29 April 2019

Royal College of Anaesthetists

Royal College of Anaesthetists' response to the NHS Confederation consultation: *Defining the role of integrated care systems in workforce development*

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 22,500 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 Elena Fabbrani at efabbrani@rcoa.ac.uk or by phone on 020 7092 1694**.**

General comments and key recommendations

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

Through perioperative medicine programmes, anaesthesia plays a prominent role in the delivery of care to patients from the point of deciding on surgery through to recovery. It is well-staffed, well-functioning and integrated Multi-Disciplinary Teams that provide safe and effective patient care. Anaesthetists work in partnership with a host of medical, nursing and allied health professionals, including Physician Assistants (Anaesthesia), to augment effective service delivery.

We therefore welcome strategies that will allow local organisations to make decisions on workforce that support the development of perioperative care pathways in hospitals.

As the focus of Integrated Care Systems (ICSs) and Sustainability and Transformation Partnerships shifts naturally to population health, increased responsibility for ICSs in local workforce decisions seems a logical evolution to ensure that the services they provide reflect the regional demographics and meet the needs of local populations.

However devolvement of workforce decisions to ICSs must happen in a considered and co-ordinated manner and we make the following recommendations:

- There should be mechanisms, oversight and accountability to ensure that the workforce plans of ICSs align to national workforce plans and policy. While it is sensible that ICSs should have more control over aspects of recruitment locally, a centralised, co-ordinated approach to workforce planning at national level remains essential, in particular to ensure a steady increase in the number of trainees for the benefit of all ICSs and regions so that they can secure adequate staffing levels long term.

- ICS leaders should maintain strong links with Medical Royal Colleges to ensure uniform standards for recruitment and training across all regions are maintained throughout the change in processes required to move to integrated systems.

- Amongst the type of data that ICSs will need to use and collect to make informed decisions on local recruitment, data on the experience and outcomes of patients going through secondary care should be collected to make the case and demonstrate the benefits of perioperative care pathways, which reduce postoperative complications and promote adoption of healthier lifestyles. Recruitment decisions should include consideration of the staffing levels and skills required to support perioperative care pathways.

Feedback on consultation questions:

- ***Do you agree with the proposed role and responsibilities of local systems for workforce development as set out in the consultation?***

As per comments in the introduction, we agree that there is scope for ICSs to have more control over how they recruit locally and make decisions around workforce, including autonomy over how they choose to spend their allocated funds. However this needs to be supported by national-level leadership through an agreed framework to ensure a co-ordinated approach to workforce planning, as currently there is a considerable amount of regional variation in the recruitment of consultants which needs to be first addressed at a national level.

Our 2018 recruitment survey of our National Clinical Director Network [vi] shows an average 7% gap in consultant numbers across the UK (up from 4.4% in 2015). However, behind that figure there was significant regional variation. East Midlands had a 4.6% gap, whereas the South West had an 8.5% gap and the East of England had an 11.6% gap. There are also significant variations for individual specialties. Kent and the East Midlands have experience considerable difficulty in recruiting intensivists whereas the Thames Valley doesn't seem to have this problem. Similarly there's variation with SAS doctor recruitment. In Scotland the SAS gap is just 8%, but in the North West, South West, East Midlands and East of England the SAS gap exceeds 23%.

Devolving all decisions and control over to ICSs may in fact worsen the issue of regional variation and lead to swings in recruitment patterns across different regions and systems as they try to address local shortages in isolation.

Long term, the only way to ensure adequate levels of the consultant workforce is to increase the number of training places. However, given the finite nature of funding for training places,

local recruitment decisions on trainee numbers by one ICS might also have a negative impact on other ICSs and make it harder for them to recruit trainees.

In addition, devolvement of recruitment decisions to ICS should not be at the expense of quality in training programmes and recruitment standards as set by Colleges and Faculties. National standards of training and recruitment will ensure that doctors wishing to move between ICSs will be able to do so and their roles will be transferrable across systems and providers.

The Medical Royal Colleges, through their networks of Regional Advisers and College Tutors, can provide a wealth of support and knowledge in the development of local strategies for training and recruitment in adherence with long established national standards and guidelines. ICSs should consult with relevant regional college representatives to ensure that agreed guidelines are included in local decision processes.

- ***What further activities or responsibilities, if any, would you recommend an ICS has future control over, specifically in relation to workforce?***

We welcome the focus in the consultation document for ICSs in trying to attract students from different backgrounds to a career in health and social care

We are aware that many medical schools use the UKCAT score to make the selection of candidates for interview. This is thought to work against applicants from local, more deprived communities.

