APPENDIX 4

MODERNISING MEDICAL CAREERS

1. Background

1.1 Modernising Medical Careers (MMC) is a UK-wide reform of all post-graduate medical training involving introduction of a two-year foundation programme followed by “run-through” specialty training programmes leading to the award of a Certificate of Completion of Training (CCT) and entry to the specialist register or general practice register of the GMC. The two-year foundation training programme will subsume the former pre-registration house officer year and the first year of senior house officer (SHO) training. The run-through specialty training programmes will last between five and seven years and subsume the training currently provided at more experienced SHO level and at specialist registrar (SpR) level.

1.2 The first year of foundation training (FY1) started in August 2005 and involved sixty-one posts in NHS Lanarkshire. The second year of foundation training (FY2) will start in August 2006 and requires conversion of sixty-one of the existing SHO posts in NHS Lanarkshire. It is anticipated that run-through specialty training will start in August 2007, but information is not yet available on the number of specialist training posts, which will be available

1.3 At the present time there are 370 post-graduate medical trainees within NHS Lanarkshire across all services

2. Advantages from introduction of MMC

2.1 The aim through Modernising Medical Careers is to introduce a better organised, structured and focused competency based post-graduate medical training, which will allow trainees to progress through their training in line with their educational development and will reduce duplication during the training period.

2.2 The new training programmes take account of the need for junior medical staff to comply fully with the European Working Time Directive (EWTD) by 2009 and with the Terms of the New Deal Standards for Junior Doctors in relation to periods of duty and rest breaks. Through focusing training into more structured programmes and reducing the commitment of junior medical staff to service provision it is expected that despite the reduced overall hours available trainees will achieve specialist status/GP status within a shorter period of time so providing the service with the required career-grade medical staff on which the service can be subsequently based.

2.3 It is proposed that the number of training posts which are retained in each specialty will be aligned with the required output of specialists to ensure services can be maintained and developed without leading to

either shortages of specialists as is currently often found, or over-supply.

3. Challenges in the introduction of MMC

3.1 The move towards reducing the service commitment of junior medical staff in training will require alternative provision to be made to ensure service shortfall does not occur. At present the only medical staff alternative to junior doctors in training and consultants/GPs who have completed specialist training are the staff-grade and associate specialist grade (SAS grades). Alternative service provision through developing other disciplines and creating new roles has a significant lead-in time (several years) making this option of limited value in the short-term.

3.2 A new SAS contract is being negotiated nationally and although due to be implemented from April 2006 seems likely to be delayed by at least six months. Within the current staffing arrangements it is very difficult for SAS doctors to return to training or to progress through to specialist level and this makes these posts unattractive to many. It remains unclear the extent to which these issues will be addressed by the new SAS contract

3.3 It has been assessed that the move towards aligning post-graduate training numbers with the required output of specialists/GPs will result in 900 of the current 2,700 SHO posts in Scotland being identified as supernumerary. As a result of an imbalance in the proportions of SHO and SpR posts throughout Scotland, 700 of the supernumerary SHO posts are in the West of Scotland. There is a similar imbalance within the West of Scotland between the Glasgow hospitals and those hospitals outwith Glasgow with the larger proportion of SpRs being in Glasgow, and the larger proportion of SHOs being outwith Glasgow. In the absence of clarity around which posts will be converted to run-through specialist training posts there remains a risk that the more able and experienced SHOs will seek and obtain run-through training positions outwith Scotland

3.4 The anticipated 30% overall reduction in numbers of trainee posts within individual specialties creates a substantial risk of being unable to maintain compliance with New Deal Standards unless rotas are amalgamated to create a smaller number of larger rotas

4. Implementation

4.1 Implementation of the FY1 training posts posed no difficulty within NHS Lanarkshire as a result of the earlier introduction of Hospital Emergency Care Teams (Hospital at Night) ensuring appropriate out of hours cover within hospitals without reliance on the pre-registration house officer posts and as a structured training programme for PRHO/FY1 already existed.

4.2 Implementation of FY2 posts will result in a service shortfall, which has been quantified (appendix 1). Agreement has now (April 2006) been reached by NHS Education Scotland (NES) and the Scottish Executive Health Department to the creation of additional short-term training posts to provide service support for the introduction of FY2.

4.3 It remains unclear how many run-through specialist training posts will be created from August 2007, though this information is anticipated in the near future.

