

# The British Society for Haematology

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## *Haematology Consultant Manpower in the 21st Century*

A Joint Intercollegiate Committee on Haematology/  
British Society for Haematology Document  
approved by  
The Royal College of Physicians  
and  
The Royal College of Pathologists

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Intercollegiate Committee on Haematology/  
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Document

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## 1 EXECUTIVE SUMMARY

1. Consultant Haematologists perform a dual role as physicians and laboratory specialists.
2. Laboratory workload has increased regularly by 5% per annum over the last decade because of automation, open access to GPs, increased volume and intensity of hospital work and new technologies.
3. Clinical workload has increased following the developments in cancer care, the increasing recognition of thrombophilic problems, expansion in the indications for anticoagulation and the proposals for *Better Blood Transfusion* (1998).
4. There have also been additional demands relating to the training of junior staff, the European Working Time directive, new management and budgetary pressures, audit, clinical effectiveness and governance issues and the need for personal development implicit in CME and CPD.
5. In order to meet these demands SWAG has accepted the need for an expansion of Consultant staff of 250 over the next 7 years, an increase of almost 50% on present numbers. A recent survey has shown that haematologists currently work an average of 6.5 sessions over contract.
6. In purely laboratory terms, for effective and continuous scrutiny of laboratory requests, there should be 2 WTE per 200,000 requests annually, 3 WTE per 250,000, 4 WTE per 350,000 and 6 WTE per 450,000 and these should not be at Sub-Consultant level.
7. Annual clinical activity limits per WTE consultant should be no more than 250 in-patients, 250 new and 1,500 follow-up out-patients, 1,500 day cases/ward attendees and 100 ward consults. This cover should be in addition to the laboratory cover.
8. Departments in hospital with a large population base and departments of Obstetrics and Gynaecology, Cardiothoracic Surgery, Oncology and Renal Services will need additional Consultants to cover clinical care. Three Consultants will be needed for a population in excess of 250,000 regardless of specialist Haematology in-patient services and populations of over 400,000 may justify further posts.
9. Where there is sub-specialty care in Paediatrics, Haemophilia/Haemostasis, Haematological Oncology (especially BMT) and Haemoglobinopathy additional appointments will be required.
10. The absolute numbers and the balance between management, laboratory, clinical and specialist input will depend on local need and the balance of interests and expertise available. In calculating the absolute manpower numbers, however, all the above factors should be taken into account.

## **2 INTRODUCTION**

Consultant Haematologists perform a central and possibly unique function in the NHS.

1. They run laboratories that investigate, diagnose and provide advice on patients across the entire health community and also, through the transfusion laboratory, treat patients with blood and blood products.
2. They run acute speciality clinical teams for direct care of patients with diseases of the blood (leukaemias, lymphomas, clotting disorders).
3. They teach and train clinical staff and other health professionals on how to manage blood disorders.

With their dual role in practice, they must pass the Membership examination of the Royal College of Physicians and the Membership examination of the Royal College of Pathologists in Haematology, with all the training requirements necessary for these examinations, in order to register with the General Medical Council as Specialist Haematologists.

Since Clinical Haematology was established in this way in the UK in the 1970s, there has been no central planning of Haematological Services and they have developed variably in response to local demand. Consequently Regional and District Health Authorities and Trusts have not always responded appropriately to the increasing demand on these services and therefore a serious manpower problem has arisen. The safe and effective care of patients with blood disorders by the NHS in the 21st century requires a major increase in the number of Consultant Haematologists.

This statement of need is justified by the following detailed information on manpower and workload.

## **3 MANPOWER**

The Royal College of Pathologists has collected figures since 1996. Those shown here are for the whole of the UK but exclude Consultants working in the National Blood Service (NBS) unless they have a joint NHS hospital appointment. These numbers of doctors are expected to cope with the haematological work from a UK population of 60,000,000, including 419 NHS Trusts, at least 280 of which are acute District General Hospitals (DGH) with a total of over 230,000 beds, and almost all General Practices.

