The Doctors’ Tale Continued

The Audits of Hospital Medical Staffing

Following the publication of The Doctors’ Tale in 1995 the Audit Commission’s auditors examined medical staffing in most NHS acute hospital trusts. This bulletin summarises the audit results.

Consultants’ operating and outpatient workload varies widely...
- complexity of cases and emergency workload do not fully explain the variation
- the number of fixed sessions in consultants’ job plans is a key factor influencing their output

...and some trusts could make better use of consultants’ jobs plans.
- 25 per cent of consultants do not have job plans
- three out of ten job plans have not been reviewed recently

The amount of supervision junior doctors receive varies...
- consultants have different standards of supervision
- different standards are applied to operations during the day and out of hours

...and in some cases junior doctors derive little or no training benefit.
- 32 per cent of SHOs see new patients in outpatient clinics without supervision
- 13 per cent of SHOs get no feedback on their work in clinics

Medical training could be better organised and managed...
- only 2 per cent of hospitals have plans to implement the requirements of their training contract
- less than one-third of hospitals monitor their performance against the training contract

...and delivery of training can be improved.
- less than one-third of junior doctors agree individual training plans with their educational supervisors
- fewer than half of junior doctors discuss their progress with their consultants

NHS trusts need to take a strategic approach to their investment in medical staff.
- regular review of consultants’ jobs should be integral to trusts’ business planning
- standards of supervision should be developed as part of trusts’ risk management strategies
- arrangements for postgraduate training should ensure consistent standards and co-ordination of activities
- aims for medical staffing should be set out in plans agreed with purchasers of clinical services

Auditors have agreed action plans with managers and clinicians to address the particular problems in their trusts, and will monitor progress on their implementation over the coming year.
The Audit Commission

... promotes proper stewardship of public finances and helps those responsible for public services to achieve economy, efficiency and effectiveness.
Introduction

1. *The Doctors’ Tale*, published by the Audit Commission in 1995, set out an agenda for hospitals to tackle issues concerning medical staff (Ref. 1). Since then, the Commission’s auditors have conducted audits in most NHS trusts and directly managed units in England and Wales that provide acute hospital services, and have agreed action plans with trust managers and clinicians to address the particular issues concerning medical staffing in each trust. This bulletin presents the findings of these audits in fulfilment of the Commission’s commitment to follow up its reports by publishing further information as it becomes available.

2. This bulletin is written primarily for trust managers and clinicians but should also be of interest to board members as well as staff in purchasing authorities responsible for planning and contracting with acute hospital trusts. It supplements the findings in *The Doctors’ Tale* with new comparative information which will help trust managers and clinicians assess the management and performance of their medical staff. It also provides examples of solutions to some common problems.

3. The results of the audits confirm the findings in *The Doctors’ Tale* and, because the data come from a much larger sample of acute hospital trusts, add weight to the original conclusions. This bulletin does not rehearse arguments that have previously been made and does not make new recommendations, but for ease of reference it gives a summary of the key findings in *The Doctors’ Tale* at the beginning of each main section.

4. The audits were concerned with doctors who work in acute surgical and medical specialties. General surgery and general medicine are used as examples in the text where it is appropriate to present data at specialty level. Data for other specialties are included in Appendix 3. They come from three sources:

- surveys of doctors’ work in operating theatres and outpatient clinics, designed to a standard specification specifically for the audits, carried out in 112 hospitals and involving 1,522 consultant firms;
- 1,887 questionnaires completed by junior doctors; and
- returns from 75 hospitals completed by auditors on issues not covered by the surveys or questionnaires.

5. The bulletin is divided into four main sections:

- **Section 1** looks at consultants’ personal contributions to patient care and treatment in operating theatres and outpatient clinics and examines some of the factors behind variation in their workload.

- **Section 2** considers the deployment and supervision of doctors in the context of national policy to increase the amount of care provided by fully trained doctors or by junior doctors working under supervision.

- **Section 3** examines the delivery of junior doctors’ training and the organisational features associated with effective training.

- **Section 4** looks at trusts’ human resource plans for their medical staff.
1. Consultants’ Workload and Job Specification

Consultants play a pivotal role in meeting both service and training needs. They work long hours and have considerable autonomy to determine their work patterns.

Consultants’ contracts are expected to include job plans setting out their day to day work. But in many hospitals these plans do not exist, do not specify the job in sufficient detail or are out of date. Very few trusts monitor consultants’ inputs, even on a sample basis. There are wide variations in consultants’ workloads within the same specialty and hospital.

Trusts should ensure that job plans:
- are completed for all consultants and specify all their duties and responsibilities; and
- are reviewed regularly. Reviews should link job plans to trusts’ service and training commitments.

6. Consultants are responsible for most of the medical care that patients receive in hospitals and, together with other doctors who work under their authority, they determine the quantity and quality of care and treatment given to individual patients. The amount of work that they do and the number of sessions they lead are crucial to a trust’s productivity and to its meeting its service and training commitments.

7. Almost all consultants are employed under national terms and conditions of service which require them to have a job plan setting out their responsibilities and programmes of work. Job plans specify fixed commitments that consultants must fulfil each week (except by agreement or in emergency). Fixed commitments in the work programme of a consultant with a whole-time or a maximum part-time contract should normally account for between 50 and 70 per cent of their total contractual commitment (Ref. 2).

8. In addition to their fixed commitments, consultants are normally on-call for emergencies for the equivalent of one or two half-day sessions and the remainder of their contractual commitment comprises activities such as teaching, clinical audit, research and management. There is some evidence that the time consultants spend on their non-clinical activities has increased since 1989 without an accompanying reduction in clinical workload (Ref. 3).

9. *The Doctors’ Tale* and associated audits focused on consultants’ work in operating theatres and outpatient clinics which, for general surgeons, typically accounts for 50 per cent of their contractual commitment. Because consultants in the medical specialties tend to have more fixed sessions for ward work, which was not analysed in detail in the audits, a smaller proportion of their work (typically 20 to 30 per cent) is covered in this bulletin (Box 1).
Variation in consultants' workloads

10. Detailed analysis of consultants’ operating workload for *The Doctors’ Tale* showed that the number of sessions they attend by consultants is the most important determinant of their output. Similarly, the number of outpatient clinics attended is an important influence on the number of consultations with patients. The length of operating sessions and outpatient clinics, and speed of working also affect output, but to a lesser extent. These findings may not seem surprising but they are important because they concern the individual contributions of consultants rather than the work of consultants plus other doctors in their teams, and, in the case of operating, take into account differences in the complexity of their work.

11. Auditors extended the analysis of consultants’ operating and outpatient sessions. Data for 343 general surgeons in 82 hospitals showed how many operating sessions consultants attend each week. Variation is due mainly to the number of sessions scheduled each week in their timetables, but also (to a lesser extent) because of differing attendance rates at those sessions (Exhibit 1, overleaf). Similarly, analysis of the work of 514 general physicians in outpatient clinics showed that the number of fixed sessions is the most important factor influencing the number of clinics they attend each week (Exhibit 2, overleaf). Since the number of fixed sessions is a key influence on consultants’ output, specification, monitoring and review of them should be a key concern of trust managers.

