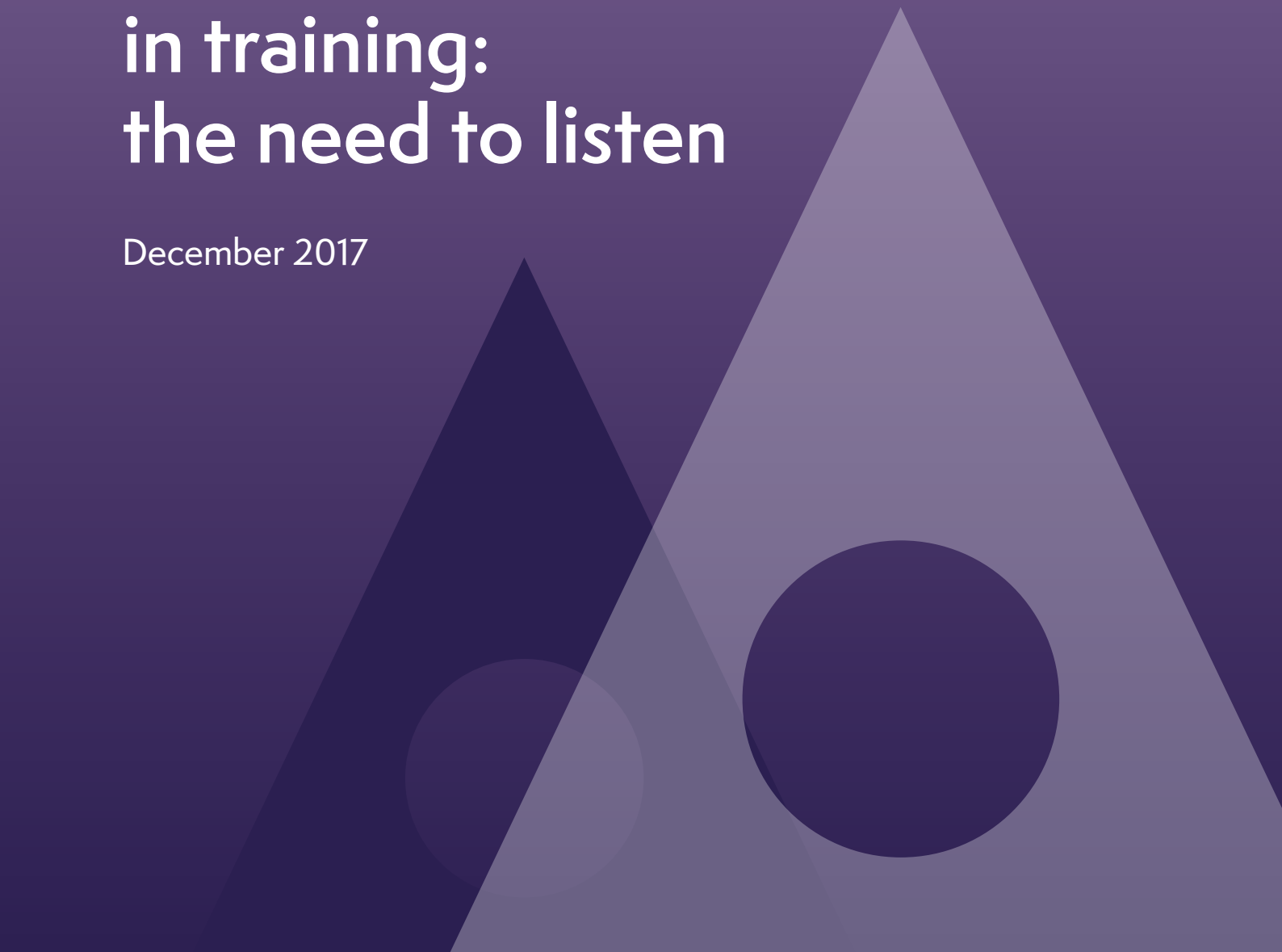
Royal College of Anaesthetists

# A report on the welfare, morale and experiences of anaesthetists in training: the need to listen

December 2017



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# A report on the welfare, morale and experiences of anaesthetists in training: the need to listen

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# About this report

Between December 2016 and January 2017, The Royal College of Anaesthetists (RCoA) conducted a survey of anaesthetists in training, to better understand their experiences of life on the frontline of UK hospital care. Well over half of all anaesthetists in training responded: 2,312 responses represent 58% of all anaesthetists in training across the UK. With over 1,000 free text comments, the survey provides a detailed picture of the issues faced by doctors training as anaesthe tists in today's NHS.

In June 2017 the results of a separate survey focussing on the impact of fatigue on the same group were published (http://bit.ly/2ijb3HJ). This survey was a joint undertaking by the RCoA and the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and achieved a similarly high response rate.

Alongside these surveys and to better understand the results, throughout 2017 the RCoA held a series of Listening Events with anaesthetists in training across the UK. These events explored the emerging themes from the RCoA Survey. The feedback from over 200 anaesthetists in training who attended these events also informs the recommendations in this report, actionable by a range of stakeholders including government, NHS leaders, employers, and professional organisations.

# Contents

# Foreword

The almost 5,000 anaesthetists in training in the UK are a window on the wider NHS.

Anaesthesia is the UK's single largest hospital specialty – 16% of all hospital consultants are anaesthetists – playing a key role in the care of two-thirds of all hospital patients.[1] Anaesthetists are central to the majority of hospital activity, 24 hours a day, seven days a week. Estimates indicate that anaesthetists affect 60% of hospital income but consume just 3% of expenditure.[1,2] This underlines the central role anaesthetists play in facilitating the sustainability of the healthcare system.

In April 2016 doctors in training undertook the first all-out doctors' strike in NHS history, taking five further days strike action until the British Medical Association suspended the action in November 2016. It is against this background that in December 2016 the RCoA survey of morale and welfare was circulated to all UK anaesthetists in training and the findings of this report should be considered in this context.

