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# **HCSA Evidence to the Review Body on Doctors' and Dentists' Remuneration for 2018-19**

December 2017

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## 1. Introduction and Key Points

1.1 The Hospital Consultants & Specialists Association (HCSA) is a nationally recognised professional association and trade union that represents and advises all grades of post-graduate hospital doctor in the UK, both in the NHS and Private Sectors. We are recognised by NHS Employers to take part in national negotiations on pay and terms and conditions of service on behalf of all grades of members.

1.2 We welcome the opportunity to submit evidence on behalf of hospital doctors for the 2018-19 pay review. We value the role of the independent DDRB in bringing an expert view to remuneration issues in relation to the NHS workforce.

1.3 Our evidence has been informed by regular engagement with HCSA members regarding their experiences and concerns over, and priorities for, pay and terms and conditions reform.

**1.4 Key findings** from a recent survey of HCSA members:

- 79.5 per cent reported unfilled vacancies
- 65.2 per cent reported that these vacancies had been open more than 12 months
- 49.9 per cent reported that the existing team was covering unfilled vacancies
- 74.4 per cent of hospital doctors said that they “always” or “often” work beyond contracted hours
- 79.9 per cent of respondents reported their morale as “low” or “very low”
- 85.3 per cent had considered leaving the profession early
- 33.1 per cent reported that in a typical week they were unreasonably stressed at work “always” or “most of the time”
- Only 35.6 per cent said they would recommend hospital doctor as a career path
- 85.6 per cent felt that current pay levels for hospital doctors are inappropriate

**1.5 Key Recommendations:**

- The independence and authority of the DDRB regarding spending priorities needs to be reaffirmed
- Pay should increase in line with RPI, which currently stands at 3.9 per cent
- All types of CEAs should rise in line with pay
- Local CEAs should remain unchanged until the new contract negotiations are complete
- The introduction of commitment awards needs to be considered
- To aid retention, focus should be placed on improving the working environment
- The launch of a joint investigation into early retirement involving trade unions and employers
- There needs to be improvement in flexible working policy and equality/diversity measures

## 2. Response to 2017-18 DDRB Report and Recommendations

**2.1 Pay: 1 Per Cent Pay Rise** – We remain profoundly disappointed at the DDRB recommendation for 2017-18 that there should be a base increase of 1 per cent to the national salary scales for salaried doctors in England, Wales, and Northern Ireland. This is well below comparable wage inflation and, with RPI inflation at that time at 3.5 per cent, doctors were again presented with a decline in their pay. At a time of low morale and motivation, and increasing workloads, this was another harsh blow for hospital doctors and did nothing to address the issues of recruitment and retention that are becoming an increasing problem throughout the NHS.

**2.2 Allowances and Awards** – First, we reiterate that the main pay recommendation of 1 per cent was insufficient. However, HCSA believes that the value of awards and allowances should rise at the same rate as pay. We therefore support the recommendation that the value of awards for Consultants – Clinical Excellence Awards, Discretionary Points and Commitment Awards – be increased in line with the main pay recommendation. We also support in principle the recommendation that the value of flexible pay premia included in the new Junior Doctor contract in England should increase at a rate not lower than this benchmark.

**2.3 Targeting** – We do not support targeted recommendations to address location or specialty recruitment issues that are outside of standard national pay scales and terms. There remains no compelling argument for undermining national pay scales. Where there are persistent shortages in certain specialties and in certain geographical areas, we feel these are more appropriately addressed at a national level. The underlying problem remains one of overall supply and therefore retention and workforce planning at a national level.

2.4 We acknowledge the current policy within NHS England for Junior Doctors of additional pay premia for trainee doctors choosing to undertake hard-to-fill training programmes, and cautiously support its continuation. However, its impact on other specialties should remain under close review. We would reiterate that such schemes will not as and in themselves tackle the wider issues surrounding retention and the attractiveness of the profession.