Number of fixed sessions in consultants’ timetables

12. Guidance on consultants’ contracts issued by the Royal Colleges says that the number of sessions in work programmes allocated for emergency work should ‘reflect the immediacy of care required of a consultant for emergencies and continuity of care’ (Refs. 4 and 6). So surgeons with more onerous on-call and emergency commitments might reasonably be expected to have fewer fixed sessions for operating. However, data collected for *The Doctors’ Tale* and subsequently in the audits...
Exhibit 1

The work of general surgeons in fixed sessions for operating

The number of operating sessions is the main factor explaining differences in workload.

Key

0.XX = correlation coefficient

Some general surgeons spend more time operating than others...

...mainly because they attend more sessions...

...and to a lesser extent because their sessions are longer.

They attend more sessions usually because they have more in their timetables...

...and to a lesser extent because of their attendance rate.

Note: The charts analyse the planned operating work of 343 consultants. Each bar represents one consultant. The bars are consistently ordered in each graph. The calculations are as follows:

- operating hours/week = operating sessions attended/week × operating hours/session
- operating sessions attended/week = operating sessions/week × attendance rate

Source: Audit Commission survey of operating sessions (general surgery specialty)
1. Consultants' Workload and Job Specification

Exhibit 2
The work of general physicians in outpatient clinics

The number of outpatient clinics is the main factor explaining differences in workload.

Key

0.70 = correlation coefficient

Source: Audit Commission survey of outpatient clinics (general medicine specialty)

Note: The charts analyse the outpatient work of 514 consultants. Each bar represents one consultant. The bars are consistently ordered in each graph. The calculations are as follows:

- Attendance hours/week = outpatient clinics attended/week \times \text{attendance hours/clinic}
- Outpatient clinics attended/week = outpatient clinics/week \times \text{attendance rate}
show no such general relationship. Nor does the number of fixed sessions relate to the proportion of operations attended by consultants at other times (Exhibit 3).

13. It is possible that there is a trade off between the numbers of operating and outpatient sessions according to different specialist areas of interest. Subspecialties with low operating commitments might have high outpatient workload and vice versa. However, considerable variation persists when fixed sessions for operating and outpatient clinics are added together (Exhibit 4). Moreover, there is a twofold variation...
variation in the average number of fixed sessions per consultant for similar-sized departments with similar ranges of work (averaging across consultants ought to eliminate any subspecialty effect) (Exhibit 5).

Attendance at fixed sessions

14. Some consultants attend more than 100 per cent of the number of fixed sessions in their timetables because they stand in for colleagues on leave. Other consultants have lower attendance rates. Attendance rates shown in Exhibits 1 and 2 exclude sessions missed due to leave and sessions cancelled for reasons outside the consultants’ control. Reasons for other absences are mostly due to consultants’ other professional commitments, both for their employers (for example, management duties) and the profession (for example, taking part in interview panels). To keep NHS duties and outside commitments in balance, Havering Hospitals NHS Trust has a general rule that regular non-NHS activities should not be scheduled for more than one morning or afternoon a week (Monday to Friday).

Making better use of job plans

15. Case mix will account for some of the variation in the number of fixed sessions for operating and outpatient clinics in consultants’ timetables, as will differences in their other responsibilities, including management duties. But consultants make a greater contribution to patient care and treatment in some trusts than in others and some of the variation arises from the way in which trust managers plan and manage their medical staff.

16. Specification and regular review of consultants’ job plans is one way for trusts to reconcile competing demands, set priorities and make sure that there is sufficient contracted activity and adequate theatre and clinic capacity to support each

Exhibit 5

Average fixed sessions in similar-sized general surgery departments

Variation in the number of fixed sessions persists when averaged across consultants.

Source: Audit Commission surveys of operating and outpatient sessions (general surgery specialty)

Note: Sample consists of 20 general surgical departments, each with four consultants with whole-time or maximum part-time contracts.
consultant post. But in many trusts job plans are not used to best effect. Although it is trust managers’ responsibility to agree a job plan with each consultant, job plans existed for every consultant in only 33 trusts out of 70 surveyed. One-quarter of the consultants employed by these trusts did not have a job plan and, while six out of ten job plans had been reviewed within the previous 12 months, reviews often consisted only of an invitation to consultants to amend their own job plans.

17. Some trusts make better use of job plans and treat reviews as an integral part of their management process. South Buckinghamshire NHS Trust has agreed broad principles for reviewing job plans to help ensure consistency between directorates. Huddersfield NHS Trust explicitly recognises non-clinical activities in job plans and when reviewing them, takes into account the service and resource needs of the directorate (Case Study 1). Havering Hospitals NHS Trust also sets performance objectives for its consultant staff, linked to clinical contracts, and audits the provision of service according to agreed job plans.

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**Case Study 1**

**Specifying consultants’ commitments and review of job plans**

1 **South Buckinghamshire NHS Trust**

The Clinical Policy Board has set out the following broad principles for the specification of consultants’ commitments in job plans:

- Job plans should be agreed first within the directorate with the clinical director before being formally agreed with the divisional manager and chief executive
- The number of fixed sessions should normally be within the range five to seven
- Fewer than seven fixed sessions can be justified by significant teaching, research or administrative responsibilities or onerous on-call duties – that is, a consultant second on-call to a senior house officer, high frequency of on-call duties, or high intensity (frequent call outs or disturbance to nights and weekends)
- Intensity and frequency of on-call work should be audited to inform decisions about reductions in the number of fixed sessions
- Directorates should consider maximum working hours and on-call hours a week for senior medical staff
- Job plans should show where the consultant is located each session and what type of work is involved in ‘flexible’ sessions

2 **Huddersfield NHS Trust**

The Trust has agreed a framework for reviews of job plans and their content.

Job plans are reviewed in relation to the service and resource needs of the directorate (for example, service developments, changes to contracts with purchasers and changes to organisational structures). In future, reviews will incorporate discussion of study leave in relation to consultants’ continuing medical education.

As well as listing fixed sessions for outpatient clinics, operating lists and ward work, job plans also specify other contractual commitments that are variable in terms of time of delivery. These include clinical audit, teaching and clinical administration (for example, writing to GPs and drawing up operating lists).
A central aim of national policy for medical staffing is to increase the quantity of care and treatment provided by, or directly supervised by, fully trained doctors; that is, to move from a consultant-led towards a consultant-provided service. The Doctors’ Tale concluded that supervision of some junior doctors is insufficient and that, as a result, they sometimes have too much responsibility given their level of training.

Audit data confirm the original findings. One in five pre-registration house officers (PRHOs) and one in ten senior house officers (SHOs) reported that they have to do a task which they feel is beyond their competence at least once every week. They are less likely to consider that they get enough advice and assistance than are their more experienced colleagues and only half of them think instruction and supervision are adequate (Exhibit 6, overleaf). The following paragraphs examine in more detail the deployment and supervision of junior doctors in operating theatres and outpatient clinics.

