15 March 2019

Royal College of Anaesthetists

# Royal College of Anaesthetists' response to the NHS Improvement's request for feedback for its *Interim Workforce Implementation Plan: emerging priorities and actions*

## About the Royal College of Anaesthetists

- Sixteen per cent of all hospital consultants are anaesthetists making anaesthesia the single largest hospital specialty in the UK[i,ii,iii]
- Anaesthetists play a critical role in the care of two-thirds of all hospital patients[iv] and 99% of patients would recommend their hospital's anaesthesia service to family and friends[v]
- With a combined membership of 22,000 fellows and members, representing the three specialties of anaesthesia, intensive care and pain medicine, we are the third largest Medical Royal College by UK membership.

Should you have any questions on this response, please contact Kathryn Stillman at kstillman@rcoa.ac.uk or by phone on 020 7092 1532.

## Introduction

The RCoA welcomes the opportunity to provide feedback to NHS Improvement's five emerging themes.

## General comments

As the single largest specialty of hospital doctors, we believe that anaesthetists can offer a unique insight as a bellwether for secondary care, to help develop solutions that are applicable throughout the NHS.

Anaesthesia plays a prominent role in secondary care, facilitating service delivery throughout the NHS, both inside and out of the operating theatre, from the point of deciding on surgery through to the patient returning to normal activity. Anaesthetists work in wide range of hospital services, often treating patients with need for high acuity care, including in maternity, paediatrics, major trauma and emergency surgery. This is coupled with a high caseload of elective procedures, which taken together, means anaesthetists are involved in the care of two in three of all hospital inpatients.

Anaesthetists have a unique skills set. Anaesthesia and intensive care medicine is not part of the generic skills set of all doctors, therefore cross cover for anaesthetic and intensive care medicine duties is not easy to provide – urgent and emergency care is compromised without our specialties.

Although we have embraced new medical associate professionals, including physicians' assistants (anaesthesia) (PA(A)s) working under an agreed and fully regulated environment, anaesthetics remains a consultant-led service. The breadth and complexity of the professional competencies of the role, increased demand on training and increasingly more complex

patients presenting in hospital demands a continuation of anaesthesia as a consultant-led service. Research from the Health Foundation showed that one in three patients admitted to hospital in England as an emergency (2015/16) had five or more health conditions – up from one in 10 patients less than a decade earlier (2006/07)[vi]

**A summary of the key points and recommendations within our submission is provided below. Our response to the themed questions, in full, is provided underneath the summary.**

**Summary of recommendations in our submission**

Theme 1

- The Department of Health and Social Care, in coordination with the relevant devolved organisations and arm's-length bodies, should support the development without delay of a national morale and welfare strategy for all NHS staff.
- The Spending Review in 2019 should be used to provide dedicated capital funding for improving NHS staff facilities, including provision of adequate rest, catering and study facilities.
- The practice of charging staff to use facilities that are essential to their safety and welfare, including rest facilities, should be banned with immediate effect.
- All employers should support a cultural shift towards a 'no-blame' learning environment that prioritises the safety of patients.
- There should be prompt and accurate payment of salaries for trainees.
- An urgent review of pension regulations is required to stop the haemorrhaging of experienced clinicians from the NHS.
- The benefits of clinical excellence awards (local and national) are well recognised and Trusts should be encouraged to award CEAs annually. Clinical excellence awards should be looked at across the workforce spectrum.

Theme 2

- More should be done to encourage the further development of clinicians in leadership roles.
- Trusts should be encouraged to support their clinicians in medical leadership roles, for example in work for Medical Royal Colleges, as an examiner, or council member, which benefit the specialty and ultimately, patients and the wider NHS.

Theme 3

- Although there is an issue with recruitment to nursing, this should not be dealt with to the exclusion of other workforce areas, and specialities, which also have shortages. Ensuring the provision of a sustainable medical workforce is a vital component in the long-term planning process for health and social care services.
- By calculating the current rate of retirement combined with the increased demand from specialty growth, we believe that there will need to be a pipeline supply of between 430 to 650 new anaesthetists each year. However, over the last five years, the number of ST3s starting in anaesthesia has averaged 340.
- More needs to be done to match the gaps in training rotas with provision for MTI in the UK, in addition to the significant investment that is necessary if the UK is to become 'self-sufficient' in doctors by 2025.
- The use of the MTI scheme could be extended to provide a temporary solution to the current workforce situation, but efforts must continue to grow the domestic workforce.
- Growing a domestic workforce will require time and in the interim the NHS should still be able to recruit talent from abroad to fill gaps and maintain adequate staffing levels. We recommend a review of the proposals in the recently published Immigration White Paper for a salary threshold of £30,000, as this will make recruiting from abroad for lower nursing grades very difficult in the future.

