



**Reshaping the Medical Workforce in Scotland:  
Consultation on Speciality Training Numbers 2013 and  
Beyond**

**Response from the Royal College of Physicians of  
Edinburgh**

**September 2012**

**Comments on**  
**Reshaping the Medical Workforce in Scotland:**  
**Consultation on Speciality Training Numbers 2013 and Beyond**

**Introduction**

The Royal College of Physicians of Edinburgh (RCPE) is pleased to respond to the Scottish Government's "Reshaping the Medical Workforce in Scotland: Consultation on Speciality Training Numbers 2013 and Beyond".

In this response the College focuses on the pressures on acute medicine to manage the needs of emergency medical patients presenting at hospitals across Scotland and the challenges of correcting the current baseline data. Consultants in Acute Internal Medicine deliver this care with significant contributions to the on call rotas from their colleagues in selected other medical specialities. The data regarding the workforce in the medical specialties are not accurate and must be corrected to ensure workforce projections reflect fully the changing needs of the service.

In acute medicine there are pressing service, training, recruitment and retention needs which must be addressed. In particular, urgent review of the consultant workforce of medical specialties which are currently involved in caring for acute medical admissions is required to ensure an accurate understanding of the future contribution to be made by these specialties. Current and projected consultant workload; proposed extended hours of consultant presence for medical receiving (e.g. twilight working); time for enhanced supervision of on call trainees; and maintaining activity in specialty (if applicable) are all issues which must be examined thoroughly. In addition, there is increasing evidence that a medical career in Scotland is now considered as being comparatively unattractive and this merits urgent attention.

The key messages in this response are grouped as follows:

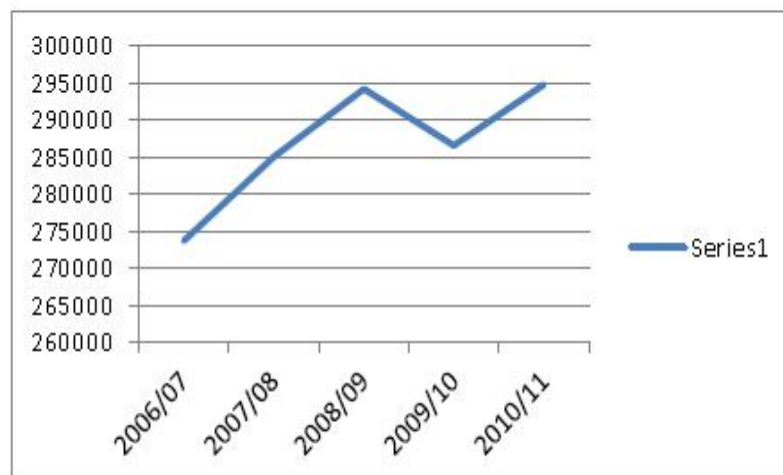
1. Rising numbers of emergency medical patients
2. Other workload factors in Acute Medicine
3. The case for consultant led care
4. Consultant numbers and the medical specialties including:
  - Estimating contributions to acute and general medicine
  - Growth in consultant numbers
  - Gender Multiplier
  - Consultant vacancies
5. Current training for GIM / AIM and Specialty
6. Trainee experience: does Scotland have the ability to attract and retain the best?
7. Recommendations

## 1. Rising numbers of emergency medical patients

Recent discharge data from ISD shows the numbers of emergency medical admissions in the medical specialties have been increasing over the past 5 years.

**Table 1. Number of medical specialty emergency inpatient discharges (Episodes) for Scotland financial years ending 31 March 2007-2011**

2006/07	273682
2007/08	285030
2008/09	294208
2009/10	286555
2010/11	294797



Source ISD data :

[Annual information by specialty \(Episodes, Stays and Patients\) - NHS Board of Treatment](#)

Table 4: Number of Episodes, CISs and Patients discharged from all NHS Boards of Treatment and other areas, by specialty and year; financial years ending 31 March 2007-2011<sup>P</sup>

<http://www.isdscotland.org/Health-Topics/Hospital-Care/Inpatient-and-Day-Case-Activity/>

In addition, simply looking at referral/admission/discharge figures to Acute Medical Units (AMUs) may not lead to a full understanding of the on-call workload. There has been a noticeable increase in same day discharges from AMUs and which relate to new outpatient management plans for an increasing number of acute medical diagnoses e.g. DVT, low grade Community Acquired Pneumonia, TIA etc. Such patients and plans for optimal management often require multiple senior reviews over and above a single patient /doctor contact made on a timetabled ward round.

## **2. Other workload factors in Acute Medicine**

There is an increasing burden of new areas of responsibility on the acute on call rotas which both consultants and trainees have accommodated and are very labour intensive e.g.

- Transfers and increased number of referrals from other specialties to medicine
- post-operative surgical referrals
- rising numbers of obstetric patients with medical complications
- children over 14 years of age
- oncology patients with non-cancer complications
- stroke thrombolysis
- impact of SEWS/rapid response to deteriorating patients
- greater public expectation of aggressive medical intervention

In addition there is a need for a better patient handover and therefore an added time dependent pressure, which should be taken into account as a patient safety issue.