### Operating theatres

Three-quarters of general surgery operations were performed in consultants’ fixed sessions. The remainder were performed at other times during weekdays (14 per cent) or out-of-hours (11 per cent). All grades of surgeons do most of their operating in fixed sessions, which provide the main opportunities for junior doctors to gain supervised operating experience (Exhibit 7, overleaf). Consultants attended fewer of the operations performed outside their fixed sessions than did junior doctors.
Exhibit 6
Advice, assistance, instruction and supervision

PRHOs and SHOs are less likely to consider that they get enough advice and assistance than are their more experienced colleagues and only half of them think instruction and supervision are adequate.

Source: Audit Commission questionnaire surveys of junior doctors (all specialties)

Note: Sample consists of 1,887 junior doctors.

Exhibit 7
Staffing at operations

All grades of surgeons do most of their operating in fixed sessions.

Source: Audit Commission surveys of operating sessions (general surgery specialty)

Note: Sample consists of 343 consultant firms; 32,228 operations.
21. Rightly, less experienced junior doctors were more likely to be supervised than colleagues with greater experience, but for all grades there was variation between consultant firms (Exhibit 8). In one-quarter of firms, for example, SHOs were always supervised in theatre, but in another quarter they operated alone at 40 per cent or more of their operations.

22. *The Doctors’ Tale* cited evidence that too many emergency operations are performed unsupervised by doctors in training grades (Ref. 7). One-quarter of all operations attended by registrars and SHOs were performed outside fixed sessions and the majority of these were urgent or in emergency. Junior doctors are supervised less at these operations than at operations performed in fixed sessions. They are also less likely to be supervised at operations performed out-of-hours than at operations performed during the day but not in a fixed session (Exhibit 9, overleaf). Supervisors also tend to be less experienced at operations performed outside fixed sessions (Exhibit 10, overleaf).

### Outpatient clinics

23. Consultants attended the majority of outpatient clinics surveyed (86 per cent in general medicine). Half attended all their clinics and three-quarters were present at 85 per cent or more. A minority of consultants cancel sessions when they are absent, but most allow them to continue, led by junior doctors. The staffing of sessions when consultants are away – which can be one-fifth or more of all sessions in a year due to leave and other commitments – needs careful planning. Havering Hospitals NHS Trust requires consultants to agree absences in advance with their lead clinicians who must satisfy themselves that appropriate arrangements have been made for service provision and emergency cover.

24. Even when senior doctors are present, supervision of junior medical staff is not guaranteed. Some consultants supervise and train juniors directly by working with them in the same consulting room, but it is more common for doctors to work in separate rooms. Under these circumstances, the degree to which juniors are supervised

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### Exhibit 8

**Supervision of junior doctors at operations in consultants’ fixed sessions**

Less experienced junior doctors are more likely to be supervised than colleagues with greater experience, but for all grades there is variation between consultant firms.

**Key**

- Upper quartile
- Median
- Lower quartile

**Source:** Audit Commission surveys of operating sessions (general surgery specialty)

**Note:** Sample consists of 343 consultant firms; 23,999 operations.
varies and, in some cases, the junior doctors derive little or no training benefit:

- one-quarter of consultants said that they discuss all patients seen by SHOs but one-fifth freely admitted that they do not discuss any patients with them;
- most SHOs see some newly referred patients but one-third said that this is done without supervision; and
- 13 per cent of SHOs said that they receive no feedback at all on their work in outpatient clinics.

**Exhibit 9**

**Supervision of junior doctors by grade and by category of operation**

Junior doctors are less likely to be supervised at operations performed outside fixed sessions.

<table>
<thead>
<tr>
<th>Supervisor Grade</th>
<th>Percentage of Supervised Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Senior registrars</strong></td>
<td></td>
</tr>
<tr>
<td>Fixed sessions</td>
<td>Other daytime</td>
</tr>
<tr>
<td>Registrar supervisors</td>
<td>100%</td>
</tr>
<tr>
<td>Consultant supervisors</td>
<td>80%</td>
</tr>
<tr>
<td>Registrar supervisors</td>
<td>60%</td>
</tr>
<tr>
<td>Consultant supervisors</td>
<td>40%</td>
</tr>
<tr>
<td>Registrar supervisors</td>
<td>20%</td>
</tr>
</tbody>
</table>

Note: Sample consists of 343 consultant firms.

Source: Audit Commission surveys of operating sessions (general surgery specialty)

**Exhibit 10**

**Grade of supervisor**

Supervisors tend to be less experienced at operations performed outside fixed sessions.

<table>
<thead>
<tr>
<th>Supervisor Grade</th>
<th>Percentage of Supervised Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consultant supervisors</strong></td>
<td></td>
</tr>
<tr>
<td>Fixed sessions</td>
<td>Other daytime</td>
</tr>
<tr>
<td>Registrar supervisors</td>
<td>100%</td>
</tr>
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<td>Consultant supervisors</td>
<td>80%</td>
</tr>
<tr>
<td>Registrar supervisors</td>
<td>60%</td>
</tr>
<tr>
<td>Consultant supervisors</td>
<td>40%</td>
</tr>
<tr>
<td>Registrar supervisors</td>
<td>20%</td>
</tr>
</tbody>
</table>

Note: Sample consists of 343 consultant firms.

Source: Audit Commission surveys of operating sessions (general surgery specialty)
Supervision

25. The extent of supervision should take into account the nature of the particular task and the ability of the doctor carrying it out. Some variation may therefore be justified because of the nature of the work and the fact that junior doctors vary in their competence at particular tasks. The extent of these influences could not be examined in the audits because few assessment schemes of doctors’ ability function at this level of detail. Some of the variation, though, is because consultants have different standards for the supervision of their junior doctors.

26. A number of trusts have started to develop principles and guidelines to help bring about greater consistency of practice by setting out junior doctors’ responsibilities and the level of supervision they can expect. Such guidelines also help clarify supervisors’ responsibilities. South Buckinghamshire NHS Trust has set out broad principles for supervision of trainees in operating theatres, while Derbyshire Royal Infirmary NHS Trust has guidelines for the treatment of emergency surgical admissions (Case Study 2).