Theme 4

- Developing anaesthetists as 'perioperative physicians' improves patient care and outcomes.
- Flexible working, including flexible 'end of career' development should be encouraged.
- For the specialty of anaesthesia, the RCoA does not see that there is scope or positive benefit in shortening the training programme without risking patient safety.
- Medical Associate Professions – including Physicians' Assistants (Anaesthesia) (PA(A)s) and Advanced Critical Care Practitioners (ACCPs) – can make a valuable contribution towards a sustainable anaesthetic workforce throughout perioperative care, but only if these roles are properly regulated.

Theme 5

- We support the proposals for the development of a single real-time workforce dataset available to national, system and local bodies.
- All roles must have national standards but decisions on numbers and exact roles can be devolved regionally to be decided in the local context.

**FEEDBACK ON THE FIVE EMERGING THEMES FROM NHS IMPROVEMENT**

**Theme 1: We can make a significant difference to our ability to recruit and retain staff by making the NHS a better place to work.**

Morale and Welfare

Reflecting the current challenge of health and social care recruitment, anaesthetists in training and consultants report significant and frequent pressure to fill gaps in trainee on call rotas.[vii,viii] This compromises the ability to deliver safe and timely perioperative care and adds to the workload of an already overstretched workforce, that may lead to training opportunities being missed. This contributes to the erosion of staff health, welfare and morale.

The RCoA urges the production of a national strategy that makes practical recommendations for improving working conditions for staff and identifies the facilities necessary in order to provide safe and sustainable patient care.

Underlying issues which are driving an erosion of morale and welfare within the NHS workforce are being amplified by high levels of fatigue, a lack of qualified staff and inadequate facilities.[ix,x] RCoA data show that as many as six in 10 anaesthetists in training report that their physical and mental health have been detrimentally affected by their job.[xi] Car parking can also be an issue for anaesthetists in training. As trainees rotate frequently, they are often not on the staff list for staff carparks, adding to their heightened stress levels.

Overworked doctors, demoralised staff and under-resourced hospitals can also undermine the quality of patient care and safety – themes that were interrogated in the *Francis Report* following the Mid-Staffordshire NHS Foundation Trust Public Inquiry in 2013.[xii]

Besides the clear clinical and ethical imperative, there is also a powerful economic case to focus efforts on improving the wellbeing of staff. The annual cost of staff absence for the NHS in England is estimated to be £2.4 billion.[xiii]

> Recommendation: The Department of Health and Social Care, in coordination with the relevant devolved organisations and arm's-length bodies, should support the development without delay of a national morale and welfare strategy for all NHS staff

The effects of fatigue on doctors of all grades are a threat to patient safety[xiv] and action is needed to address the lack of rest facilities. At a minimum, 24-hour rest facilities should be available – free of charge – for healthcare staff working in acute specialities during and after on-call periods, including anaesthetists.

Provision of adequate facilities should include sufficient office, study and IT facilities. In addition, doctors need confidential space for peer-support, discussion of clinical issues and lifelong learning.

We believe that a proportion of the funds identified in the Naylor Review of NHS property and estates[xv] would be an appropriate mechanism for providing this investment.

> Recommendation: The Spending Review in 2019 should be used to provide dedicated capital funding for improving NHS staff facilities, including provision of adequate rest, catering and study facilities.
>
> Recommendation: The practice of charging staff to use facilities that are essential to their safety and welfare, including rest facilities, should be banned with immediate effect.