During this year the RCoA has endeavoured to better understand the results of that survey and the experiences of anaesthetists in training. The resulting report makes uncomfortable reading in places. Many of the issues highlighted will also resonate with consultants and SAS grades in anaesthesia, colleagues in other specialties and indeed all health and care professionals. A number of organisations, including the Royal College of Physicians (http://bit.ly/2iiDiGP), Royal College of Psychiatrists (http://bit.ly/2mVCCbI), and the Royal College of Surgeons of Edinburgh (http://bit.ly/2igMMC6) have also looked at the morale and welfare of their members and this report echoes their findings.

This survey and others suggest that poor morale is driving some doctors to quit the profession. Persistent difficulties in recruiting doctors – including anaesthetists in some parts of the UK – coupled with the challenges of retaining doctors beyond foundation training, emphasise the urgent need to ensure doctors in training continue their careers in the NHS to provide care for patients who desperately need their expertise. This has to be a system wide approach and the recommendations at the end of this report are aimed at all parts of the healthcare sector. Equally, while appreciating the many frustrations resulting from system pressures, comments which glorify bygone days are often unhelpful and can even add to the stress of anaesthetists in training.

Besides the clear clinical and ethical imperative there is also a powerful economic case to improve on the current worrying situation, with the annual cost of NHS staff absences in England estimated at £2.4 billion per annum. Ensuring better support for the health and well being of health care workers is likely to pay significant dividends.[3]

The findings presented here should act as a wakeup call to a wide range of stakeholders and national decision makers particularly from a specialty that has traditionally weathered the trials and tribulations of NHS pressures well. This report presents a moral and financial imperative to safeguard the health and wellbeing of the anaesthetic workforce, supported by a number of recommendations to improve the working lives of anaesthetists in training.

To end on a positive note, I was heartened that neither the survey nor the listening events revealed any regret from a doctor having chosen to specialise in anaesthesia. It is clear that anaesthesia is highly valued for its clinical challenges, team working, application of basic scientific knowledge at every patient encounter and diverse career opportunities.

We need to listen to what our younger colleagues are saying: it is the system in which they are being expected to work and train that is the problem, not the specialty in which they practise.

**Dr Liam Brennan**
President, Royal College of Anaesthetists

@RCoANews

# Summary of recommendations

## For individuals

1 Doctors should reflect on how well they look after themselves and how they support each other.

## For anaesthetic departments

2 Work schedules and rotas need to allow trainees to develop personally and professionally.

## For employing organisations

3 Provide adequate rest and catering facilities for all clinicians during and after on-call periods.

4 Support a cultural shift towards a no-blame learning environment that prioritises the safety of patients and the development of staff.

## For the Royal College of Anaesthetists

5 Undertake regular monitoring of workforce welfare and morale.

6 Consider welfare and morale while rewriting the anaesthetic CCT curriculum and assessment guidance.

7 Collect and report indices of curriculum delivery across the UK.

8 Co-ordinate training with the Faculty of Intensive Care Medicine (FICM), to support the training needs of both specialties.

## For HEE and the devolved nations' health authorities

9 Plan, recruit and retain an adequate anaesthetic workforce.

10 Anaesthetists in training need time to train and trainers need time to provide training.

11 A UK-wide working party should be convened to review the provision of training for those who wish to undertake LTFT training, or require other flexible training patterns.

## For government and senior NHS leadership

12 Department of Health, in coordination with the relevant devolved organisations and arm's-length bodies, should support the development of a national morale and welfare strategy for all NHS staff.

13 Support the expansion of services such as the NHS Practitioner Health Programme across the UK.

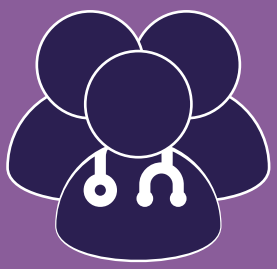
14 Capital funding should be extended to provide adequate facilities for anaesthetists to have a positive working environment.

15 Government should mandate employers to carry out systematic assessments of the working environments of doctors in training.

For the full recommendations, please see page 20.

# 5,000

The number of anaesthetists in training in the UK



# 62%

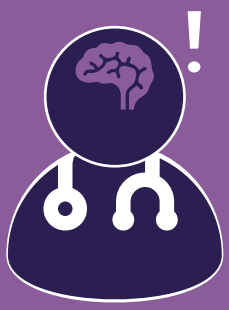
of respondents had worked through a **full shift without a meal**

# Up to 78%

of anaesthetists in training have experienced a **detrimental impact to their health** as a direct result of their employment

# 75%

of respondents had been through a shift **without sufficient hydration**



# 61%

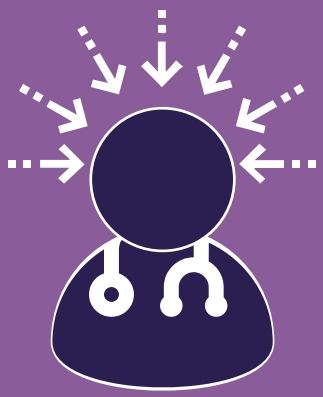
of respondents felt their job negatively affected their mental health

# 95%

of respondents had stayed on after their shift. 26% had stayed more than two hours longer

# 19%

of anaesthetists in training are regularly managing self-reported **excessive levels of stress** associated with their role



# 85%

of anaesthetists in training are at **higher risk of burnout**

The annual cost of **staff absences** in the NHS in England is estimated at

## £2.4 billion per annum

**this represents 2.5% of the entire budget**

Anaesthetists in training are asked to fill rota gaps an average of

## six times each month

Data gathered from December 2016 survey of anaesthetists in training. 2,312 responses received.

# Data collection

## Methods

Between December 2016 and January 2017, the RCoA ran a survey of anaesthetists in training, to understand their experiences of life on the frontline of hospital care. In total 2,312 responses were received, representing 58% of anaesthetists training in the UK. In addition, 742 (32%) of respondents provided 1,025 free text comments, which are also considered in this report.