27. Auditors also found a variety of practices used by consultants to supervise and review the work of junior doctors in outpatient clinics and to ensure an appropriate match of staff to work. These included:

- guidelines on the management of common conditions presented in clinic;
- guidance on making major decisions in clinic, including discharge from the clinic, deciding on the need for, and timing of, further appointments, and admission as an inpatient; and

Case Study 2

Setting standards for supervision

1 South Buckinghamshire NHS Trust
The Clinical Policy Board has set out broad principles for supervisory standards for operating and on-call work:

- A consultant should always be available when junior doctors are in theatre. The closeness of supervision will vary according to the experience of each junior doctor. Normally a consultant should be in the theatre suite when SHOs or junior registrars are performing ‘cold’ operations and on-site when senior trainees are operating, except for emergencies at night and over the weekend when the consultant on call should be readily available (that is, able to be in theatre within half an hour)
- Trainees should only be allowed to perform operations in which they have been instructed and where their ability has been verified by their supervising consultant
- A junior doctor performing an operation for the first time should have direct consultant supervision in theatre
- Explicit and reliable arrangements need to be made for when the supervising consultant is on leave – for example, nominated cover by another senior doctor
- Consultants on-call should normally be available to give advice over the telephone within five minutes and, if needed, to be in the hospital within half an hour

2 Derbyshire Royal Infirmary NHS Trust
The Directorate of Surgery has produced guidelines for the treatment of emergency admissions. The guidelines specify decisions on the treatment of emergencies (including those where no surgery is proposed) which the senior registrar and registrar must discuss with the consultant on duty before proceeding. SHOs must discuss the management of all ill patients with the registrar, including all decisions to operate. The guidelines are readily accessible to all junior doctors in their handbook.
planning sessions in advance to take account of known absences and setting standards for consultant contact with outpatients (Case Study 3).

**Staffing for emergency work**

28. Elective work is usually planned to be led by consultants and the consultant decides when a junior can work without supervision. By contrast, emergency work is generally led by junior doctors who call their consultant for advice and assistance when they consider that they need it. In specialties with significant amounts of emergency work, progress towards a consultant-provided service will require more consultant involvement in emergency care. Junior doctors, however, will continue to have a crucial role in emergency care, even in those specialties where consultant involvement increases. *The Doctors’ Tale* reported that some junior doctors still work excessively long hours and that duty rosters are often poorly matched to workload.

29. The New Deal, which trusts are obliged to implement, effectively determines whether junior doctors providing emergency services should be working an on-call rota, partial- or full-shift duty system (Ref. 8). Auditors found that only one-fifth of 179 departments (in 56 hospitals) complied fully with all the New Deal targets and that in one-third of departments junior doctors are still working more than the maximum allowed of 56 hours a week. In the remainder, the departments simply did not have enough data for auditors to tell one way or the other.

30. Good progress has been made towards achieving the limits on contracted hours and latest Department of Health figures show that about 93 per cent of posts comply with targets for the end of 1996. The main problems, however, are in specialties with heavy on-call work during the night and the slow progress in introducing shift systems where the workload calls for them. The extent of the...
problems is difficult to gauge because few trusts have satisfactory systems for collecting data on actual hours worked and rest periods (Exhibit 11).

31. The surveys that trusts organise to collect data on hours worked and periods of rest often fail because doctors do not complete diary forms if they are very detailed. But complex data collection systems are not needed to check whether working patterns are appropriate to the workload. The Oxford Regional Task Force has devised a simple questionnaire which provides enough information (Case Study 4, overleaf).

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**Exhibit 11**

**Monitoring junior doctors’ hours**

Few trusts have satisfactory systems to monitor actual hours worked and rest periods.

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**Percentage of hospitals**

<table>
<thead>
<tr>
<th>Percentage of hospitals</th>
<th>Yes, all doctors</th>
<th>Yes, some doctors</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracted hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actual hours worked</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rest within duty periods</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Are the controls on junior doctors’ hours monitored?**

- **Yes, all doctors**
- **Yes, some doctors**
- **No**

**Source:** Audit Commission: auditors’ returns (all specialties)

**Note:** Sample consists of 56 hospitals.
**Case Study 4**

**Collecting data on junior doctors’ hours**

**Oxford Regional Task Force**

The Task Force found that getting junior doctors to fill in diaries is difficult and often results in a small number of returns, with the danger that the results are unrepresentative. Instead of using diaries to survey junior doctors’ hours, they devised a simple questionnaire which provides enough information to tell whether or not a working pattern (that is, rota or shift) is appropriate to the workload.

**Questionnaire for Junior Doctors**

<table>
<thead>
<tr>
<th>Actual hours of duty and intensity of work</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you work a standard week (Monday to Friday)?</td>
</tr>
<tr>
<td>2. (a) What is your usual start time (when not on call)?</td>
</tr>
<tr>
<td>(b) If earlier than 9am, why is this? (ward round, blood round, etc)</td>
</tr>
<tr>
<td>3. (a) What is your usual finish time (when not on call)?</td>
</tr>
<tr>
<td>If this varies, what is your <strong>average</strong> finish time?</td>
</tr>
<tr>
<td>(b) If this is not 5pm, why is it later? (late ward round, routine work continuing into the evening, teaching session, late retrieval of blood results, late arrival of routine admissions, etc)</td>
</tr>
<tr>
<td>4. Are you supposed to take one or more half-days off per week?</td>
</tr>
<tr>
<td>If so how many? Are you able to take them? If not, what proportion can you take? What time, on average, do you leave when you do take a half-day?</td>
</tr>
<tr>
<td>5. How many hours rest do you get on a typical on-call weekday night? (please include total sleep and other rest periods during the evening)</td>
</tr>
<tr>
<td>If on-call nights vary widely, what is your <strong>average</strong> rest?</td>
</tr>
<tr>
<td>6. How many hours rest do you get on a typical on-call weekend? (please include both total sleep at night and other rest periods taken during Saturday and Sunday, day and evening)</td>
</tr>
<tr>
<td>If on-call weekends vary widely, what is your <strong>average</strong> rest?</td>
</tr>
</tbody>
</table>
3. Junior Doctors’ Training and Education

The role of NHS hospitals in training staff is second only to their role in providing patient care, but training is often poorly organised and managed. The national guidelines on postgraduate medical training make provision for each trainee to have an educational supervisor and personal training programme, and for their progress to be properly assessed, but these provisions are often not met locally.

The boards of NHS trusts are responsible for medical training and:

- every trust should have a training strategy which sets out the responsibilities of all staff concerned with training and co-ordinates training activities and standards across the hospital; and
- every 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.

The Doctors’ Tale

32. All doctors have to spend some time training in NHS hospitals and most hospital specialties, as they are presently organised, depend on trainee doctors’ contribution to patient care and treatment. New arrangements, begun in 1993, link funding for part of the cost of employing junior doctors to contracts between postgraduate deans and trusts. The monetary value of these contracts is a small part of a trust’s total income but if funding were to be withdrawn due to inadequate training, services could be jeopardised.

33. Auditors found many examples of good practice and innovation, often arising out of an individual consultant’s interest and enthusiasm for training. A consistent theme in auditors’ reports, however, is that trusts need to develop a strategic approach to training. Almost all trusts have a committee for postgraduate training and education, and most specialties have one consultant with overall responsibility for training. Only 2 per cent of hospitals, though, have drawn up plans at specialty level to implement the requirements of the training contract, and less than one-third of hospitals monitor their own performance against the training contract. Havering Hospitals NHS Trust is an example of a trust that has recognised the strategic importance of training and taken steps to strengthen its arrangements to ensure its future as a training institution (Case Study 5, overleaf).