4.4 The period over which training numbers are to be brought into line with required output is not yet clear, nor is the process by which existing posts will be decommissioned

4.5 A more equitable distribution of trainees throughout Scotland and within the Regions will be required to ensure that appropriate education is provided and that disruption to service provision is minimised. The appointment of individuals to run-through specialist training programmes is likely to be through a single application process for all specialties across the whole United Kingdom with applications which express a preference for a post in Scotland being sent to NES. NES will, through local deaneries and working with health boards, grade the applications and employers will subsequently make offers of employment.

4.6 Consideration of the medical manpower implication of MMC has been included within the NHS Lanarkshire workforce plan (appendix 2).

5. Impact on service provision in NHS Lanarkshire

5.1 It is anticipated that additional short-term training posts will be put in place by August 2006 to support the service during the introduction of Foundation Year 2. NHS Lanarkshire has made budgetary provision for this additional expense.

5.2 When the information is made available on the number of run-through training posts per specialty, detailed work will be required to identify the most effective and efficient way of providing the training for those posts, how the service short-fall can be minimised, and how the junior doctor rotas can be reconfigured to ensure New Deal Standards are maintained and European Working Time Directive fully met.

5.3 It is expected that the reduction in the number of junior medical staff training posts and the loss of the service input from those that remain will require to be replaced by a mixture of additional nursing and therapy posts and extended role development, new posts such as physician assistants, additional SAS posts and additional consultant posts. Clarification of these roles and staff numbers will be provided with subsequent iterations of the NHS Lanarkshire workforce plan.

5.4 The anticipated 30% overall reduction in the number of trainees will result in a need to reduce the number of specialist trainee rotas within Lanarkshire with concentration of these into larger, more robust units, able to ensure an appropriate level of training and supervision and to ensure rotas remain fully compliant.

5.5 Details of proposed medical staff rotas in A&E and Intensive Care are shown in appendix 3.

6. Conclusion

6.1 The introduction of MMC in the UK will result in improved postgraduate training of medical staff and better alignment of trainee numbers with future service requirement for specialists and GPs.

6.2 The short term changes in medical manpower (5-10 years) resulting from the introduction of MMC can be accommodated by concentration of training within larger specialist units with sufficient numbers of trainees to maintain rota compliance with New Deal Standards and the European Working Time Directive, with sufficient specialist staff to provide high quality training within structured programmes and with sufficient throughput of patients to ensure appropriate experience.

6.3 The proposals for concentration of specialist services within A Picture of Health will ensure NHS Lanarkshire can continue to provide medical staff training within suitable departments and improve recruitment of specialists and GPs.