Respondents were invited to answer 11 questions. Ten of the questions contributed quantitative data, including a question to measure psychological burnout using the Oldenburg Burnout Inventory (OLBI) (https://goo.gl/XU6Hke). Two questions contributed qualitative data by inviting free text comments.

In addition to the survey, two further sources of data inform the conclusions and recommendations of this report. The first is a supplementary survey of fatigue among anaesthetists in training. This was undertaken as a joint initiative between the RCoA and AAGBI and collected data from 2,170 respondents.

The second is qualitative data collected at Listening Events attended by anaesthetists in training across the entire UK.[†] The President of the RCoA, other Members of Council and RCoA staff met with over 200 trainees to hear their views and discuss themes arising from our 2016/2017 trainee survey. Each event allowed time for trainees to suggest what the College might do to improve their working lives directly to the President of the College.

[†]London (twice), Belfast (Northern Ireland), Dunkeld (Scotland), Cardiff and Bangor (Wales), Warwickshire, Wessex, and Newcastle.

RCoA Listening Event held in Cardiff, June 2017

## 2,312 responses
were received, representing 58% of anaesthetists training in the UK

## 742 (32%) of respondents
provided 1,025 free text comments

## Data from 2,170 respondents
was collected from a joint survey undertaken by the RCoA and AAGBI

## Over 200 trainees at eight Listening Events
met with the President of the RCoA

# Key findings

**Risk of burnout** was quantified using the OLBI that assesses exhaustion and disengagement attributable to work. Anaesthetists in training were asked a series of questions to **measure their risk of burnout**:

- 85% of anaesthetists in training who responded to these optional questions had an OLBI score suggestive of a higher risk of burnout.

Anaesthetists in training were asked if they felt their job has **negatively affected their physical health**:

- 64% of respondents indicated that their physical health has suffered and 23% reported that this occurred frequently.

Anaesthetists in training were also asked if they felt their job has **negatively affected their mental health**:

- 61% of respondents felt their job negatively affected their mental health and 21% reported that this occurred frequently.

Anaesthetists in training work shifts which may last as long as – but should not exceed – 13 hours. The survey asked **how common it was to work without adequate nutrition or sufficient hydration**:

- 62% of respondents had worked through a full shift without a meal and 16% reported that this was a frequent occurrence.
- 75% had been through a shift without sufficient hydration and 33% reported this was a frequent occurrence.

Anaesthetists in training were asked how often, and for how long they **stayed at work beyond the end of a rostered shift**. The data collected revealed that, in the preceding month:

- 95% of respondents had stayed on after their shift; 26% had stayed more than two hours longer.

Data on **rota gaps** was analysed by location and by the amount of notice given:

- anaesthetists in training are asked to fill rota gaps in their employing hospital an average of six times each month
- on average respondents received three requests a month to cover a service gap in a local hospital (which was not their employing hospital) at less than 48 hours' notice. Such requests doubled to six times a month when more than 48 hours' notice was provided.

The persistent **late provision of rotas** (below the minimum eight weeks outlined in the 2016 Code of Practice document[4]) was a major issue. In some cases work/life balance was so poor that it resulted in physical and mental health problems, with some taking time out of training to redress the balance, and others resigning from training:

- 19% of anaesthetists in training are regularly managing self-reported excessive levels of stress associated with their role.

Anaesthetists in training reported that **patient safety was safeguarded above all else** by the work ethic of staff, even to their personal detriment. However, when questioned about **factors that might impact patient safety**, three major issues emerged:

- lack of available hospital beds
- staff morale – of all grades and disciplines
- rota gaps.

Anaesthetic departments overwhelmingly were considered welcoming and friendly, where trainees feel valued and supported. Supervising consultants in anaesthesia were seen to be accessible. The supportive role of senior trainees – including opportunities for teaching more junior colleagues – was noted as a mutually beneficial cultural feature that fostered effective team working within the specialty.

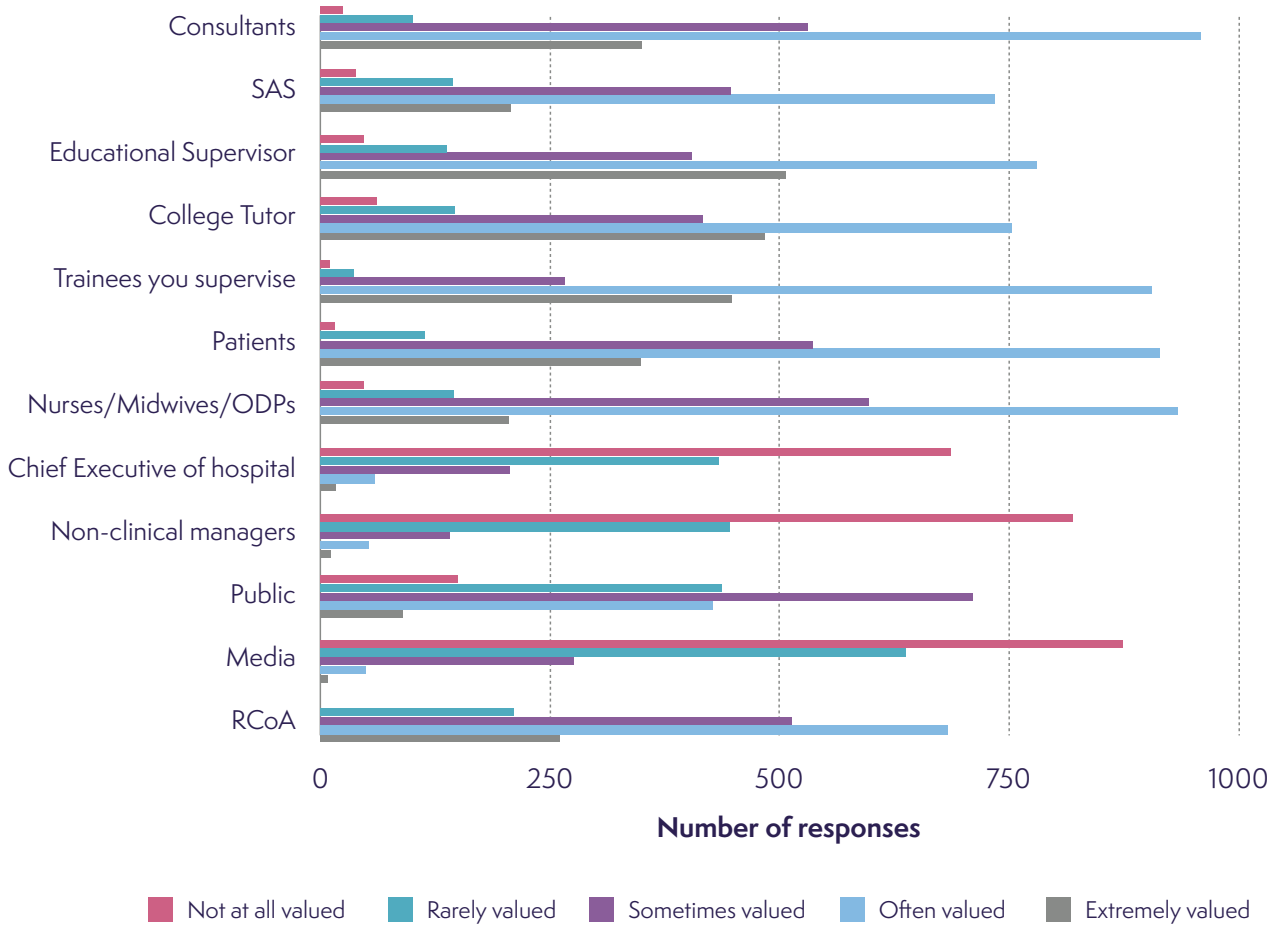
However, the issue of **support from senior colleagues** did prompt some concerns from a minority of anaesthetists in training:

- 160 respondents experienced difficulty accessing supervising consultant advice which had a 'serious' or 'extremely serious' negative impact on them.

Anaesthetists in training were asked **how valued they felt** by a number of organisations, including the RCoA:

- only 4% of respondents said that they felt valued by the Chief Executive of their hospital
- nearly half of respondents (48%) said that they felt 'extremely' or 'often' valued by the RCoA. There were 14% of respondents who said that they felt 'rarely' valued by the RCoA.

## How valued do you feel by...



Respondents perceived the RCoA's lack of power to counter the systemic NHS pressures trainees experienced at work and felt they could do more to safeguard the workforce. However, comments also praised and thanked the College for trying to understand the views of its trainees, as well as for releasing supportive statements during the junior doctors' contract dispute.

## Fatigue survey

In June 2017 the results of a separate survey – conducted jointly by the RCoA and AAGBI – concerning the **impact of fatigue among anaesthetists in training** were published in the journal *Anaesthesia*.[5] The results of this survey revealed that:

- 75% of respondents drive to work and 60% have a commute of 30 minutes or more
- 84% of respondents have felt too tired to drive home after a night shift
- 57% of respondents have had an accident or a near miss during their commute to or from work
- only 36% of respondents have access to rest facilities and just 18% get 30 minutes or more uninterrupted rest.

There are examples of hospitals which offer dedicated rest facilities for anaesthetists in training and SAS grades/ consultants that can be booked for those undertaking on-call. However, the results show that the majority of anaesthetists in training do not have access to dedicated facilities. There are also examples of hospitals which charge staff for the use of overnight rest facilities,[‡] however, there is no clear picture of the scale of this practice.

57%

of respondents have **had an accident or a near miss** during their commute to or from work

Only 36%

of respondents have access to **rest facilities** and just **18% get 30 minutes or more** uninterrupted rest

84%

of respondents have felt **too tired to drive home** after a night shift

[‡]While this information is in the public domain we have chosen to remove reference to the name of the trust as the example is indicative of the practice of charging – not the practice of just this particular trust. The reference for the figure is available here: http://bit.ly/2mQuqcH and the description is here: http://bit.ly/2mROiMt. The information was accessed at 16.58 on 6 September 2017.

# Emerging themes

The surveys and Listening Events raised a number of emerging themes, reflected in this section.

## System pressures

System pressures were seen to negatively impact efficiency and productivity at work, and resulted in additional personal stress. For example, lack of beds and facilities leads to cases being cancelled but also to loss of training opportunities and frustration, due to the inability to provide excellent care. Clinical teams can feel powerless against managerial decisions relating to patient care but all too often retain responsibility for delivering apologies to patients for systemic failings.

> *"I took a break because I felt useless, working in a failing system despite my best efforts, I felt a part of that failure. Nothing I did was good enough. Things got worse, not better. This affected my ability to do my job, to feel good at it... so I took a break to try and restore my self-esteem."*
>
> **Post-FRCA Specialty Registrar**

Some respondents noted that system pressures caused them to be asked to cover non-anaesthetic specialties, such as emergency medicine and acute medicine, despite having no formal training in either.[6] Moreover anaesthetists are frequently asked to support colleagues in other specialties in performing basic technical skills, such as venous cannulation, which adds considerably to their workload. Workload intensity was noted to have increased significantly in recent years, resulting in fewer rest breaks, and longer time taken to fully recover after shifts. For the majority of respondents, service provision frequently outweighed training opportunities.

## Examinations

Professional examinations were reported to be particularly stressful, perceived to be difficult in comparison to other specialty exams, but also felt to not always be relevant to contemporary clinical practice.

> *"The exam seems to be a test of ability to remember obscure pieces of information rather than the ability to give a safe anaesthetic. Trying to study for an exam, work nights and weekends, miss out on life events and pay £320 a time for the pleasure is seriously getting me down. I have never felt as stupid and as worthless as I do now."*
>
> **Anaesthetist in Core Training**

The significant commitment required to pass the exams was a factor in eroding trainees' work-life balance. Some felt that the necessary investment of personal time was excessive. Anaesthetists in training who struggled with exams, felt there was inadequate support from their Schools and the College, resulting in repeated unsuccessful attempts and increasing demotivation.