2.5 With regards more senior grades, the impact of any local targeting at Trust level would likely only begin to be felt after several years, once trainees whose choices were impacted by the changes had qualified. In the short term, it would have a negative impact, merely churning the existing workforce as existing staff moved to posts advertised on higher salary points. This is the reason why the existing flexibility of a 30 per cent recruitment premium has rarely, if ever, been applied by Trusts.

2.6 Our own research reveals that vacancies are widespread and not simply confined to a few specialties or regions, although we acknowledge that there are some particularly extreme examples. The fact that vacancies are commonplace leads us to conclude that steps to aid retention are the real answer to problems of recruitment. This will require addressing those factors impacting on morale and well-being, as well as the very real impact of long-term erosion of real-terms pay, pensions and other benefits. We set out our own recommendations in this area in Section 5 (5.6-5.10).

**2.7 Retention** - We support the DDRB's recommendation that health departments and employers in England, Wales, and Northern Ireland investigate why doctors are taking early retirement. Acknowledging the importance of this phenomenon, we have already undertaken research into this area with our members. A recent survey of HCSA members showed that 85.3 per cent had considered leaving the profession early, with respondents identifying "workplace stress", "poor work-life

balance”, “pay deflation”, and “pension taxation” as significant factors. Therefore, we support systematic investigation in this area. However, we feel that trade union input into this assessment is vital. We propose a joint NHS/Department of Health and HCSA/BMA investigation to explore why doctors leave the profession. Assessment needs to be made to understand why older doctors are retiring prematurely, and younger doctors are exiting to work in other parts of the world or in other professions. It should consider the impact of tax changes, pay, pension changes, occupation stress, and job planning issues etc. We propose that this work is undertaken with vigour and speed, and that findings are fed back so that recommendations can be made to the DDRB before its next review.

### 3. Contract Negotiations

3.1 HCSA has since December 2016 been formally recognised by NHS Employers for all grades of hospital doctor within its membership – Foundation, Core/Specialty Trainee, SAS/Associate, Non-Career/Trust Grade, and Consultant.

3.2 Since early 2017 HCSA has been involved in talks with NHS Employers and the Department of Health on the shape of the new Consultant Contract. These have taken place in parallel with the BMA, which has rejected the suggestion of joining us in joint sessions.

3.3 Current discussions around the Consultant Contract focus on possible replacements for Local CEAs, and also the issue of safeguarding. However, these discussions are proceeding at an extremely slow pace and we do not anticipate a conclusion in the near future, and possibly not until 2020 or beyond. Both the HCSA and BMA are publicly committed to a ballot of their respective memberships, which may further delay implementation.

3.4 There are currently no Junior Doctor Contract negotiations taking place. However, a review of issues arising from the latest contract is scheduled in 2018.

3.5 SAS doctors are not currently engaged in contract negotiations, although initial discussions are expected shortly.

3.6 We urge the DDRB to make its recommendations on the basis of existing contracts given the fact that Consultant Contract talks covering doctors in England and Northern Ireland are ongoing and delayed, with a conclusion not likely before 2020-21, and because its recommendations cover all parts of the UK, including those not covered by current negotiations.

## 4. Review Body Request Areas

4.1 The DDRB terms of reference requested that parties comment on particular general issues. This section outlines our responses to the areas we have evidence on, and are relevant to us.

### Recruit, Retain and Motivate

#### **Workload Continues to Increase**

**4.2 The Changing UK Demographics** – The population of the UK is increasing, and the population is ageing. The population is forecast to increase to 67 million by 2020, and to reach over 70 million by 2028. Life expectancy has been increasing over the last few decades. Females born in 2015 are expected to live 82.8 years from birth, an increase of four years from 1991. Males born in 2015 are expected to live until 79.1 years from birth, a 5.7-year increase from 1991<sup>1</sup>. The percentage of the population that is 65 years or older is growing. It increased between 1975 and 2015, from 14.1 per cent of the population to 17.8 per cent. It is projected to continue to grow to nearly a quarter of the population by 2045<sup>2</sup>. As a result, doctors are required to treat more patients, and care for an ageing population which is more vulnerable to chronic and multiple long-term conditions. An ageing population and a growing UK population are placing additional strain on an already underfunded and understaffed NHS.