IDENTIFIED SERVICE GAP ARISING FROM MMC

SPECIALITY/SITE	***FY2 equivalent Baseline staffing***	***PROPOSED FY2***	***Educational Supervision/Assessment***		***HOSPITAL INDUCTION***		***DEPT INDUCTION***		***FORMAL TRAINING***		***Dept Teaching Programme***		***LOSS of Service***	
NHS Lanarkshire			**Cons**	**Junior**	**Cons**	**Junior**	***Cons***	***Junior***	***Cons***	***Junior***	***Cons***	***Junior***	***Cons***	***Junior***
Form Completion - see Comments	*(note 2)*	*(note 3)*	*(note 4)*	*(note 5)*	*(note 6)*	*(note 7)*	*(note 8)*	*(note 8)*	*(note 9)*	*(note 10)*	*(note 11)*	*(note 11)*	*(note 12)*	*(note 12)*
(note 1)	***Hours***	***Hours***	***Hours***	***Hours***	***Hours***	***Hours***	***Hours***	***Hours***	***Hours***	***Hours***	***Hours***	***Hours***	***Hours***	***Hours***
A&E Monklands (3)	7560	6480	108	108		24	12	24		288 (720)	128	320	96	840
A&E Hairmyres (3)	7297	6480	108	108		24	12	24		288 (720)	128	320	96	840
A&E Wishaw (2)	4701	4320	72	72		16	12	16		192 (480)	80	210	64	560
General Medicine (incl Med for Eld) Monklands (9)	20679	19440	324	324		72	12	72		864 (2160)	35	90	991	1391
General Medicine Hairmyres (5)	12116	10800	180	180		40	12	40		480 (1200)	N/A	N/A	1040	1040
General Medicine Wishaw (4)	9259	8640	144	144		32	12	32		384 (960)	N/A	N/A	936	832
General Surgery Monklands (2)	4665	4320	72	72		16	12	16		192 (480)	N/A	N/A	640	805
General Surgery Hairmyres (2)	4878	4320	72	72		16	12	16		192 (480)	N/A	N/A	640	805
General Surgery Wishaw (2)	5037	4320	72	72		16	12	16		192 (480)	N/A	N/A	640	805
Orthopaedics Monklands (2)	4320	4320	72	72		16	12	16		192 (480)	N/A	N/A	400	720
Orthopaedics Hairmyres (2)	4524	4320	72	72		16	12	16		192 (480)	N/A	N/A	400	720
Orthopaedics Wishaw (2)	4334	4320	72	72		16	12	16		192 (480)	N/A	N/A	400	720
Psychiatry Lanarkshire (5)	8640	8640	180	180		40	12	40		480 (1200)	N/A	N/A	*	*
Med for Elderly Hairmyres (2)	4911	4320	72	72		16	12	16		192 (480)	12	24	720	*
Med for Elderly Wishaw (2)	5040	4320	72	72		16	12	16		192 (480)	N/A	N/A	*	*
ENT Surgery Monklands (2)	4269	4320	72	72		16	12	16		192 (480)	N/A	N/A	*	*
Ophthalmology Hairmyres (1)	2295	2160	36	36		8	12	8		96 (240)	N/A	N/A	*	*
Obstetrics & Gynaecology Wishaw (9)	19217	19440	324	324		72	12	72		864 (2160)	N/A	N/A	*	*
Paediatrics (General & Neonatal) Wishaw (7)	15120	15120	252	252		56	12	56		672 (1680)	N/A	N/A	*	*
Postgraduate Tutor					24									
Consultant time for training									288					
TOTAL (66)														
Application of Solutions to reduce Service gap														
Activities not needed by specialty	See note (a)													
Redesign solution within specialty	See note (b)													
Redesign solution within hospital eg														
Unscheduled Care collaboratives	See note ©													
Hospital at Night	See note (d)													
Redesign solution within region														
Net Additional Hours Required														
Task substitution by														
Transfer to existing staff	See note (e)													
Physician Assistants	See note (f)													
Endoscopists														
Nurse Practitioners	See note (g)													
Extended Nurse Roles	See note (h)													
Extended AHP Roles														
Radiographers														
Other (list)														
Additional SPRs	See note (I)													
Additional Consultants	See note (j)													
Additional SAS Grade														

Net Additional Costs Anticipated
Transfer to existing staff
Physician Assistants
Endoscopists
Nurse Practitioners
Extended Nurse Roles
Extended AHP Roles
Radiographers
Other (list)
Additional SPRs
Additional Consultants
Additional SAS Grade

IDENTIFIED SERVICE GAP ARISING FROM MMC

Notes on Hours Calculations

1. Against each specialty/site the bracketed figure is the agreed number of posts that can convert to FY2. Actual posts converting may be less than this number depending on individual rotations and may vary from year to year.

2. FY2 equivalent baseline staffing

   The hours noted are calculated from number of posts, average hours as at November 2005, and assuming a 45-week year.

3. Proposed FY2

   Hours calculated from number of posts x 48-hour working week x 45-week year

4. Educational Supervision/Assessment – Consultant

   Assumes 0.25PA of consultant time required per trainee and takes into account existing 0.05PA of consultant time provided at present.

5. Educational Supervision/Assessment – Junior

   Assumes additional 0.2PA of junior time required for each trainee.

6. Hospital Induction – Consultant

   Hospital inductions will require 1PA of time from postgraduate tutors per hospital per induction and assumes 2 additional inductions per year.

7. Hospital Induction – Junior

   Assumes that each junior will require 1PA per annum for induction within each of the hospitals on the rotation. The rotation within the consortium will result in a requirement for additional induction. It is anticipated that there will be a move of a proportion of activity currently undertaken in the hospital induction to departmental induction, and that other parts of hospital induction will be dealt with through DOTS, reducing the time required for hospital induction, but resulting in an increase in the time required for departmental induction.