## **3. The case for consultant led care**

Repeated reports have advocated that hospitals undertaking the admission of acutely ill medical patients should have a consultant physician on site for at least 12 hours per day, seven days a week, at times relating to peak admission periods. The consultant should have no other duties scheduled during this period <sup>i</sup>.

If consultant-delivered care does produce better outcomes for patients it cannot be acceptable that this is only available for some patients and only over certain periods during the day or week. Achieving the benefits for patients of consultant-delivered care therefore requires greater consultant presence in hospitals than at present. Work intensity in acute medicine is rising with fewer and less experienced trainees. The position is similar to that of emergency medicine where the ratio of consultants to trainees has prompted increased recruitment to allow greater direction of trainees. This does not mean 24 hour full consultant attendance across all medical specialties is required. However, it will generally require consultant presence on a 7 day basis for at least 12 hours a day for many and certainly for the acute admissions teams. Whilst such work patterns are already usual in some specialties they are not the norm across all specialties <sup>ii</sup>. It is important to recognise the

impact of Working Time Regulations on consultants and that such extended working will mean loss of daytime hours at other times of the week, potentially with knock on effects to specialty activity.

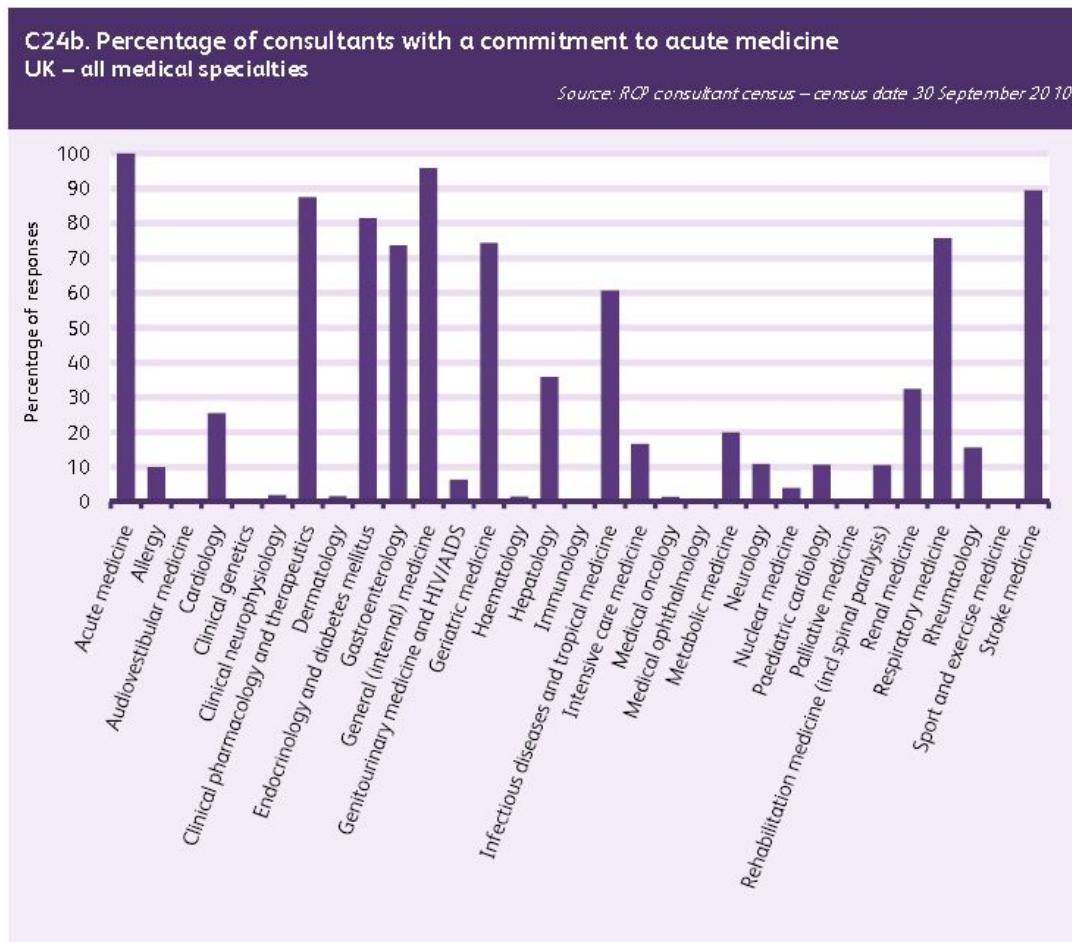
If, as the recent NHS London <sup>iii</sup> report suggests, over 500 additional people may die per year because of the differential consultant staffing in London hospitals at weekends the case for change is very strong. The Temple Report<sup>iv</sup> was also very clear in its recommendation of the need to move to a consultant-delivered service.