**4.3 Patients' Expectations are Increasing** - Demands from the public are also increasing. The public are making increased demands on health services and health professionals, seeking more involvement in the decision-making process around their care. They also have higher expectations of what the NHS can, and should, do for them. This is placing additional strain on hospital doctors, as well as on resources.

#### **Increased Workloads - The Effect on Hospital Doctors' Motivation, Morale, and Well-being**

4.4 There is a widespread shortage of hospital doctors, leaving unfilled vacancies across the country. NHS Digital reported that the number of available full-time equivalent medical and dental posts advertised via NHS Jobs in England rose from 2,521 in March 2016 to 3,011 in March 2017 – a 19.4 per cent increase<sup>3</sup>. This snapshot is reflected in a wider upwards trend elsewhere in the number of advertised vacancies. In the first quarter of 2017, 8,469 such positions were advertised, up from 7,627 in the first quarter of 2016<sup>4</sup> – a 11 per cent rise. In 2016, 45 per cent of advertised consultant posts were not appointed to: 65 per cent due to no applicants and 19 per cent due to no suitable applicants. The proportion of posts not appointed to due to lack of applicants has increased from 32 per cent in 2008, to 39 per cent in 2011, to 65 per cent in 2016<sup>5</sup>. Therefore, while Trusts are creating new posts to respond to a rise in demand, there is often no candidate to fill the post. This places increased strain on those hospital doctors who are in post who are bearing the weight of an understaffed NHS.

4.5 A significant contributing factor to the understaffing of the NHS is that the UK has not been training enough doctors. The number of medical students has been decreasing in recent years. However, an October 2017 report by admissions service UCAS, which assessed applications to courses

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<sup>1</sup> <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/mar2017>

<sup>2</sup> <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/mar2017>

<sup>3</sup> <https://digital.nhs.uk/catalogue/PUB30033>

<sup>4</sup> <https://digital.nhs.uk/catalogue/PUB30033>

<sup>5</sup> <https://www.rcplondon.ac.uk/projects/outputs/2016-17-census-uk-consultants-and-higher-specialty-trainees>

up to 15<sup>th</sup> October, highlighted that universities were currently seeing a record number of medicine applicants in 2017<sup>6</sup>. UCAS stated that during this cycle, there had been 20,730 applicants to medicine, the largest number since 2014. This represented an increase of 8 per cent from the previous cycle (an additional 1,520 applicants). This increase follows a succession of declines between 1 and 10 per cent from 2015 to 2017<sup>7</sup>. While we remain hopeful that these numbers will continue to rise, simply obtaining more medical students is not enough. We need to ensure that those who apply are of sufficient quality, and that, when they are trained, they join and stay within the NHS to address the issues of shortages and rota gaps.

4.6 Recent research among HCSA members reflects the scale of the current workforce crisis, with 79.5 per cent of respondents reporting unfilled vacancies in their department, and 65.2 per cent reporting that these vacancies had been open for more than 12 months. The number of unfilled vacancies has a significant impact on the workload on doctors and medical staff, leading to staff taking on supplementary work. Staff shortages are currently placing an additional work burden upon existing staff – 49.9 per cent of HCSA members reported that the existing team was covering unfilled vacancies, with 74.4 per cent stating that they “always” or “often” worked beyond contracted hours. This increases workplace stress and impacts on well-being and retention.

4.7 Staff shortages are leading to numerous problems. First, due to increased workloads doctors have insufficient time for education and training. Second, doctors are often left exhausted – this can impair decision-making and ultimately impact on patient safety and patient care. Third, overwork is leading to poor work-life balance, low motivation and morale, and poor well-being.