**Table 1 - Consultant Haematologists**

Country	Year			
	1996	1997	1998	1999
England	457	457	462	510
Wales	26	29	30	32
Scotland	62	62	63	71
NI	14	13	13	18
Total	559	561	568	631

of which

Vacant	-	15	22	32
Part-Time	-	26	43	35

*The figures below Table 1 are included in the totals.*

Thus there are on average

- 1 Consultant per 100,000 population
- 1.4 Consultant per Trust
- 2.1 Consultant per acute DGH
- 1 Consultant per 380 acute beds

These ratios are both useful and misleading. They confirm that the overall number of Consultant Haematologists is inadequate for the provision of a safe, modern and responsive NHS. However, they also conceal an irregular distribution of posts with many hospitals and populations served by a much lower level of Consultant manpower.

The figures collected by the College also show that expansion of Consultant numbers had been low until 1999 when there was an unexpected increase by 8%. This compares with an average annual increase of between 2.5% and 3.5% from 1984 and 1989 falling steadily to 0.4% in 1998, with occasional fluctuations. There is no indication that the increase in 1999 will be sustained.

There has also been an increase in part-time posts which now account for 5% of the total number. While it is useful to retain the skills of those Consultants with other commitments and their contribution is crucial, the part-time element dilutes the above ratios, which would be better expressed as WTEs. Table 1 may also conceal a number of Consultants who, although full-time, have part-time contracts with the NBS or management commitments. These posts further dilute the above ratios.

There has also been an increase in vacant posts, rising from 3.6% in 1997 to 5.7% in 1999, for no clear reason.

**Table 2 - Trainee Haematologists (excludes Transfusion posts)**

Country	Year		
	1997	1998	1999
England	242	241	272
Wales	12	13	10
Scotland	33	30	23
NI	6	6	6
Total	293	290	311

of which

Research	35	24	25
HEFC	-	-	12
Part-Time	17	26	11
Vacant	11	19	16
Visiting	23	22	25

*The figures below Table 2 are included in the totals.*

No new National Training Numbers (NTNs) were introduced for Specialist Registrars (SpRs) in the three years covered. The rise in England of 13% in 1999 is thought to include some of the research posts that have come back into the system but may not have been identified as part of the total counted in 1997 and 1998.

From the current numbers, between 30 and 40 trainees should be available annually from whom Consultant appointments could be made. However, when those posts that are totally or partially non-contributory to the pool are taken into account, including those that were vacant or occupied by visitors from overseas and the trainee wastage rate, the numbers drop significantly. These numbers may fluctuate but it is reasonable to assume that on average 250 posts are in the pool at any one time. In addition, although the training programme is scheduled for five years, a recent survey has shown that over 30% of trainees are taking time out for research, increasing the training period to nearly seven years. This number must cover replacement of retiring Consultant Haematologists and the creation of new posts.

The predicted retirement rate rises across the UK as indicated in Table 3.

**Table 3 - Consultant Haematologists Predicted Retirement**

Country	Year					
	1999	2004	2009	2014	2019	2024
England	3	10	18	19	29	26
Wales	0	2	0	3	1	0
Scotland	2	4	3	4	0	5
NI	2	0	2	1	1	1
Total	7	16	23	27	31	32

The rate of retirement may increase as pressures on Consultants within the NHS increase and there were unexpectedly 12 early retirements in 1999. A recent survey by the College predicts that there will be on average eight early retirements per year over the next five years.

Current Consultant appointments annually are in the region of 30-40, which are the numbers needed to replace those retiring and to supply the average modest increase of 3.5-4.5%. It can be seen from the figures that the numbers of trainees are barely adequate to support these numbers and any variation in trainee numbers, not contributing to the overall pool available for Consultant posts, will seriously impair the rate of expansion.

This interpretation is supported by the fact that less than 10% of trainees need to apply for three or more Consultant posts to gain a career position and there is an average of only 2.5 applicants per Consultant post. Just under a third of successful candidates are moving from an existing Consultant post.

