

To: HA chief executives
NHS Trust chief executives
Chief executives of public bodies and government agencies

Copies: Regional directors of public health
Postgraduate medical and dental deans
Deans of Medical Schools and Faculties
Directors of postgraduate education for general practice
Presidents of medical and dental Royal Colleges
Chairmen of local medical workforce advisory groups
Chairmen of regional education and development groups
Chairmen of consortia
Public Health Laboratory Service
National Blood Authority
General Medical Council
General Dental Council
NHS Confederation
British Medical Association
Joint Consultants' Committee
Community Health Councils

14 April 1997

EL(97)25

Dear Colleague

**A WORKING DRAFT TO DEVELOP A QUALITY FRAMEWORK FOR HCHS
MEDICAL AND DENTAL STAFFING**

1. This letter introduces a working draft from which we intend to develop the Quality Framework. We are publishing the draft for consultation. We are seeking views and operational experience on its format and practical value as a working tool.
2. We intend the Framework to become a key strand of a new medical workforce strategy based on quality. The broad aims were outlined to NHS managers at regional conferences in the autumn of 1995 and we have, since then, developed the detailed arrangements, working closely with NHS management and the medical profession.
3. Our aim is to help trusts in securing an appropriate medical workforce to provide high quality patient care. The new arrangements acknowledge the responsibilities and freedoms of trusts as employers and providers of services in setting the shape and composition of the workforce locally. They also recognise the educational and standard setting role of the medical profession, including the Royal Colleges.
4. In August 1996 we set up Local Medical Workforce Advisory Groups (LMWAGs -

EL(96)68). Their purpose is to advise regional offices on the quality aspects of trusts' medical staffing plans and to help, where requested, trusts and their purchasers in the development of those plans. They can provide a focus for discussion on medical staffing quality issues locally and may provide a useful forum in which key parties can discuss the major questions.

5. It would be difficult for the main interests to work together to consider and establish quality standards without providing them with guidance. The present working draft aims to do this and to explain the context within which planning a quality medical workforce can take place. The document is, therefore, a compendium of the policy and guidance relating to quality which has been issued in the past few years.

6. It is inevitably a long document, but it is a reference work which is not intended to be read as a whole. It brings together in one volume much of the material which might influence trusts' thinking. It will enable LMWAGs and purchasers to discuss the quality of the medical workforce against a clear set of standards.

7. Given the size of the draft and its purpose as a reference tool it is not necessary to distribute the entire document widely. Initially, one copy is being sent to each trust, LMWAG member and to other key interests. However, Annex 1 to this EL should be regarded as an *executive summary* for the purposes of this consultative draft. This conveys the important messages which will shape the Quality Framework including its purpose, a summary of the new medical staffing arrangements and the context in which it should be used. This EL and executive summary may helpfully be copied more widely amongst senior managers in trusts and health authorities. We are considering the need to develop a more refined user guide to accompany future editions.

8. The working draft contains a detailed introductory section which is largely reproduced in the executive summary at Annex 1. It may be helpful, however, to outline here some of the main points. The document is divided into four main parts. The first sets out the requirements of good medical practice - the standards of care to which all doctors aspire is the foundation on which all our planning must be based. The following three parts offer guidance on seeking, and maximising the contribution of, the right staff, supporting high quality professional practice and dealing with problems. Further detail is provided in the annexes and appendices. Some sections contain matrices which list and reference key quality features and indicate whether they are statutory *requirements* or *expectations* enshrined, for example, in the Planning and Priorities Guidance, or *good practice*.

9. Trusts will need to consider how the service they provide compares to the standards set in the document. They may wish to discuss this with their purchasers and with LMWAGs. Where there is concern about quality, the standards set can be used to develop plans which, if they involve changes in doctor numbers, will help us to plan centrally.

10. There is one important new feature - Section 4, *Staff skill-mix ratios*. Trusts will already know that we conducted an exercise in October to validate and refine data from the 1995 medical and dental census. The object of this was to provide LMWAGs with information on medical staffing ratios which would allow them to begin their consideration of quality issues. Much of the data has now been refined and is contained in this section and its appendix. It will allow both trusts and purchasers to look at individual specialties and to

compare their staffing profiles with the national picture and with trusts of a similar type. As a starting point for their work LMWAGs are asked to consider first the specialties in trusts which fall into the lowest 10% of the distribution nationally.

11. These ratios, however, should not be seen as inflexible requirements. Rather, they represent the basis for enquiry and discussion. LMWAGs will be able to take into account local circumstances and plans already in place and are likely to resolve many of their concerns directly with trusts. Where quality problems are identified by LMWAGs they can, if asked, help a trust to find a solution.