Studies designed to improve patient care which have incorporated earlier involvement of consultants have resulted in better patient outcomes, more efficient use of beds and decreased length of stay. An NCEPOD review of the care of patients who died in hospital within four days of admission found that “in 25% (407/1635) of cases there was, in the view of the advisors, a clinically important delay in the first review by a consultant”<sup>v</sup>. In intensive care similar measures have resulted in better triage and decreased futile care<sup>vi</sup>.

#### **4. Consultant numbers and the medical specialties**

Any proposed workforce figures for physicians should represent the views of all the specialities, but must take account of the current contribution of the specialties to acute and general medicine. Figures quoted in the consultation paper on p.19 illustrate the percentage of consultants who deliver general medicine sessions: 74% of gastroenterologists, 67% of geriatricians, 44% of rheumatologists, 25% of cardiologists, and 32% of nephrologists. However, in Scotland we must have a better understanding of the actual contribution of the specialties to acute and general medicine and the paper itself accepts that this detailed level of information is not available from ISD. The most recent census of consultant physicians and medical registrars conducted on behalf of the Federation of Royal Colleges of Physicians of the UK (December 2011) Tables 2a & b below provide the following breakdown of data on a UK wide basis:<sup>vii</sup> This demonstrates that consultants in endocrinology and diabetes, infectious diseases and respiratory medicine are also among major contributors to acute medicine.

**Table 2a**



**Table 2b**

**C24c. Commitment to acute medicine (2002–2010)**  
UK – selected medical specialties

*Source: RCP consultant census – census date 30 September 2010*

Specialty	2002	2003	2004	2005	2006	2007	2008	2009	2010
	%	%	%	%	%	%	%	%	%
Cardiology	53.2	46.6	45.8	53.9	41.3	32.3	29.1	31.2	25.5
Endocrinology and diabetes mellitus	89.6	87.3	86.1	92.2	84.4	84.6	79.5	83.6	81.4
Gastroenterology	86.4	85.6	82.4	87.4	80.2	75.9	72.5	80.3	73.7
Geriatric medicine	88.6	88.3	86.1	89.4	80.2	66.6	67.8	72.5	74.4
Renal medicine	52.0	47.4	45.6	56.1	41.4	37.6	32.8	33.2	32.5
Respiratory medicine	86.7	86.5	83.7	87.9	80.2	81.6	77.0	75.1	75.7

Scottish data are now being collected and analysed on not only the specialties which participate in acute and general medicine, but also the percentage of time devoted by consultants to these areas outside their primary specialty. This is derived from the recent collaborative RCPE and RCPSCG survey together with data collated by Dr Donald Farquhar from the national Training Leads and Specialty Societies earlier this year. Preliminary analysis indicates that the data gathered through these sources is varied and there are significant discrepancies between the specialties. This will require detailed examination and comparison with local health board data in job plans and existing ISD statistics in order to obtain a more accurate basis for workforce planning decisions.

As consultants with split responsibilities retire, employers must consider carefully their specialty and acute medical requirements, including for example how many acute medicine consultants might be needed if new specialty consultants no longer participate in the acute take? How many consultants in, for example GIM/ cardiology retiring in the next 5 years, will be replaced by pure cardiologists? It is vital that we plan for future changes with the increasing demand for specialty rotas particularly in areas such as cardiology and renal medicine.

### **Estimating contributions to acute and general medicine:**

The overall response to the RCPE and RCPSCG survey from physicians with an acute medical specialty (excluding acute medicine) suggests that 22% of respondents spend 50% or less of their time on their specialty and 43% of respondents spend 70% or less of their time on their specialty. This indicates that nearly half of consultant physicians in the acute medical specialties in Scotland spend at least 30% of their time contributing to acute and general medicine.

#### *Endocrinology & Diabetes*

54% of respondents to the survey spent at most 50% of their time on their specialty; while 79% of respondents spent at most 70% of their time on it. Overall 87% contribute to acute and/or general medicine to some extent.

In a UK survey of Young Diabetologists published in August 2012, 45 respondents out of 51 who had been appointed to substantive consultant posts were contributing to either their



specialty and acute; specialty, GIM and acute or specialty and GIM. Only 3 out of 51 respondents were working in a post with purely specialist commitment<sup>ix</sup>.

### Gastroenterology

21% of respondents spent at most 50% of their time on their specialty; 55% of respondents spent at most 70% of their time on it. Overall 74% contribute to acute and/or general medicine to some extent.

### Geriatrics

19% of respondents spent at most 50% of their time on their specialty; while 40% of respondents spent at most 70% of their time on it. Overall 67% contribute to acute and/or general medicine to some extent.

### Respiratory Medicine

23% of respondents spent 50% of their time or less on their specialty; 62% of respondents spent 70% of their time or less on it. Overall 88% contribute to acute and/or general medicine to some extent.