Table 1 indicates an increasing number of vacant Consultant posts implying an inadequate number of trainees. A survey of Regional Training Directors in Haematology suggests that there needs to be an increase of approximately 250 consultants to maintain the current level of service. These calculations have been accepted by SWAG, but in order to achieve this there would need to be an increase in appointments of approximately 7% per year, for the next seven years. To meet this demand there would need to be a significant increase in trainee numbers.

The Clinical Benchmarking Company has provided further anonymised evidence on Consultant Haematologists' manpower. This wholly independent company collects, analyses and reports to subscribing laboratories on their manpower and workload. The detailed, in-depth, national profiles provided are not available through any equivalent NHS body and validate many of the points illustrated by the data from the Royal College of Pathologists.

Some of their main findings are as follows:-

### 96/97 Report (65 labs)

Outside Teaching Hospitals there is, on average, less than 1 Consultant per DGH Trust.

### 97/98 Report (90 labs)

Outside Teaching Hospitals there is less than 1 Consultant WTE in one third of the DGH Trusts.

Overall 1.37 WTE/site

Median of 6.5 sessions worked over Contract in all hospitals.

### 98/99 Report (105 labs)

Median Consultants Sessions in Lab: no rise

Teaching Hospital Consultant Sessions: up from 13.8 to 19 per week.

Total number of Consultant increased by up to 5.9%, mostly in Teaching Hospitals.

The figures for 1998/99 confirm the rise in Consultant numbers reported by the Royal College of Pathologists, but suggest that this increase has not affected staffing levels in non-teaching DGHs and the expansion in number of Consultants and trainees is inadequate when considered against the expanding workload. However, the numbers of Sub-Consultant Career Grade staff have increased significantly.

**Table 4 - Sub-Consultant Career Grades (Staff Grade/Associate Specialist/  
Clinical Assistant)**

Country	Year		
	1997	1998	1999
England	37	77	90
Wales	6	6	6
Scotland	14	12	13
NI	0	1	1
Total	57	96	110

In three years these have doubled. This confirms that pressure of workload has forced an expansion in manpower, but suggests that there are obstacles to expansion of Consultant numbers.

The increase in Sub-Consultant Career Grades almost equals the Royal College of Pathologists' prediction in 1996 of the needed expansion in numbers of Consultants (67) in England and Wales. While these career grades have helped to deliver specific aspects of clinical care, they should not be seen as a substitute for Consultant expansion and many have

not been recruited from the ranks of adequately trained juniors. The growing NHS haematological workload can only be managed safely and efficiently with an adequate number of trained, qualified, registered, revalidated and unsupervised specialists.

## **4 WORKLOAD**

Consultant Haematologists must provide both laboratory and acute medical services. The annual surveys of the Clinical Benchmarking Company confirm that on average they spend their time equally on both these services. The respective workload pressures in the two different activities are considered separately.

### **1 Laboratory**

- In 25 years the number of laboratory tests has more than doubled.
- The independent Clinical Benchmarking Company results show a recent average annual increase in requests of 5.5%
- Requests from General Practice account for 50% of the average DGH laboratory's workload and are increasing faster (10% annually) than hospital requests. Funding for GP open access has been inadequate and often the increase has not been appropriately acknowledged.
- In the 1998/99 report from the Clinical Benchmarking Company, the laboratories in the group of larger than average Trusts had very large workloads with over 400,000 requests per annum (maximum 700,000). This translates into over 2,000 reports daily for every Consultant Haematologist. The report states that "such figures ..... seem to deny the possibility of an effective medical service". Similar extreme volumes are seen in the other groups of hospitals surveyed.
- This company's 1996/97 report showed a 12% annual rise in Consultants' productivity, which is unsustainable at current manpower levels. Technical advances in automated analysis allow timely processing of samples, but such huge demands cannot be adequately controlled despite the obvious financial and clinical implications. This could only be achieved with the sufficient consultant numbers to provide the obligatory safe and effective, advisory and interpretative service.
- In the laboratory Consultants must cope with:-
  - Increasing volume, intensity, speed and complexity of hospital activity leading to less discriminating use of lab investigations.
  - Reduced continuity of cover by junior hospital doctors and GPs as they reduce their hours on-call.