Central medical workforce controls

12. At the core of the new strategy is a concern to ensure a high quality medical workforce in a way which allows trusts to exercise local responsibilities with support and input from the key interests. These arrangements replace the existing central medical workforce controls largely established in the 1987 agreement *Achieving a Balance*. With immediate effect, therefore, the national ceiling on staff grade numbers is removed. The LMWAGs will not become involved in individual staff grade appointments. This will be the responsibility of trusts. However, LMWAGs will need to consider the quality aspects of each trust's overall medical staffing profiles as they relate to non-consultant career grades and to discuss concerns with trusts where necessary. The intention in removing these central controls is not to encourage a significant change in the proportion of care delivered by non-consultant career grades but, rather, to provide trusts with more flexibility in the development of appropriate medical skill-mixes.

13. At the same time, it is necessary to introduce new arrangements for the appointment of associate specialists. These are set out in **Annex 2**. In summary, the existing mechanism for the approval of personal regradings by regional manpower committees is replaced by a new quality control arrangement which will see representatives of the relevant Royal College or Faculty involved in the regrading process. We have also expanded the scope for the competitive recruitment of associate specialists, again with appropriate quality controls. As with staff grades, LMWAGs will have an overall quality assessment role which will take in the numbers and mix of associate specialists.

Medical workforce planning

14. In time, LMWAGs will use trusts' annual business and three-yearly strategic plans as the basis of their discussions with them. We recognise, however, that medical workforce planning is not uniformly well-developed at local level and such workforce issues are not always made explicit in plans. It would be unrealistic now to expect trusts to produce quickly the detailed plans which might be of use to LMWAGs and for central planning.

15. We intend, therefore, over the next few months, to develop guidance which will help trusts to produce medical workforce plans which:

are consistent in content and format;

enable LMWAGs to hold meaningful discussions with trusts;

fit in with the integrated approach to workforce planning envisaged in EL(96)46;

reflect the standards identified in the Quality Framework and action to address concerns;

inform central planning.

16. Medical workforce planning cannot be seen in isolation but should form part of integrated workforce strategies. An important step has been to establish cross-membership between LMWAGs and REDGs. We shall, however, need to build on this and to develop NHS workforce planning as a whole. Regional offices are already arranging meetings, workshops and seminars to promote better understanding of integrated workforce planning.

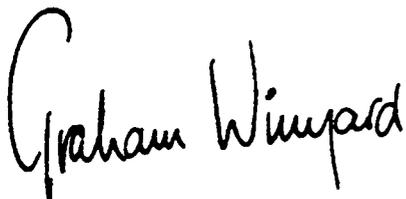
Consultation

17. I commend the working document to you and I hope and expect it will prove a valuable tool. We intend to use the experience gained in operation to develop a fully-fledged Quality Framework in the next year. For it to be of help in the future it will, of course, need to be updated to reflect policy developments and new guidance. With this in mind, we are exploring the options for effective updating and dissemination of subsequent editions. One possibility may be to make the Framework available via the NHS WEB where it would be readily available to users and easily updated.

18. I would very much welcome comments both on the contents and format of the working draft and on future options for dissemination, particularly whether the NHS WEB would be a welcome medium. I am, as noted above, conscious of the length and detail contained in the working draft. It is particularly important to have your views on how far the inclusion of detail, for example, in matrices, annexes and appendices is helpful. Comments should be addressed to: *Paul Loveland, (0113 254 6118), Room 2W30, Quarry House, by 30 September 1997.*

19. Further copies of the Quality Framework, this EL and its Executive summary are available from the NHS Executive RESPONSELINE on 0541 444455.

Yours sincerely,



Dr Graham Winyard
Medical Director
NHS Executive

This letter will be cancelled on 1 February 1998

EXECUTIVE SUMMARY

a

working draft to develop

the

QUALITY FRAMEWORK

for

HCHS medical and dental staff

April 1997

FOREWORD

I am very pleased to be able to introduce this working document from which we intend to develop the *Quality Framework for medical staffing in the hospital and community health services*.

Every trust needs enough well-trained doctors to provide a high quality, cost-effective service to its patients. The NHS Executive's policy is to provide an environment which helps trusts to achieve this, assisted as appropriate by purchasers, regional offices including postgraduate deans, and most importantly by the medical profession itself which continues to take responsibility for standards of professional practice.

The Quality Framework will bring together for the first time all the current requirements, guidance and good practice which underpin the quality of medical staffing. This working draft represents an important first step. It is a comprehensive compendium of existing guidance which deliberately reproduces much of the detail of the original guidelines. In order to develop this into a Framework which provides the practical working tool the NHS requires, a document that is well focused and tailored to meet your needs, we must first benefit from your operational experience based on this approach.