### Rheumatology

There is considerable regional variation in this specialty, for example, in NHS Greater Glasgow and Clyde & NHS Tayside, most rheumatologists contribute to acute take ward rounds and further care of medical admissions, however elsewhere in Scotland this is not common practice.

Overall, 11% of respondents spent 50% of their time or less on their specialty; while 33% of respondents spent 70% of their time or less on it. Overall 67% contribute to acute and/or general medicine to some extent.

### Cardiology

17% of respondents spent 50% of their time or less on their specialty; 45% of respondents spent 70% of their time or less on it. Overall 72% contribute to acute and/or general medicine to some extent.

## Renal Medicine

26% of respondents spent 50% of their time or less on their specialty; 37% of respondents spent 60% of their time or less on it. Overall 42% contribute to acute and/or general medicine to some extent.

From this information we can start to estimate the average proportion of time spent by consultants in acute medicine who are currently classified as being in another medical specialty. Table 3 summarises this information and but the response rate was modest and these early indications require verification by reference to local job plans.

**Table 3: Estimates of Specialty Contributions to Acute Medicine**

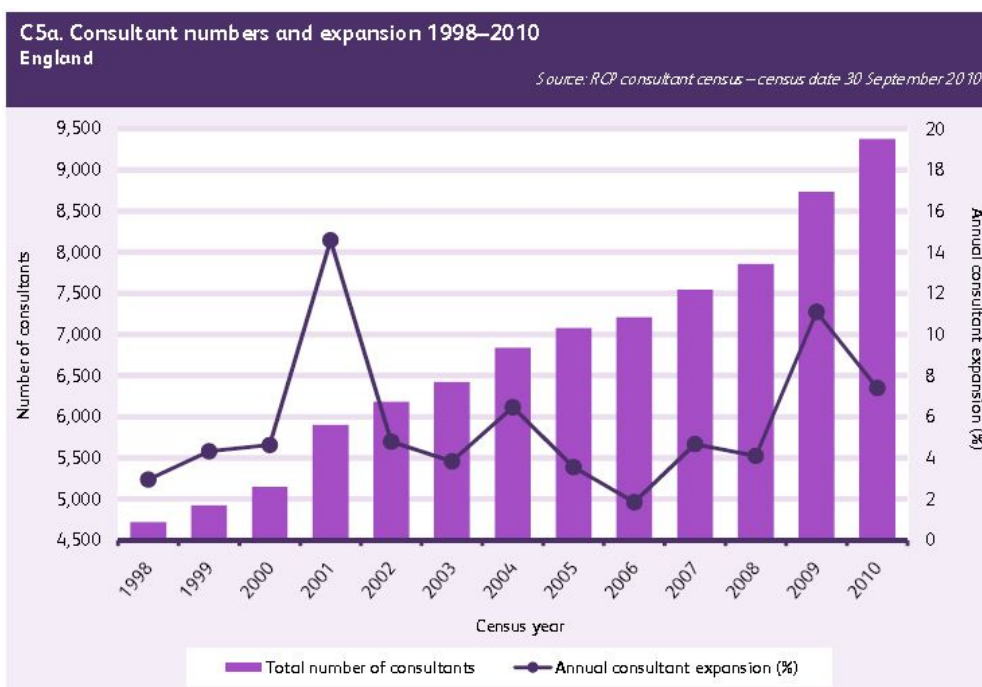
<b>Specialty</b>	<b>% Consultants contributing a minimum of 30% to all age acute medicine</b>	<b>Indicative % Contribution of the specialty to all age acute medicine</b>
Endocrinology and Diabetes	79	24
Gastroenterology	55	17
Geriatrics	40	12
Respiratory Medicine	70	21
Rheumatology	33	10
Cardiology	37	11

### **Growth in Consultant numbers**

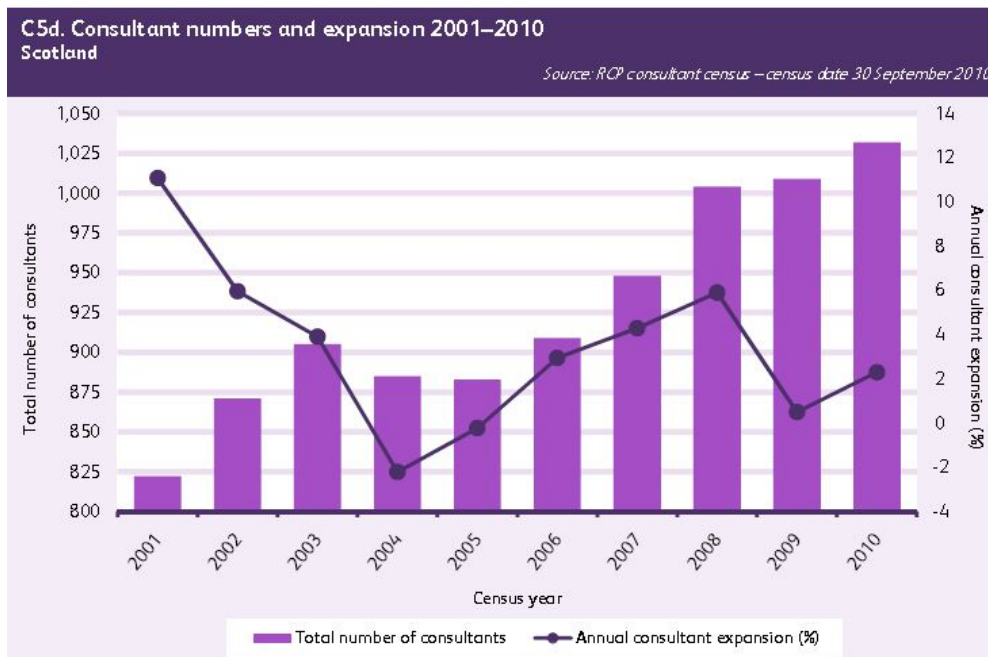
During the last 10 years there may have been “considerable expansion of the consultant workforce in Scotland” but this has not necessarily been in the specialties covering acute medicine.