The recent extension of the deadline for achieving the Final FRCA to the middle of ST5 was largely seen as positive. However, some trainees felt pressurised to sit exams when inadequately prepared. The cost of exams and associated revision courses was felt to be prohibitive by some.

## Assessment requirements

While the curriculum structure was perceived as clear, the assessments required were felt by some to be excessive and in some cases counterproductive. Some commented that workplace based assessments were 'tick-box' exercises, rather than meaningful learning tools, and the volume of evaluation created a feeling of 'constantly being assessed'. Many respondents reported a poor understanding of the requirements and difficulty getting assessments approved by trainers.

> *"There should be more diverse opportunities for research, education, and stimulating discussions that encourage trainees to take up projects which are based on genuine clinical need and are widely beneficial. This would (help) prevent the current box-ticking mentality (eg closing the loop of an audit, just for the sake of it)."*
>
> **Anaesthetist in Training**

The increased assessment burden for dual training with intensive care medicine (ICM) was repeatedly cited as difficult to manage.

The anaesthesia training e-Portfolio was reported by some as being unfit for purpose. Similarly, the logbook was felt to add a significant additional workload for only of minimal educational value.

Large regional variations in the conduct of Annual Review of Competence Progression (ARCP) were noted. Those ARCPs reported as being of generally poor educational and developmental value, were also described as feeling adversarial, with limited opportunity for reciprocal feedback on the quality and experience of training.

Some respondents reported adverse outcomes at ARCP relating to a lack of protected training time, particularly with short rotations during intermediate/advanced modules.

## Training

A common theme was the perception of a loss of control and a feeling that trainees were not equal partners in deciding their learning needs, many citing their lack of say over the location of hospital rotations to meet their training needs. Many anaesthetists in training responding to the welfare and morale survey noted the detrimental impact of long commutes and consequent difficulties to:

- engage fully with training opportunities
- complete non-clinical training elements such as preparation for exams
- engage with quality improvement activity, audit and teaching
- achieve a positive work-life balance.

Three-month and six-month rotations were felt to be too short, and resulted in trainees feeling unsettled professionally and personally.

> *"It is awful being shipped around between hospitals every three to six months. Yes we get three months' notice, but it's still awful. By the time you've made connections and settled in, you are off again."*
>
> **Post-FRCA Specialty Registrar**

Anaesthetists in training reported 'overwhelming' pressure to undertake the range of non-clinical activities required by the curriculum, such as: quality improvement/audit activity, delivering teaching events and seeking leadership and management opportunities. Respondents noted that these supporting professional activities (SPA) type requirements were almost exclusively carried out in their personal time.

It was appreciated by many anaesthetists in training that clinical supervisors frequently cover service commitments to allow access to training opportunities. The ready availability of advice, guidance and support from supervisors was considered to be notably better than for colleagues in many other specialities.

Initiatives such as allowing anaesthetists in training to undertake solo lists with the oversight of a dedicated supervising consultant were praised for allowing anaesthetists in training to develop autonomy within a safe, supportive working environment.

The true cost of training (professional subscriptions, exams and mandatory courses) was felt to be unrecognised, opaque, prohibitive and inadequately compensated by study leave budgets. Anaesthetists in training generally reported high levels of student debt and noted the impact of the on going pay freeze with respect to inflation. These concerns were often coupled with problems associated with payroll – particularly after moving to a new rotation.

> *"The uncertainty of not knowing what my salary is going to be next year (ST4) despite already being in a training post is very stressful. Financial planning in this context with a new-born, stay at home mum and a mortgage is very difficult. You wouldn't have a lawyer/architect/accountant accepting a job without knowing how much they were going to earn."*
>
> **Pre-FRCA Specialty Registrar**

## Accommodating diversity and flexible working patterns

Existing structures appear to favour development of a 'standardised' trainee without reflecting the breadth of interests, skills and aptitude of the people in training. This 'standardisation' meant that the training and personal needs of doctors who were less than fulltime (LTFT) were not always appropriately accommodated. One respondent to the welfare and morale survey also noted the difficulties in balancing family and work commitments:

> *"I am female with a young family – I don't have time to publish articles, set up teaching programmes, and all the other extra-curricular activities that add points to my portfolio. This is the first time that I feel my gender and family has actively counted against me, and I am angry, and disappointed, and frustrated and grieving the loss of my career plans."*
>
> **Pre-FRCA Specialty Registrar**

In general, the opportunity to work LTFT was seen to be positive in maintaining motivation and engagement at work, with an acceptable work-life balance. Anaesthesia was seen to have embraced LTFT. However, while it conveys lifestyle advantages, the proportional loss of earnings makes it unattractive to some anaesthetists in training.

Anaesthetists in training noted that the best Deaneries were those which had comprehensive policies for returning to work, LTFT training and maternity leave. While this also applies elsewhere, programmes which facilitate 'senior trainees' to support those who are new to an area were also praised by LTFT respondents. By contrast, those Deaneries which were inflexible or unresponsive to the specific needs of LTFT training, or issues relating to maternity or study leave, were criticised.

There were some reports of perceived misogyny, bullying and discrimination among the comments Analysed. This behaviour is always unacceptable and we support the pan-specialty campaign to #knockitout (http://bit.ly/RCoA-KnockItOut).

## Facilities

The survey revealed widespread dissatisfaction with the facilities available to anaesthetists in training. There are inadequate rest facilities for breaks during overnight working, and also for resting before commuting. This raises concerns about people's ability to drive home safely.

Food and drink facilities were severely restricted, out of hours, which particularly penalises acute specialties such as anaesthesia. Breaks are increasingly pressured, resulting in 're-fuelling' in the anaesthetic room rather than taking contractual rest breaks. Other members of the surgical team and managerial staff could be unsympathetic to anaesthetists' need for breaks. The attitude of non-clinical staff towards the need to take adequate rest was a major frustration for many.