It may be helpful if I outline the structure of this working draft, and explain how the Quality Framework which will develop from it fits into the new medical staffing arrangements.

This draft is divided into five parts. The first contains explanatory material on how the Framework might be used in the context of the new medical staffing arrangements. The following parts - the Guidelines - summarise existing guidance under four headings. The first of these sets out the requirements of good medical practice. The standards of care to which all doctors aspire must act as the foundation on which all our planning is based. The second looks at achieving the right balance of medical staff. The appointment process is crucial in ensuring the quality of medical care particularly as it relates to consultants, who take overall responsibility for patient care and who are being appointed to a lifetime career post. The importance of retaining staff by offering good working conditions and support for professional development is increasingly recognised. The two major innovations here are the introduction of Local Medical Workforce Advisory Groups and the replacement of national controls and ceilings by a new process which, by using comparative data, recognises that local needs and circumstances play an important part in deciding on the right blend of doctors.

The third and fourth parts of the guidelines look, respectively, at professional practice and dealing with problems. These are issues which are vital to high quality medical care. They may not, however, need to be made explicit in the planning process in the same way as the medical skill mix or junior doctors' hours. Nevertheless, there are direct links between the quality of medical care provided and programmes of continuing professional development and clinical and medical audit. Problems which arise, complaints, untoward incidents and disciplinary matters are also often indicators of quality.

The New Medical Staffing Arrangements

National and local strategies for HCHS medical staffing need to complement one another. To create a more dynamic system to deliver both the national strategy and to enable medical staffing to be more responsive to local needs, the NHS Executive has introduced a new approach to medical staffing arrangements. This removes the central, largely numerical controls on the numbers and grades of doctors in the training and career grades. These new arrangements have been developed in collaboration with NHS managers and the profession and have two main elements:

- a. trusts will be expected to produce explicit information on their medical staffing plans, as part of their normal business and strategic planning arrangements. These plans should be supported by their main purchasers, and be consistent with the quality guidelines set out in this Framework. Further information on trusts' medical staffing plans is contained at Part III;
- b. regional offices will ask Local Medical Workforce Advisory Groups (LMWAGs), established under EL(96)68, to consider and advise on these plans in the context of the Quality framework. LMWAGs will provide a focus for discussion of quality issues relating to medical staffing. They will also liaise closely with their local REDG and consortia who are responsible for providing advice to the RO on integrated workforce questions. The role of LMWAGs is described in more detail in Part IV of the explanatory section.

The Quality Framework will underpin the new medical staffing arrangements and will be the key to their success. It will provide a set of quality indicators by which trusts, their purchasers and the NHS Executive can measure the quality of medical care provided by trusts in the context of national and local strategy, and purchaser demand. It is intended to:

- * help trusts to take a comprehensive approach to ensuring high quality, cost effective medical care; and
- * promote a productive and effective dialogue between trusts and purchasers about medical staffing issues.

The Quality Framework will help to ensure the quality of patient care provided by doctors, while reflecting trusts' staffing freedoms as well as the NHS Executive's commitment to a consultant-based service.

The recent publication by Secretary of State for Health *The National Health Service: A Service With Ambitions* promotes high quality, particularly in terms of professional standards and personal development, as one of the fundamental principles for the future development of the NHS. The aims set out by this publication and those of the Quality Framework are mutually supportive.

This is a working document published for consultation, from which we intend to develop the Quality Framework you need. We intend that it be used widely in order that it can be modified and developed in the light of your experiences. We welcome your views on its format, presentation and effectiveness as a working tool. We would also like suggestions

about future dissemination of the Framework, including views on making it available use on the NHS Web. Please send your ideas and comments to *Mr Paul Loveland, NHS Executive, Room 2W30, Quarry House, Quarry Hill, Leeds LS2 7UE* by 30th September 1997.

**DR GRAHAM WINYARD
MEDICAL DIRECTOR
NHS EXECUTIVE**

April 1997

DEVELOPING THE QUALITY FRAMEWORK

I - ROLES & RESPONSIBILITIES OF THE KEY PARTIES

Before considering how the Quality Framework will be developed and used in the context of the new HCHS medical staffing arrangements, it is necessary to understand the roles and responsibilities of all the key parties and how they will wish to use it. These are outlined below:

1. **Trusts** have the responsibility to provide high-quality, cost-effective care for their patients, an appropriate educational environment to train junior doctors, as well as promoting continuing education and development for career grade staff. The Quality Framework will help them to consider their medical staffing in the context of their overall plans and the views of their purchasers. It will help trusts to safeguard quality, while reflecting their freedom to employ the mix of staff best suited to their needs.
2. Within trusts, **medical directors and clinical directors** have key responsibilities. **Medical directors** are guardians of the quality of medical services for the trust as a whole. This role covers assuring the skills and competence of the doctors in each specialty and grade. They are also responsible for doctors' performance, complaints about clinical standards and untoward incidents as well as matters such as continuing medical education and profession development for career grade doctors and training for junior doctors. **Clinical directors'** responsibilities mirror in many ways those of the medical director but, of course, they act at a clinical directorate level. **Human Resource directors** have a key role in determining overall human resource strategy and also have overall responsibility for employment issues.
3. **Purchasers** including GP fund-holders are responsible for obtaining appropriate, high-quality clinical services within the resources available to them, on behalf of the population they serve. They need to know that trusts' staffing patterns will deliver the services needed by their local population, that the quality of service is assured, and that services are provided cost-effectively reflecting, as far as possible, the requirements of that population and their preferences.
4. The **medical and dental professions** have a major responsibility for maintaining standards of clinical performance. The Quality Framework will provide assurances for the profession and involve it in a constructive way in future developments.
5. **Regional offices** maintain an overview of services, which they exercise by review of both purchasers and providers. In particular, regional offices need reliable and up-to-date information for workforce planning and to know whether medical staffing policies are being delivered. Regional offices will, where necessary, review trusts' medical staffing plans in the light of advice from LMWAGs and raise issues with trusts where a RO cannot endorse their plans.
6. **Postgraduate deans** commission and manage postgraduate medical training. There is a clear link between the quality of training and the quality of service.

7. **Consortia** comprise representatives from Health Authorities, Trusts and other employers of health care staff based in geographical patches and/or in relation to one or more major education provider. Consortia have responsibility for estimating workforce needs, commissioning the necessary education and training, and providing advice through their REDGs on the numbers and types of doctors needed and on local arrangements for PGMDE. Consortia proposals must be forwarded to their REDG for consideration. Both consortia and REDGs will liaise closely with LMWAGs.

8. Within each regional office Consortia are supported by a **Regional Education and Development Group (REDG)** which includes representation from each consortium and the regional office, and an independent education expert. Consortia proposals are forwarded to REDGs who will advise the RO on the acceptability of the proposals across the region. In doing so REDGs will take an overview in balancing training places with the future need for non-medical staff within the framework of national policy.

9. LMWAGs will advise regional offices on the quality aspects of trusts' medical staffing plans in the context of the Quality Framework and will, if requested, advise trusts and their purchasers in the development of those plans. They will provide a focus for discussion on medical staffing quality issues locally. LMWAGs will liaise closely with their local REDG and consortia in the development of integrated workforce plans.

10. **The NHS Executive** as a whole acts on behalf of ministers, to ensure that the NHS is able to secure sufficient, appropriately-qualified doctors to provide the services required within the resources available.

II - HOW THE QUALITY FRAMEWORK WILL BE USED

1. This Part explains how the Framework is intended to be used by the key parties.
2. Each trust will be encouraged to develop medical staffing plans (considered in more detail in Part V) which are:
 - *consistent* with its overall planning and development strategies;
 - *supported* by its main purchasers;
 - *considered* by the relevant LMWAG;
 - *acceptable* to regional offices, advised by their LMWAGs, on whether the plans meet the key policy and quality criteria.
3. Each of these parties will need to consider whether trusts' plans (medical staffing, business and strategic development) reflect the Quality Framework. However, the parties will form this view from different perspectives.

Within Trusts

4. Trusts will wish to ensure that their medical staffing provides high-quality and cost-effective patient care and an appropriate training environment for junior doctors. The Framework should help them to consider quality, while reflecting their staffing freedoms. The trust medical director will have a leading role to play in this process together with the Director of Human Resources who will wish to ensure that medical staffing complements the trust's overall human resource strategy.
5. Trust boards and senior management will need to consider their current and future medical staffing arrangements alongside the Framework. Part V provides more information on the kinds of issues likely to be covered in trusts' medical staffing plans. They will need to view these in the context of relevant parts of the Framework.

Purchasers' role in relation to the Framework

6. Without becoming involved in organisational detail but in line with their responsibility for the achievement of key national policies, purchasers will need to know whether trusts' staffing will provide the service required by their populations, that the quality of service is assured, and that services are provided cost-effectively. The dialogue between purchasers and trusts should include a review of current and planned medical staffing arrangements, in relation to the quality guidelines.

LMWAGs' role in relation to the Framework

7. LMWAGs' main role, is to comment and advise on individual trusts' current and proposed medical staffing in the context of the Quality Framework. The exchange of views between LMWAGs and trusts, and purchasers, should be informal, supportive and constructive. LMWAGs will also advise regional offices.