8. Departmental Induction – Consultant/Junior

   Assumed that two additional departmental inductions will be required each year (senior trainees continue for six-monthly inductions and FY2 require four-monthly induction, and each will involve 1.5PA consultant time (1PA for delivery and 0.5PA for preparation) and 1PA for trainee attending. See also note 7.

9. Formal Training – Consultant

   Ongoing work within the curriculum sub-group continues to define the input required by consultants to deliver training. Assumption made that training time required would be similar to that identified for FY1. 72PA required for training by consultants assuming 66 FY2 posts each requiring twelve off-site days, five groups of trainees. Sixty days off-site training required and assumed Lanarkshire provides 3/5ths of training (five hospitals in consortium; three in Lanarkshire).

10. Formal Training – Junior

    Assume twelve days off-site training per trainee. Recent proposals for "clinical taster sessions" would be additional to figures shown, but are assumed would be accommodated within total allocation for study leave. Figures shown in brackets in this column are the total additional hours if all study leave is taken. Current utilization of study leave time would require to be netted off. (Information from deanery suggests average of 5-9 days study leave used at present by SHOs).

11. Departmental Teaching Programme

    Information on current and proposed departmental teaching programmes is not available for most specialties.

12. Loss of Service

    Asterisk (*) indicates incomplete figures. Individual specialties have different views about the impact of MMC on loss of service and further details are provided in the specialty notes.

Application of Solutions to Reduce Service Gap

Notes

(a) Activities not needed by Specialty

Each specialty will require to assess the potential for reduction in return appointments using benchmarked information across Scotland. This is work in progress.

(b) Redesign Solution within Specialty

See individual specialty notes

(c) Unscheduled Care Collaborative

Initiatives are beginning to develop from the Unscheduled Care Collaborative programme and the implementation timetable and the potential for these to impact on introduction of MMC are in the process of being assessed.

(d) Hospital at Night

The Hospital at Night programme was introduced into Lanarkshire in August 2004 and work is currently ongoing to assess the cost and impact of extending this to 24-hour 7-day cover.

(e) Transfer to Existing Staff

Capacity exists for existing staff (consultants and senior trainees) to take on some of the activities required within existing resources, particularly in relation to educational supervision/assessment, hospital induction and departmental induction. Although this may be accommodated for FY2 there will be little if any scope remaining to absorb such activities in relation to run-through training. Some specialties, particularly those which have little reliance on juniors for service provision within outpatients, have indicated an ability to absorb the potential impact of the time required by juniors for formal training and potential for loss of service. Information in relation to these specialties is shown on the notes against each specialty.

(f) Physician Assistants

There is interest in the proposal to develop physician assistants which may assist not only with implementation of FY2 but of run-through training, but timescales would suggest this will not be available for August 2006. Full potential impact remains to be assessed.

(g) Nurse Practitioners

These roles have been introduced in some specialties and are being considered in others. See individual specialty notes.

(h) Extended Nurse Roles

These have been introduced in some specialties and are proposed in others. The development time for new roles is such that they would be unlikely to be available in time for August 2006. These activities are likely to be of benefit not only with the introduction of FY2, but also with run-through training.

(i) Additional SpRs

NHS Lanarkshire has very small numbers of SpRs in comparison to teaching centres within the West of Scotland and there is considerable scope for redressing the imbalance both in the West of Scotland and Scotland as a whole. There is also scope for temporary additional SpRs as part of the solution to the supernumerary SHOs, but information on both possibilities is awaited.

(j) Additional Consultants

Consideration is being requested from a number of specialties for additional consultant posts, particularly within A&E, general medicine and general surgery, but in many cases the additional hours required would not justify that in relation to FY2, but consideration will need to be given to expansion of consultant numbers to cope with run-through training.

Specialty Specific Notes

i. A&E

Due to the working patterns within A&E and the significant reliance on junior staff for service provision there will be a considerable impact on the department from the introduction of MMC both for FY2 and for run-through training. Extension of the "Hospital at Night" to 24-hour working would have little impact on the service. Extended-role working of nursing staff is well developed and has a capacity for further development though over the medium- rather than short-term. Redesign proposals are beginning to emanate from the unscheduled care collaborative and the potential impact of these on implementation of MMC remains to be assessed. The most pressing need within the A&E department is for additional middle grade staff, which ideally would be SpRs in view of considerable difficulties over recruitment of SAS staff. Consideration should be given to creation of SpRs in acute medicine. Consideration is also being given to additional consultant staffing to cope with the combination of FY2 and run-through training.