4.8 A recent survey of HCSA members showed that 79.9 per cent of respondents reported their morale as “low” or “very low”. We also found that 85.3 per cent had considered leaving the profession early. Respondents identified “workplace stress”, “poor work-life balance”, “pay deflation” and “pension taxation” as significant factors. Around a third (33.1 per cent) reported that in a typical week they were unreasonably stressed at work “always” or “most of the time”. From those we canvassed, only 35.95 per cent stated that they would recommend hospital doctor as a career path.

4.9 Alongside increased workload pressures, poor working environments are also a significant contributory factor to low motivation and morale, and poor well-being. When speaking to HSCA, several members highlighted the poor environment in which they were working. For example, members highlighted that in many instances there was no access to fresh drinking water, hot beverages, healthy eating options or appropriate rest facilities, and no opportunity to take necessary breaks.

4.10 The unsuitable working environments in which hospital doctors are often expected to work is an underappreciated cause of workplace stress and poor well-being. We feel that this is an area that requires significant consideration and action.

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<sup>6</sup> Assessment of UCAS applicants to courses with 15 October deadline, UCAS Analysis and Research, October 2017, <https://www.ucas.com/file/1308a26/download?token=dTbAdkWd>

<sup>7</sup> <https://www.ucas.com/file/1308a26/download?token=dTbAdkWd>

## Principle of Equal Pay for Equal Work

4.11 We identify two major areas of concern that fall under the principle of equal pay for equal work: gender equality and contractual variations created by the implementation of Junior Doctor contracts.

### **Gender Equality and the Gender Pay Gap**

4.12 General Medical Council figures show that 45.5 per cent of the medical workforce are women<sup>8</sup>. However, while the number of women in the profession has been rising steadily, there appears to be gender disparity within specialties. For example, only 11.5 per cent of UK surgeons are female<sup>9</sup>.

4.13 Research shows that female doctors earn less than their male colleagues and that this gap exists at all levels of responsibility. Therefore we welcome the work currently underway by the Department of Health to commission an independent report to examine the gender pay gap in the medical profession. We need a thorough examination of pay differentials and an understanding of why they exist and what we can do to remove them. While we acknowledge that this is in part due to factors such as women tending to work fewer hours than men overall, we need an examination as to why this is the case. Issues such as being unable to work flexibly and barriers (both institutional and perceived) to returning to work after maternity leave need to be examined.

4.14 There needs to be a full assessment of why many female doctors do not seek to specialise in certain “male-dominated” areas, and why there is a disproportionately low level of CEA applications by women. As the DDRB 2017 report highlighted, only 20 per cent of applicants for CEAs were women, although female Consultants make up 34 per cent of the workforce. The root cause of this needs to be identified, and action needs to be taken.

4.15 Some HCSA members have expressed a belief that there remains an embedded difference in how men and women are treated in the medical workplace. While there has been a move towards “feminisation” of the workforce, further change is needed in order to alter the unequal culture that persists within the NHS, and incentivise and promote certain areas of work.

4.16 There also needs to be more done to promote gender equality in leadership positions, such as through an “ambassadors” scheme that is fully supported and funded. There should be more support for women returning to work after maternity leave, or a period of absence. There also needs to be more done to support and inform applicants with potential family commitments. For example, vacancies should be fully advertised with a clear role description. This should include a statement on travel requirements, support granted, anti-social hours required to work, and flexibility available.

### **Variations in Contracts**

4.17 HCSA has seen growing evidence of concerns around the implementation of the Junior Doctors contract. Inadequate national guidance around transitional arrangements has created a situation in which we are witnessing differences in payment within Trusts between doctors on the same grade and in the same rota due to inconsistencies around how the new contract is being introduced. This is clearly counter to the principle of equal pay for equal work, and such cases point to the existence of a serious flaw in the transitional arrangements governing the new Junior Doctor contract that needs to be addressed. We have test cases that reflect this issue, and would therefore ask that the DDRB to consider this phenomenon.