- The need to control the effective use of blood and blood products (the NBS depends on DGH Consultants for this).

These issues have meant that Consultant Haematologists often spend significant time guiding the clinical management of patients not under their care.

- Performance management requires increasing time:-
  - National Quality Assurance schemes ensure accuracy of results (NEQAS).
  - Standards are maintained by national external inspection (Clinical Pathology Accreditation: CPA).
  - Restricted budgets mean careful restraint of unit costs of tests.
  - The introduction of new tests requires evaluation and careful costing.
  - Budget and contract setting and monitoring require constant attention.
  - Effective IT systems must be established and maintained for rapid and mass transportation of results.

All these pressures require a continuous presence of Consultants in sufficient numbers in the laboratory. The workload and manpower pressures have meant that it is becoming increasingly difficult to maintain ethical, educational and economical standards in delivering an effective service in conjunction with the demands caused by the expansion of clinical work.

## **2 Clinical**

Haematology was one of the first medical specialties to develop an acute service operating separately from emergency medical admissions and few Consultant Haematologists are now involved in general medical acute admission rotas. Haematologists have also developed a model service for the care of patients with cancer. The care of patients with haematological malignancies is almost exclusively in their hands and in many DGHs they also provide medical care for patients with all types of tumours, i.e. they are general medical oncologists.

### **1 *Malignant Disease***

- In the Leukaemia Research Fund Surveys of 1984-88 and 1984-93 the incidence rate for all new haematological malignancies was almost 40 per 100,000 population per year. The population base selected (excluding most metropolitan and many elderly populations) conceals wide regional variation and may be an underestimate according to other local surveys.

- In an average DGH covering 300,000 people there will be an average 120 new cases of haematological malignancy per year and approximately 40 will need prolonged and intensive in-patient care to control and potentially cure their disease. All will need follow-up in clinics and many will need frequent, regular, day-case care.
- Over 50% of all these patients in the UK are now entered into clinical trials. This is ten times greater than patients with non-haematological cancers. As an example, in the past 30 years in the MRC trials of adult acute myeloblastic leukaemia, long-term survivors who are free from disease five years from diagnosis have risen from 15% to 50% with the obvious implications for long-term follow-up. This work is very labour-intensive and time-consuming for Consultants. It has not been adequately recognised or funded from any source, including the R&D initiatives. The new National Cancer Plan could and should provide this recognition and funding.
- To achieve and maintain this success the following are essential parts of Consultants' work:-
  - Immediate response to GPs referrals - waiting lists are unacceptable.
  - Long and detailed explanation of the diagnosis, treatment and outlook with the patient and family.
  - Description of complicated clinical trials and getting informed consent.
  - Planning and delivery of chemotherapy.
  - Care of complications of treatment, in particular, to prevent deaths from bleeding and infection.
  - The Consultant Haematologist must run a multi-disciplinary team (doctors, nurses, pharmacists, dieticians etc.) to deliver this complex kind of care.
  - In-patient care in a Haematology Unit is not only labour-intensive for all the staff involved, but in itself is often a form of intensive care.
  - The increase in elderly population has been associated with an increase in numbers of older patients with chronic marrow failure (myelodysplastic syndromes or pre-leukaemias). These patients do not need high intensity care, but they do need initial, lengthy, careful discussion of their condition followed by prolonged day-case support and regular follow-up and review.

## 2 *Clotting Disorders*

There are a number of very different types of work for the Consultant Haematologist in the care of these disorders.