ii. General medicine

The impact of implementation of MMC on general medicine will be considerable in view of the extensive use of junior medical staff for service provision, particularly in relation to out-patient clinics, but also for daily inpatient ward round. NHS Lanarkshire introduced the "Hospital at Night" scheme from August 2004 and this has had a considerable impact on the requirement for out of hours working for junior staff. It is anticipated that extending the Hospital at Night scheme to 24-hour 7-day working will further improve the efficiency of junior staff working, but the detailed impact and costs of this remain to be identified. Consideration is being given to the potential for reducing return outpatient visits. Interest is being expressed in physician assistants, but the impact of these remains to be assessed and the timescale would be beyond August 2006. It is likely that additional consultant posts will be required in general medicine, but further work is necessary to assess the need for these in relation to individual medical sub-specialties and for acute medical and the impact of run-through training. It is felt that additional SpRs in medicine would be valuable and consideration is being given to development of further extended roles within nursing particularly in relation to post-angioplasty clinics and inflammatory bowel disease follow-up, but the timescale for such developments would be beyond August 2006.

iii. General Surgery

The impact of implementation of MMC on general surgery will be considerable in view of the extensive usage of junior medical staff for service provision, particularly in relation to outpatient clinics, day case activities and ward work. Consideration is being given to amalgamation of surgical specialty rotas, particularly between general surgery and orthopaedic surgery

Consideration is also being given to the introduction of peri-operative care practitioners, though this would not be implemented prior to August 2006, but may be of relevance in relation to run-through training. As with other specialties consideration is being given to the potential for reducing return outpatient visits. It is likely that additional consultant posts will be required in general surgery, but further work is necessary to assess this and to take into account the impact of run-through training.

iv. Psychiatry

Psychiatric services within Lanarkshire are being redesigned and this along with the size of the department and the lesser reliance on trainee staff for service provision allows the additional consultant and junior hours resulting from the implementation of FY2 to be absorbed within existing resources.

v. Obstetrics and Gynaecology

Obstetric services are concentrated within NHS Lanarkshire on a single-site and gynaecology services are in the process of being redesigned and this, along with the size of the department and the relative lower-reliance on junior medical staff for service provision allows the department to absorb the additional consultant and junior hours required for MMC within the existing resources.

vi. Paediatrics

Paediatric services in Lanarkshire are concentrated on a single-site and it is considered that the additional consultant and junior hours required for implementation of FY2 can be absorbed within existing resources, though with some difficulty and additional resources will be required for run-through training.

vii. Medicine for the Elderly

The impact of MMC on medicine for the elderly services is likely to be significant, but further work is required on this to assess the details and to identify the most appropriate solutions.

viii. Surgical Specialties

The impact of implementation of MMC on individual surgical specialties is likely to be less significant due to the small numbers of trainees involved, but work is ongoing to assess the details and the actions required to ensure service loss is minimized.

ix. Consultant Time for Training

An estimate of the consultant hours required for this has been given, but details of individual specialty requirements remain to be determined and will be dependent on the detailed curriculum.

Shaping the Vision

There will continue to be a need to plan the numbers of staff we need in each staff group for some time to come. This section attempts to reconcile and integrate the service-based projections with the professional groups, to provide the next stage in the bottom-up approach to planning the future workforce. It is based on this that we can begin to plan the number of training places required and identify the potential requirement for proactive recruitment activity on a local, regional and national basis.

Medical Staff

Workforce Demand

Capacity planning - considerable work has been done in relation to the waiting times targets and the additional establishment identified for 2006/08 has largely evolved from this, although further work remains in relation to capacity planning for outpatient targets and for diagnostics.
Redesign - the main focus for redesign will be the Picture of Health project, but other issues which take place within a shorter timescale will also require manpower issues to be considered in detail. Reconfiguration has already taken place within urology and gynaecology and is expected to take place in clinical haematology, thoracic surgery and oral and maxillo-facial surgery. Current medical manpower figures do not yet take account of the changes anticipated through the “Picture of Health” project.