No-blame culture

Although there are examples of good practice, the NHS remains affected by a 'blame' culture. Healthcare professionals live under the constant threat of punitive action when things go wrong. For many years the RCoA has called for steps to facilitate a 'no-blame' learning environment where staff and healthcare organisations can learn from mistakes when they do occur. The recent Williams Review and GMC's review into medical manslaughter have investigated the issue of 'culture' in the NHS in detail. These reviews, triggered by high profile cases, were set against a backdrop of an NHS under unprecedented pressure. NHS staff, including our fellows and members, are understandably concerned that genuine mistakes made in difficult, challenging circumstances where there are wider systemic failings may lead to a criminal conviction. In order to make pursuing a career in healthcare attractive the NHS must foster a culture of support and learning when mistakes are made.

> Recommendation: All employers should support a cultural shift towards a 'no-blame' learning environment that prioritises the safety of patients

Remuneration

Whilst it is not within the remit of the RCoA to comment on salary scales, the issues affecting prompt and accurate accuracy of salary payments, and of pensions does impact on the welfare and morale of our membership.

The introduction of the new terms and conditions of the 2016 junior doctor contract in England highlighted many issues for anaesthetists in training, in particular that of pay. Following the 2017 August job changeover, the RCoA and the Association of Anaesthetists (Association), were made aware of multiple issues surrounding pay for anaesthetists in training, and surveyed its anaesthetist in training members.

- 79% of respondents had received a late or inaccurate salary, and had experienced this on multiple occasions
- the majority of salary issues (57%) were still not resolved at the time of completing the survey
- less than one in five (18%) respondents who had experienced a salary problem had it resolved within a month

Issues were identified around: tax codes; increment errors; banding errors; discrepancies in calculating less than full-time (LTFT) hours; issues around protection; and difficulty understanding payslips.

The results were used to strengthen our joint engagement and advocacy work with national organisations such as NHS Employers, who developed the following resources to help: http://bit.ly/SalaryResources. The RCoA and the Association are again surveying its members one year on, and will continue to raise the issue of late and incorrect payments with NHS Employers and use feedback from the 2018 survey to press for further change.

> Recommendation: There should be prompt and accurate payment of salaries for trainees.

The current pensions cap is forcing many doctors to reduce their contracted work sessions, and discourages them from providing cover for additional clinical work (waiting list initiatives, uncovered out of hours on call sessions), which compounds the workforce issues. Many are leaving the pension scheme many years before retirement to avoid stiff tax penalties for breaching the new HMRC limits so the income/contributons to pensions is reduced.

> Recommendation: An urgent review of pension regulations is required to stop the haemorrhaging of experienced clinicians from the NHS.

The Clinical Excellence Awards (CEA) scheme in England and Wales is intended to recognise and reward those consultants who contribute most towards the delivery of safe and high quality care to patients and to the continuous improvement of NHS services. This includes those consultants and senior academics who do so through their contribution to academic medicine. However, many Trusts have been inconsistent, or worse, withholding the award of CEAs annually to deserving individual/s, further eroding the morale of clinicians

> Recommendation: The benefits of clinical excellence awards (local and national) are well recognised and Trusts should be encouraged to award CEAs annually. Clinical excellence awards should be looked at across the workforce spectrum.

Recent reports that patients are increasingly dissatisfied with their experience of the NHS add to poor staff morale. It is demoralising for hospital staff to feel that their patients are unhappy, when the reasons for the dissatisfaction are system based, and beyond the staff's sphere of influence. It is equally demoralising for NHS employees to hear frequent adverse reports of medical care in the media, or to encounter with increasing frequency, friends and family who have been treated badly by the NHS. If we get it right for patients, staff morale will be helped.

**Theme 2: If our workforce plan is to succeed, we must start by making real changes to improve the leadership culture in the NHS.**

The RCoA strongly supports and is actively involved in supporting and developing future professional medical leaders. The unique qualities required and associated with senior medical leadership roles closely matches the personal and professional skills and attributes required for delivery of anaesthesia, critical care and perioperative medicine.

The RCoA and Association of Anaesthetists are at the forefront of providing local, regional and national professional development resources, maintain an established network of clinical managers and leaders. Anaesthetists account for the largest secondary care membership of the Faculty of Medical Leadership and Management (FMLM).

A basic level of management training is included on the current anaesthetic training curriculum but this is primarily focused on clinical management. We would welcome looking at

how advanced management skills could be provided that would enable clinicians to take on service/managerial roles beyond the immediate clinical environment.

