Changes are needed to the non-training grades for doctors below consultant level to:

- help trusts to manage the required reduction in hours worked by doctors in training;
- provide a smooth transition to consultant level for newly qualified specialists;
- provide flexibility for doctors to move in and out of training posts; and
- clarify competencies and improve the status of doctors working in non-training grades.

Doctors in these grades are the fastest growing group.

Most consultants have job plans, but in the average trust 14 per cent of consultants still do not have them. Trusts have little or no central information on consultants fixed commitments.

The numbers of doctors per 1,000 admissions vary fivefold between hospitals and, even between similar types of acute hospitals, they vary twofold.

About one-third of trusts were not able to provide figures on the costs of locums by specialty group, which implies poor control of locum expenditure.

The quality of management and supervision of doctors in training has improved since the introduction of the Calman training scheme in 1996, but there is still some way to go.
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Background

1. Doctors are a fundamental part of acute healthcare. Their number, deployment and training all crucially affect the quality and quantity of care a hospital delivers. There are currently some 64,000 whole-time equivalent doctors working in hospitals in England and Wales at an annual cost of about £4 billion. A typical NHS acute trust employs some 280 doctors, accounting for about 13 per cent of its budget.

2. The Audit Commission first reported on hospital medical staffing in the mid 1990s with *The Doctors’ Tale* (Ref. 1) and *The Doctors’ Tale Continued* (Ref. 2). These identified the key challenges facing doctors and NHS hospitals, such as:
   - increasing the number of consultants and extending their role in treating patients;
   - reducing the long hours that many junior doctors work;
   - developing more structured postgraduate medical training; and
   - encouraging doctors to take more responsibility for their use of resources and for organising and managing their day-to-day work.

3. In 1994 many NHS trusts were not addressing these challenges and there were significant problems in the way doctors were deployed and managed. These included poor specification of doctors’ roles and responsibilities and poor monitoring and supervision of their work. The Audit Commission also found wide variations in the numbers and grades of doctors between NHS trusts with similar workloads.

4. The Audit Commission also investigated temporary doctors, or locums, in a separate report, *Cover Story* (Ref. 3), which found wide variations in the extent of their use. It suggested that hospitals could reduce their need for locums by better aligning their permanent medical staff to patient workload, although it acknowledged that this would not be easy.

5. Over recent years the number of doctors has grown by nearly 4 per cent a year, and there are plans to increase this rate. The NHS Plan (Ref. 4) projects a 30 per cent increase in the number of consultants between 2000 and 2004. The number of medical school places in England is planned to increase by 57 per cent between 1999 and 2005. It is therefore timely to take a fresh look at medical staffing and to see what changes have taken place since the mid 1990s.

6. The Audit Commission has selected indicators mainly from its previous work on hospital medical staffing to monitor change and provide an up-to-date picture of the current position. This work is part of the Acute Hospital Portfolio (see back cover).

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1 All references to numbers of doctors in this review are expressed in ‘whole-time equivalents’ (WTEs) unless otherwise stated. The actual headcount of doctors is around 72,000. Part-time working accounts for the difference.
7. This review presents the national findings based on data collected in July 2001 from 88 per cent of acute trusts. Auditors have already produced individually tailored performance reports for each trust and are taking up any issues highlighted. This may lead to further detailed investigations and action plans for improvement by trusts. As with all topics in the Acute Hospital Portfolio, medical staffing will be reviewed again nationally within four years.

8. The findings are set out in five sections:
• the current medical workforce;
• consultants;
• doctors in training;
• non-consultant career grade doctors; and
• locum doctors.
Findings

The current medical workforce

Grades

9. The hospital doctor’s career ladder is long and complex. After studying at university for between four and six years, a newly qualified doctor can expect to spend at least seven years (depending on specialty) in formal postgraduate training before being eligible to apply for consultant posts \[\text{EXHIBIT 1, overleaf – see Appendix for explanation of the grades}\]. This is considerably less than the 10–12 years postgraduate training typical up to the mid 1990s. This reduction resulted from the Calman Report (Ref. 5), which compressed the previous registrar and senior registrar grades into a single ‘specialist registrar’ grade (SpR) and introduced more formalised training programmes. The report also updated the arrangements for accrediting specialists by introducing the Certificate of Completion of Specialist Training (CCST).