Achieving Quality Framework standards

8. Each of the parties above will need to form a view as to where a trust's current and proposed medical staffing arrangements stand in relation to the Quality Framework. This review, and the preparation of trusts' plans, should be seen as part of the normal business planning process.

9. Within each quality guideline, the criteria against which judgements should be made are indicated. The criteria can be categorised as follows:

- | | | |
|----|----------------------|---|
| a. | Required | the guideline is determined by legislation or, for example, by formal agreement; |
| b. | Expected | the guideline is regarded as a requirement, for example, because it is covered by the NHS Planning and Priorities Guidance; |
| c. | Good Practice | the guideline is offered as good practice advice, and its application is for local discretion. |

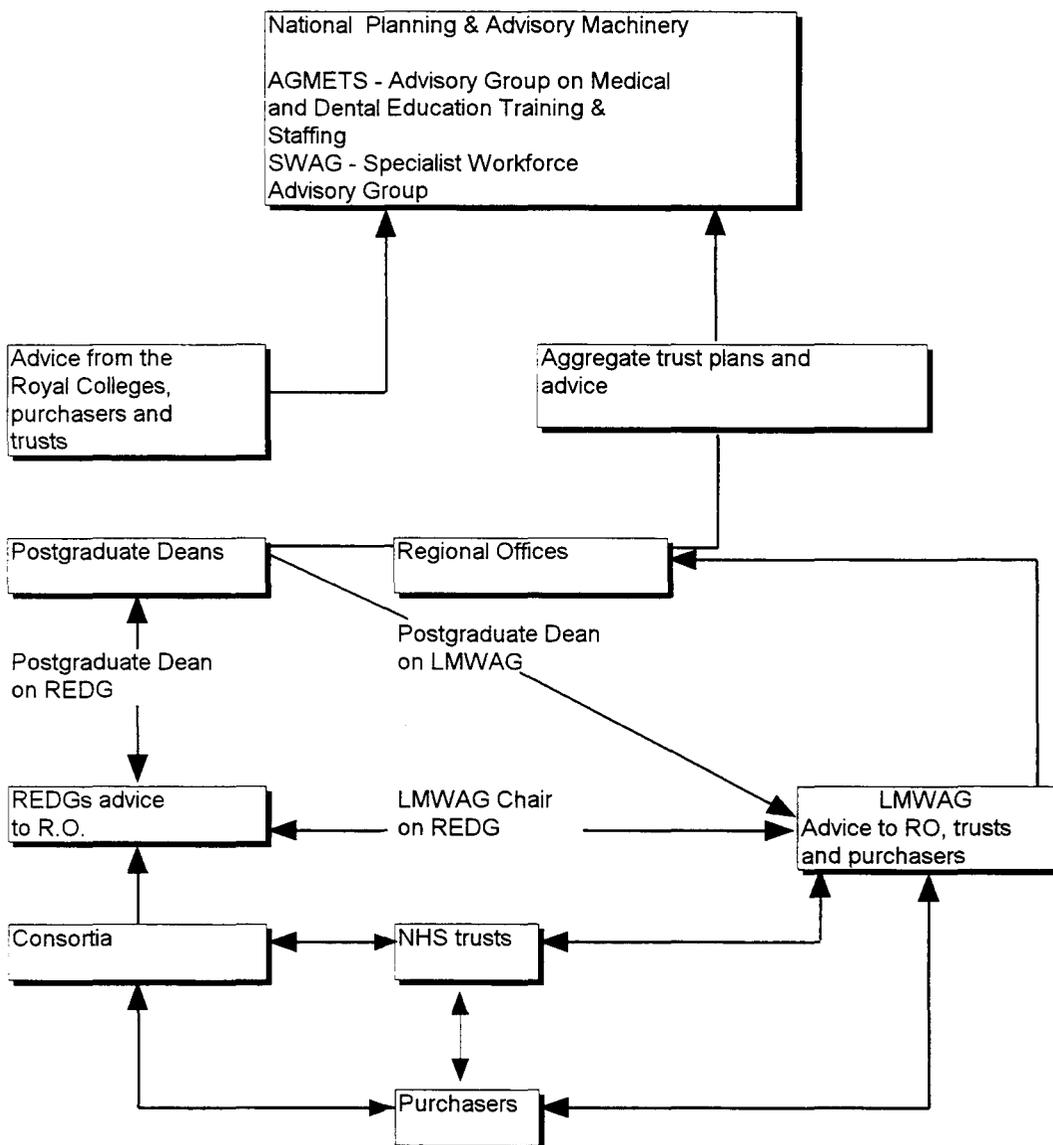
10. Trusts will wish to ensure that their medical staffing arrangements meet the requirements covered by the first two categories. Although the guidelines in the third category are discretionary, it seems likely that they would also want their medical staffing arrangements to be broadly consistent with these.