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<sup>8</sup> [https://www.gmc-uk.org/doctors/register/search\\_stats.asp](https://www.gmc-uk.org/doctors/register/search_stats.asp)

<sup>9</sup> [https://www.gmc-uk.org/GMC\\_SOMEPEP\\_2016\\_Reference\\_tables\\_about\\_the\\_register\\_of\\_medical\\_practitioners.pdf\\_68101182.pdf](https://www.gmc-uk.org/GMC_SOMEPEP_2016_Reference_tables_about_the_register_of_medical_practitioners.pdf_68101182.pdf)

## 5. Recommendations: What Needs to Be Done?

### The Independence of the DDRB

5.1 The Independence of the DDRB needs to be reaffirmed. The DDRB was established as an independent authoritative body to advise on the pay of doctors and dentists in order to ensure that any decisions around pay were fair, evidence-based, transparent and apolitical. However, in recent years, the authority of the body has been undermined as the Government has ignored the suggestions made by the DDRB. We feel that the existence of an independent body to consider pay without prejudice is extremely important. Therefore, we ask the DDRB to continue to assert its independence and make full and fair recommendations. We ask the Government to respect the role of the DDRB, and honour its recommendations. We call for the DDRB to officially state its disappointment when recommendations have not been accepted or implemented by UK or devolved governments.

5.2 We also would call on the DDRB to comment on process and procedure. The Department of Health was late in producing remit letters, placing undue difficulties on HCSA and forcing us to work within a restricted timeframe. The DoH has also stated that it will submit its evidence late. As a result, we would seek assurances from the DDRB that the DoH is not able to review the submissions by other parties prior to the production of its own. If this is not guaranteed it calls into question the independence, fairness and credibility of the process as it privileges the DoH at the expense of other respondents. We call on the DDRB to address the issues surrounding process, and to consider how this impacts on impartiality and decision-making.

### Pay

5.3 Over a sustained period, doctors have faced a sharp real-terms decline in pay and a significantly steeper decline than the median. We believe that this long erosion of real-terms pay is having a clear detrimental impact and needs now to be addressed. Since 2010, RPI inflation of 23 per cent, against basic pay awards totalling only 3 per cent, means that most hospital doctors have experienced a 20 per cent real-terms decline in basic wages since 2010. The DDRB has previously noted that due to the low inflationary environment within the wider economy the relative decline has slowed since 2014. However, inflation has risen sharply in recent months, further compounding the downward pressure on real-terms wages. **We therefore propose an increase for 2018-19 in line with the rate of RPI, which is currently at 3.9 per cent.** We believe that this would represent a first step in the process of acknowledging the impact of the damaging pay erosion that medical staff have endured.

### Awards and Allowances

5.4 In 2015 the DDRB highlighted that it was in favour of a replacement for the Local CEA system. We are not opposed to the consideration of alternative schemes. We acknowledge that there are flaws with the current system, and we see merit in phasing out LCEAs over time, but only in favour of a system of equal value recognising a similar number of hospital doctors. As an alternative to suggestions of an “appraisal-based” system, which we do not favour, HCSA has put forward various alternatives to modify or supersede LCEAs that we believe would be mutually beneficial to the NHS and Hospital Doctors. These include a final pay increase for senior staff to aid retention, a local medically driven innovation and development fund, and a protected study leave fund. Research among HCSA members about possible replacements to the current system showed that the most popular option was a late-career pay increment (23.2 per cent). If Local CEAs were to be replaced, funding would be needed in order to ameliorate the immediate impact of any changes.

5.5 Any changes to the Local CEA system should only be introduced once the Consultant Contract negotiations are concluded. We believe that while they remain in their present form, as with National CEAs their value should rise in line with the core pay award.

### **Vacancies and Targeting**

5.6 We have stated (2.3-2.6) our opposition to forms of locally targeted pay variation that sit outside national pay agreements, not least because of the widespread phenomenon of hospital doctor vacancies. We feel that the key to tackling this issue lies in addressing those factors impacting on morale and well-being, as well as acknowledging the very real impact of the long-term erosion of real-terms pay, pensions and other benefits.