Over the last 30 years, medical management roles have become more firmly embedded in the NHS. Doctors bring particular skills, values and credibility to leadership roles in healthcare. However, doctors in leadership roles are not necessarily understood, embraced and engaged optimally across the healthcare system.

The FMLM reports that evidence shows that increasing the number of clinicians at board level can lead to better performance and improved patient outcomes and highlights how medical and clinical leadership is prominent in national approaches to system-wide issues. It states that "given this major dependency on effective leadership, more could be done to reinforce 'professionalism' of medical leaders and to enhance its standing by achieving parity with clinical medicine practices".

'Middle Managers' play an important role, and further development of their leadership skills are to be encouraged.

Doctors find it increasingly difficult to get time away from the workplace in order to pursue work for the wider NHS. This causes personal stress, fatigue and guilt. Officers and senior members of Medical Royal Colleges are increasingly in demand for their advice and support to government and arms length bodies, particularly to support the long term plan. The time to gather data and opinions and meet stakeholders is considerable, and Trusts must accept some of this time as part of doctors' job plans.

> Recommendation: More should be done to encourage the further development of clinicians in leadership roles.
>
> Recommendation:
> Trusts should be encouraged to support their clinicians in medical leadership roles, for example in work for Medical Royal Colleges, as an examiner, or council member, which benefit the specialty and ultimately, patients and the wider NHS.

**Theme 3: Although there are workforce shortages in a number of professions, disciplines and regions, the biggest single challenge we currently face nationally is in the nursing and midwifery profession.**

Anaesthetists work in a multidisciplinary team, and this is not possible if one section of the team is deficient, including nurses. However, **although there is an issue with recruitment to nursing, this should not be dealt with to the exclusion of other workforce areas, and specialities, which also have shortages. Ensuring the provision of a sustainable medical workforce is a vital component in the long-term planning process for health and social care services.** In light of integrated care across health and social care, a joined approach for both workforces is advisable.

We welcomed the Government's decision to provide 1,500 extra medical training places from September 2018.[xvi] However, the increased cohort of medical students will not graduate until 2023 and are not anticipated to complete specialist training in anaesthesia until 2032. The Care Quality Commission (CQC) has noted that inadequate staffing numbers and a lack of skilled staff continues to pose a risk to patient safety.[xvii] The House of Commons' Public Accounts Committee estimates that the NHS is short of at least 50,000 staff.[xviii]

While we acknowledge the need to reduce the costs associated with agency expenditure on medical locums,[xix] projections indicate significant medium-to-long-term shortfalls in the supply of doctors working in the specialties of anaesthesia and intensive care medicine, which will

only be mitigated by protected investment in medical education & training at the soonest opportunity.

How many doctors do we have working in anaesthetics?
The RCoA published its most recent census in 2015[xx] which remains the most comprehensive record of the number of consultant and staff and associate specialist grade (SAS) anaesthetists working across the UK.[1] Based on information provided by 100% of UK anaesthetic departments the census recorded that in 2015;

- there were 7,422 anaesthetic consultants across the UK
- there were 2,033 anaesthetic SAS and trust-grade doctors across the UK

A 2015 report by the Centre for Workforce Intelligence (CfWI) found that the number of fully trained anaesthetists and intensivists needed to meet demand by 2033 would be 11,800 full time equivalents.[xxi]

Based on historical rates of growth we estimate that there are currently around 8,200 consultant anaesthetists working in the UK'.

> Recommendation: By calculating the current rate of retirement combined with the increased demand from specialty growth, we believe that there will need to be a pipeline supply of between 430 to 650 new anaesthetists each year. However, over the last five years, the number of ST3s starting in anaesthesia has averaged 340.