Many trainees reported having no access to a secure locker, or even a safe space for belongings, which contributed to a feeling of being undervalued and insecure.

> *"It's the little things at work which impact on morale: lack of lockers, clothes getting stolen from the 12 changing rooms, lack of on-call rooms and having to rest on the floor or uncomfortable chairs."*
>
> **Post-FRCA Specialty Registrar**

## Impact of the junior doctors' contract dispute

The junior doctor contract dispute in England provided a negative backdrop to the survey, with anaesthetists in training commonly reporting they feel 'blamed', 'undermined' and 'undervalued'. This was compounded by a perceived negative portrayal in the media. Many trainees took this personally and described negative feelings of self-worth and professional value and identity. This extended to reports of a significant distrust in non-clinical NHS leadership.

The new contract provides a mechanism for 'exception reporting,' which has the potential to give doctors the power to drive change and improve working conditions. Under schedule 5 of the Terms and Conditions of Service for Doctors and Dentists in Training (England) 2016,[7] junior doctors may now file exception reports about excessive hours or inability to take rest breaks. The new Guardians of Safe Working Hours (GoSWHs)[8] will play a vital role in ensuring that issues regarding workload, rostered hours and associated fatigue are either resolved or appropriately escalated to the Trust Board – to which the GoSWHs are accountable.

Engagement with this process could have a positive effect on both the welfare and morale –and the working conditions – of anaesthetists in training but this will require buy-in from across the whole secondary care system. Those who supervise anaesthetists in training have a responsibility to promote a culture where safeguards are utilised fully.

> *"It has become clear over the past few years that at a management and government level, there is a tragic devaluation of doctors. This is most overt at the trainee level where morale is at rock bottom."*
>
> **Post FRCA Specialty Registrar**

## Low morale

The high response rate to the respective surveys on welfare and morale and fatigue, coupled with the engagement at the Listening Events, signals the strength of feeling regarding these issues. The detailed free text responses and the open and candid discussion at the Listening Events indicate a potential breakdown in the relationship between government, NHS leadership and doctors. Poor relationships exist between anaesthetists in training and hospital management: only 4% of respondents said they felt 'extremely' or 'often' valued by their Chief Executive.

It is clear that the relentless nature of the junior doctors' dispute, conducted with intense media scrutiny, left some anaesthetists in training feeling exhausted and despondent. There is no quick fix to mend relationships, however; it is for all parties involved to move forward and seek solutions to the problems identified.

Overworked doctors, demoralised staff and under-resourced hospitals were cited in the Francis Report following the Mid Staffordshire NHS Foundation Trust Public Inquiry in 2013.[9] It is worrying that these themes are still apparent in our survey and Listening Events nearly five years later.

The impacts of low levels of staffing on doctors' morale and on access to high quality hospital care are indivisible. In its *The State of Care in NHS Acute Hospitals* report, the Care Quality Commission (CQC) noted that inadequate staffing numbers and lack of skilled staff continued to pose a risk to patient safety.[10] The House of Commons Public Accounts Committee estimate that the NHS is short of at least 50,000 staff.[11]

It is clear that no single factor is to blame for what can be described as a deep-rooted and endemic morale problem. For example, one question surveyed the degree to which 20 different factors contribute to respondents' poor morale. All but one factor was selected by at least 10% of respondents as negatively affecting morale 'a great deal'.

| Themes contributing to low morale | Number of comments containing theme |
|---|---|
| Workplace culture | 315 |
| Training | 260 |
| Work/life balance | 211 |
| Assessment burden | 209 |
| System pressures | 179 |
| Politics | 123 |
| Exams | 94 |
| Junior doctor contract | 74 |
| Finance | 70 |
| Rota gaps | 66 |

# Summary

The report provides a number of recommendations for a range of stakeholders and decision makers, but one recommendation is overarching and should be heeded by all: 'listen'.

Policy makers and senior NHS leaders need to listen to staff and engage with clinicians, in order to work with them to manage the current service pressures and financial realities of today's NHS. Professional organisations, including the Medical Royal Colleges, need to improve the co-development of resources, standards and curricula, listening to the perspectives of all members, many of whom have an increasingly 'non-standard' working pattern and aspire to a portfolio career.

Finally, individual doctors need to listen to colleagues and be open and honest in their conversations.

# Recommendations

## For individuals

### Recommendation 1

### Doctors should reflect on how well they look after themselves and how they support each other

Embedding a culture of care for staff is crucial in the day-to-day wellbeing of healthcare professionals. Traditional 'heroic' models of working relentless hours, and unbounded selflessness, exchanges short-term altruism for long-term risk of burnout and adverse consequences for physical and mental health. Doctors are well aware of the importance of their patients living a healthy lifestyle: exercise, healthy eating, sleep hygiene and fatigue awareness. However, they can be notoriously poor at recognising their own needs or, if they do, can be powerless to take back control within the current system. It needs to be remembered that doctors are vulnerable to the same mental and physical ill health as the rest of the population, and are more at risk of conditions such as burnout and addiction.[12] The high rate of anaesthetists in training reporting deterioration in their physical and mental health underlines the issue. Everyone should familiarise themselves with the AAGBI's and RCoA's fatigue education resources, to ensure that they maintain their own welfare and the safety of their patients (www.aagbi.org/professionals/wellbeing/fatigue).

We must encourage a listening culture, in which all colleagues enter into a dialogue, for example, where senior members of the specialty get to know more about the lifestyle issues of younger members. This should be part of every day interaction between the generations and not just in set piece events and meetings.

Interpersonal networks and their support structures are changing and the practice of medicine and anaesthesia in 2017 is very different to even a decade ago. Current anaesthetists in training have worked their professional lives without early exposure to the ready-made support networks of the hospital residence, the doctors' mess and the clinical firm. Support networks take longer to grow and more frequent rotations can impede their development.