34. Training and education, which are provided in formal education programmes and as part of service duties, are more likely to be effective if both trainers and trainees know what needs to be learnt and what skills should be acquired during a post. Yet less than one-half of middle-grade doctors met their consultant at the start of their job to discuss their training needs and fewer still agreed a training plan to meet those needs. The position is worse for PRHOs and SHOs (Exhibit 12, overleaf).
**Case Study 5**

**Strengthening arrangements for medical education and training**

**Havering Hospitals NHS Trust**

The Trust sees the delivery and development of medical education and training as a key strategic issue that is intrinsically linked to its own future. It has drawn up plans to strengthen its arrangements for medical education and training. Key features of the new arrangements will be:

- a Medical Education Directorate with a single management structure;
- a medium term objective to unify all education and training activities within the Medical Education Directorate;
- a Director of Education reporting to the Chief Executive;
- reconstitution of the Education Board to ensure input from each specialty in the Trust;
- development of a strategy for education and training; and
- three-year plans with timetables and milestones for delivering a robust infrastructure in each directorate. Plans will include an assessment of the implications of the new specialist training scheme.

A key responsibility of the Director of Education, Clinical Directors and Education Leads is to deliver the contract for postgraduate medical and dental education as agreed with the postgraduate dean.

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**Exhibit 12**

**Agreeing training plans for junior doctors**

SHOs and PRHOs are less likely to have discussed their training needs and agreed a training plan than middle-grade doctors.

<table>
<thead>
<tr>
<th>Percentage of doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle grades</td>
</tr>
<tr>
<td>Education and training needs discussed</td>
</tr>
<tr>
<td>Individual training plans agreed</td>
</tr>
</tbody>
</table>

Source: Audit Commission questionnaire surveys of junior doctors (all specialties)

Note: Sample consists of 1,887 junior doctors.
35. Formal education programmes are generally well organised and consultants have made considerable efforts to encourage and enable junior doctors to attend meetings. Auditors found many examples of innovative approaches to education programmes, including the core curriculum in medicine at North Staffordshire Hospital NHS Trust and the induction course for PRHOs at Salford Royal Hospitals NHS Trust (Case Study 6).

36. All clinical activities can provide opportunities for training but designating some as teaching sessions in junior doctors’ timetables helps to ensure a proper balance between service duties and training. The teaching timetable for PRHOs in the surgical department at Worthing and Southlands Hospitals NHS Trust includes clinical sessions that the doctors are expected to attend for training purposes, as well as formal education meetings (Case Study 7, overleaf).

37. Junior doctors’ progress should be assessed regularly to ensure that their work is satisfactory, to make plans where they need more experience or to make improvements. Just over one-half of middle-grade doctors, and smaller proportions of SHOs and PRHOs, have their progress systematically assessed (Exhibit 13, overleaf). Regular structured assessment is a feature of the new specialist training scheme which began to be implemented at the end of 1995 so the position, at least for middle-grade doctors, should improve.

---

**Case Study 6**

**Innovative approaches to junior doctors’ education**

1. **North Staffordshire Hospital NHS Trust**
   The Postgraduate Core Curriculum in Medicine is a comprehensive course for medical SHOs, lasting two years. Relating to basic training in postgraduate clinical training, the course involves:
   - formal lectures which cover the whole of mainstream medicine and basic sciences appropriate to clinical practice;
   - tutorials to discuss major clinical topics which include slide recognition, data interpretation and case analysis;
   - bedside teaching on the general medical and specialist departmental wards; and
   - weekly lunchtime case presentations.

   Funding for the course has been obtained by negotiating half-day release as study leave. Doctors are expected to attend at least 70 per cent of formal lectures and 40 per cent at both tutorial and clinical sessions.

2. **Salford Royal Hospitals NHS Trust**
   The week long induction course for PRHOs concentrates on the practical needs of doctors starting their first jobs. It takes place in the week before they take up post and includes:
   - practical skills sessions (including cardiopulmonary resuscitation and preparing IV drugs);
   - shadowing the incumbent PRHO and team;
   - management skills (for example, time management and stress prevention); and
   - management of common conditions (for example, patients with chest pain).
38. The SHO personal development plan at Northern General Hospital NHS Trust brings together elements of good practice. Individual training objectives are agreed with each SHO, means to achieve the objectives are agreed (for example, study leave) and progress is assessed at least twice during a post. The scheme for SHOs in the Department of Surgery at Queen Mary’s Sidcup NHS Trust links the assessment of competence to the degree of supervision required, in recognition that surgical skills need to be taught by example and under supervision (Case Study 8).
3. Junior Doctors' Training and Education

Exhibit 13
Assessment of junior doctors' progress

Just over one-half of middle-grade doctors, and smaller proportions of SHOs and PRHOs, have their progress assessed.

Source: Audit Commission questionnaire surveys of junior doctors (all specialties)

Note: Sample consists of 1,887 junior doctors.

<table>
<thead>
<tr>
<th>Percentage of doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
</tr>
<tr>
<td>75%</td>
</tr>
<tr>
<td>50%</td>
</tr>
<tr>
<td>25%</td>
</tr>
<tr>
<td>0%</td>
</tr>
</tbody>
</table>

Middle grades SHOs PRHOs

Note: Sample consists of 1,887 junior doctors.

Case Study 8
Assessing junior doctors' progress

1 Northern General Hospital NHS Trust
SHOs agree a personal development plan with their educational supervisors at the start of their jobs. Training objectives are agreed under three headings:
- clinical and practical experience;
- theoretical knowledge; and
- research and studies.

Plans are made with each SHO so that training objectives can be achieved and may include educational half-days, study time, audit, study leave and in-service training. Achievement of plans is recorded at reviews between SHOs and their educational supervisors.

Each SHO’s progress is assessed halfway through and at the end of the job. Criteria for assessing each objective are defined and ability scored on a scale of 1 (poor) to 9 (excellent) by educational supervisors and through self-assessment by the SHO.

2 Queen Mary’s Sidcup NHS Trust
On appointment, SHOs complete a record of operative experience which indicates procedures they have seen, assisted with, or performed unsupervised. The record is completed again after six months so that the training programme can be adjusted to fill as many gaps as possible in the second six months. At the six-month review, and again at 12 months, the trainee and consultant supervisor make an assessment of the level of competence achieved in individual procedures. Competence is assessed at four levels:
(i) needs training to perform the task;
(ii) needs supervision while performing the task;
(iii) can perform the task unsupervised;
(iv) can train others to perform the task.

The value of the scheme is that it defines the basic operating content of the SHO training programme, allows the programme to be tailored according to trainees’ previous experience and progress in the job, and gives a clear indication of which procedures the trainee can and cannot perform unsupervised.
39. Consultants’ workload, job specification, deployment and supervision, and junior doctors’ training and education, are all interlinked. Solutions to problems therefore need to be co-ordinated. The agenda is large and the changes complex. Implementation of solutions to many of the issues will take a number of years. A consistent theme in auditors’ reports is that trusts need to develop their planning processes to co-ordinate and prioritise action on medical staffing issues.