Consultant Provided Service - the expectation of moving towards a consultant-provided service will require consideration of extended day working, for example, 8am to 8pm followed in due course by consultant presence 24-hours; most likely initially in acute medicine/A&E, acute surgery, obstetrics and anaesthetics. It is assumed that as a first stage the move will be towards a career grade provided service with initial expansion of the SAS grade and subsequent focus on consultant expansion depending on availability and affordability.

Workforce Demographics - there are a considerable number of uncertainties within the workforce demographic and supply issues, particularly in relation to the current inequalities between ratios of staff/population and the distribution of trainees. In addition the impact of Modernising Medical Careers and the new SAS Contract will significantly influence the medical workforce demographics.

The drive for increased productivity through the new contract will be significantly dependent on redesign of services and on support available. Further work requires to be done on the impact of gender change within the medical workforce.

There is evidence in some specialties, especially anaesthetics, of consultants reducing the number of EPAs they are willing to agree to. If this trend continues there will need to be an adjustment to the WTE numbers to take account of this.

Consultant Retirals - out of 334 consultants (including locum staff) 130 are aged 50 or over. There is nothing within the new consultant contract to encourage staff to remain beyond age 60. There is a risk that those in the age range 57 to 59 may retire even earlier once they have reached the maximum of the new consultant scale.

Consultants	Age 57 to 59	Age 60 or over
Total	34	34
General Medicine	6	9
Surgery	4	1
Anaesthetics	6	1
Obstetrics	4	2
Radiology	0	6
Pathology	1	2

Table 6

The potential for United Kingdom policy to impact on retiral age is not expected until 2013 to 2016.

Actions Requiring Further Detailed Work:

- Impact of extending HECTs (Hospital at Night) to 24hour 7 day
- Impact of MMC
- Impact of gender balance
- Impact of Picture of Health

Medical Workforce Projection Assumptions

The medical staff projections in Appendix F are based on the following assumptions. We have already identified additions to the establishment for 2006-08 or proposed sources of funding in the following areas:

2005-06	Orthopaedics	1
	Vascular	1
	Gastroenterology	1
	General Surgery	1
	Anaesthetics	5
	Obstetrics (Sexual and Reproductive)	1
2006-07	Renal Medicine	1
	Orthopaedics	2
	Ophthalmology	0.5
	Obstetrics	0.5

Table 7

- There is likely to be further potential consultant expansion to meet the needs identified in outpatient capacity planning.
- The implementation of MMC will result in the potential need for staff grade and consultant expansion in A&E/acute medicine; general medicine and general surgery
- Additions to establishment 2010-15 are made on the basis of the following assumptions:
  - Extended day working 8am to 8pm will become the norm by 2010
  - Career grade staff presence 24-hours will be implemented from 2015 for acute medicine/A&E; acute surgery; obstetrics; anaesthetics moving to consultant presence 24-hours over time
- Impact of implementation of NHS Lanarkshire "Picture of Health" project not yet incorporated into medical workforce figures
- All non-consultant career grade posts will be subsumed within the new SAS contract from April 2006
- There will be a move towards the acute component of general medicine being delivered by acute care physicians with a drop in the proportion of time or proportion of the numbers of individuals in medical specialties dealing with acute medicine

Changes to trainee numbers in post and our response to this have been projected as follows:

- Up to twenty time-limited training posts may be funded in NHSL between August 2006 and July 2008 as part of implementation of MMC (FY2) but as national agreement to this has not yet been received no additions to trainee numbers has been included and instead SAS and consultant numbers have been increased
- Implementation of "run-through training" within MMC will be from August 2007, and
  - Will involve equitable distribution of training posts within Scotland and the West of Scotland
  - Will be accompanied by a 30% reduction in training posts with funding from these lost posts being returned to the service, this being implemented progressively between 2007 - 2010
  - Will result in 25% loss of service activity from remaining training posts
  - Loss of service resulting from implementation of run-through training will be offset by a mix of increase in SAS grades; increase in consultants; increase in extended role nurse/midwife and AHP practitioners, and addition of new posts such as physician assistants, funded from resources released by loss of training posts
  - Service output from SAS grade equivalent to 1.2-1.4 trainees and consultant equivalent to 2.0 trainees
- HECTs will be extended to provide 24/7 cover by 2007
- All posts will fully comply with EWTD by August 2009