10. In practice, most doctors entering postgraduate training straight from university are likely to take longer than the minimum training period to reach consultant level. This is partly because in some specialties it may be judged necessary to have more experience before becoming a consultant than is afforded by the minimum training period. But it is also because the numbers at each grade are not always in balance. This forces those who are eligible for promotion, but cannot obtain it, to mark time or extend their experience by accepting various ad hoc posts on offer (including some research posts) or by working abroad. Doctors still in training also need access to non-training posts below consultant level to give them flexibility in their training arrangements according to their personal circumstances and commitments.

11. The need for hospital doctors below consultant level to have access to alternative non-training posts is matched by a need on the part of hospitals for more of these doctors than the official training post quotas provide \[\text{BOX A, overleaf}\]. This has been exacerbated by the New Deal (see para. 36 below), which reduces the time trainees have to treat patients. So, in order to fulfil their commitments to treating patients, trusts are employing an increasing number of doctors, below consultant level, who are not in training posts.
EXHIBIT 1
The career ladder for a hospital doctor

The path to becoming a consultant is long.

Source: Audit Commission
12. At senior house officer (SHO) level, these doctors are usually referred to as ‘trust doctors’. This is not an officially recognised category and therefore there are no statistics to track their numbers and growth. But, as a brief look at the medical press will confirm, they now comprise a substantial proportion of recruitment advertisements in some specialties.

13. For those doctors with more than three years’ relevant experience, there are ‘staff grade’ posts or, at a higher level, ‘associate specialists’. These are known collectively as non-consultant career grades (NCCGs). However, these posts are intended for doctors who will not progress to consultant grade and, in any case, the perception within the medical profession is that taking such a post will jeopardise a doctor’s subsequent career.

14. Despite the disadvantages of the non-consultant career grade posts, this group is the fastest growing section of the medical workforce. While the total number of doctors in England grew by 44 per cent between 1991 and 2001, the number of non-consultant career grade doctors expanded more than fourfold. These are known collectively as ‘staff grade posts’ or, at a higher level, ‘associate specialists’. However, these posts are intended for doctors who will not progress to consultant grade and in any case the perception within the medical profession is that taking such a post will jeopardise a doctor’s subsequent career.

15. The Department of Health and the medical profession urgently need to accept that part of a hospital doctor’s progression towards consultant level will almost certainly comprise working in posts which are not training posts. This could pave the way to establishing a structure of respected career posts acceptable to both those doctors who intend eventually to become consultants and those who do not. This might be assisted by aligning the non-training posts to their equivalent training grade posts and to facilitate movement between equivalent training and non-training posts.

It is possible to transfer from these grades back to the training ladder, but the movement is very small.

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**Box A: Approval of training posts**

Pre-registration house officer (PRHO), senior house officer (SHO) and specialist registrar (SpR) training posts must be approved by the postgraduate dean for medical education in the area where the hospital is located. The training content must be approved by the appropriate royal college for SHO and SpR posts. Approved posts are wholly or partly funded by the postgraduate deans. Posts that are not approved cannot be classified as training posts.
EXHIBIT 2

Growth in medical workforce by category, England

Numbers in all grades have increased, but the fastest growing group is ‘non-consultant career grade doctors’.

Source: Department of Health, Statistical Bulletin, February 2002

16. It is a longstanding policy of the Department of Health to increase the number of consultants while containing the number of doctors in training, thus increasing the percentage of consultants in the medical workforce. This was first set out in Achieving a Balance (Ref. 6) and recently reiterated as part of the NHS Plan (Ref. 7). But what has happened in practice? Certainly, the increase in the number of consultants between 1991 and 2001 was much faster than the increase in the numbers in training grades over the same period – 51 per cent compared with 31 per cent. But, as a proportion of the total medical workforce, the percentage of consultants has increased very little (from 35 per cent to 37 per cent), because it has been offset by the rise in the numbers of non-consultant career grades [EXHIBIT 2]. The Department needs to clarify its plans for the composition of the medical workforce and the roles the different grades are expected to carry out.