Comparison to England in this respect is very unfavourable. Figures published in December 2011 from the *Census of Consultant Physicians* (see table 4a & 4b below) show that while England enjoyed a consistent 5-6% yearly growth in physician numbers during the period 2005-2010, Scottish figures by comparison showed an average of 3% yearly growth and with no significant growth in the numbers contributing to acute medical rotas. These figures imply that consultants will have better prospects in England due to expansion and growth in Consultant numbers, and therefore enhanced career opportunities.

**Table 4a**



**Table 4b**



## Gender Multiplier

Data from the consultant census and JRCPTB databases demonstrates significant specialty preferences by gender. Female trainees dominate many of the “cold” medical specialties as identified in the consultation document where palliative medicine is singled out. However this misses the obvious female dominance in dermatology and GUM, illustrating that applying a standard multiplier may introduce further inaccuracy and merits review.

## Consultant vacancies

In the Medical Specialties, at 31 March 2012 there were 44.2 wte posts vacant and 987.3 wte staff in post, giving a vacancy factor of over 4%. Many of these had been vacant for more than 6 months. Of the 44.2 vacancies, 13.9 (31%) were in General (acute) medicine with a resulting vacancy rate of 12% in established posts in this specialty. The position is exacerbated in the North Region of NHS Scotland, where 23% of established General (acute) medicine posts and 14% of established Geriatric posts were vacant at 31 March 2012<sup>x</sup>. Attracting physicians to remote and rural areas of Scotland clearly remains a challenge.

The second report on the External Advisor service provided by the Scottish Academy<sup>xi</sup> advises that of the 219 completed selection panels across the specialties in Scotland, between 1 July 2010 and 30 June 2011, 47 were cancelled and did not reach interview stage, generally due to a lack of suitable applicants. This, when added to the failure to fill rates at CMT level and the attrition from medical training posts, is worrying evidence of Scotland losing out to other parts of the UK and the international market for doctors.

## 5. Current training for GIM / AIM and Specialty

There are currently 3759 UK trainees enrolled in GIM plus another specialty. Of this total, 385 trainees are enrolled in AIM plus GIM as the additional specialty, with only very small numbers enrolled in AIM plus another specialty. Over recent years the JRCPTB database (Table 5 below) suggests that 50-55% of trainees have been granted CCTs in “GIM plus specialty”.

**Table 5: CCT Recommendations to August 2012**

Year (Jan to Jan)	Total Medical CCT Recommendations	GIM Only	GIM & Specialty (% of total)
2007	800	10	418 (52%)
2008	860	19	447 (52%)
2009	926	35	506 (55%)
2010	901	34	447 (50%)
2011	979	78	520 (53%)

For completeness Table 6 overleaf shows the list of specialty CCTs granted thus far in 2012 in those specialties where there are no trainees developing competencies to participate in the acute medical rota.

**Table 6**

**2012 UK totals by Specialty of STRs awarded CCTs (Jan-Aug)  
Single Specialty CCT (No GIM)**

<i>Parent Specialty</i>	<i>Total</i>	<i>Subspecialty</i>	
		<i>Stroke</i>	<i>ICM</i>
Allergy	<b>0</b>	0	0
Audiology	<b>2</b>	0	0
Clinical Genetics	<b>6</b>	0	0
Clinical Neurophysiology	<b>3</b>	0	0
Dermatology	<b>24</b>	0	0
GUM	<b>26</b>	0	0
Haematology	<b>30</b>	0	0
Immunology	<b>1</b>	0	0
Medical Oncology	<b>20</b>	0	0
Medical Ophthalmology	<b>0</b>	0	0
Neurology	<b>33</b>	2	0
Nuclear Medicine	<b>9</b>	0	0
Paediatric Cardiology	<b>3</b>	0	0
Palliative Medicine	<b>27</b>	0	0
Pharmaceutical medicine	<b>18</b>	0	0
Rehabilitation Medicine	<b>11</b>	1	0
Sport and Exercise Medicine	<b>6</b>	0	0
Tropical Medicine	<b>0</b>	0	0
<b>TOTAL</b>	<b>219</b>	3	0

To enhance both service delivery and supervision of trainees on acute medical rotas we are limited to the workforce in those specialties with confirmed competencies and holding CCTs in GIM and / or AIM. Table 7 below is a snapshot of the numbers of Specialty Registrars completing training earlier this year with dual accreditation and identifies the UK numbers in specialties with the required competencies to contribute to acute medical rotas throughout Scotland; AIM, Geriatrics, Endocrinology & Diabetes, Gastroenterology and Respiratory Medicine.

