long-term commitment to the NHS, particularly for those who will become consultants in the future. First, doctors – as well as nurses and other staff – who are working hardest for the NHS and improving services for patients, will have access to bonus payments from the National Performance Fund. Second, we will reform the existing distinction awards and discretionary points schemes. Together they provided £170 million last year in superannuable bonus payments – ranging from £2,500 to £60,460 – to consultants. But they are not sufficiently related to the NHS work these doctors undertake. They will be merged into a single, more graduated scheme with increased funding: to enable more awards to be made; to ensure that the bulk of any new awards go to consultants who are making the biggest contribution to delivery and improving local health services; and to ensure that bigger rewards go to consultants who make a long-term commitment to the NHS.

Following consultation with doctors and their representatives, we will publish explicit new criteria for the new single scheme by the end of the year. The new arrangements will come into force by April 2001:

- by 2004 we will aim to increase the number of consultants in receipt of a superannuable bonus from under one half of all consultants at present to around two-thirds and to double the proportion of consultants who receive annual bonuses of £5,000 or more
- the new scheme will be weighted so that consultants who are contracted exclusively to the NHS have accelerated access to proportionately bigger bonuses
- there will still be special provision for clinical academics (and for the first time academic GPs) and those consultants of national and international renown.

8.26 The new consultant contract will make clear that in the early and middle part of their careers, consultants will be expected to devote the bulk of their time to direct clinical care. It will also stipulate, however, that towards the end of their careers, consultants will have the flexibility to reduce their fixed clinical sessions without detriment to their pensions. We envisage a greater role for mentoring, training and leadership, for example.

Medical education

8.27 We will modernise the Senior House Officer grade, with the aim of providing better and broader educational experience and a reduction in inappropriate workload. New arrangements will be introduced progressively from September 2001. Junior doctors' hours will continue to fall.

8.28 We will rationalise the complex arrangement for medical education. As a first step we will establish a new body – the Medical Education Standards Board – to provide a coherent, robust and accountable approach to postgraduate medical education, replacing the separate bodies for general practice (the Joint Committee for Postgraduate Training in General Practice) and hospital specialties (the Specialist Training Authority). The Board will ensure that patient interests and the service needs of the NHS are fully aligned with the development of the curriculum and approval of training programmes. Membership of the new body will be drawn from the medical profession, the NHS and the public. It will accredit NHS organisations as training providers. We will wish to see consideration of options for overseeing medical undergraduate curricula considered as part of the radical review of the role of the General Medical Council, together with proposals for shortening the medical undergraduate course to three years for existing graduates and four years for others.

Clinical governance

8.29 The overwhelming majority of doctors provide safe, high quality care for patients. Medicine, however, is not an exact science. Mistakes do and will sometimes happen. The NHS has a responsibility to ensure that it has the right systems in place to keep mistakes to a minimum and to learn from them when they happen. That is why the Government has put a new focus on improving service quality. Patients have the right to expect assurances about the quality of care that they receive wherever they receive it in the NHS. There are new national standards, new systems of quality improvement and, for the first time a statutory duty of quality on all NHS organisations. The new system of clinical governance is being introduced into all parts of the NHS. There will be extra targeted investment in doctors continuing professional development to ensure that all doctors can meet the highest quality standards and requirements of clinical governance and revalidation, coupled with new regulatory safeguards.

Conclusion

8.30 The health service has much to be proud of in terms of the quality and reputation of its doctors. By 2004 there will be more doctors in the NHS with better rewards. They will be working in new ways to new contracts. Their ability to deliver redesigned services for patients, however, is partly dependent on developing new roles for nurses and other NHS staff.