Staffing levels

17. A reasonable measure of whether trusts are generously or tightly staffed is the number of whole-time equivalent doctors per 1,000 admissions. This ratio varies fivefold, from 2.6 to 14.1, with a median of 4.7. Some of this reflects the significant variations between different types of trust, with London undergraduate teaching trusts being the most generously staffed. They have approximately twice as many doctors per admission as a typical district general hospital.
18. When these variations are explored by grade, the difference is greatest for specialist registrars, where the London undergraduate teaching trusts have three times more doctors per admission than the average. Although doctors in teaching hospitals do contribute to patient care, the extra numbers may be justified by research or more complex case mix. There is insufficient evidence to resolve this issue.

19. Even when comparing NHS trusts of the same kind, for example, those comprising district general hospitals, there are wide differences. Staffing levels vary by a factor of two, for no apparent reason [EXHIBIT 3].

EXHIBIT 3

WTE doctors per 1,000 admissions, England and Wales 2001

NHS trusts of the same kind show wide variations in staffing levels.

Note: These trusts exclude undergraduate teaching trusts and all trusts in London
Source: Audit Commission

Specialties

20. There are eight main groups of specialties in which hospital doctors practise (the 2001 Audit Commission survey did not include psychiatry). The groups with the most doctors are medicine and surgery, followed by anaesthetics. The group with the fewest is A&E [EXHIBIT 4, overleaf].
The core specialties of medicine, surgery, obstetrics and gynaecology and paediatrics have on average about two junior doctors for every consultant. The main diagnostic specialties of radiology and pathology are consultant dominated; training only takes place at specialist registrar level and is concentrated in undergraduate teaching hospitals. Accident and emergency services have relatively fewer consultants, and are essentially provided by doctors below consultant level [EXHIBIT 5]. This may be justified because, unlike the other specialties, A&E doctors treat a

There are very few pathology SHOs.
a wide range of patients, of whom only a proportion is seriously ill. However, the number of A&E consultants has been growing at 8 per cent per year, the highest rate of any specialty.

22. This wide variation demonstrates that if policies or plans relating to the composition of the medical workforce are to be robust, they must address the main specialty groups separately.

Consultants

23. Consultants are at the top of the medical career ladder. They carry considerable responsibility for their patients and play a dominant role in determining the nature and quality of care delivered and the resources used by hospitals. Consultants have the right to undertake private practice whilst employed by the NHS and have considerable autonomy to determine their work patterns. Nevertheless, NHS trusts should be clear about what they expect from the consultants they employ [BOX B].

BOX B

The consultant contract

There are two principal forms of consultant contract. The first normally applies to newly appointed consultants and is known as a ‘whole-time contract’. This allows them to work in private practice but restricts their earnings from private practice to 10 per cent of their NHS salary.

Consultants who wish to can move to a ‘maximum part-time contract’, which removes the restriction on earnings from private practice, but is paid at 10/11 of those on full-time contracts. However, despite the drop in salary, the contractual commitment to the NHS is unchanged and is the same for the two groups (…substantially the whole of their professional time…)¹.

Consultants tend to opt for a maximum part-time contract when they get established and begin to build up a substantial private practice. However, some remain on a whole-time contract, either because their private practice is small, or they do not wish to develop one.

In addition to their daytime sessions, most consultants are expected to be on-call out of normal hours. This is typically for one night a week and one weekend in four or five, but could be more where there are only a few consultants on the rota.

Honorary contracts. Holders of clinical posts in medical schools who devote part of their time to hospital work will hold honorary (unpaid) appointments with the hospital where they work.

New consultant contract. The Department of Health and the British Medical Association have agreed (13 June 2002) a new consultant contract to be implemented from 1 April 2003. For all full-time consultants this comprises a core working week of ten ‘programmed activities’ of four hours each, all committed to the NHS. It also links job plans and appraisals with pay progression, and makes meeting the time and service commitments in the job plan a contractual responsibility.