Where are the gaps in staffing of anaesthetic services?
Data collected through November and December 2018 from clinical directors across 86% of anaesthetic departments in the UK found that;

- Overall, 75% of departments across the UK have at least one unfilled consultant post. This represents a combined total of 411 unfilled consultant posts or a 6.9%[xxii] gap across the UK; a 57% increase since 2015[xxiii]
- Around half (48%) of departments have advertised a consultant post that they have been unable to fill
- The most common reasons for anaesthetic departments reporting that they could not fill consultant posts were a lack of applicants (34%) and a lack of qualified applicants (35%).
- There are 276 unfilled SAS posts, representing a gap of 18.9% across the UK

Table 1: The anaesthetic consultant gaps across the UK is increasing

| Source | Consultant gap (UK) |
|---|---|
| 2015 RCoA workforce census[xxiv] | 4.4% |
| 2017 RCoA clinical directors' survey[xxv] | 5.2% |
| 2018 RCoA clinical directors' survey[xxvi] | 6.9% |

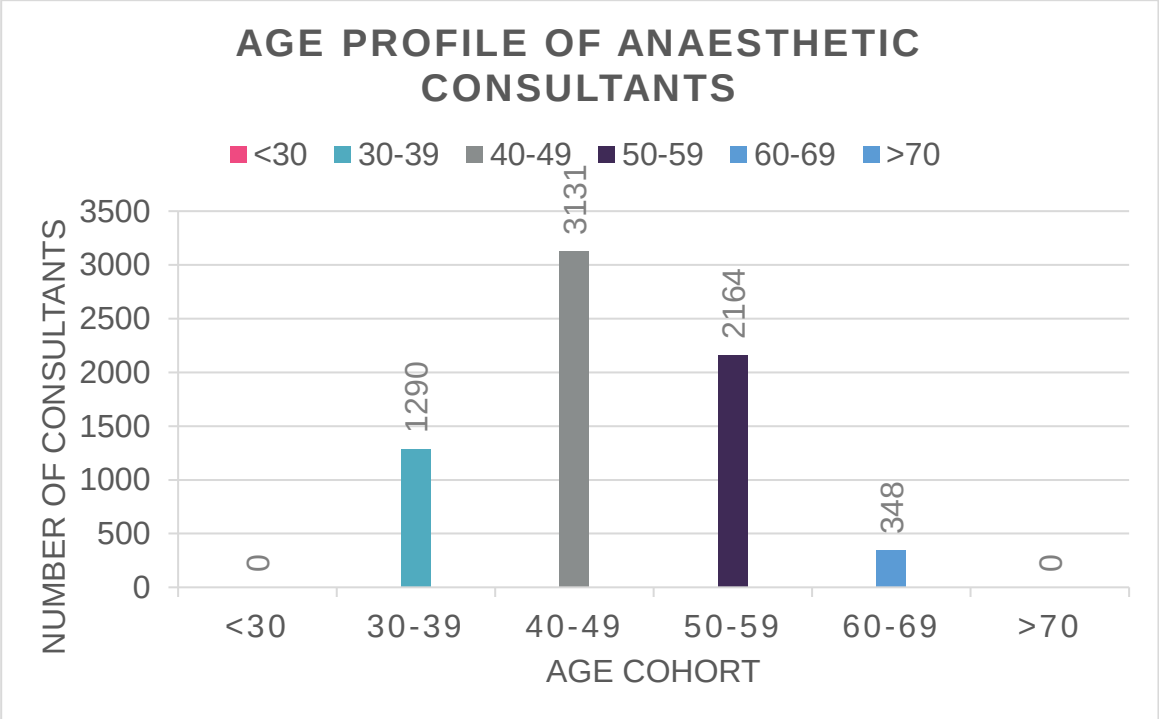
**Table 2:** There is significant variation in workforce trends across the UK, Source: RCoA clinical directors' survey (2018)

[1] n.b these figures do not include crown dependencies such as the Isle of Man or Channel Islands)

| Workforce component | England | Scotland | Wales | Northern Ireland * small sample size |
|---|---|---|---|---|
| **Locum consultant (% of total consultants)** | 224 (4.5) | 20 (3.9) | 9 (3.9) | 3 (4.8) |
| **Percentage of departments with unfilled consultant posts** | 76% | 71% | 83% | 66% |
| **Consultant gap (%)** | 358 (7%) | 34 (6.5%) | 16 (6.7%) | 3 (4.8%) |
| **SAS gap (%)** | 254 (19.8%) | 6 (7.8%) | 9 (11.7%) | 7 (31.8%) |
| **Retirement (%)** | 235 (4.9%) | 25 (5.1%) | 10 (4.5%) | 4 (6.7%) |

Between 2010 and 2015 there has been a 28% increase in the number of consultant anaesthetists aged between 50 and 59 years, indicating an ageing of the consultant population.[xxvii] This ageing cohort is also a feature of the SAS grade workforce – nearly four in 10 of whom have experience of a decade or more as an SAS anaesthetist and their retirement will represent a loss of significant expertise within anaesthetic services.[xxviii]

**Figure 3** shows the age profile for anaesthetic consultants. As 95% retire by the age of 60, we can predict that around 280 consultants will retire and need to be replaced each year until 2035.