11. In many cases, trusts' arrangements and plans will reflect the Framework. In a minority of instances, there may be differences between the standards suggested by the Framework and the reality of service provision. There may be well-founded reasons for such differences; or action to resolve problems may be already planned or taking place. Each party will need to use a certain amount of judgement when forming a view.

12. Where trusts' medical staffing arrangements are not consistent with the Framework and appropriate action has not already been considered, the relevant parties will need to assess whether action is required. In what is likely to be a very small number of cases, the regional office will need to decide whether they can endorse the trust's plans if they are significantly at variance with the expected standards of quality.

II - SUMMARY OF THE NEW ARRANGEMENTS

The diagram below summarises the arrangements for workforce planning and quality assurance in relation to HCHS medical staffing. It also indicates the relationships between the key parties - Trusts, purchasers, the medical and dental professions, LMWAGS, postgraduate deans, regional offices, REDGs/consortia and NHS Executive headquarters.



III - TRUSTS' MEDICAL STAFFING PLANS

1. Trusts need to produce an annual business plan and every third year a strategic development document covering the period 5 years ahead. These plans are considered by the regional office.
2. Under existing arrangements, trusts do not have to consider their medical staffing in an explicit way. However, given the level of NHS expenditure on the medical workforce, and the increasing demand for HCHS doctors and dentists, it is essential to ensure that this vital resource is properly planned and managed.
3. We expect that trusts will wish to focus more closely on the structure of their medical workforce, bringing consideration of the numbers, types and grades of doctor they employ and predict they need over the next 3 - 5 years, more formally into their planning. It is very important that trusts, with their purchasers and the regional office, take a long-term view of their medical staffing needs.

Trusts' medical staffing plans

4. Trusts' medical staffing planning might be viewed on three levels:
 - a. operational plans designed to meet a trust's own needs;
 - b. less detailed plans which can be shared with regional offices, purchasers, consortia, REDGs and LMWAGs;
 - c. information which can be used by the NHS Executive for national workforce planning.
5. Their overall workforce plans will take account of the composition of their existing workforce and expected changes to it, as well as their overall human resource strategies, reflecting recent or expected HR-related developments.
6. The NHS Executive intends to encourage trusts to develop explicit medical workforce plans which can be used for the purposes noted in paragraph 4 above. Such plans would focus on specific issues relating to doctors, for example, the New Deal, the Calman reforms of specialist medical training and other medical staffing initiatives.
7. Trusts could, of course, structure plans for their own internal use as they think fit. However, where plans were being shown to purchasers, LMWAGs and regional offices, they would need to be in a format that allowed them to be considered alongside the Quality Framework.

National medical workforce planning

8. As indicated above, consortia, REDGs and NHS Executive headquarters need information to feed into national workforce planning. This information includes:

- a. data on future demand for consultants by specialty group;
- b. indications of expected levels of recruitment, retention, wastage and retirement;
- c. indications of career preferences and trends in working patterns.

This will complement the detailed data about numbers of doctors employed, collected via the deans' databases and the NHS Executive's annual census.

Current action

9. We regard the development of medical workforce plans as best achieved over the next year and further guidance will be issued. In the meantime, LMWAGs will look at the medical skill-mix of trusts using information on individual trusts derived from the annual census. An exercise to validate and, where necessary, update census data was conducted in October 1996.

IV - LOCAL MEDICAL WORKFORCE ADVISORY GROUPS

Introduction

1. Providing high quality, cost-effective services depends on an adequate, balanced and well-trained medical workforce. Trusts and their purchasers see this as a central issue, both with respect to service delivery and in ensuring adequate training capacity to meet the NHS's long-term needs. The issues involved are often complex, requiring a balance to be struck between service, educational and other imperatives, such as the New Deal.
2. The new medical staffing arrangements reflect:
 - a. the responsibilities and freedoms of trusts as employers and providers of services;
 - b. the educational, standard-setting and standard-maintaining roles of the medical profession and the medical Royal Colleges.

Local Medical Workforce Advisory Groups (LMWAGs) have been created (EL (96)68) to advise RO's on quality issues related to the medical workforce (throughout this section the term medical workforce should be interpreted as including the dental workforce). LMWAGs will need to establish quickly a clear focus for their work and to assess, in liaison with the key interest groups, the value they can add to the medical workforce planning process. They will need to ensure that their activities facilitate the new medical workforce arrangements and safeguard the quality of medical services without imposing significant extra burdens upon NHS management or the medical profession.