***Congenital bleeding disorders.*** The UK Haemophilia Centre Doctors Organisation has collected incidence and prevalence data on inherited bleeding disorders for many years. The latest prevalence is about 12,000. These patients tend to cluster around Comprehensive Haemophilia Care Centres in metropolitan areas, but most DGHs deliver first-line care to many patients. This is very labour intensive and Consultant dependent.

- Replacement therapy is now effective and safe, but needs extra patient and family education, monitoring and control.
- Life expectancy is greatly improved.
- Follow-up workload is therefore growing.
- Blood product acquired viral infections (HIV, Hepatitis C) have created a large multi-disciplinary workload.

***Congenital thrombotic disorders.*** Around 8% of the population have a genetic defect that increases the risk of clotting (thrombophilia). Department of Health advice that women with this problem should avoid oral contraception and hormone replacement therapy has resulted in a 50% increase in new cases referred by GPs to Consultant Haematologists for counselling, testing, preventive measures and treatment. This advice was not supported by increased funding.

***Acquired thrombotic disorders.*** In many DGHs Consultant Haematologists will assume the responsibility for the overall care of patients with venous thrombo-embolism. They implement and audit protocols for the management of these patients, provide their in-patient care and run long-term, out-patient, anti-coagulant clinics. These clinics have doubled in size in the last two decades as the Royal Colleges and the Department of Health recommended new indications for life-long anti-coagulation. Again, no new resources came with these recommendations.

As pregnancy is the most potent risk factor for venous thrombosis, all Consultant Haematologists covering an Obstetric Unit must run an anticoagulant prophylaxis service for the growing number of women identified with this problem.

***Acquired bleeding disorders.*** Acute and life-threatening failure of clotting occurs with increasing frequency as:-

- More aggressive and intensive treatment is given to more patients in hospital.
- More patients on long-term prophylaxis become acutely over-anticoagulated for a variety of reasons (usually injudicious drug interactions).
- The increasing recognition of disseminated intra-vascular coagulation as a correctible and major cause of morbidity and mortality in acutely ill patients.
- Loss of circulating platelets (usually auto-immune thrombocytopenia) also causes life-threatening bleeding. These patients present regularly, many need initial in-patient care and often remain chronically dependent out-patients if their platelet counts do not recover.

The Consultant Haematologist must be available immediately to assist colleagues in other disciplines to correct these problems. This is an incessant, unpredictable and growing call on their time.

### 3 *Other Clinical Areas*

- There is an increasing involvement of Haematologists in the management of children with haematological disorders. Although there may be dedicated Paediatric Haematologists in a few, large DGHs, advice is more often given by Haematologists who will have had variable paediatric exposure as part of their training.
- The growth in the non-white and non-Caucasian people increases the number of patients with red cell disorders (haemoglobinopathy and enzymopathy) who need long-term intensive support (counselling, testing and treating).
- More intensive therapies (medical and surgical) in other hospital specialties create increasing haematological complications (including clotting failure described above).
- Chronic anaemias are frequently complex and need painstaking investigation in Haematology clinics.

### 4 *Clinical Activity Measures*

There is no standardised systematic survey of Consultant Haematologists' clinical activity. However in 1992 the British Committee for Standards in Haematology (a sub-Committee of the British Society for Haematology) carried out a postal enquiry among Consultants producing the figures shown in Table 5.

**Table 5 - Consultants' Clinical Activity: BCSH Survey 1992**

Activity	Annual range of patient episodes	Percentage of Consultants
In-Patients	200-499	75
	500+	18
Out-Patients	2000-4999	70
	5000+	18
Day-Cases	200-499	67
	500+	22

- Internal urgent referrals from other clinicians are rising. The degree will depend on the mix of specialties within any one hospital, but on average, in a large DGH, there will be 10 per week. These are very time-consuming and must be dealt with urgently.
- Out-Patient, day-case, internal referrals and ward round duties increasingly fix Consultant Haematologist time and make it harder for them to respond flexibly to other urgent laboratory and clinical demands.
- To try to contain this trend, many centres now have established nurse-run clinics and specialist nurses now oversee much day-case work. This activity, however, still needs close consultant supervision.
- With the changes in training requirements plus the restriction of hours at work following the European Working time directive, junior doctors are less available for service delivery and are less able to provide continuity of care. Consultants have filled the gaps created by these changes. In addition SpR training now requires more of the Consultants' time and involvement in the process. An expansion in Consultant numbers was promised with the introduction of new SpR training but has not been delivered.
- Consultants' time is also being diverted into proof of competence with the growth of appraisal schemes, audit of their own and other specialists' clinical activity, personal accreditation and development schemes and the developing revalidation schemes as described by the GMC.