¹ Department of Health and Welsh Office (1994), Hospital Medical and Dental Staff (England and Wales), Terms and Conditions of Service, Department of Health.
24. The central means of doing this is through ‘job plans’. A consultant’s working week is divided into ‘notional half days’. The core of a job plan is the allocation of these notional half days, balanced against the out-of-hours on-call commitments. Some of the notional half days will be designated as ‘fixed commitments’, typically outpatients’ clinics, theatre sessions, some ward rounds and occasionally postgraduate teaching. Other commitments will not be fixed, which means that the consultant is expected to be engaged on hospital work, usually on the premises, but not for any specific task. These notional half days might be used for research, further ward rounds, teaching, preparing letters following outpatients’ clinics, departmental meetings or other administrative work.

25. The national guidelines for England and Wales state that: ‘…for a consultant on whole-time or maximum part-time contract, between five and seven notional half days, depending on the specialty, should normally be allocated to fixed commitments…’ (Ref. 8). The guidelines do not indicate where particular specialties might lie within the range of five to seven notional half days, leaving flexibility around issues such as a consultant’s age, level of on-call duties and extent of junior support.

26. The Doctors’ Tale (Ref. 1) found wide variation in consultants’ total activity, and assembled data to examine the underlying causes. It concluded that the chief determinant of activity was the number of fixed commitments. This emphasises the importance of clarity about this number and of its inclusion in job plans.

27. Consultants have been required to have job plans for more than ten years, and this was recently strengthened by the Department of Health (Ref. 7). Since April 1st 2001 all trusts are required to have in place a system of appraisals for consultants, which includes job plans. However, in the 2001 Audit Commission survey, only 14 per cent of trusts had all their consultants holding job plans, and the median trust had job plans for 86 per cent of its consultants [EXHIBIT 6]. Most trusts therefore have some way to go before they can meet the Department’s requirements, and a significant minority is seriously behind. The new consultant contract provides a strong incentive for all consultants to have job plans by linking them with appraisals and with pay progression.
The absence of job plans may in some cases reflect poor information at trust level. Many trusts had to obtain information for the Audit Commission survey by examining individual consultants’ personnel files. Eight per cent were not able to provide any data on whether their consultants held job plans. The information contained in job plans, such as the number of fixed commitments of different types to be carried out by consultants (discussed in para. 30), is essential for planning and should be readily available as management information.

Undergraduate teaching trusts tend to have a greater proportion of consultants without job plans (20 per cent on average) than non-teaching trusts (14 per cent on average). This difference may in part result from the much higher level of honorary consultants in undergraduate teaching trusts whose work for the NHS is often less well documented.

However, honorary consultants are given similar control over NHS resources, and have the same rights, privileges and responsibilities as other consultants, so they should be equally subject to job plans, as laid down in the new consultant contract.

The average number of fixed commitments in job plans varies widely between trusts. After adjustment for part-time working, nearly two-thirds of trusts (61 per cent), show an average which lies between the five and seven commitments per job plan recommended by the Department of Health. A further 31 per cent of trusts have an average of more than seven commitments, whereas only a small minority (8 per cent) have fewer than five fixed commitments, on average, per job plan. The new consultant contract stipulates that ‘there will typically be a minimum of eight programmed activities for direct clinical care’ during the first phase of a consultant’s career, which subsequently reduces to seven.
Most trusts show an average at or above the recommended range of between five and seven commitments per week.

Source: Audit Commission

31. *The Doctors’ Tale Continued* (Ref. 2) analysed the fixed operating and outpatient commitments for consultants in surgery. The average surgeon (median) had 5.4 fixed commitments a week in these two categories taken together, with a range between 3 and 8. Analysis of the 2001 data for general surgery showed a similar pattern, with a median of 5.7 commitments per week.

32. Consultants carry out highly specialised work, often in rapidly advancing fields, so it is crucial that they have ample opportunities to learn about new practices and techniques. Continuing professional development should be incorporated into a trust’s training plans with a separately identified budget. One measure of this is the extent to which consultants take up their study leave entitlement of up to 30 days in any 3 years, or an average of 10 days per year.