The pattern of CCT holders in GIM has been complicated over the past decade by the emergence of acute internal medicine as a separate specialty in 2009. Although acute medicine as a specialty was developed to improve overall patient care in the acute medical unit, medical receiving had been run for many years by Consultants in GIM. Prior to 2007, therefore, most trainees in the acute medical specialties combined their specialty with GIM. From 2007 to 2009 trainees were thought to be able to train for only one CCT and so trainees in the acute medical specialties enrolled to receive a CCT in their primary specialty combined with a credential in GIM. The GIM CCT holders in Table 7 are trainees who aimed to specialise in acute medicine but the only CCT available to them, prior to 2009, was GIM. This also explains why there are no trainees obtaining a CCT in AIM in 2012. With the advent of the separate 2009 curricula in AIM and GIM, trainees can now obtain two CCTs, one in their primary specialty and one in GIM.

**Table 7**

**UK Totals for STRs awarded CCTs in specialties contributing to acute medicine**

**(Jan-Aug 2012)**

<i>Specialty</i>	Parent Specialty			Sub-specialties		
	<i>Total</i>	<i>Single</i>	<i>Dual (%)</i>	<i>Stroke</i>	<i>Hep</i>	<i>ICM</i>
Acute Internal Medicine (AIM)	0	0	0	0	0	0
Cardiology	70	58	12 (17%)	0	0	0
Clin. Pharm. & Therapeutics	5	1	4 (80%)	0	0	0
Endocrinology & Diabetes	33	1	32 (97%)	0	0	0
Gastroenterology	29	0	29 (100%)	0	3	0
Geriatrics	58	0	58 (100%)	14	0	0
General Internal Medicine*	47	47	0	4	0	3
Infectious Diseases	15	2	13 (87%)	0	0	1
Renal Medicine	29	10	19 (66%)	0	0	1
Respiratory Medicine	50	1	49 (98%)	0	0	3
Rheumatology	31	19	12 (39%)	0	0	0
<b>TOTAL</b>	<b>367</b>	<b>92</b>	<b>228 (72%)</b>	<b>18</b>	<b>3</b>	<b>8</b>

\*The majority of CCT holders in the "GIM only" category are based in England however in there are 8 in Scotland coming from all four Scottish deaneries.



## **6. Trainee experience: does Scotland have the ability to attract and retain the best?**

### Core Training

The CMT programme has a two year curriculum. Of the 2009-2011 intake, 56 trainees from a total of 89 have remained in Scotland to progress to ST3 in a medical speciality (63%). Of the remaining 33, 19 trainees have left Medicine (21%) with, 8 entering GP training, 1 moving into Radiology, 1 to Paediatrics and 1 to Virology. Eight doctors are no longer in the training system in Scotland, with several taking jobs in Australasia (where there will be a need to import physicians until at least 2025). One trainee has moved to England and 2 have taken non-training grade posts. The remaining 14 trainees (16%) are in remediation.

The STB Medicine audit confirms that attrition is fairly high both during and after core training. The minimum rate of attrition is 21% and if some trainees in remediation also choose an alternate career, the attrition rate will approach 30%. Anecdotally there is also a concern that acute medicine trainees within the ACCS programme are switching to anaesthetics or critical care and this requires review in Scotland.

### **Specialty Training**

There were 95 ST3 jobs available in Scotland during the 2011 recruitment round – but only 56 Scottish core trainees progressed into these. The overall fill rates in Scotland for ST3 jobs and LAT's were 86% and 40% respectively. The fill rates in England were higher at 91% and 50% respectively. Figures from the 2012 recruitment round of ST3 medical specialty posts in Scotland show an overall fill rate of 58%. This figure drops to a 44% fill rate in the North of Scotland where 15 posts out of 27 (56%) were left unfilled.