Table 1: Total doctors, general practitioners and ratio GPs to non GPs, by gender, England, 1995 to 1999

	1995	1996	1997	1998	1999
Population	48,903,440	49,089,085	49,284,242	49,494,582	49,752,864
Male					
Number of doctors	56,435	57,410	58,926	59,794	60,787
Doctors per 100,000 pop.	115.4	117.0	119.6	120.8	122.2
GPs	20,007	19,925	19,909	19,802	19,815
GPs per 100,000 pop.	40.9	40.6	40.4	40.0	39.8
Ratio GPs to non GPs	1:1.8	1:1.9	1:2.0	1:2.0	1:2.1
Female					
Number of doctors	26,608	29,210	29,978	30,643	31,195
Doctors per 100,000 pop.	58.5	59.5	60.8	61.9	62.7
GPs	10,172	9,895	9,480	9,191	8,862
GPs per 100,000 pop.	20.8	20.2	19.2	18.6	17.8
Ratio GPs to non GPs	1:1.8	1:2.0	1:2.1	1:2.3	1:2.5
Total					
Number of doctors	84,459	86,584	89,619	91,837	93,981
Doctors per 100,000 pop.	172.7	176.4	181.8	185.5	188.9
GPs	28,869	29,116	29,389	29,697	29,987
GPs per 100,000 pop.	59.0	59.3	59.6	60.0	60.3
Ratio GPs to non GPs	1:1.9	1:2.0	1:2.0	1:2.1	1:2.1

As at 30 September each year

Table 2: Doctors qualifying, medical house officers (interns and junior residents) and registrars (residents), England, 1995 to 1999

	1995	1996	1997	1998	1999
<i>Medical degrees – accepted applicants</i>					
Degrees awarded	4,235	4,471	4,577	4,683	4,871
<i>Hospital medical house officers, by specialty</i>					
All specialties	3,220	3,220	3,360	3,450	3,540
Surgical	1,557	1,550	1,591	1,527	1,622
General medicine	1,640	1,616	1,708	1,748	1,831
Paediatric	14	14	18	26	36
<i>Hospital Medical Staff – Registrar Group*</i>					
Registrars	10,820	10,840	11,360	11,590	12,100

Note: * the specialist registrar grade was introduced on 1 April 1996; comparisons across years should therefore be interpreted with caution

Source: UCAS Department of Research and Statistics, Department of Health medical and dental workforce census

Table 3: Hospital specialists/consultants, by specialty group and gender, England, 1995 to 1999

	1995	1996	1997	1998	1999
Number of practitioners					
<i>Male</i>					
All specialists	14,940	15,480	16,130	16,650	17,297
Surgical group	3,582	3,734	3,909	3,975	4,191
General medicine	3,609	3,756	3,865	3,962	4,103
Paediatrics	727	753	789	827	845
Pathology	1,216	1,271	1,299	1,325	1,339
<i>Female</i>					
All specialists	3,640	3,740	4,070	4,390	4,720
Surgical group	162	175	185	211	240
General medicine	601	700	791	847	912
Paediatrics	376	400	438	472	510
Pathology	480	497	539	563	593
<i>Total</i>					
All specialists	18,400	19,220	20,200	21,040	22,017
Surgical group	3,744	3,914	4,094	4,186	4,431
General medicine	4,210	4,427	4,656	4,809	5,015
Paediatrics	1,103	1,156	1,227	1,299	1,355
Pathology	1,696	1,781	1,838	1,888	1,932
Practitioners per 100,000 population					
<i>Male</i>					
All specialists	30.5	31.5	32.7	33.6	34.8
Surgical group	7.3	7.6	7.9	8.0	8.4
General medicine	7.4	7.7	7.8	8.0	8.2
Paediatrics	1.5	1.5	1.6	1.7	1.7
Pathology	8,139.2	8,210.6	8,053.3	7,958.0	7,741.2
<i>Female</i>					
All specialists	7.1	7.6	8.3	8.9	9.5
Surgical group	0.3	0.4	0.4	0.4	0.5
General medicine	1.2	1.4	1.6	1.7	1.8
Paediatrics	0.8	0.8	0.9	1.0	1.0
Pathology	13,872.8	13,288.8	13,243.2	12,824.6	12,563.6
<i>Total</i>					
All specialists	37.6	39.2	41.0	42.5	44.3
Surgical group	7.7	8.0	8.3	8.5	8.9
General medicine	8.6	9.0	9.4	9.7	10.1
Paediatrics	2.3	2.4	2.5	2.6	2.7
Pathology	9,217.4	9,266.4	9,099.0	8,973.4	8,775.0

Note: as at 30 September each year