33. The Audit Commission’s 2001 survey showed that the number of consultants who report taking their full entitlement of annual study leave is low. Only one trust reported that all its consultants had taken ten days or more. The median trust reported that 18 per cent of its consultants took ten or more days’ study leave and 8 per cent of trusts reported that none of their consultants had taken ten days’ study leave [EXHIBIT 8]. However, this may reflect low reporting rates rather than low levels of study leave actually taken. It is important that consultants keep up to date with new developments in the profession. They should take their study leave and their trust should monitor it accurately.
Doctors in training

34. Doctors in training grades represent a very wide range of skills and experience, from those who are newly qualified to those on the threshold of becoming consultants (see Appendix). Nearly all trusts employ training grade doctors and provide them with postgraduate training. The time needed for training has to be balanced against the time needed to provide a high quality and efficient service to patients.

35. *The Doctors’ Tale* (Ref. 1) recommended urgent improvements in the specification, supervision and management of the work of doctors in training. For example, ‘Each individual trainee doctor should have a consultant supervisor whose main tasks are to:

- agree a training programme specific to the needs of that doctor;
- monitor the doctor’s progress; and
- provide feedback and assessment.’

Recent evidence shows that practice still has some way to go, but there has been improvement in all three of these areas (Ref. 9) [EXHIBIT 9, overleaf].
36. Since the introduction of the New Deal (Ref. 10) in 1991, trusts have been obliged to restrict the working hours of training grade doctors; essentially to an average of no more than 56 hours a week with adequate rest breaks. Many trusts have not been able to comply with this requirement. However, the contract for employing trainee doctors was changed in December 2000 in a way that gives trusts a financial incentive to comply. In addition, all contracts issued after August 1 2003 must be compliant with the New Deal, otherwise the employing trust will be in breach of contract. These measures should lead to an improvement in future.

37. In 2004 the requirements for rest periods will be strengthened to 11 hours in 24 (if this is not met, the rest time must be granted later), as part of the staged implementation of the European Working Time Directive. Time spent on-call in the hospital, but not actually working, will no longer count as rest, which will increase the imperative to work shifts rather than on-call rotas.

38. The Audit Commission’s 2001 survey found only 2 per cent of trusts where all training posts were compliant with the New Deal. The remaining trusts cover the complete range, with 1 per cent reporting that none of their posts was compliant (EXHIBIT 10).
Most trusts have a long way to go before they are compliant with New Deal requirements.

39. There is a significant geographic variation. The North West and the West Midlands show the highest figures where, on average, trusts have 56 per cent of their training posts compliant with the New Deal; whereas in Wales the equivalent figure is 20 per cent [EXHIBIT 11]. Part of the explanation underlying this is the problem of meeting the requirements at small hospitals in remote locations. Specialist and teaching trusts have the highest average compliance at 55 per cent, compared with ordinary acute trusts which average 43 per cent compliance. There is a marked variation by specialty. Three: radiology, pathology and A&E, show a mean of around 90 per cent compliance. All other specialties are in the range 39 to 45 per cent.
40. If trusts are going to be able to comply with the current, let alone the new requirements, they will have to consider options other than employing more doctors, such as changing the ways that doctors are deployed and making better use of other members of the healthcare team. Facilitating easier movement of doctors between training and non-consultant career grades, as recommended earlier (para. 15), could make a contribution here.

Non-consultant career grade doctors

41. The need to find more doctors in order to meet the New Deal targets partly explains why this is the fastest growing category of hospital doctor. Three-quarters of these doctors are ‘staff grade’ for which the basic requirement is full or limited registration plus three years’ relevant experience. There are no standards of postgraduate qualifications required, the training they might expect or the competencies that they should be able to demonstrate. They carry out similar duties to specialist registrars (see Appendix) and they can often be the resident doctor on-call overnight for a specialty.