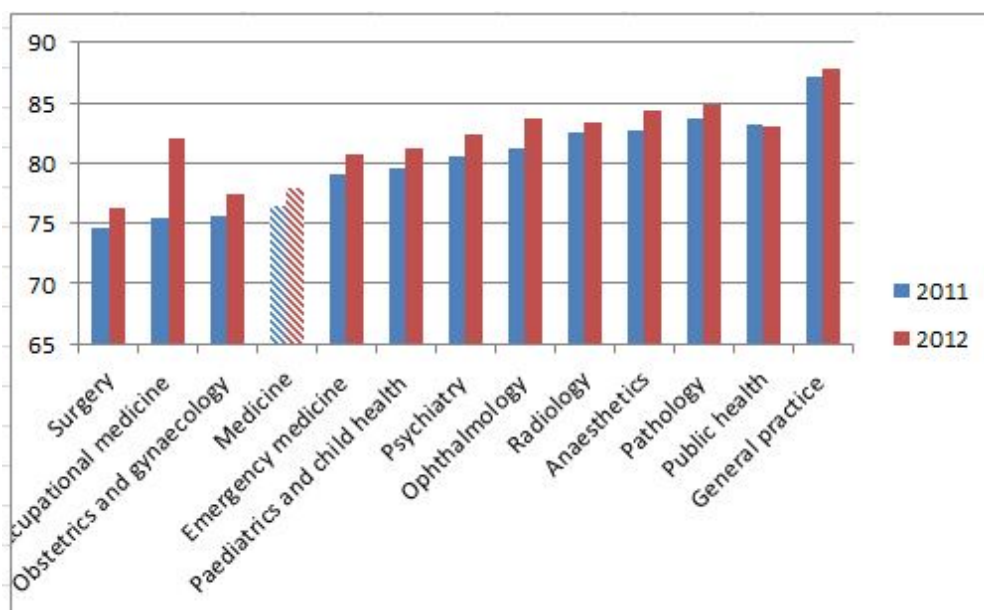
Discussion at the April 2012 meeting of the Selection and Recruitment Delivery Board indicated recognition of early signs that Scotland is becoming a less attractive place to train and that different factors contribute to this, including geography. Dr Stewart Irvine, Director of Medicine at NES stated that Scotland “received 0.8 applicants per job for all specialties whereas nationally in the UK the statistics were 1.6 applicants per job.”<sup>xii</sup>

## Trainee satisfaction 2010 – 2012

The Federation of Medical Royal Colleges provides key manpower data through its Medical Workforce Unit (MWU). Recent MWU surveys of medical registrars in the UK using the Joint Royal Colleges Postgraduate Training Board (JRCPTB) database have highlighted increasing levels of dissatisfaction and widespread concerns regarding training and future career prospects<sup>xiii,xiv</sup>. A survey carried out amongst F2 doctors in the East Midlands deanery (unpublished data) supports anecdotal evidence that the workload and pressure on the on call medical registrar is a major deterrent to trainees considering applying to core medicine and the specialties.

A more recent survey of all levels of medical trainees undertaken in autumn 2011 with data shortly to be published, included some CMTs in Scotland and confirmed this dissatisfaction. Many trainees perceive that workloads are "unmanageable" for the on-call medical registrar, generate a poor work-life balance and produce low satisfaction /enjoyment rates. Worryingly these perceptions are shared by foundation trainees, deterring applications into the medical specialties and by many of the medical registrars themselves. This both a patient safety and training issue.

**Table 8 - GMC Survey on Trainee Satisfaction 2011/2012**



Data from previous GMC trainee surveys, as shown in Table 8<sup>xv</sup> above, has shown consistently that the overall satisfaction score varied by the specialty in which the trainee was working at the time of the survey (post specialty group). The data confirms that those in GP posts are the most satisfied, and in 2011 and 2012 have been at least ten percentage points more satisfied than trainees in medicine generally across the UK.

It is important to note that although the majority feel adequately trained, data from 2010 (published in 2011<sup>xvi</sup>) suggests that nearly one third of medical registrars were unsure that that their training would prepare them adequately to be a consultant and one in ten reported that they felt their training was inadequate prepare them adequately. This in part reflects the pressure on training caused by service commitments and inadequate staffing levels, e.g. rota gaps and prioritising acute admissions over specialty training. The GMC's recent announcement about accreditation of trainers adds to the pressure on hospitals and consultants to ensure training is not compromised and is an area where Scotland could create a competitive advantage.

The College's Fellowship networks provide an ideal framework on which to offer support to trainers and new consultant appointments. Formal shadowing of consultants new to the on call rota should be encouraged as good practice and will of course add to the workload pressures on all doctors.

## 7. Recommendations

### Increased Trainee Places in Core Medicine Training

As discussed in this document, the College believes a combination of factors result in a very strong case for an incremental increase in trainee places in Core Medicine Training to deliver expansion in capacity at consultant level (AIM and other acute specialties) and support acute medical receiving. These include:

- increasing referrals and activity within the acute sector
- pressing service, training (given the demonstrated attrition rates) , recruitment and retention needs; and
- most importantly, quality of care and patient safety issues.

Scotland will have to work hard to recruit high calibre candidates into these places by demonstrating a commitment to training and offering attractive career opportunities.