## **5 *Current Obligatory Job Plans***

- The Clinical Benchmarking Company has shown that Consultant Haematologists' median excess of sessions (notional half days: NHDs) across the UK is 6.5.
- This is confirmed through the recurrent "diary" exercises required by the EU's Working Time Directive. These regularly indicate a working week in excess of 60 hours.
- To cover all the workload described above with the current manpower levels and to fulfil all the duties and responsibilities currently required of a Haematology service, Table 6 would be a 'typical' DGH Consultant's weekly timetable.
- Such figures create considerable difficulties for the delivery of sustainable, safe and effective delivery of Haematological care in the NHS and support the need for an early and significant increase in consultant numbers. They also undermine the proposition that amalgamation of departments will achieve economies of scale.

**Table 6 - Workload-Enforced Job Plan**

<b>Type of work</b>	<b>Number of NHD per week</b>
Ward	2-3
Out-Patient	2-3
Laboratory	5-7
Admin/Management	1-2
On-Call	3-6
Audit	1
Research/Special Interest	0-2
Teaching/Training/Examinations/Accreditations	2
<b>Total</b>	<b>16-26</b>

## **5 FUTURE EXPANSION**

The data on manpower and workload provide persuasive evidence for the creation of additional Consultant posts. However, they need to be interpreted in a way that can be used at District level. Central manpower planning accepts the need for an additional 250 posts but these have to be identified locally where the business case for their funding will need to be made. The aim should be to produce a case that achieves continuity of Consultant time to cover:-

- The Speciality's own clinical workload.
- The provision of an expert haematological advisory/educational/training service for all other parts of the Health Community.
- The management of demand on the Laboratory.
- The control of the use of blood.
- The maintenance of quality of this service.

The case could be presented in a number of ways.

### **1 Laboratory Workload-Based**

- Outside teaching hospitals:
  - 1.37 Consultants cover each DGH
  - One-third of DGHs have less than one consultant
  - 50% Consultant time spent outside lab

These figures indicate that there cannot be adequate continuity of Haematology laboratory cover across the NHS. The very minimum increase in Consultants required to provide the most basic cover in the smallest DGH would be 50%.

- Laboratory workload data indicate that larger DGHs need an even greater number of Consultants to cope with rapidly increasing numbers of laboratory requests. The mean workload data by groups of hospitals from the Clinical Benchmarking Company 1998/99 report are shown in Table 7. The proposed pro-rata increase in WTE Consultant laboratory sessions starts from the baseline of two per hospital to give continuity for laboratory cover.

**Table 7 - Mean Group Lab Workloads/Consultant Numbers**

Hospital Group	Annual Tests (X10 <sup>3</sup> )	Consultant WTE needed/lab	WTE Needed/Hospital
Smaller DGHs	217	1	2
Medium DGHs	260	1.5	3
Large DGHs	344	2	4
Teaching Hospitals	438	3	6

As the volume of workload rises, so does the range and complexity of tests. It is not possible to provide an interpretative and advisory service across the country with only 1 WTE per laboratory.

The increased need in teaching hospitals reflects the provision of tertiary level investigations. The group ranges collected by the Clinical Benchmarking Company have wide extremes, which sometimes overlap, and many individual laboratories have annual workloads greatly in excess of the mean. These should claim the staffing level appropriate to the workload rather than the hospital grouping.