42. The remaining quarter of non-consultant career grade doctors are the more senior associate specialists. They often take on considerable responsibility and fulfil a service role that is comparable with the highest level of specialist registrars and, in some cases, close to consultants. For example, a common duty is to share an on-call rota with consultants.

43. The classification of both of these posts as ‘career grade’ means that the postholders cannot normally expect any promotion. Referring in particular to staff grade posts, the BMA points out: ‘the majority of those practitioners who enter the grade will remain in it until they retire. The opportunity to progress to another grade is limited’. Staff grades have been referred to as ‘the lost tribe of doctors, providing significant service at middle grade and senior levels in the NHS but separated from the main career pathways and opportunities for professional development’ (Ref. 11).

44. It is not surprising therefore, that there is wide variation in the qualifications of staff grade doctors. Only 18 per cent of trusts reported that all their staff grade doctors had postgraduate specialist qualifications, and 5 per cent of trusts admitted that none of them had [EXHIBIT 12].

Staff grades have been referred to as ‘the lost tribe of doctors’...
EXHIBIT 12
Percentage of staff grade doctors who had postgraduate specialist qualifications, England and Wales 2001

Only just over half of staff grade doctors have postgraduate specialist qualifications.

Source: Audit Commission

45. The substantial proportion of middle grade doctors (see Appendix) in hospitals who are in this group may be taking considerable responsibility, such as seeing outpatients or performing emergency operations out of normal working hours without immediate supervision. It is inappropriate that a single grade should encompass such a wide range of qualifications, and minimum standards should be set for their specialist qualifications and skills.

46. The evidence indicates a general lack of continuing professional development for non-consultant career grades and shows that they take even less study leave than consultants. Only 2 per cent of trusts reported that all their staff grade doctors had taken ten or more days’ study leave in 2001, and 27 per cent reported that none of their staff grade doctors had taken 10 days’ study leave [EXHIBIT 13].

EXHIBIT 13
Percentage of staff grade doctors taking ten or more days’ study leave in year, England and Wales 2001

Many trusts reported that no staff grade doctors had taken their full study leave entitlement.

Source: Audit Commission
47. The growing contribution to the NHS made by non-consultant career grade doctors needs to be more formally acknowledged by the Department of Health and the medical profession. Many of them are very experienced and highly skilled, and acute hospitals could not function without them. Adopting the recommendations advanced earlier in this review in the section on ‘Grades’ (para. 15) – about aligning the non-consultant career grades more closely with the training grades – would do much to remove the anomalies attached to this category of doctor.

**Locum doctors**

48. Locum doctors are used by all NHS hospitals to provide continuity of patient care when permanent staff are sick or on leave or when posts are temporarily vacant. On a typical day, there are around 3,500 doctors (headcount) working as locums in NHS hospitals in England and Wales, at a cost of over £200 million a year.

49. The Audit Commission’s 1999 report, *Cover Story* (Ref. 3), pointed out that, while the employment of locum doctors is often entirely appropriate, some hospitals use locums to provide care for planned leave even though full prospective cover by permanent staff has been negotiated and agreed. It found that expenditure on locums varied widely between trusts and recommended that trusts should:

- seek to minimise their use of locums through effective medical workforce planning;
- work in partnership with only a small number of locum agencies; and,
- establish a clear picture of all spending on locums by type and specialty.

50. The Audit Commission’s 2001 survey showed that trusts spend on average 7.2 per cent of their medical staff expenditure on locums. This includes both those employed directly by the trust (NHS locums) and those employed via a commercial agency. However, one-quarter of trusts spend 10 per cent or more of their medical staff costs on locums, and 5 per cent of trusts spent more than 15 per cent. This implies either poor medical workforce planning or difficulties with recruitment [Exhibit 14].
Most trusts spend a small percentage on locums, but some spend more than 10 per cent.

Source: Audit Commission

The percentage of expenditure on locums varies significantly between different types of trust. The group with the highest percentage is the London non-teaching trusts. The groups with the lowest expenditure are specialist trusts and undergraduate teaching trusts, in and out of London [EXHIBIT 15].

Different types of trust spend significantly different amounts on locums.