An example of responsibility and good practice used locally to help attract local applicants is the 'Access to Birmingham'[vii] (A2B) scheme run by the University of Birmingham. The A2B programme supports applicants to the University of Birmingham, who have little or no experience of higher education, discover what studying at university involves.

For recruitment to non-medical roles, we would also suggest that NHS employers should be more active in the use of the apprenticeship levy locally at system level.

In addition we propose that NHS Confederation looks at the following areas in terms of the role and responsibilities of ICSs in managing workforce locally:

Maintaining standards in recruitment and training

As stated in the introduction, devolvement of recruitment decisions to ICS should not be at the expense of quality in training programmes and recruitment standards as set by Colleges and Faculties. Adherence to national standards of training and recruitment will also ensure that doctors wishing to move between ICSs will be able to do so and their roles will be transferrable across systems and providers.

For example, the requirement for an external professional assessor, appointed after consultation with the relevant college or Faculty, should remain an essential element of the recruitment process of doctors. Through representation on Advisory Appointment Committees (AACs) the RCoA seeks to help employing authorities to attract the best available candidates and to ensure high quality posts. We are concerned that Foundation Trusts are currently exempt from the requirement to arrange for College representation on AACs and we would strongly urge ICS leaders to look at how such representation is consistently safeguarded, and where necessary introduced, across their systems and STPs.

Retention of experienced staff

There is a developing issue caused by the age profile of the current consultant anaesthetist workforce, which compounds the recruitment challenges faced today.

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 consultant population[viii]. (see table 1). The age profile of SAS anaesthetists mirrors that of the consultants. We know that experienced anaesthetists have a wealth of clinical and non-clinical experience that will be vital to the development of the future of the specialty. Across all grades, 46% of respondents to the RCoA's 2016 member survey noted involvement in education, and 35% in training, as part of their non-clinical activity[ix].

However, nowadays there is much greater awareness across all age groups of the published evidence on the effects of ageing, and doctors increasingly value their life-work balance.

Secondly, with the recently introduced contractual changes, consultants starting in post today will be expected to work until they are at least 68 years old, which may demand even greater adjustments in rotas and shift work to accommodate the later part of their career.

Table 1: Age distribution of consultants *(RCoA Medical Workforce Census 2015[x])*

Age (yrs)	England	Northern Ireland	Scotland	Wales
<30	1	0	0	0
30–34	116	4	25	10
35–39	878	58	128	71
40–44	1280	45	149	69
45–49	1289	42	157	100
50–54	1055	40	151	81
55–59	662	28	100	47
60–64	257	7	24	15
65–69	39	0	2	4
70 or over	3	0	0	1

Furthermore, there is evidence that there is a proportion of consultants, SAS doctors and other career grades (2.7%) have retired and returned to work[xi] so this will need to be taken into account when introducing new models of workforce planning and projections.

The above trends will be compounded by the fact that more than half (54%) of all doctors in training (i.e. not just anaesthetists in training) do not progress directly from the second year of the Foundation programme (F2) into a specialty training programme[xii]. While data shows that the majority return to training - with 93% of the 2012 F2 cohort in specialty or GP training within five years - more than one in 20 (7%) have not returned to training at all[xiii].

Support for flexible working and training for doctors

The 2015 RCoA Workforce Census showed that 8.4% of consultants were working less-than-full-time (LTFT), with a preponderance of females (5.4% vs 3.1%). The figures suggested that

approximately 17% of female consultants were working LTFT compared to 4.6% of males. There was an increase in the proportion of female consultants between 2007 and 2015, and this looks set to continue. If the proportion of male and female consultants working LTFT remains the same then it can be estimated that there could be an increase in the number of LTFT consultants of 25–30%. The consequent reduction in clinical activity would require additional workforce numbers to maintain services.

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. The BMA reports that more than half of junior doctors take time out of training. [xiv] This trend will need to be factored into workforce planning for anaesthetic and perioperative care services for the future.

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.

Sharing information and workforce data across ICSs

ICSs should have responsibility for publishing comprehensive workforce data to be made publicly available to local health providers so that there is a co-ordinated and transparent approach to the development of workforce plans. Neighbouring STPs and ICSs must work in a coordinated way to ensure that decisions around workforce and recruitment taken by one system or STP area do not negatively impact a neighbouring area.

