

# The workload deficit and hospital doctors: looking for a manageable solution

**N**HS hospitals have too few doctors (Department of Health, 2001a), and those we have now are overworked. There is good evidence that patient outcomes improve as the numbers of doctors increases (Jarman et al, 1999), so resolution of this problem is essential.

In 1991, the New Deal was introduced to reduce the actual hours of work of junior doctors to 56 hours per week by December 1996. However, 4 years later, official figures suggested only 72% compliance (Taylor, 2000) and, more recently, banding criteria in the junior doctors pay structure has suggested a much lower percentage. The problem is that there are not enough people to provide medical care for patients within 56 hours per week, and doctors are not prepared to leave patients in the lurch.

Changes in skill mix have helped, and further developments in this area, such as the proposed new post of health-care practitioner (Royal College of Physicians, 2000a), will be valuable. However, these will take time to introduce and none can overcome completely the fundamental problem that there just are not enough doctors.

It has also become apparent that consultants are overworked. For example, the 1999 Royal College of Physicians (RCP) census of consultants in England, Wales and Northern Ireland (Royal College of Physicians, 2000b) showed that they work considerably more than their contracted hours — so much so that if they only worked those hours, an extra 2627 consultant physicians would have to be recruited to make up the difference, mainly in district general hospitals.

Using the quality criteria set out in *Working for Patients* (Royal College of Physicians, 1999), a doubling of consultant numbers would be required.

Unlike junior doctors, consultants are not exempt from the European Working Time Directive, yet many are working over 48 hours per week. For consultants involved in acute general medicine and specialty work, the average is just under 60 hours per week, and 13% work 65 hours per week or over. Academic physicians work over their clinical contracts.

In addition to their work with patients, nearly all physicians have other duties such as management, research, audit, teaching, committee and advisory work as well as continuing professional development. Future demands such as clinical governance will take another 4–6 hours per week. As junior doctors move towards shift systems (in order to try and reduce their hours), the responsibility on consultants increases as they seek to provide supervision and training of these doctors as well as good patient care. Is it surprising that morale is so low if trusts and purchasers do not respond appropriately to this?

For family, academic or managerial reasons, an increasing number of doctors will not work full-time. Fifty per cent of medical school graduates are women, and more are entering specialist registrar training. The RCP is shortly to produce a report on women in medicine. Interestingly, surveys of male specialist registrars also indicate a number who would wish to work part-time for personal reasons (Mather, 2000). Flexible trainees are not always welcomed by trusts who have to finance their additional duty payments.

## GOVERNMENT INITIATIVES

Establishing four new medical schools and increasing places at existing institutions will create extra medical school places. By 2005, there will be just under 60% more medical students compared with 1997 (Department of

Health, 2001a). However, those entering training over the next few years will not qualify until the end of the first decade of the 21st century and will not have completed the necessary postgraduate training until the middle or end of the second.

The government has commissioned an internal report on workforce planning, which was published as a consultation document in the spring of 2000 — *A Health Service For All The Talents* (Hardogan and Staniforth, 2000). It advocated an increased orientation of workforce planning to service needs and a greater degree of multidisciplinary working and education. There was an acceptance that the NHS needed more consultants.

Subsequently, the NHS Plan (Department of Health, 2000a) was produced with the twin aims of investment (including an increased number of consultants) and reform of the service. Within this has been the demand for changes in the consultant contract and the thinly veiled threat of more non-consultant career grades (NCCG) if this is not achieved. In fact, NCCGs appointments are increasing now as a response to reduced hours for doctors in training.

Organizational changes reflecting the principles in both these documents are now being implemented. In the past, the postgraduate dean supervised education and training for junior doctors and dentists. For nurses and other health-care professionals that was the responsibility of local educational consortia. In future, 24 medical workforce confederations (Department of Health, 2000b), working closely with the postgraduate dean, will place contracts for all health-care professionals covered by educational levies. They will ensure that planning and commissioning of education is integrated for all specialties including the medical workforce. A regional workforce task-

force, chaired by the regional director of workforce development, will lead governance for these confederations.

The successor to the Specialist Workforce Advisory Group is also to be a single integrated body (the Workforce Numbers Advisory Board) to consider and advise on the numbers needed in training all staff groups (Department of Health, 2001a). It will receive advice from the Medical Workforce Review Team, which will liaise with the specialties and Royal colleges among others. The remit will be broader, covering all doctors from qualification to consultant or GP. Input from the NHS will be sought via confederations.

Expansion seems more likely in specialties favoured by national service frameworks, health improvement programmes or care group workforce teams such as those orientated to coronary artery disease or cancer. Will allowance be made for the workload of consultants with an emergency general component in addition to specialty work?

### WHAT DOES THE FUTURE HOLD?

Health authorities are required to produce workforce plans which look forward 3–5 years, yet how many frontline hospital doctors or other health-care professionals have seen these, let alone been consulted about them? Can we be confident that they are credible or reflect the needs of patients? The RCP has made positive proposals to remedy the plight of single-handed consultants. The government is persuaded, but will this trickle down locally?

Concentration of clinical resources in fewer centres, except when geography precludes this, would help in some respects, but the number of patients is not likely to decrease and consultants are already overworked.

Increasing the number of training posts in hospital specialties would ease workload and excessive hours for doctors in training, but it is not a practical proposition without an assurance of consultant opportunities. To ensure consultant appointments for holders of national training numbers (NTN) in the six major acute medical specialties, a 74% expansion must be achieved by 2009. Even with this expansion, it is

clear that the necessary increase in consultants required to satisfy quality issues and increase in demand based on 1999 levels is not likely to be achieved within 10 years.

In order to resolve the current problems by then, more NTN holders need to be recruited, but is it safe to do so? No one wishes to see a repetition of the debacle in obstetrics and gynaecology in other specialties. Doctors in training need to be assured that there are posts available for them. It is also essential that those posts should carry a much lighter workload than that borne by present consultants. The current approach by trusts to the manpower and working time crisis among junior doctors is to appoint NCCGs and trust-grade doctors. This is unsatisfactory in that these individual's educational, training and development needs are often ignored, and thus they are left without a satisfactory career path. Moreover, they are not, because of their training, able to provide a consultant-level service nor undertake many of the other roles performed by consultants (Royal College of Physicians, 2000b).

The aim of the hospital service must be to have patient care delivered mainly by consultants and for other medical staff to be adequately supervised and trained. This requires guaranteed consultant expansion over a long timescale as well as 'skill mix' initiatives. Stoppag solutions, such as NCCG appointments, are only justified to meet New Deal requirements.

Another short-term strategy to which the government is committed is continued part-time working for those consultants reaching retirement age (Department of Health, 2001b). This could help, but will demoralized and

overworked consultants, who already contribute so much to the NHS, be willing to continue, even on a part-time basis, without more evidence that things will improve? Government, health authorities, workforce confederations and other bodies in a future 'reformed NHS' have to persuade the professions that they are prepared to address the problems realistically. Then perhaps one can be confident that the NHS will achieve the standard of patient care in the future to which we all aspire. **HM**

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### KEY POINTS

- The UK is short of doctors, and both consultants and doctors in training work excessive hours.
- Multidisciplinary working and skill mix initiatives will help, but only consultant expansion can achieve proper supervision of training and patient care.
- The government plans to retain and recruit more consultants, but will health authorities, primary care and hospital trusts make this a reality?
- Will new workforce planning arrangements improve things, and will the easy option of appointing more non-consultant career grades continue?