40. Some trusts already have human resource strategies for medical staff and others have started to draw up medical staff plans (Case Study 9). It is unlikely that any one model will suit all hospitals; instead, each trust will need to devise its own approach. But with clinical services and postgraduate medical education and training already funded through contracts, and other activities such as research likely to follow, agreement of plans for medical staff with purchasers is essential. A key feature of the approach taken by Southampton University Hospitals NHS Trust is that proposals for new posts are assigned to a funding programme which is put to the relevant purchaser in a detailed business case.

41. For most trusts, developing strategies and implementing plans for medical staffing will present a new challenge. Unless trusts take up this challenge, progress is likely to be partial and solutions to problems in one area may well conflict with aims and requirements in another.

---

4. Planning the Medical Staffing Resource

Placing greater control in the hands of individual trusts will require a much closer working relationship between doctors and managers and for doctors to become more involved in the management of their own work.

Doctors and managers should work together to implement the recommendations through a medical staffing plan.

The Doctors’ Tale
1. **Southampton University Hospitals NHS Trust**

   The Trust’s medical staffing plan for 1995/96 sets out all proposed changes across all grades of medical and dental posts in the year. The plan was constructed following discussion with each directorate and is presented in a series of directorate action plans.

   The action plans include proposals for new posts, each of which is assigned to one or more of five funding programmes (service development, New Deal, postgraduate medical education, part-time funding and miscellaneous). Each of the funding programmes is put to the relevant purchaser in a detailed business case.

   The plans also include trust-wide initiatives for action by each directorate (the two initiatives for 1995/96 are to ensure adequate annual leave planning and administration for consultants and to prepare action plans for implementing the new specialist training scheme) as well as initiatives relevant to individual directorates. Responsibility for actions and target dates for completion are clearly identified alongside each item in the plans.

   The Trust is now working to integrate the medical staff planning process into its business planning cycle.

2. **Huddersfield NHS Trust**

   The medical and dental staffing policy sets out a series of ‘core values’ for its medical staff and the requirements for each grade in terms of skills, knowledge, training and aptitude; responsibilities of the grade; and employment conditions.

   The Trust’s policy is to remain as a training institution and as a hospital providing a 24-hour emergency service. It analyses anticipated changes over the next five years, particularly as they will affect consultants, and identifies criteria to prioritise new consultant appointments consequent to changing work practices and to enable service developments.

   The Trust is now devising a strategy for medical staffing to help tackle changes over the next five years.

3. **Chase Farm Hospitals NHS Trust**

   The Trust has five broad objectives for service developments. The first objective, for example, includes achieving Patient Charter standards, reducing waiting times for treatment and achieving the required reduction in junior doctor hours. The five-year service development plan for 1993 to 1998 identifies the medical staff resource implication of meeting each objective in detail for each of the first three years and in outline for the last two years.
5. Conclusion

42. The wide variations in doctors’ working practices shown by the audit data confirm the findings in *The Doctors’ Tale*. This is of value in itself, because the information now covers a much larger number of hospitals, specialties and doctors. It also raises further questions about the interpretation and understanding of the data which can be answered only at local level. It is for this reason that this bulletin does not attempt to quantify good or poor performance.

43. The audits have emphasised a need for trusts to take a strategic and managed approach to medical staffing issues. Four themes have emerged:

- **Consultants’ jobs need to be managed as part of trusts’ business planning processes** to ensure that they are working towards the same objectives as the trust. Job plans can be an important part of a trust’s arrangements which may also include setting performance objectives linked to clinical and other contracts.

- **Trusts need to develop delegation and supervision schemes** as part of their risk management and training strategies in order to ensure greater consistency in supervision and to minimise those occasions when supervision or back up is inadequate.

- **The adequacy of arrangements for implementing the requirements of the training contract** should be high on trusts’ agendas. They need to make sure that responsibilities for training are clear and that management structures result in co-ordination of training activities and standards across the trust and within departments.

- **Trusts need to take a strategic approach to investment in medical staff and to develop medical staff plans**, in collaboration with purchasers of clinical services and medical education and training, as an integral part of business planning.

44. It is too soon to expect significant change as a result of the audits, but the comparative data and examples of good practice set out in this bulletin will be of assistance to managers and clinicians in trusts as they implement the action plans they have agreed with their auditors. Their progress will be monitored by auditors over the next and following years.
Glossary

Firm
Team of doctors led by one or more consultant.

Fixed sessions (or commitments)
Activities identified in job plans which consultants must attend (except by agreement or in an emergency); for example, operating sessions, outpatient clinics and ward rounds.

Flexible commitments
Activities which are part of consultants’ contractual commitments but which are variable in terms of time of delivery.

Full shift
Doctors work a shift on a regular basis, rotating around the shift pattern.

Job plan
A description of a consultant’s job which sets out their main duties and responsibilities and includes a work programme for the ‘typical week’.

Maximum part-time contract
Same sessional commitment as holders of whole time contracts but pay is $\frac{9}{10}$ of the whole-time salary. No restrictions on the amount of earnings from private practice.

Middle grade
Registrar or senior registrar. Specialist training grades at the end of which doctors are ready to accept consultant responsibilities.

On-call
Responsibility for dealing with emergencies.

On-take
Responsibility for admitting new patients to a specialty.

Partial shift
Doctors work normal weekdays most of the time, but at intervals work a different duty; for example, a week of nights every four weeks.

PRHO
Pre-registration house officer: a doctor, with limited registration as a medical practitioner, in the final year of basic medical training.

Rota
Doctors work normal weekdays and are ‘on-call’ in rotation for the rest of the 24-hour period and weekends.

SHO
Senior house officer: the most junior medical training grade for a doctor with full registration as a medical practitioner.

Specialist registrar
A new grade, launched in December 1995, to replace the registrar and senior registrar grades.

Whole-time contract
Holders expected to devote substantially the whole of their professional time to the NHS and a minimum commitment equivalent to 10 ‘notional half days’ of 3½ hours each. Earnings from private practice restricted to 10 per cent of gross salary.
Appendix 1: Audit Coverage and Data Sources

Audits were carried out at 187 NHS trusts and directly managed units in England and Wales. Three specialties, chosen locally, were examined in each audit. The data in this bulletin come from audits where the survey work was completed by December 1995.

Data sources

1  Surveys of operating sessions and outpatient clinics

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of hospitals</th>
<th>Number of consultants</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>82</td>
<td>343</td>
</tr>
<tr>
<td>Urology</td>
<td>20</td>
<td>33</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>31</td>
<td>125</td>
</tr>
<tr>
<td>ENT</td>
<td>19</td>
<td>52</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>12</td>
<td>28</td>
</tr>
<tr>
<td>General medicine</td>
<td>87</td>
<td>514</td>
</tr>
<tr>
<td>Care of the elderly</td>
<td>22</td>
<td>47</td>
</tr>
<tr>
<td>Obstetrics and gynaecology</td>
<td>48</td>
<td>168</td>
</tr>
<tr>
<td>Other specialties (each with fewer than 12 hospitals represented)</td>
<td>62</td>
<td>212</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
<td>1,522</td>
</tr>
</tbody>
</table>

Note: Some consultants working in departments chosen for audit were not included in the surveys and are excluded from the table.