In addition ICSs should have responsibility for sharing employment checks, within GDPR regulations, and developing ICS employment passports to make it easier for staff to relocate to different regions or systems. All roles, especially new roles/ways of working developed by ICSs, should adhere to a national framework and national standards, so that patient safety is assured.

Looking after the morale and welfare of the local workforce

Overworked and 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.[xv]

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. [xvi,xvii] 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.[xviii]

The effects of fatigue on doctors of all grades are a threat to patient safety[xix] 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 specialties during and after on-call periods, including anaesthetists.

There must be provision for sufficient office, study and IT facilities. In addition, doctors need confidential space for peer-support, discussion of clinical issues and lifelong learning. We are aware that car parking can be a troublesome issue for anaesthetists in training. As trainees

rotate frequently, they are often not on the staff list for staff car parks, adding to the stress of working long and challenging shifts.

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.[xx]

The RCoA has called for the development 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.

Therefore, there is a strong case for ICSs and healthcare providers to do everything they can to develop local strategies to improve, where necessary, the working conditions of their workforce.

Promote a 'no blame' culture

In order to make pursuing a career in healthcare attractive the NHS must foster a culture of support and learning when mistakes are made. 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 addition to loss of earning potential or loss of career.

While a change in culture can and should be directed at national level, local leaders, managers and employers must assume a greater role in supporting a cultural shift towards a 'no-blame' learning environment across their STPs and ICSs.

Developing anaesthetists as 'perioperative physicians' to improve patient care, outcomes and flow

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. The concept of perioperative medicine presents an opportunity for anaesthetists to play a transformational role as a hospital's 'perioperative physicians'.

The move toward system-wide integrated care 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[xxi]. 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'.

Developing the role of senior clinical leadership to enable change

The consultation document contains excellent examples of local innovation and pilot schemes to attract young people to a career in health. ICS leaders however must consider the contribution that senior clinical leaders can make in developing and then drive a programme of change, which will be required to enable integration.

Senior clinical leadership, adequately supported and skilled, have the ability to lead change in deeply entrenched ways of working and decades of competitive cultures towards collaborative networks. The challenge will be the creation, recruitment and retention of these leaders, and how to make these roles attractive.

- ***Is it fair to place an expectation on ICS leaders to sign up to the commitments listed under any new future operating model?***

In principle yes, but with the right support, funding and leadership from national organisations. As stated above, moving to integration and collaborative working will require a seismic cultural shift in the way providers have become used to working over the years. The development of guidance and good practice from national organisations could provide a blueprint for how all ICSs can adopt a unified approach to change.

National organisations should also support ICSs by pushing for the changes in legislation required for the regulation of Physician Assistants (Anaesthesia) (PA(A)s and other medical associate professional roles, the development of a framework for credentialing and flexible working, international recruitment and good practice to enable effective local recruitment.

- ***What support would ICSs and STPs value the most, whether referenced in this document or not?***

Lack of accurate workforce data has hampered the precise characterisation of workforce issues. 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 ST7)
- 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

We therefore believe that a single real-time workforce dataset should be developed and made available to national, system and local organisations to enable them to make accurate workforce decisions.

Data that would help with planning that is not collected currently include:

1. The true impact of winter pressures in terms of staff time and rotas[xxii]. There needs to be a long-term strategy and plan in place to address the pressure placed on funding, workforce and the health and care system we see on an annual basis.

2. The unpaid hours people work outside their normal rota or shift patterns and the amount of time doctors spend covering extra operating lists, clinics/ services because of understaffing. For example the Rotamap's CLWRota system for anaesthetics is used in approximately two thirds of UK NHS anaesthesia departments. CLWRota collects data on extra sessions undertaken beyond full-time contracts. This is a strong consolidated measure of unmet need and of the corresponding increased pressure on existing staff.

In addition to NHS workforce data, ICSs should also have access to workforce data on social care, the voluntary sector and the independent sector. Some volunteers and carers play a significant role in managing the health of patients and populations and can bring a considerable amount of knowledge and experience of managing medical conditions. ICSs should have access to an accurate picture of what organisations, services and volunteers are available in their areas to involve them in the delivery of integrated services across communities.