Source: Audit Commission
52. Working in partnership with only a limited number of locum agencies was recommended because it would lead to more cost-effective contracts, provide better control over the standards of care provided by locums and enhance continuity of patient care. This recommendation has been widely adopted. About half the trusts in the 2001 survey use fewer than four agencies for nearly all their expenditure, which implies good practice. However, 20 per cent of trusts use six or more agencies, which could imply poor management of the locum contracting process but could also mean difficulty in securing locum doctors in the face of shortages. The establishment of ‘NHS Professionals’ by the Department of Health to bring all locum agencies within an NHS framework by April 2003 will make it easier for trusts to apply this principle.

53. Most use of locums, particularly agency locums, is for short durations, typically a few days. However, trusts also employ longer-term locums, for durations of over three months, particularly to fill posts where they cannot recruit permanent staff of the desired calibre. This is especially common practice with consultant posts. Although, on average only 3 per cent of consultant posts are filled by locums at any time, 4 per cent of trusts reported that more than 10 per cent of their consultant posts were filled by long-term locums. This could reflect administrative delays in filling posts, but it could also mean that posts are filled by consultants who are not considered suitable for substantive positions.

54. About one-third of trusts were not able to provide figures on the costs of their locum doctors by specialty group, indicating that they are most unlikely to be monitoring and controlling their locum expenditure effectively.
Conclusion

55. This review has reported considerable growth in the medical workforce in recent years and found some improvement in the organisation and management of doctors in training, as recommended eight years ago in *The Doctors’ Tale* (Ref. 1). However, there are still many significant problems to be tackled. These include:
   - the anomalies in the grade structure of hospital doctors;
   - the lack of recognised posts available for doctors below consultant level who are not currently in approved training posts; and
   - the need to recognise and plan for the growing role of non-consultant career grade doctors.

56. In principle, doctors in any grade should be appointed solely on the basis of their competency for the post. In particular, this applies to the non-consultant career grades where further progression is inhibited simply as a result of taking up a post. This is detrimental to doctors’ careers and restricts the pool for recruitment to more senior positions.

57. The Government’s stated objective of achieving a consultant delivered service needs clarification in the light of recent and expected changes in the composition of the medical workforce. On some measures it is not being realised fast enough and the means of achieving it are not entirely clear. It should become a much more significant component in central medical workforce planning, but must take account of the significant differences in the proportions of grades between specialties.

58. In other areas, such as use of job plans and management of locums, which come under the direct control of trusts, they should work closely with their auditors to identify the particular problems they face and make plans to correct any shortcomings. Many trusts are already not coping with the New Deal governing the working hours of doctors in training, and will face further problems implementing the European Working Time Directive.

59. There is an urgent need for trusts to improve their information systems. Important information from consultants’ job plans, such as the number and type of fixed commitments ought to be available in trusts’ central information systems as well as in individual consultants’ personnel files. The requirements of the new consultants’ contract increase this need.
Appendix – Grades of doctor

Consultants

Hospital consultants have reached the top of their profession. They play a pivotal role in meeting both the service and training objectives of NHS hospitals. They determine the quality and quantity of most of the medical care that individual patients receive.

Much of this is achieved through consultants’ direction and supervision of teams comprising trainees and non-consultant career grade doctors. Consultants, however, remain legally responsible for the medical care provided, whether or not they are personally involved.

Consultants predominantly work in outpatient clinics and operating theatres, with formal ward rounds each week and informal contact with the wards when required. When providing emergency cover, consultants are likely to be on-call in the hospital during the day and at home outside normal working hours. A significant proportion of their time is spent on a variety of non-clinical work: teaching; research; management; audit and clinical governance.

Training grades

Pre-registration house officer (PRHO)  
One year

Following qualification, doctors in the UK hold only a provisional registration/licence to practise (hence the grade’s full title). The work is largely ward-based and is likely to include taking histories from new patients, organising tests, and following up consultants’ instructions. Under supervision, house officers contribute to the medical cover at nights and weekends, during which time they are likely to be resident in the hospital.