2  Questionnaire surveys of junior doctors

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior registrars</td>
<td>164</td>
</tr>
<tr>
<td>Registrars</td>
<td>400</td>
</tr>
<tr>
<td>SHOs</td>
<td>839</td>
</tr>
<tr>
<td>PRHOs</td>
<td>484</td>
</tr>
<tr>
<td>Total</td>
<td>1,887</td>
</tr>
</tbody>
</table>

3  Auditors’ returns from 75 hospitals
Appendix 2: Surveys of Operating Sessions and Outpatient Clinics – Scope and Definitions

The surveys covered all outpatient and operating sessions, as well as all other operations performed outside fixed sessions, under the responsibility of consultants in the three specialties selected for audit. The surveys were carried out over a six week period agreed between auditors and each hospital.

Definitions

Other daytime operations | Operations not in consultants’ fixed sessions, starting after 8am and before 6pm, Mondays to Fridays.
Out-of-hours operations | Operations not in consultants’ fixed sessions, starting after 6pm and before 8am, Mondays to Fridays and all weekend.
Attendance at sessions | Attendance at any time during a session.
Attendance at operations | Presence in the operating theatre at any time during an operation.
Attendance time at clinics | Length of time between arrival and departure of consultant from the clinic.
Operating time | Time between skin incision and closure – ie excluding gaps between operations.
Supervision at operations | Junior doctor attending an operation with a doctor of a more senior grade present in the operating theatre.
Supervisor at operations | A doctor accompanying a more junior doctor in the operating theatre.

Operating time

Operating time, as defined, is a useful comparative measure of surgeons’ operating workload because it is easy to record consistently between hospitals. The time between skin incision and closure represents only part of the process of operating; surgeons also have to spend time in the operating theatre preparing for, and completing records of, each operation. Analysis for The Doctors’ Tale, however, showed that exclusion of the time between operations does not bias the comparison of operating workload (Ref. 1, p81).

No distinction is made in the analysis between different roles; operating time for a consultant includes time supervising junior doctors performing operations.
Adjustments to source data

Source data relating to consultants’ activity were adjusted to make them comparable between consultants:

1. **Availability factor**
   Adjustment for sessions held but not recorded in the surveys and non-attendance due to leave or cancellations beyond the consultant’s control. (Note: Data relating to deployment and supervision are not adjusted by the availability factor.)

2. **Contracted sessions factor**
   Adjustment applied to data for consultants with fewer than 10 sessions a week committed to the hospital to enable direct comparison with full-time consultants.
Appendix 3: Surveys of Operating Sessions and Outpatient Clinics – Specialty Data

3.1 General Surgery
3.2 Urology
3.3 Trauma and Orthopaedics
3.4 Otolaryngology (ENT)
3.5 Ophthalmology
3.6 General Medicine
3.7 Care of the Elderly
3.8 Obstetrics and Gynaecology
Appendix 3.1: General Surgery

Operating theatres

Number of fixed sessions for operating = 5,042
Number of operations: fixed sessions = 23,999
other daytime = 4,758
out-of-hours = 3,471

Key

0.XX = correlation coefficient
Lower quartile
Median
Upper quartile

1 Consultants’ work in operating theatres

Consultants

Operating hours per week

Operating sessions attended per week

Consultants

Operating hours per session

Consultants

Operating sessions per week

Attendance rate

Number of hospitals = 82
Number of consultant firms = 343

Note: Each bar represents one consultant. The bars are consistently ordered in each graph.
2 Supervision of junior doctors by grade and by category of operation

Operations attended by junior doctors in each grade accompanied by a more senior doctor, as a percentage of all operations attended. Charts show the interquartile range of consultant firms.

### Senior registrars

<table>
<thead>
<tr>
<th></th>
<th>Fixed sessions</th>
<th>Other daytime</th>
<th>Out of hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper quartile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower quartile</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

### Registrars

<table>
<thead>
<tr>
<th></th>
<th>Fixed sessions</th>
<th>Other daytime</th>
<th>Out of hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper quartile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower quartile</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

### SHOs

<table>
<thead>
<tr>
<th></th>
<th>Fixed sessions</th>
<th>Other daytime</th>
<th>Out of hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper quartile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower quartile</td>
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</tbody>
</table>

3 Supervisors

Grade of doctor accompanying a more junior doctor as a percentage of all supervised operations. Charts show the interquartile range of consultant firms.

### Consultant supervisors

<table>
<thead>
<tr>
<th></th>
<th>Fixed sessions</th>
<th>Other daytime</th>
<th>Out of hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper quartile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower quartile</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Senior registrar supervisors

<table>
<thead>
<tr>
<th></th>
<th>Fixed sessions</th>
<th>Other daytime</th>
<th>Out of hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper quartile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower quartile</td>
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<td></td>
<td></td>
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</tbody>
</table>

### Registrar supervisors

<table>
<thead>
<tr>
<th></th>
<th>Fixed sessions</th>
<th>Other daytime</th>
<th>Out of hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper quartile</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Median</td>
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<td></td>
</tr>
<tr>
<td>Lower quartile</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Chart for senior registrars includes data for consultant firms with senior registrars only. Similarly, chart for registrars includes data for consultant firms with registrars only.

**Key**

- Upper quartile
- Median
- Lower quartile
Outpatient clinics

Number of clinics surveyed = 3,505
Number of patient consultations = 92,271

4 Consultants’ work in outpatient clinics

Key

<table>
<thead>
<tr>
<th>0.XX</th>
<th>= correlation coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower quartile</td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td></td>
</tr>
<tr>
<td>Upper quartile</td>
<td></td>
</tr>
</tbody>
</table>

Note: Each bar represents one consultant. The bars are consistently ordered in each graph.
Appendix 3.2: Urology

Operating theatres

Number of fixed sessions for operating = 404
Number of operations: fixed sessions = 2,469
other daytime = 325
out-of-hours = 58

Key

0.XX = correlation coefficient

Number of hospitals = 20
Number of consultant firms = 33

Note: Each bar represents one consultant. The bars are consistently ordered in each graph.
2 Supervision of junior doctors

Operations in consultants’ fixed sessions attended by junior doctors in each grade accompanied by a more senior doctor, as a percentage of all operations attended. Chart shows the interquartile range of consultant firms.

<table>
<thead>
<tr>
<th>Key</th>
<th>Percentage of operations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Upper quartile</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Median</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Lower quartile</strong></td>
<td></td>
</tr>
</tbody>
</table>

3 Supervisors

Grade of doctor accompanying a more junior doctor as a percentage of all supervised operations in consultants’ fixed sessions.