How many anaesthetists do we need to be trained to meet future demand in the UK?

Although fill rates have increased in regions that have struggled to recruit, % recruitment and fill rates do not always reflect the workforce problem. Between 2012 and 2018 the number of doctors in training in the anaesthetic specialty programme nationally has declined by 6.5%

(2,844 to 2,660).[xxix] In addition, nearly one in five (19%) of anaesthetic departments across the UK needed to cover training grade or specialist rota gaps every day.[xxx]

Anaesthetists work in wide range of hospital services, often treating patients with need for high acuity care, including in maternity, paediatrics, major trauma and emergency surgery. This is coupled with a high caseload of elective procedures, which taken together, means anaesthetists are involved in the care of two in three of all hospital inpatients.

The College supports the evolution of the anaesthetic workforce, including expansion of physicians' assistants (anaesthesia) (PA(A)s) working under an agreed and fully regulated environment[xxxi] and the re-opening of the Associate Specialist Grade.[xxxii] However, anaesthetics remains a consultant-led service

Clinical audit also demonstrates the positive relationship between consultant-led care and improved patient outcomes. The fourth report of the National Emergency Laparotomy Audit (NELA) found that improvements in the care of patients before, during and after emergency bowel surgery has led to the national 30-day mortality rate falling from 11.8 to 9.5% over the last four years. This represents approximately 700 patients' lives saved in 2017 year compared to 2013.

- Patients' average hospital stay has also been reduced from 19.2 days in 2013 to 15.6 days in 2017 – saving the NHS an estimated £34 million annually
- Nearly 24,000 people undergo this high-risk operation each year.

Based on the NELA outcomes, the proposals for the 2019/20 national tariff include the introduction of a best practice tariff for emergency laparotomy that reflects the recognised value of consultant-led care.[xxxiii]

International workforce and recruitment

NHS hospitals have relied on free movement, not only of clinicians, but also of non-clinical staff working at all levels. We support the concerns of NHS Employers over impractical salary thresholds and proposed restrictions for low-skilled migration from across the world contained in the Immigration White Paper. These policies do not recognise the true value of contributions from international colleagues to our health and social care sector.

The College supports the ambition for the development of a home grown workforce, but this will take many years to advance and it may never be achievable – or even desirable – to reach a point where all NHS staff are UK trained. The NHS is strengthened by its ability to attract trained staff from Europe and beyond in response to address shortages and as part of schemes such as the Medical Training Initiative (MTI).

The RCoA represents a large and diverse membership with 8.7% of our members working outside of the UK and fellows and members in a total of 75 different countries.[xxxiv] More than 1,400 of our members and fellows are based outside of the UK – of those, the largest proportion (38%) are in Australasia and the South Pacific region.[2]

The Long Term Plan for the NHS states that 'International recruitment will be significantly expanded over the next three years, and the workforce implementation plan will also set out new incentives for shortage specialties and hard-to-recruit geographies'.[xxxv] It is unclear how

[2] RCoA membership data. January 2016. Data included in the RCoA's Global Partnerships Strategy 2016-2019. https://www.rcoa.ac.uk/system/files/Global-Partnerships-Strategy.pdf

this – and the reported expansion of the Medical Training Initiative (discussed below) is compatible or will co-exist with the government ambition for the NHS to be 'self-sufficient' in doctors by 2025. [xxxvi]

Expanding the workforce, through encouraging more UK students into medicine or in combination with international recruitment, requires an increase in training places above those already committed.