Finally, as the remit of ICSs is to look after the health of their populations, accurate 'population health' data should be available and collected in a way that is relevant to decisions around what health and social care services and staffing are required. Public Health England and NHS England are developing a framework to 'draw attention to the skills, knowledge and system enablers that are required to support a data-to-decisions journey so that local areas can assess whether they have the right capabilities in the right places'. ICSs and STPs should contribute to this and other initiatives (such as NHS Digital's NHSX) around place-based intelligence to ensure that future data collection systems consider local workforce requirements.

Looking at secondary care, we believe that perioperative care pathways can have a significant positive effect on population health and the prevention agenda. Ensuring a patient is in the best possible condition for their operation, receives high quality care during surgery and is supported through to a full recovery should not be seen as three separate aims. Instead, every patient's journey should be along a single, coordinated pathway of care, in which the right services and staff are all involved. There are examples of initiatives that are cutting postoperative complication rates by 50%, reducing the length of an individual hospital stay by a number of days, or helping patients return to full or even improved levels of fitness after major treatment[xxiii].

Quality of care should not be measured by time based targets and theatre efficiency alone, but also include post-operative outcomes, length of stay in hospital and the quality of life after surgery. This is the sort of data that should be collected by ICSs to ensure that they have adequate staffing and skills to support perioperative care pathways.

What is happening locally that should be highlighted as part of a wider good practice toolbox to other areas across England?

In 2017 the RCoA, along with the support of HEE coordinated three workforce stakeholder events in regions suffering from poor specialty fill rates (North East, Yorkshire and Humber and East Midlands) and produced a report outlining the recommendations and workforce solutions that were agreed following each of the events.

In 2018 the College was pleased to see that all three regions had improved their fill rates with an increase of 10% from the previous year.

Some of the recommendations for action were similar across all three regions and could be taken forward at national and ICS level as an efficient and cost-effective solution for tackling workforce shortages. The recommendations included providing more support for trainees, improving engagement with medical students and focus on supporting, developing and retaining the existing workforce.

Below are the main recommendations from the report which could be used as examples of good practice by ICSs.

- **Improving the profile of anaesthesia amongst undergraduates** – particularly in regions where fill rates are an issue. The College recently published an undergraduate framework to support leads in medical schools to incorporate anaesthesia, critical care, pain and perioperative medicine into their education programmes. This document outlines how clinical attachments in anaesthesia, intensive care, pain and perioperative medicine can support medical students in developing the knowledge and skills required to successfully enter the Foundation Programme. It also provides examples of how specialists in these areas can support other aspects of learning such as basic medical sciences and the development of essential professional skills such as communication and team working.
    - The College is improving its links with schools and undergraduates through workshops/careers fairs and has recently launched a membership category for undergraduates and foundation doctors. This work will be targeted in the north of England and particularly in the eastern side of the country.
    - As outlined above the North East have increased the profile of anaesthesia within the University of Newcastle Medical School by: greater engagement with undergraduate anaesthetic societies and its increased delivery of high quality Student Selected Components (SSCs) in anaesthesia.

- **Focus on supporting, developing and retaining the existing workforce, non-training grades**, MTI, Fellows, Specialty doctors, PA(A)s. Improve the support provided for these groups from the College.

    - Yorkshire and Humber have recently completed a review of their rotations aimed at developing more supportive training to retain the workforce. The region is also supportive of the MTI scheme, which offers a way of filling gaps and allow international doctors to take back knowledge gained to their countries of origin.

    - The East Midlands is supportive of focusing on building on the existing workforce and non-training grade MTI, Fellows, Specialty doctors, PA(A)s.

- **Improved marketing and promotion of the high quality training in the regions to attract trainees;** consider what the region has to offer outside of training and advertise accordingly via the College bulletin and through national/regional meetings, e.g. National Parks, good schools and affordable housing.

    - The Yorkshire and Humber school of Anaesthesia website is currently being updated by fellows with appropriate support and hopefully this will promote the training programme. Also with the programme restructure, all placements are now within a one hour commute maximum, this again will help positively promote the region.

    - In the East, Hull is looking at ways to improve attractiveness, starting with accommodation.

- The North East are looking to develop and offer a small number of high quality advanced training modules reflecting regional strengths which will be advertised nationally to improve recruitment into the region.

- **Marketing and promotion of anaesthesia** - Promote the Schools' excellence and their high quality training programmes via a new RCoA RAA reporting system introduced in 2018.

- **Communication - Improve communication between School/Deanery and Trusts,** particularly for Northern and the East Midlands. HEE to think about mechanisms to improve discussions and communications within region as well as cross boundary working.