3. LMWAGs are advisory. Their main aim is to:
 - a. provide a source of expert opinion on medical staffing issues which trusts can use when developing their medical staffing strategy; and purchasers and regional offices can use in assessing it;
 - b. provide a forum for purchasers, trusts and the medical profession to discuss and comment on trusts' current and future medical staffing strategies in the context of the Quality Framework, and to formulate advice for regional offices, trusts and purchasers.
4. LMWAGs are not involved directly in workforce planning, for which trusts are responsible, acting in concert with their main purchasers, postgraduate deans, other trusts and regional offices. LMWAGs add value to the planning process by providing trusts with a pool of expertise and working in collaboration with trusts and purchasers to assure regional offices that trusts' medical workforce strategies are consistent with the Quality Framework.

5. They advise trusts, purchasers and regional offices on the medical staffing implications of local trusts' development proposals (whether, for example, they are realistic and achievable), the aggregate effect on the demand for medical staff, and the implications for services in the local area. They can offer help to trusts with staffing difficulties and advise purchasers on the quality aspects of medical staffing generally and with respect to specific problems. They will, therefore, provide a focus for much of the discussion on medical staffing quality issues locally and may provide a useful forum in which key parties can discuss the major questions.

6. LMWAGs, through their overview of trust medical staffing plans will have a useful view of the medical staffing profile. It will be particularly important for LMWAGs to develop close links with their local REDG and consortia who are responsible for estimating overall workforce needs in each region, including the number and type of doctors.

Working methods

7. LMWAGs will be asked to consider all business plans annually. LMWAGs will focus on trusts' strategic plans viewed from the medical staffing perspective, with the opportunity to comment on medical staffing issues within annual business plans as they are presented by trusts to regional offices. As medical staffing strategies are unlikely to change much from year to year, it may not be necessary for LMWAGs to see all business plans annually.

9. Trusts will need to seek LMWAGs' opinions at an appropriate stage in the planning cycle if LMWAGs are to offer useful and effective advice. LMWAGs' consideration of the medical staffing aspects of trusts' plans will be expeditious, and must not delay the normal business planning activity at trusts or regional offices.

10. Information made available to LMWAGs may contain sensitive details about trusts' business plans or intentions and must be treated in strict confidence by the members. Also, members should at all times be alert to a possible conflict of interest.

11. Regional offices, trusts and purchasers (advised by LMWAGs) will be seeking progress towards a consultant-based service. The intention is to ensure that the numbers of consultants and other grades of doctor are based on a careful appraisal of service and training commitments, the tasks required and the skills and competencies needed. These requirements will vary according to the type of trust and local circumstances, taking into account the views of other parties, including purchasers and the postgraduate dean. There ought to be a reasoned and reasonable relation between the numbers of consultants and other medical staff.

12. Where the LMWAG is concerned that a trust's staffing profile may potentially be significantly inconsistent with the Quality Framework or expose questions about patient safety, the regional office will be expected to raise the problem with the trust and inform the LMWAG of action taken, or why further action was considered inappropriate.

13. LMWAGs' interests will generally relate to medical staffing matters in trusts, leaving issues relating strictly to medical education/training to others, including postgraduate deans and Royal Colleges. However, LMWAGs will be able to raise issues of education/training with the postgraduate dean, who will be a member of the group. Similarly the postgraduate dean will be able to report to the group on matters arising from training or education.

14. Consortia must also necessarily form views about the numbers and types of doctors needed, as they develop strategies for their workforce as a whole. They have direct links into and involvement in REDGs. It will therefore be important for LMWAGs to develop close links with the consortia and REDGs, to ensure that the streams of workforce plans reflect a coherent strategy. The postgraduate dean will be a member of the LMWAG and the REDG and the LMWAG chairman will be a member of the REDG. Other cross-representation at these important planning levels is desirable.

Reporting lines

15. The Regional Director of Public Health, on behalf of the Regional Director, appoints members nominated by the major parties with interests in medical staffing matters. The RDPH is the key channel of communication with LMWAGs, advising the committee on national policy and key local issues and ensuring that the various views are transmitted effectively to the regional office.

Membership

16. It is essential that the membership of an LMWAG commands the confidence of NHS management and the medical profession. This requires an appropriate balance between the various interests. To achieve this balance, while keeping the numbers involved to a minimum, there is a core membership which can be augmented in the light of the geographical or specialty issues under consideration. There is cross-membership with the consortia and REDG, to ensure close liaison between all the groups. Annex 1 sets out the constitution and membership.