> Recommendation
> More needs to be done to match the gaps in training rotas with provision for MTI in the UK, in addition to the significant investment that is necessary if the UK is to become 'self-sufficient' in doctors by 2025.
>
> Recommendation
> The use of the MTI scheme could be extended to provide a temporary solution to the current workforce situation, but efforts must continue to grow the domestic workforce.
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> Recommendation
> Growing a domestic workforce will require time and in the interim the NHS should still be able to recruit talent from abroad to fill gaps and maintain adequate staffing levels. We recommend a review of the proposals in the recently published Immigration White Paper for a salary threshold of £30,000, as this will make recruiting from abroad for lower nursing grades very difficult in the future.

**Theme 4: To deliver on the vision of 21st century care set out in the LTP will not simply require 'more of the same' but a different skill mix, new types of roles and different ways of working.**

Developing anaesthetists as 'perioperative physicians' to improve patient care and outcomes
Anaesthetists are involved in the care of two-thirds of all hospital inpatients and so are in a unique position to engage with patients to support long term, positive changes to their health and lifestyle. This can happen from the moment that surgery is contemplated, through to a full recovery. This is the concept of perioperative medicine that presents an opportunity for anaesthetists to play a transformational role as a hospital's 'perioperative physicians'.

We recognise that the move toward integrated care that is being delivered through the new care models programme (in England) is closely aligned to our ambitions for perioperative medicine. The College published, 'A teachable moment: delivering perioperative medicine in integrated care systems' in February 2019.[xxxvii] The report highlights how multi-disciplinary perioperative care is good for patients, good for the NHS and good for the economy too – illustrated by existing initiatives from across the NHS.

NHS England's National Medical Director, Professor Stephen Powis, used his foreword to identify perioperative medicine as 'pragmatic medicine' and concludes that 'The most expensive, ineffective and inefficient care is poor care. An optimised perioperative approach is good for patients, good for the NHS and good for the wider economy as well'.

In the same report, these views are echoed among the local leaders in ICS areas across England, for example, Professor Des Breen, Medical Director for South Yorkshire and Bassetlaw ICS said, 'Perioperative physicians have the potential to make patient flow more effective and safer'.

This report echoes finding from the Health Services Research Centre's Perioperative Quality Improvement Programme (PQIP). [xxxviii] PQIP makes a number of recommendations for quality

improvement based on protocols in hospitals that are performing well – many of these are simple, practical changes related to medicines management, delivery of fluids or encouraging mobility during the perioperative period.

> Recommendation: Developing anaesthetists as 'perioperative physicians' can improve patient care and outcomes.

Flexible working

In addition to increasing numbers of staff in the system, the NHS – as the country's largest employer – needs to demonstrate an ability to accommodate contemporary working patterns, such as through the facilitation of less than full time (LTFT) roles – including during clinical training programmes.

One region in which recruitment to specialist anaesthesia training has been challenging, is currently piloting flexible 'Step Out, Step In' training in conjunction with HEE. In practice, this means trainees can seamlessly pause their training for 6 to 12 months and then return. The aspiration is that this will improve recruitment and retention.

Between 2010 and 2015 there has been a 28% increase in the number of consultant anaesthetists aged between 50 and 59 years, indicating an ageing of the consultant population.[xxxix] This age profile is also seen in the specialty and associate specialist (SAS) grade; nearly four in 10 of whom have experience of a decade or more as an SAS anaesthetist.[xl]

Retaining the skills and experience of a growing cohort of older doctors will be crucial to service delivery in the short-term and for the training of new doctors in the long-term. This will demand adjustments in the type of work being performed and the design of rotas. The development of perioperative medicine, making use of the broad expertise of anaesthetists as physicians, pharmacologists and technicians, provide opportunities beyond what has been understood as the traditional role of an anaesthetist within the operating theatre environment.

> Recommendation Flexible working, including flexible 'end of career' development should be encouraged.

What are the possibilities to reduce length of training?

The Long Term Plan commits the new national workforce group to examine further 'expanding the number of accelerated degree programmes'.

Specialty training in anaesthesia is competency based, rather than a purely time/service based programme. The purpose of the anaesthetic curriculum is to enable doctors to become consultant anaesthetists with the generic professional and specialty specific capabilities to lead, develop and deliver high quality anaesthetic, perioperative and critical care and pain medicine. The current CCT training scheme provides doctors with the knowledge, skills, and attitude necessary to provide the wide range of general skills required as a consultant anaesthetist in the UK, who is able to deal with all patients and conditions presenting to any hospital.