#### Good practice example

Schwartz rounds (http://bit.ly/2zqvtpD) provide an open forum for all staff to come together to discuss the social and emotional aspects involved in working in healthcare. This can help to breakdown negative hierarchies, improve communication between clinical and non-clinical colleagues, and reduce the sense of stress and isolation that can result from acute and high intensity clinical work. There is evidence to show that Schwartz rounds reduce stress and improve communication for participating staff, make staff more confident in caring for both the physical and emotional needs of their patients, and contribute to an open organisational culture where compassionate care is valued and championed.

### Good practice example

Colleagues in Wessex run Culture of Care workshops to give protected space to doctors to talk and listen.[13,14] These initiatives help to embed a culture of care for staff, which is crucial in the day-to-day wellbeing of healthcare professionals.

## For anaesthetic departments

### Recommendation 2

### Work schedules and rotas need to allow trainees to develop personally and professionally

Becoming a lifelong professional learner requires particular skills which must be nurtured and developed during training. The individual and the educational supervisor need to ensure that there is capacity within an individual's pattern of work for this to occur. There is emerging evidence that ergonomic rostering could provide a solution to some of the negative results of on-going shift work.[15]

**Recommendation 2a: Rotas should be designed collaboratively with all participants**

Ensuring that all team members within a department receive timely access to their work schedule/rota is an important component in improving professional and personal lives. Autonomy is of paramount importance to maintain a sense of control. A healthy work-life balance reduces the risk of burnout but is hindered by poorly designed and administered rotas. This must be a central tenet in any comprehensive plan to improve the wellbeing of anaesthetists in training.

### Good practice example

The RCoA Scottish Board, in partnership with Scottish Government, has developed a supportive improvement tool to promote safe and healthy working patterns. This initiative, the Professional Compliance Analysis Tool (PCAT) is currently being used to analyse and improve all anaesthetic rotas in Scotland (see also Recommendation 15).

**Recommendation 2b: Consider allocation of SPA time for anaesthetists in training**

Allocating a period of time for SPA to anaesthetists in training (analogous to the approach established for more senior colleagues) has been tested in pilots in Oxford, the North West and Southampton. This initiative has been well received by all those involved and has been seen as embedding professional behaviours at an early stage of doctors' careers.

# For employing organisations

## Recommendation 3

### All employers should provide adequate rest and catering facilities for all clinicians working during and after on-call periods

The effects of fatigue on doctors of all grades are a threat to patient safety[16] and demand action to address the lack of rest facilities – particularly for clinicians working in the most acute specialities. Furthermore, poor facilities – or their total absence – impacts on how valued health professionals feel by employers and the wider NHS (see also Recommendation 14).

## Recommendation 4

### All employers should support a cultural shift towards a no-blame learning environment that prioritises the safety of patients and the development of staff

There should be structured and meaningful feedback from reported adverse incidents, to ensure that these are used for learning and improvement. The outcomes from investigations into reported adverse incidents should be communicated promptly to mitigate any associated anxiety for all involved.

### Good practice example

The Safe Anaesthesia Liaison Group (SALG) (www.rcoa.ac.uk/salg) was set up by RCoA, AAGBI and NHS bodies to review anaesthesia-specific adverse incidents. SALG also evaluates anaesthetic safety reports for further investigation through research or audit, and for dissemination to the wider anaesthesia community via quarterly reports and its network of over 800 patient safety leads. Hospitals should work with the patient safety leads to address incidents in a safe environment.

**Recommendation 4a: Methods for excellence reporting should be implemented to support a positive workplace culture**

### Good practice example

Learning from Excellence[17] and GREATix[18] are locally-developed initiatives which are gaining national recognition. They are based on learning from episodes of peer-reported excellence. Both initiatives have reported significant improvements in staff morale and patient experience across all professions and a positive cultural shift. Learning from excellence is equally as valuable as reflecting on failure.

# For the Royal College of Anaesthetists

## Recommendation 5

### The RCoA should undertake regular monitoring of workforce welfare and morale

The RCoA should continue to monitor the morale and welfare of anaesthetists in training and look at extending this to all grades. The scope should be widened to capture issues relating to fatigue – identified in the separate RCoA/AAGBI survey – in a single monitoring tool.

**Recommendation 5a: The RCoA should incorporate UK-wide Listening Events, attended by senior College officials, into its rolling events programme**

### Good practice example

At the Listening Events, networking with colleagues was valued and represented an excellent opportunity to disseminate good practice between departments and Schools. The opportunity for anaesthetists in training to share their thoughts with the President, Council members, senior staff of the College and partner organisations, at the events run in 2017, has been welcomed and should not be a unique exercise.

## Recommendation 6

### The RCoA must consider welfare and morale while rewriting the anaesthetic CCT curriculum and assessment guidance

In 2015 the College attempted to overhaul its workplace based assessment (WPBA) guidance and move away from summative to formative WPBAs, involving feedback. However, the College acknowledges that this message has had limited success in reaching trainers and anaesthetists in training, with respondents reporting ongoing summative WPBAs.

The curriculum rewrite should be taken as an opportunity for the RCoA and General Medical Council (GMC) to revisit this and other training-related issues raised in this report.

**Recommendation 6a: The College must ensure that the curriculum is structured to drive meaningful formative workplace based assessment**

## Recommendation 7

## The RCoA should collect and report indices of curriculum delivery across the UK

There is variation in the implementation of the curriculum, as well as in the trainee-perceived quality of both training and the training environment.

Collection and reporting of indices of training quality can be used to promote continuous improvement as per the GMC's *Promoting excellence: standards for medical education and training* (http://bit.ly/2ik46GB) expectations of bodies involved in postgraduate education.

**Recommendation 7a: Schools should be encouraged to review the requirements set for ARCP sign-off**

Whilst it is an established facet of medical culture to strive for excellence, doctors are clearly being encouraged to undertake a considerable amount of additional non-clinical work, some of which is beyond curricular requirements.