5.7 We therefore feel a better approach would include an increase in national pay scales to acknowledge the impact of real-terms decline in pay and benefits, and improvements to working conditions and hospital doctors' working environment. HCSA would also like to see far better clinical engagement by those planning and leading transformation programmes, an area which HCSA has highlighted in our November 2017 study, *STPs: Destined to fail or the road to better care?*. Tackling these core issues will aid recruitment and retention across the NHS.

5.8 While HCSA is opposed to any measure that dilutes the principle of all medical training and specialties being of equal value, we would support a return to the previous "hard-to-fill" approach to Consultant posts based on the national pay scale, whereby once a job had been vacant for at least a year, and the post had been advertised twice without a suitable candidate being found, the employing authority could advertise the post at the top of the pay scale. When the post was filled, other Consultants within that hospital whose principal commitment was in the same specialty would also be advanced to the top of the salary scale from the date that their new colleague took up the post. We feel that this would provide appropriate flexibility for employers to incentivise and recruit staff.

5.9 We continue to cautiously support pay premia for Junior Doctors undertaking hard-to-fill training programmes as a mechanism to attract a greater number of trainees. However, this will not tackle wider issues surrounding the attractiveness of the profession. Indeed, if any extension of pay premia is to be funded from within an existing "pay envelope", then the increase for some specialties would lead to detriment to others. Any extension of pay premia should come from additional funding, and not form part of the core pay settlement.

5.10 We support the DDRB's previous stated position on targeted funding and believe that any proposed mechanism for "targeted" pay solutions must be paid for from additional national resources, and we would add that they should be subject to proper impact testing to ensure they are effective.

### **Recruitment and Retention**

5.11 We believe that in order to aid recruitment and retention there must be an adequate salary and other benefits to attract prospective doctors to the profession and ensure that, once qualified, they remain. One of the great issues faced within our hospitals is the high level of vacancies. This places additional pressure on remaining staff and therefore increases the risk of further attrition, either through early retirement, or from leaving the UK health system altogether. Given the high costs of training and corrosive impact of this trend, it is urgent that a level of remuneration and reward is struck that is sufficient to reduce this outflow. **Steps must therefore include raising pay nationally to address the growing gap between earnings and the real value of wages, reviewing steps to ameliorate the detrimental impact of changes to the pension system, and considering the introduction of commitment awards.**

5.12 **Second, work-life balance needs to be fully considered. This would include a review and improvement of flexible working policies.** While flexible working policies exist within Trusts, in practice getting agreement for work-life balance changes is often difficult. This is particularly the case where Trusts have a high number of unfilled vacancies, and feel that they cannot do without the workplace presence of the individual applying for the work-life balance arrangements. We have examples where individuals, both male and female, caring for an elderly parent have been denied flexibility. In this way, we are losing doctors. One way to improve the issue of unfilled vacancies is to properly embed a system where work-life balance and flexibility is available. Guaranteeing this would mean that individuals will not feel that if they do need to change their hours to less than full time they have no choice but to leave the profession.

5.13 Third, **the working environment of hospital doctors needs to be improved.** As highlighted above, the conditions that hospital doctors are often working in is unsatisfactory, such as no access to appropriate rest facilities and no access to healthy food options. **Therefore, we call for a full analysis of the conditions throughout the UK, and a series of recommendations for improvements to be made.**

5.14 Fourth, **hospital doctors need to be involved in the transformation agenda. The expertise and views of hospital doctors need to be not only considered but also fully embedded into decision-making processes.** The lack of influence over restructuring and reform is an issue that affects many doctors, and contributes to low morale.

5.15 We propose an urgent joint investigation into the causes and to propose solutions around early retirement, involving the Department of Health, NHS, HCSA and BMA.