It is for this reason that the RCoA does not see that there is scope or positive benefit in shortening the training programme. There is an indicative length of time based on the programmed acquisition of competences, which is 7 years; and 8 years of Acute Care Common Stem (ACCS) plus anaesthetic specialty training. The current training time enables

anaesthetists in training to meet the curriculum requirements. Despite this, a study into the impact of less than full time training on the anaesthetics workforce found that the average time taken to complete training and gain a CCT in anaesthesia was 8 years, 5 months and 6 days. This supports our view that the length of the training programme should not be reduced.

To date, the RCoA has received very few requests to shorten training time. There is a need to maintain the current length of training in order for CCT holders to achieve the appropriate knowledge, skills and capabilities required for independent and unsupervised practice. It is also important to preserve the existing training options such as academic and dual training.

If the training programme were to be shortened, this would create a deficit of skills, confidence and experience that will need to be augmented through an alternative arrangement – such as supplementing an individual's experiences by extending training in the UK or overseas – in order to adequately prepare specialists for independent consultant practice.

> Recommendation: For the specialty of anaesthesia, the RCoA does not see that there is scope or positive benefit in shortening the training programme without risking patient safety.

Medical Associate Professionals (MAPs)

The Long Term Plan notes the need for a greater number of clinicians with a 'generalist' skillset. (This was a conclusion that was arrived at in an editorial in the British Journal of Anaesthesia published in parallel to the Long Term Plan, though independently of it.)[3]

The changing demographics of the UK indicate a need for a 25-40% expansion in the anaesthetic workforce by 2035.[xli]

Physicians' Assistants (Anaesthesia) - PA(A)s - are trained via the PA(A) postgraduate diploma programme. The College believes that, to date, the absence of a proper regulatory framework has deterred large-scale enrolment in the diploma programme, due to the limitation in enhancing the scope of the role without statutory regulation in place.[xlii] A result of the low numbers enrolling in the diploma programme has been that now, just one organisation – the University of Birmingham – offers the diploma programme. There are currently around 180 PA(A)s working in NHS hospitals across the UK, The RCoA has supported PA(A)s by setting up and maintaining a voluntary register.

PAAs are not seen as competing with doctors, but may be able to safely take up roles in perioperative care so that medical staff can be released for other tasks.[xliii]

We were pleased that the government has committed to the introduction of statutory regulation for PA(A)s following a consultation process.[xliv]

> Recommendation: Medical Associate Professions – including Physicians' Assistants (Anaesthesia) (PA(A)s) and Advanced Critical Care Practitioners (ACCPs) – can make a valuable contribution towards a sustainable anaesthetic workforce throughout perioperative care, but only if these roles are properly regulated.

[3] G.L. Ackland et al. Perioperative medicine and UK PLC. British Journal of Anaesthesia, 122 (1): 3 – 7 (2019). doi: 10 .1016/j.bja.2018.09.023

Credentialling

Some areas in which anaesthetists practice are also covered by other roles, and it may be advantageous to offer a credential to provide top-up training to other professions and give assurance to patients.

**Theme 5: We must look again at respective roles and responsibilities for workforce across the national bodies and their regional teams, ICSs, and local employers, to ensure we are doing the right things at the right level.**

All roles, especially new roles, such as MAPs including PA(A)s, should have a national framework and national standards, so that patient safety is assured, and that roles are transferrable between sites of work, and staff employed can easily move to a recognised post in another hospital or area. Their exact role, numbers and location of work can be devolved to regions and determined in the local context. For example, numbers of specialists should match the demographic and illness profile of the area, and care should be offered where it is most convenient to the patient population.

There is no single dataset on the UK workforce in anaesthesia, critical care and pain medicine that includes:

- The numbers enrolled in a training programme from the start of core training through to the end of the specialty training programme (i.e. CT1 to ST8)
- The number of doctors working across all grades (and including PA(A)s)
- A projection for the demand for anaesthetic, critical care and pain services over an agreed time-set, that is universally recognised as the 'official' projection
- Comprehensive figures on the recruitment, retention and retirement of the workforce

Recommendation: We support the proposals for the development on a single real-time workforce dataset available to national, system and local bodies.

Recommendation: All roles must have national standards but decisions on numbers and exact roles can be devolved regionally to be decided in the local context.

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