There should be a focus on areas that are relevant to requirements of training and add value both to the individual undertaking the work and the wider NHS. Work that is deemed necessary should be quantified and accommodated whenever possible within working timetables.

## Recommendation 8

## The RCoA should co-ordinate training with the Faculty of Intensive Care Medicine (FICM), to support the training needs of both specialties

Supporting the dedicated ICM workforce to become self-sufficient would significantly reduce the over-reliance of hospitals on anaesthetists in training, outside of their ICM training modules, for ICM service delivery. The RCoA should also work closely with FICM in its drive to increase the medical workforce available for ICM, which is a key recommendation from its recent report, *Critical Futures*.[19] However, this expansion must not be at the expense of the anaesthetic workforce.[20]

**Recommendation 8a: The RCoA and FICM should work with Health Education England (HEE) to develop a single recruitment process to dual training in anaesthesia and ICM**

The RCoA should work with FICM to remove the current limitations of the central recruitment database with HEE. All parties should recognise that, while retaining plurality of access to respective training programmes, it would be a great step forward to be able to recruit to both parts of the dual programme in a single year.

# For HEE and the devolved nations' health authorities

## Recommendation 9

## Plan, recruit and retain an adequate anaesthetic workforce

Anaesthetists in training reported significant and frequent pressure to fill gaps in rotas. This adds to workload and may lead to them missing training opportunities.

**Recommendation 9a: There should be an increase in core training (CT1) posts to increase the numbers eligible for ST3 appointment**

In 2017 the national fill rate for anaesthetics at CT1 was 98.17%[21] (down from 99.34% in 2016) and at ST3 grade the fill rate 86.18%, down from 89.04% in 2016. However, since 2015 the fill rate at ST3 has fallen by more than 7.5%, which suggests a more concerning trend.[20] These UK-wide figures hide the significant geographic variation in fill rates, which has proven a persistent issue in many areas (data obtained from the Anaesthetics National Recruitment Office at: https://anro.wm.hee.nhs.uk/).

**Recommendation 9b: HEE should work with Royal Colleges in reviewing the attrition rate of doctors in training at various stages of their careers**

Trainees in recent years are less likely to progress seamlessly from foundation through to the end of specialty training. Action is needed to ensure recruitment numbers are appropriately adjusted and maintained. Reasons for attrition should be explored, and more support is needed in regions with difficulties in specialist training recruitment.

### Good practice example

The RCoA is working in collaboration with HEE on events in those regions with lower ST3 recruitment. These round table discussions, with employers, anaesthetists in training and regional specialty leaders, are looking for local and national solutions to the recruitment shortfall.

## Recommendation 10

## Anaesthetists in training need time to train and trainers need time to provide training

The increasing service pressures on hospitals can leave service and training unbalanced. There needs to be central direction from HEE and the devolved nations' health authorities to reverse this worrying trend. Trainers need respect, reward and time for educational supervision (see *Promoting excellence: standards for medical education and training* http://bit.ly/2ik46GB). This includes time away from their clinical duties for recruitment and ARCPs so that they can be conducted thoroughly in an unrushed environment.

**Recommendation 10a: ARCPs should have adequate time for formative discussion and be adequately, resourced. HEE should work with the RCoA to evaluate whether the standardisation of ARCP requirements would reduce regional variation (see Recommendation 7)**

## Recommendation 11

### A UK-wide working party should be convened to review the provision of training for those who wish to undertake LTFT training, or require other flexible training patterns

Our survey and Listening Events found that there are significant challenges faced by those who train less than full time. It does not necessarily equate to more flexible training and should not be considered a 'solution' for burnout or poor morale.

### Good practice example

We are encouraged by the GMC[22] and HEE[23] work-streams to improve flexibility in training and recommend further work across the health service to improve the working lives of this cohort.

**Recommendation 11a: The Department of Health and devolved administrations should work with employers and professional bodies, including Medical Royal Colleges, to ensure that LTFT working patterns do not restrict career choices**

**Recommendation 11b: Equal consideration must be given to other doctors in training who wish to work full time but require flexible arrangements, to suit personal circumstances**

# For government and senior NHS leadership

## Recommendation 12

### The Department of Health, in coordination with the relevant devolved organisations and arm's-length bodies, should support the development of a national morale and welfare strategy for all NHS staff

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. In England, we recommend the National Quality Board as the most appropriate body to progress these issues.

**Recommendation 12a: The impact of a Commissioning for Quality and Innovation (CQUIN) incentive should be closely monitored as a tool for driving behavioural change**

More action on NHS staff health and wellbeing is noted as a priority in NHS England's *Next Steps on The Five Year Forward View* document.[24] This includes recognition of the need to address staff welfare through a package of measures, including the use of the CQUIN incentive payments.

## Recommendation 13

### Support the expansion of services such as the NHS Practitioner Health Programme across the UK

The Practitioner Health Programme (PHP)[25] is a confidential NHS treatment service for doctors and dentists. At present the PHP accepts self-referrals from all doctors and dentists living in London but there is limited access to the service outside the capital.

Expansion of services such as PHP to cover the entire UK, will enable more NHS health professionals to access the expert support required when they are experiencing deteriorating physical and mental health.

## Recommendation 14

### Capital funding should be extended to provide adequate facilities for anaesthetists to have a positive working environment

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

#### Good practice example

University Hospitals Coventry provides excellent rest facilities and working environments for anaesthetic staff of all grades. These include:

- on-call rooms with en-suite facilities for staff of all grades
- generous communal/computer office space
- a large coffee room with fully equipped kitchen
- private rooms for confidential meetings.

## Recommendation 15

### Government should mandate employers to carry out systematic assessments of the working environments of doctors in training

#### Good practice example

The Scottish Government's Health Workforce Directorate is supporting Health Boards to systematically improve working lives of doctors in training using the Professional Compliance Analysis Tool (PCAT) process. PCAT is a quality improvement framework focussing on the employing hospital's capability to ensure patient safety, high quality training and to value trainees, physical and mental wellbeing.

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