<table>
<thead>
<tr>
<th>Consultants</th>
<th>Senior registrars</th>
<th>Registrars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average</td>
<td>87</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: Insufficient data to analyse ‘other daytime’ and ‘out-of-hours’ operations.
Outpatient clinics

Number of clinics surveyed = 264
Number of patient consultations = 6,636

4 Consultants’ work in outpatient clinics

Note: Each bar represents one consultant. The bars are consistently ordered in each graph.
Appendix 3.3: Trauma and Orthopaedics

Operating theatres

Number of fixed sessions for operating = 1,736
Number of operations: fixed sessions = 6,247
other daytime = 1,441
out-of-hours = 1,167

Key
0.80
0.52
0.76
0.55

Consultants

Operating hours per week

Operating sessions attended per week

Operating sessions per week

Attendance rate

Note: Each bar represents one consultant. The bars are consistently ordered in each graph.
2 Supervision of junior doctors by grade and by category of operation

Operations attended by junior doctors in each grade accompanied by a more senior doctor, as a percentage of all operations attended. Charts show the interquartile range of consultant firms.

Note: Chart for senior registrars includes data for consultant firms with senior registrars only. Similarly, chart for registrars includes data for consultant firms with registrars only.

Key

- Upper quartile
- Median
- Lower quartile
Outpatient clinics

Number of clinics surveyed = 1,914
Number of patient consultations = 60,211

Key

0.XX = correlation coefficient
Lower quartile
Median
Upper quartile

4 Consultants’ work in outpatient clinics

Note: Each bar represents one consultant. The bars are consistently ordered in each graph.
Appendix 3.4: Otolaryngology (ENT)

Operating theatres

Number of fixed sessions for operating = 736
Number of operations: fixed sessions = 4,348
other daytime = 461
out-of-hours = 40

Key

0.XX = correlation coefficient

Lower quartile

Median

Upper quartile

1 Consultants’ work in operating theatres

Operating hours per week

Consultants

Operating sessions attended per week

Consultants

Operating hours per session

Consultants

Operating sessions per week

Consultants

Attendance rate

Consultants

Note: Each bar represents one consultant. The bars are consistently ordered in each graph.
2 Supervision of junior doctors

Operations in consultants’ fixed sessions attended by junior doctors in each grade accompanied by a more senior doctor, as a percentage of all operations attended. Chart shows the interquartile range of consultant firms.

3 Supervisors

Grade of doctor accompanying a more junior doctor as a percentage of all supervised operations in consultants’ fixed sessions.

<table>
<thead>
<tr>
<th>Key</th>
<th>Percentage of operations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper quartile</td>
<td>100%</td>
</tr>
<tr>
<td>Median</td>
<td>75%</td>
</tr>
<tr>
<td>Lower quartile</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consultants</th>
<th>Senior registrars</th>
<th>Registrars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average</td>
<td>92</td>
<td>3</td>
</tr>
</tbody>
</table>

Note: Insufficient data to analyse ‘other daytime’ and ‘out-of-hours’ operations.
Outpatient clinics

Number of clinics surveyed = 829
Number of patient consultations = 19,035

4 Consultants’ work in outpatient clinics

Key

0.XX = correlation coefficient
Lower quartile
Median
Upper quartile

Note: Each bar represents one consultant. The bars are consistently ordered in each graph.
Appendix 3.5: Ophthalmology

Operating theatres

Number of fixed sessions for operating = 515
Number of operations: fixed sessions = 1,300
other daytime = 35
out-of-hours = 14

Key
0.XX = correlation coefficient
Lower quartile
Median
Upper quartile

1 Consultants’ work in operating theatres

Consultants

Operating hours per week

Consultants

Operating sessions attended per week

Consultants

Operating hours per session

Consultants

Operating sessions per week

Consultants

Attendance rate

Note: Each bar represents one consultant. The bars are consistently ordered in each graph.
2 Supervision of junior doctors

Operations in consultants’ fixed sessions attended by junior doctors in each grade accompanied by a more senior doctor, as a percentage of all operations attended. Chart shows the interquartile range of consultant firms.

Note: Insufficient data to analyse ‘other daytime’ and ‘out-of-hours’ operations.

3 Supervisors

Grade of doctor accompanying a more junior doctor as a percentage of all supervised operations in consultants’ fixed sessions.

<table>
<thead>
<tr>
<th>Key</th>
<th>Percentage of operations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper quartile</td>
<td>100%</td>
</tr>
<tr>
<td>Median</td>
<td>75%</td>
</tr>
<tr>
<td>Lower quartile</td>
<td>25%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consultants</th>
<th>Senior registrars</th>
<th>Registrars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average</td>
<td>86</td>
<td>3</td>
</tr>
</tbody>
</table>

Note: Insufficient data to analyse ‘other daytime’ and ‘out-of-hours’ operations.
Outpatient clinics

Key

0.XX = correlation coefficient
Lower quartile
Median
Upper quartile

Number of clinics surveyed = 593
Number of patient consultations = 14,444

Note: Each bar represents one consultant. The bars are consistently ordered in each graph.
Appendix 3.6: General Medicine

Outpatient clinics

Number of clinics surveyed = 6,579
Number of patient consultations = 120,824

1 Consultants’ work in outpatient clinics

Key

0.XX = correlation coefficient
Lower quartile
Median
Upper quartile

Number of hospitals = 87
Number of consultant firms = 514

Note: Each bar represents one consultant. The bars are consistently ordered in each graph.
Appendix 3.7: Care of the Elderly

Outpatient clinics

1 Consultants' work in outpatient clinics

Number of clinics surveyed = 301
Number of patient consultations = 3,642
Number of hospitals = 22
Number of consultant firms = 47

Key

- Lower quartile
- Median
- Upper quartile

Note: Each bar represents one consultant. The bars are consistently ordered in each graph.

Outpatient clinics

Consultants' work in outpatient clinics
Appendix 3.8: Obstetrics and Gynaecology

Operating theatres

Number of fixed sessions for operating = 2,472
Number of operations: fixed sessions = 9,726
other daytime = 2,906
out-of-hours = 1,724

Key

0.XX = correlation coefficient

Operating hours per week

1 Consultants’ work in operating theatres

Consultants

Consultants

Consultants

Consultants

Consultants

Consultants

Note: Each bar represents one consultant. The bars are consistently ordered in each graph.
2 Supervision of junior doctors by grade and by category of operation

Operations attended by junior doctors in each grade accompanied by a more senior doctor, as a percentage of all operations attended. Charts show the interquartile range of consultant firms.

3 Supervisors

Grade of doctor accompanying a more junior doctor as a percentage of all supervised operations. Charts show the interquartile range of consultant firms.

Note: Chart for senior registrars includes data for consultant firms with senior registrars only. Similarly, chart for registrars includes data for consultant firms with registrars only.

Key
- Upper quartile
- Median
- Lower quartile
Appendix 3.8: Obstetrics and Gynaecology

Outpatient clinics

Number of clinics surveyed = 3,269
Number of patient consultations = 71,261

Key

0.XX = correlation coefficient
Lower quartile
Median
Upper quartile

4 Consultants’ work in outpatient clinics

Note: Each bar represents one consultant. The bars are consistently ordered in each graph.
References