### Detailed review of STR and Consultant Numbers

From the data we have gathered the case for any regional or local growth in *pure* Cardiology, Renal Medicine and Rheumatology specialist numbers must be judged against the increasing Scotland-wide pressures that acute medicine is now facing. The shape and numbers of specialty posts in medicine requires thorough review to meet the service requirements of health boards and the percentage contribution of some specialities to acute medicine in addition. We recommend serious consideration of an expansion in the numbers in those specialties *significantly* contributing to the acute workload e.g. AIM, Geriatrics, Endocrinology & Diabetes, Gastroenterology and Respiratory Medicine. This would also allow a progressive move to extended working hours.

At the same time and for same reasons we would suggest no further changes in the “non acute” specialties that feature in Table 7, with an interim "retiral/ replacement policy only" and no net growth for 2013-14.

## Phasing careers to Protect “Generalism”

It is clear that the NHS in Scotland requires greater capacity in acute medicine to deliver a high quality service over extended hours to emergency medical patients. Encouraging trainees to achieve CCTs in GIM/AIM and their preferred specialty will improve their employability and address these important service needs. An option worthy of further debate and consideration would be for the job plans of newly accredited consultants in appropriate (acute) specialties to reflect a more significant commitment to acute medicine in the early years on the understanding that the specialty components of their initial roles would be sufficient to maintain skills and offer greater flexibility as their careers progress. This may be particularly challenging for those seeking to work less than full time and needs further work and consultation. For such a strategy to be successful an exit route (which could be phased over a number of years) back into specialty in later years must be guaranteed.

Finally, workforce planners in Scotland must remain mindful of parallel planning across the UK. Planning in isolation will bring problems particularly if Scotland continues to be perceived as a less attractive place to train and work in a medical specialty.

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<sup>i</sup> <http://www.rcplondon.ac.uk/press-releases/patients-benefit-continued-consultant-cover>

<sup>ii</sup> P.20, *The Benefits of Consultant Delivered Care*, Academy of Medical Royal Colleges (2012) <http://www.aomrc.org.uk/about-us/news/item/benefits-of-consultant-delivered-care.html>

<sup>iii</sup> NHS London (2011) *Adult Emergency Services: Acute Medicine and emergency general surgery. Case for change*. Nuffield Trust for NHS London.

<sup>iv</sup> P. vii, *Time for Training: A Review of the impact of the European Working Time Directive on the quality of training*, Professor Sir John Temple (May 2010) <http://www.mee.nhs.uk/PDF/14274%20Bookmark%20Web%20Version.pdf>

<sup>v</sup> p.8, *Caring to the End? A review of the care of patients who died in hospital within four days of admission* A report by the National Confidential Enquiry into Patient Outcome and Death (2009) [http://www.ncepod.org.uk/2009report2/Downloads/DAH\\_summary.pdf](http://www.ncepod.org.uk/2009report2/Downloads/DAH_summary.pdf)

<sup>vi</sup> P6, *The Benefits of Consultant Delivered Care*, Academy of Medical Royal Colleges (2012).

<sup>vii</sup> P.51 *Census of consultant physicians and medical registrars 2010: Federation of Royal Colleges of Physicians of the UK* <http://www.rcplondon.ac.uk/resources/2010-census-summary>

<sup>viii</sup> P.52, *Ibid*

<sup>ix</sup> *Young Diabetologists's Forum Survey 2010, Clinical Medicine 2012, Vol 12, No 3, 244-7*

<sup>x</sup> ISD statistics: HCHS medical and dental consultant vacancy rate table <http://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables.asp?id=877#877>

<sup>xi</sup> 2<sup>nd</sup> report since the National Health Service (Appointment of Consultants) (Scotland) Regulations 2009 came into force on 1 July 2009.

<sup>xii</sup> Item 4.1, *Minute of the 24<sup>th</sup> meeting of the Selection and Recruitment Delivery Board, Friday 13<sup>th</sup> April 2012*

<sup>xiii</sup> Goddard AF, Evans T and Phillips, C. *Medical registrars in 2010: experience and expectations of the future consultant physicians of the UK. Clinical Medicine 2011; 11(6): 532-5.*

<sup>xiv</sup> Goddard AF. *Consultant physicians for the future: report from a working party of the Royal College of Physicians and the medical specialties. Clinical Medicine 2010; 10(6): 548-54.*

<sup>xv</sup> P.3 *GMC Survey 2012* [http://www.gmc-uk.org/National\\_training\\_survey\\_2012\\_key\\_findings\\_final.pdf](http://www.gmc-uk.org/National_training_survey_2012_key_findings_final.pdf) 49303306.pdf and *GMC Survey 2011* p.14 [http://www.gmc-uk.org/NTS\\_trainee\\_survey\\_2011.pdf](http://www.gmc-uk.org/NTS_trainee_survey_2011.pdf) 45270429.pdf

<sup>xvi</sup> Goddard AF, Evans T and Phillips, C. *Medical registrars in 2010: experience and expectations of the future consultant physicians of the UK. Clinical Medicine 2011; 11(6): 532-5.*