#### **Data Gaps**

5.16 We note that there is a lack of comprehensive data around several areas, and therefore a need for data to be collected. We feel that it is appropriate for the DDRB to commission work in these areas. We have identified the following:

- **Vacancies and rota gaps** – Further work is needed to assess how these gaps and shortages are being filled.
- **Gender equality** – As stated above, while we welcome the work currently underway by the Department of Health on the gender pay gap, we believe that more work needs to be done to assess trends that underpin the headline figures.
- **Disability equality** – An assessment of the career trajectory of disabled doctors within the NHS would be welcome.
- **Assessment of the implementation of Junior Doctors' contracts** – Steps should be taken to identify how widespread the problem of uneven implementation of the new contract is (where two identical doctors in the same Trust face different treatment).

5.17 We would be pleased to work with the DDRB, and commissioned bodies, to assess what information is needed, and identify the most useful and appropriate means to collect this information.

## 6. Conclusion

6.1 The Government is continuing to undervalue hospital doctors. Hospital doctors have repeatedly been asked to accept a continued real-terms loss of earnings, and at the same time shoulder an ever-increasing workload that is causing considerable strain on individuals. A pay rise of 1 per cent when inflation is far higher is explicitly a pay cut in real terms, not an increase. Hospital doctors are expected to work harder than ever before to provide a high standard of service, but they are often doing so at the expense of their own personal well-being. This needs to be appropriately recognised, and action needs to be taken. Morale and motivation among hospital doctors is low, which is impacting upon recruitment and retention. We believe that continuing with a low, or zero, pay rise will intensify this problem.

6.2 The DDRB should use its voice to champion the value of hospital doctors, and make recommendations based on their contribution to society. We look forward to being able to follow up this submission with an oral presentation if requested.

## 7. References

General Medical Council, List of Registered Medical Practitioners – statistics, [https://www.gmc-uk.org/doctors/register/search\\_stats.asp](https://www.gmc-uk.org/doctors/register/search_stats.asp) [accessed 15<sup>th</sup> November 2017]

General Medical Council, The state of medical education and practice in the UK: 2016 [https://www.gmc-uk.org/GMC\\_SOMEF\\_2016\\_Reference\\_tables\\_about\\_the\\_register\\_of\\_medical\\_practitioners.pdf\\_68101182.pdf](https://www.gmc-uk.org/GMC_SOMEF_2016_Reference_tables_about_the_register_of_medical_practitioners.pdf_68101182.pdf) [accessed 15<sup>th</sup> November 2017]

Hospital Consultants and Specialist Association, Survey of Members, HCSA unpublished document, November 2017.

Hospital Consultants and Specialist Association, ‘Who Cares for the Carers? The Impact of Workplace Stress on Senior Hospital Doctors’, September 2015, <https://www.hcsa.com/media/71192/HCSA-stress-survey-who-cares-for-the-carers.pdf>

NHS Digital, NHS Vacancy Statistics England, February 2015 - March 2017, Provisional Experimental Statistics, <https://digital.nhs.uk/catalogue/PUB30033> [accessed 13<sup>th</sup> December 2017]

Office of National Statistics Overview of the UK population: March 2017 <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/mar2017> [accessed 13<sup>th</sup> November 2017]

Rimmer, A. (2017) Do we still need to tackle discrimination against women in medicine? [http://careers.bmj.com/careers/advice/Do\\_we\\_still\\_need\\_to\\_tackle\\_discrimination\\_against\\_women\\_in\\_medicine%3F#ref1](http://careers.bmj.com/careers/advice/Do_we_still_need_to_tackle_discrimination_against_women_in_medicine%3F#ref1) [accessed 15<sup>th</sup> November 2017]

Royal College of Physicians, 2016–17 census (UK consultants and higher specialty trainees) <https://www.rcplondon.ac.uk/projects/outputs/2016-17-census-uk-consultants-and-higher-specialty-trainees> [accessed 13<sup>th</sup> November 2017]

UCAS, Assessment of UCAS applicants to courses with 15 October deadline, UCAS Analysis and Research, October 2017, <https://www.ucas.com/file/1308a26/download?token=dTbAdkWd> [accessed 13<sup>th</sup> November 2017]