Senior House Officer (SHO)  
At least two years, often more

Following completion of the house year, and acquisition of Full Registration, doctors will spend at least two years in specialties in and around their chosen subject. During their time in the grade, they will change specialties (and often hospitals) every six months. During this time much of the training received will be ‘on the job’ – again ward-based as well as helping at outpatient clinics and theatre commitments – but a significant amount of time will also be spent in formal education commitments. For some specialties basic specialist training will also take place at SHO grade. The grade is central to the provision of out-of-hours cover, either as part of an on-call rota, or within a shift system. Prospective GPs will also spend at least two years as SHOs and make a significant contribution to service delivery.

Specialist registrar (SpR)  
At least four years

Advanced specialisation within hospital medicine begins with the specialist registrar grade. Entry to the grade is tightly controlled by a quota system and it is expected to lead to a consultant job. As with consultants, SpRs work mainly in outpatient clinics and operating theatres, but they tend to have more contact with the wards. Like consultants, much of their time is taken up on correspondence, research and formal training activities, but not usually on management tasks.
Unlike the consultant grade, they provide most of the specialist out-of-hours cover, resident in the hospital.

Non-consultant career grades

Associate specialist

These doctors are close to consultant status and tend to work in similar way to consultants, although they are technically accountable to a consultant for all their patients.

Staff grade

Staff grade doctors currently make up the majority of non-consultant career staff and are a fast growing component of the medical workforce. In part this is because such non-training posts may be filled without reference to the bodies regulating medical training. Staff grades tend to work well-defined shifts in specific clinical areas. They carry out many of the tasks and responsibilities of SpRs and often share on-call rotas with them. To be included in this category, doctors must have at least three years’ post-qualification experience.

Other grades

Clinical assistant

This category is usually taken to apply to local GPs who work perhaps one or two sessions a week (up to a maximum of six) in the hospital. However, it also includes doctors who are in posts which are not approved training posts and who do not have three or more years of post-qualification experience. They are often referred to as ‘trust doctors’ or SHOs, but as defined in the annual Medical Census they are classified as clinical assistants.

Generic terms

Traditionally the term ‘junior doctor’ has referred to any doctor below consultant level, in particular SHOs and SpRs. For training grades the preferred term is now ‘doctors in training’. The term ‘middle grade’ is sometimes used for all doctors between senior house officer and consultant and typically comprises SpRs, staff grades and associate specialists.
References


The Acute Hospital Portfolio is a collection of audits that are available for auditors to undertake at acute trusts, according to local priorities. They focus on key service areas or resources within the trust that are of concern to trust managers and patients. Each year the Audit Commission selects up to four topics from the Portfolio to survey across all trusts. Three main stages to the survey work are carried out in sequence on an annual cycle:

Data collection April–July
- Emphasis on data quality
- Support from auditors

Diagnostic audit from November
- Independent tailored review by auditors
- Takes account of local context
- Information for decision-making

In-depth audit from February
- Targeted on problem areas
- Action plan for change

The data collection and diagnostic work is the core of the survey, and each trust receives from its auditor a tailored assessment of its performance based on the data collected. In-depth audit work is then carried out at only a minority of trusts – those that demonstrably need it. This survey is repeated for each topic within four years, so that progress can be monitored both at individual trusts and nationally. A maximum of 16 topics is currently envisaged to allow coverage of all the key issues and service areas.

This review reports the results from the survey of Medical Staffing. It is one of the four topics in the second phase of the Portfolio. Similar reviews have already been published for each of the other three topics this year – Procurement and Supply, Medicines Management and Radiology. Next year the topics are: Outpatients, Bed Management, Operating Theatres and Waits for Admission. Previous reviews have been published from the first phase of work covering Accident and Emergency, Catering, Day Surgery and Ward Staffing.

More details are available on the Acute Hospital Portfolio website (http://www.audit-commission.gov.uk/itc/acuteportfolio.shtml). The data for the first phase of four topics and the accompanying computer software are also available to NHS trusts for comparative purposes. The data for the second phase will become available shortly. For details see the website.