    - In the Yorkshire and Humber School networking event and meetings are set up for all the College Tutors and Training Programme Directors along with Heads of School. Meeting others from across the region helps share good practice, provide support and offer solutions for the workforce shortage across the region.

- **Reduction of paperwork/assessments** - following feedback from the regional meetings and the RCoA programme of listening events,[xxiv] the College will consider this issue with the rewrite of the CCT Curriculum. The recent HEE report, Enhancing Training and the support for learners,[xxv] has looked at how the Annual Review of Competence Progression process can be improved with engagement from stakeholders.

- **Additional year at core training** - both East Midlands, Yorkshire and the Humber are keen to have a third year of training at core level. Currently the duration of the entirety of the training programme is being considered through the review and eventual rewrite of the curriculum.

The College is continuing to work closely with representatives across all three regions to take forward the recommendations and develop action plans and it will continue to monitor the situation and provide assistance where appropriate.

The above are examples of how engagement with Royal Colleges can help ICSs in the development of local workforce strategies.

References

[i] NHS Digital. *NHS Hospital & Community Health Service (HCHS) monthly workforce statistics - Provisional Statistics*. July 2017.
[ii] Stats Wales. *Medical and dental staff by specialty and year.* March 2017.
[iii] Information Services Division Scotland. *HSHS Medical and Dental Staff by Specialty*. December 2016.
[iv] Audit Commission. *Anaesthesia under examination: The efficiency and effectiveness of anaesthesia and pain relief services in England and Wales*, National report, 1998.
[v] EMK Walker, M Bell, TM Cook, MPW Grocott, and SR Moonesinghe for the SNAP-1 investigators. Patient reported outcome of adult perioperative anaesthesia in the United Kingdom: a cross-sectional observational study. British Journal of Anaesthesia 2016
[vi] RCoA Anaesthesia Recruitment Survey to Clinical Directors 2017 and 2018, data provided by Dr Hamish McLure, *Consultant Anaesthetist, Leeds, England Representative for the RCoA Workforce Strategy Committee ,Deputy Chair of the RCoA Clinical Director Executive*
[vii] Access to Birmingham Scheme https://www.birmingham.ac.uk/teachers/pupil-opportunities/post-16/access-to-birmingham.aspx
[viii] The Association of Anaesthetists of Great Britain & Ireland. Anaesthesia News, August 2016 (no.349). ISSN 0959-2962
[ix] Royal College of Anaesthetists Membership Survey 2016. Analysis undertaken by Member Engagement Services and presented to RCoA. Results are based on a response rate of 5,196 members.
[x] Royal College of Anaesthetists Medical workforce census. 2015. https://www.rcoa.ac.uk/system/files/CENSUS-REPORT-2015.pdf
[xi] Ibid
[xii] General Medical Council. 2017 national training surveys summary report: initial results on doctors' training and progression. November 2017
[xiii] General Medical Council. Training pathways: analysis of the transition from the foundation programme to the next stage of training. Working paper 1 – November 2017.
[xiv] British Medical Association. Understanding trends among current doctors in training. 2018. https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/juniors-career-survey
[xv] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. www.midstaffspublicinquiry.com/report . February 2013
[xvi] Royal College of Anaesthetists. *'RCoA warns that one-third of anaesthetists are struggling to deliver effective patient care'*. 27 Oct 2016
[xvii] Royal College of Anaesthetists. Membership Survey 2016 - Results. October 2016
[xviii] Dennis Campbell. *Two-thirds of young hospital doctors under serious stress, survey reveals.* The Observer. 11 February 2017
[xix] Fatigue and Anaesthetists. AAGBI, London 2014. Accessed at http://bit.ly/2lWyMem
[xx] NHS England. Simon Stevens announces major drive to improve health in NHS workplace. 2 September 2015.
[xxi] Royal College of Anaesthetists. *A teachable moment: delivering perioperative medicine in integrated care systems.* February 2019
[xxii] Royal College of Anaesthetists. Statement on winter pressures. 2018. https://www.rcoa.ac.uk/news-and-bulletin/rcoa-news-and-statements/rcoas-statement-support-of-aomrc-winter-pressures
[xxiii] Royal College of Anaesthetists. *A teachable moment: delivering perioperative medicine in integrated care systems.* February 2019
[xxiv] The Royal College of Anaesthetists, A Report on the Welfare, Morale and experiences of anaesthesia in training: the need to listen. December 2017
[xxv] Health Education England, Enhancing training and the support for learners January 2017