LOCAL MEDICAL WORKFORCE ADVISORY GROUP

Membership

- a. the chairman and deputy chairman to be elected from their membership by the LMWAG;
- b. the Regional Director of Public Health (or nominated deputy);
- c. the postgraduate dean (who should ensure that a deputy attends meetings which he or she cannot);
- d. one member nominated by the Academy of Medical Royal Colleges;
- e. one member nominated by the relevant university(ies);
- f. one member nominated by the Junior Doctors' Committee of the BMA (plus nominated alternative who may attend as an observer);
- g. two members from the relevant deanery nominated by the Regional Consultants and Specialists Committee (RCSC);
- h. one member nominated by trust chief executives in the LMWAG area (preferably a chief executive or director of human resources);
- i. one member nominated by trust medical directors in the LMWAG area;
- j. two members nominated by purchasing authorities in the LMWAG area;
- k. one member nominated by the Regional Committee for Hospital Dental Services (RCHDS) who will receive the meeting's papers and have the right to attend when appropriate;
- l. a general practitioner.

Terms of Reference

LMWAGs will be responsible formally to the Regional Director. They will :

- a. have access to appropriate information about trusts' medical staffing, to be able to offer advice to the regional office, trusts and their major purchasers using their local knowledge and the Quality Framework. The advice to the regional office about the medical staffing aspects of a trust's strategic plans could, if appropriate, also extend to the collective effect upon other trusts and services;

- b. foster a constructive dialogue at local level between LMWAGs, trusts and purchasers about medical staffing;
- c. seek and maintain an informed working relationship with local educational consortia and the REDG;
- d. monitor the continued working of the New Deal in association with regional task forces;
- e. formulate a collective view and offer advice via the appropriate channels about the aggregate needs for medical staff, in particular consultants.

APPOINTMENTS TO THE ASSOCIATE SPECIALIST GRADE IN THE MEDICAL AND DENTAL SPECIALTIES

1. The need for the post

Trusts considering an appointment to the Associate Specialist Grade should first establish the need for the post. They should consider carefully whether the service need cannot more appropriately be met by a consultant appointment and should seek advice from the relevant Royal College or Faculty and, may also wish to seek advice from the Local Medical Workforce Advisory Group on general quality issues. The following factors should be taken into account:

- a. the need to develop a consultant-based service;
- b. overall consultant responsibility for patient care;
- c. consultant cover, both in and out of hours, in the relevant specialty and, where necessary, in related specialties;
- d. provision for the teaching of junior doctors and for the supervision of both junior and career grade medical staff.

An associate specialist post should be established only where this is in the best interests of the service.

2. Appointment criteria

To be eligible for appointment to the associate specialist grade, doctors and dentists should have completed 10 years medical or dental work since obtaining a primary medical or dental qualification which is (or would at the time have been) acceptable by the GMC/GDC for full, limited or temporary (but not provisional) registration. The doctor or dentist should have served for a minimum of four years in the Registrar or SpR grade, or in the Staff Grade. Two of these years should have been served in the appropriate specialty. Equivalent service is also acceptable, with the agreement of the relevant College or Faculty Regional Adviser and of the Postgraduate Dean.

3. Job Description

The job description for the associate specialist post should be drawn up with the advice from a representative of the relevant Royal College or Faculty.

4. Appointment committee

The appointment committee should comprise, as a minimum, a senior manager and a consultant (or if appropriate a senior associate specialist) from the trust, and preferably in the relevant specialty, and a further external senior hospital doctor nominated by the relevant

Royal College or Faculty. For posts which have been advertised (see paragraph 6 below) there should be a further Royal College or Faculty representative. The trust may appoint extra members to the committee as necessary. Trusts should ensure that all members of appointment committees are aware of relevant national and European law and are trained or experienced in appointment procedure including good practice in equal opportunities.

5. Personal regrading *without advertisement*

Personal regrading *without advertising the post* is the normal route into the associate specialist grade. Where a suitable candidate is already employed by a trust, he or she should make an application for regrading, subject to meeting the criteria set out in paragraph 2 above. The applicant will then be considered by a trust appointment committee where the need for a post has been established as in paragraph 1.

6. Appointment of Associate Specialists *by advertisement*

While personal regrading is the normal route for the appointment of associate specialists, in certain circumstances trusts may advertise for and recruit associate specialists directly, by competition. This would be appropriate where an existing associate specialist had vacated a post and the trust had established a continuing need for an associate specialist or where it had established that a new associate specialist post was required, and that it would *not be appropriate* to create a consultant post. The criteria in paragraph 1 above need to be followed in deciding the need for an associate specialist post.

As in paragraph 4 above, the appointment committee for an advertised post should be augmented by a further Royal College or Faculty representative. *The same criteria concerning clinical experience and preparation of the job description apply - see paragraphs 2 & 3 above - irrespective of whether a post is advertised or not.*