MEDICAL STAFF	2005			2006	2007	2008	2010	2015
		Staff in		Average WTE	Average WTE	Average WTE	Average WTE	Average WTE
ACUTE	**Funded WTE**	**Post WTE**	**Diff**	**Expected**	**Expected**	**Expected**	**Expected**	**Expected**
General	168.11	166.8	1.31	173	174	171	171	176
Consultant	49.97	42.7	7.27	52	54	56	62	68
SAS	15.04	14.1	14.1	18	23	28	32	28
Trainee	103.1	110	-6.9	103	97	87	77	80
A&E	46.75	40.3	6.45	52	54	54	54	54
Consultant	9	8	1	12	13	15	16	18
SAS	7.75	3.3	4.45	10	13	14	16	12
Trainee	30	29	1	30	28	25	22	24
Geriatrics	29.13	32.6	-	35	35	36	35	38
Consultant	12.95	12.5	0.45	15	15	16	16	18
SAS	2.18	5.5	-	6	7	8	9	8
Trainee	14	14.6	-0.6	14	13	12	10	12
General	87.68	86.3	1.38	90	89	88	87	90
Consultant	24.6	21	3.6	25	26	27	30	32
SAS	8.08	6.3	1.78	10	11	13	18	16
Trainee	55	59	-4	55	52	48	39	42
Surgical	59.44	50.5	8.94	63	62	61	60	62
Consultant	24.92	18.1	6.82	25.5	26	26	28	30
SAS	6.52	9.4	-	9.5	10	11	12	10
Trainee	28	23	5	28	26	24	20	22
Anaesthetics	85.24	76.7	8.54	89	88	89	87	89
Consultant	39.25	37.3	1.95	43	44	45	46	48
SAS	15.79	13.4	2.39	16	16	18	20	18
Trainee	30.2	26	4.2	30	28	26	21	23
Orthopaedic	48	47	1	48.5	48.5	48	47	49
Consultant	16	10	6	16.5	16.5	17	18	20
SAS	8	7	1	8	9	10	12	10
Trainee	24	30	-6	24	23	21	17	19
Obs & Gyn	46.79	38.2	8.59	47	47.5	47	46.5	48
Consultant	15.79	13.5	2.29	16	16	16	16	18
SAS	4	3.7	0.3	4	5.5	7	10.5	8
Trainee	27	21	6	27	26	24	20	22
Labs	29.74	21.8	7.94	30	30	30	32	34
Consultant	23.32	18.8	4.52	24	25	26	29	32
SAS	2	2	0	2	2	2	1	0
Trainee	4.42	1	3.42	4	3	2	2	2
Radiology	29.82	20.2	9.62	30.5	30	33	33	36
Consultant	25.52	20.2	5.32	26.5	27	30	30	33
SAS	0.4	0	0.4	0	0	0	0	0
Trainee	3.9	0	3.9	4	3	3	3	3
ACUTE	**630.7**	**580.4**	**50.3**	**658**	**658**	**657**	**652.5**	**676**

	2005			2006	2007	2008	2010	2015
		Staff in		Average WTE	Average WTE	Average WTE	Average WTE	Average WTE
PRIMARY CARE	**Funded WTE**	**Post WTE**	**Diff**	**Expected**	**Expected**	**Expected**	**Expected**	**Expected**
Psychiatry		88.8		91	91	88	94	94
Consultant		39.6		41	41	46	54	58
SAS		26.0		26	26	22	20	18
Trainee		23.2		24	24	20	20	20
Paediatrics		54.4		55	55	57	58	62
Consultant		10.0		11	12	14	18	24
SAS		18.3		18	20	20	23	19
Trainee		26.1		26	23	23	17	17
Family		1.0		1.0	1.0	1.0	1.0	1.0
Trainee		1.0		1.0	1.0	1.0	1.0	1.0
Palliative		2.0		2.0	2.0	2.0	2.0	2.0
Trainee		2.0		2.0	2.0	2.0	2.0	2.0
PC TOTALS		**146.2**		**148**	**148**	**147**	**154**	**158**

PUBLIC HEALTH								
Consultant		8		8		8		8
SAS		0		0		0		0
Trainee		4		4		4		4
PH TOTALS		**12**		**12**		**12**		**12**

OTHERS								
OCC.MEDICINE								
Consultant		4		4	4	4	4	4
SAS		0		0	0	0	0	0
Trainee		0		0	0	0	0	0
OTHERS		**4**		**4**	**4**	**4**	**4**	**4**