- The Joint Working Group of the BMA and the Royal Colleges of Physicians and Surgeons, in their report "Provision of Acute General Hospital Services" of 1998, recommends that four Consultant Haematologists' are needed to support the work of a major, acute, general hospital serving a population of 450,000 to 550,000. This translates into one per 100,000 population for laboratory work alone and is in keeping with the actual data collected for this document.

## 2 Clinical Workload-Based

- The collected data confirm that there is less than 1 WTE equivalent consultant on average per non-teaching DGH to provide continuity of care for all the clinical indications described in the workload section. This is insufficient to support safe practice, the new Clinical Governance initiatives and the developing managerial culture in the NHS.

- The workload described by the BCSH survey cannot be dealt with effectively and safely at this level of Consultant staffing. The Royal College of Physicians (RCP) Report of 1999, “Consultant Physician’s Working for Patients”, in defining job plans for specialists, recommends a weekly workload in specialty clinics of six new patients, 15 return patients and six specialty interest patients. These limits could not be met at current manpower levels.
- The BCSH “Guidelines on the Provision of Care of Adult Patients with Haematological Malignancies” of 1995 recommend that level one centres require continuous availability of a Consultant Haematologist. From level two centres upwards at least two Consultants are required who are clinically committed, experienced in the management of these patients and aware of recent advances. Most DGHs will be delivering level two care in Haemato-Oncology which merits two Consultant posts in its own right.
- The recommended ceilings in Table 8 are well in excess of the RCP’s guidelines, but are a realistic assessment of current working practices. These figures are, however, significantly lower than those in the BCSH Report on Clinical Workload of 1992 and support the stated need for a 50% increase in Consultant numbers.
- Where Consultants are involved in a significant additional amount of work as a result of clinical trials, they should request additional Consultant sessions. The National Cancer Plan should acknowledge this effort and provide new financial support for it.

**Table 8 - Recommended Maximum Clinical Workload  
for Consultant Haematologists**

Activity	Annual number of patients
In-Patients	250
Out-Patients	
New	250
Return	1500
Day-Cases/Ward Attenders	1500
Ward Consults	100

### **3 Job Plan-Based**

- The current demand as collected by the Clinical Benchmarking Company indicates that Consultants are working at a mean of 6.5 NHDs above contract.
- The BMA Model Pathology Workload Document of 1996 suggests that a Job Plan for Consultant Haematologists should not exceed 13 NHDs. Table 6 confirms that the specialty is driven by population-based demand and shortage of staff, to work well beyond that.

- The EU Working Time Directive does not allow such excessive continuous workload.
- A 50% increase in manpower will still leave Consultants working beyond contracted hours, but would significantly redress the balance.

## 6 CONCLUSIONS

- Haematology, as a discipline, is being overwhelmed by increasing commitments required from its Consultants.
- Consultant grade expansion is very low, particularly outside teaching hospitals, trainee numbers have not increased and there has been an uncontrolled increase in Sub-Consultant Career Grade posts.
- These developments threaten the future of Haematology as a specialty delivering high quality care consistently and uniformly across the NHS.
- An expansion of at least 50% in Consultant posts is needed urgently with associated increases in SpR numbers.
- This will only be achieved by insistence on workload ceilings and realistic discussions at a local level supported by the Society's and Colleges' documents.
- The EU Working Time Directive will force Trusts, Health Authorities and PCGs/PCTs to seriously consider the pressures on Haematologists in their dual role as clinicians and pathologists.
- The Colleges, the BSH and CPA should enter into dialogue with the Department of Health and NHSE over the need to increase Consultant numbers, control the expansion of Sub-Consultant Career Grade posts and put pressure locally on individual Trusts.
- Consultants themselves must be prepared to control their workload.
- ***Better Blood Transfusion*** and an audit-based control of expanding laboratory workload may control expenditure and help to fund this expansion locally and internally. The National Cancer Plan should deliver support for significant clinical trial work.
- Sub-Specialty appendices to this report may now be written which are specifically relevant to their interests.

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