Royal College of Anaesthetists

December 2017

Briefing: The anaesthetic, intensive care and critical care workforce

The briefing outlines recommendations to inform a robust and sustainable approach to anaesthetic workforce planning, provision and wellbeing. From the analysis, a number of priorities emerge which impact on the safe delivery of high-quality, patient-centred care and inform the Royal College of Anaesthetists' (RCoA) recommendations.

About the Royal College of Anaesthetists

- 16% of all hospital consultants are anaesthetists, making anaesthesia the single largest hospital specialty in the UK[1 2 3]
- Anaesthetists play a critical role in the care of two-thirds of all hospital patients[4] and 99% of patients would recommend their hospital's anaesthesia service to family and friends[5]
- With a combined membership of 22,000 fellows and members, representing the three specialties of anaesthesia, intensive care and pain medicine, the Royal College of Anaesthetists (RCoA) is the third largest Medical Royal College by UK membership.

Recommendations

- The overall supply of core training posts should be increased and local strategies should be applied to fill specialty training posts for anaesthesia. We also support an increase in the intensive care medicine (ICM) workforce so long as this does not limit resources for the provision of the anaesthesia services[6]
- The UK Department of Health – working with the Devolved Administrations and relevant Arms-Length-Bodies (ALBs) – should develop and publish a national wellbeing strategy for all NHS staff, which makes practical recommendations for improving working conditions and providing the required facilities to deliver safe and sustainable care
- Following consultation, statutory regulation of Medical Associate Professions – including Physicians' Assistants (Anaesthesia) and Advanced Critical Care Practitioners – should be implemented across the UK
- The UK Government should accept the proposal of the Lords' Committee on the Long-Term Sustainability of the NHS and establish an Office for Health and Care Sustainability, which makes recommendations independently of Government[7]
- The UK Department of Health and Devolved Administrations should work with employers and professional bodies, including Medical Royal Colleges, to ensure that less-than-full-time working patterns, adopted by some doctors, do not restrict career choices or create barriers in career pathways
- After the UK leaves the European Union (EU) a flexible migration model should be implemented, which facilitates healthcare providers to continue to attract and retain talented staff from outside the UK
- The UK Government should agree a Brexit deal which ensures the rights of all non-UK staff working in the health and social care sectors and which avoids any new restrictive or (financially) burdensome measures

Recruitment and training

Despite increases in the number of consultant anaesthetists and staff grade, associate specialist and specialty (SAS) doctors, the RCoA workforce census report for 2015[8] highlights that anaesthetic departments continue to experience difficulties in filling hospital rotas:

- In England 26% of anaesthetic departments reported a gap in the consultant rota approximately once a week. There is considerable variation across the UK and this figure rises to as high as 60% in Wales
- Almost 70% of anaesthetic departments across the UK needed to cover gaps in trainee or SAS rotas more frequently than once a week. Nearly a fifth (19%) of departments needed to do so every day
- Nearly half (48%) of anaesthetic departments across the UK rely on consultants 'acting down' to cover gaps in trainee or SAS rotas.

The latest fill rate data for 2017 recruitment[9] reveal a slight decrease in the overall fill rate at core training (Acute Core Common Stem (ACCS) Anaesthetics and Anaesthetics CT1) and specialty training (ST3). In 2017 the national fill rate for core training was 98.17% (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.[10]

Overall anaesthesia and critical care numbers remain robust in comparison to other specialties.[11] However, these UK-wide figures hide the significant geographic variation in fill rates which has proven a persistent issue in many areas. For example, the fill rate at ST3 was just 50% in Yorkshire & the Humber and 66.67% in the North East of England, but in a number of areas, including London and the South West of England, the rate has been stable at 100%. The Chief Executive of NHS England, Simon Stevens, has suggested that incentives may be offered to encourage an increased uptake of posts in areas which have proven difficult to attract trainees.[12]

The number of unfilled ST3 posts nationally over the last five years provides evidence of the need to increase the overall supply of core training posts and maintain the number of ST3 posts at least at current levels. We also support an increase in the ICM workforce. However, any funding for ICM expansion should not be taken from the anaesthetic budgets without a joint review and agreement by relevant parties.[13]

We believe that different parts of the UK will require tailored strategies to address their particular local issues. Areas which have struggled to recruit in sufficient numbers could, in the short term, look to increase core training intakes by converting ST3 vacancies to core training posts. This would generate a better supply and, in the longer-term, could help to sustain a higher fill-rate at ST3 in all parts of the UK.

Evidence from Scotland indicates that increasing core training numbers is beneficial to the ST3 fill rate for anaesthesia. A sustained increase in core training numbers since 2013 has led to the ST3 fill rate across Scotland to increase from 63% in 2013 to 90% in 2017.[14] Gaps which still exist are in large-part explained by residual vacancies from previous years.

Analysis of core training appointments in Scotland over the period 2008-2010 show that approximately one in four (24.83%) doctors in training did not progress into an ST3 post in Scotland. This attrition rate was broadly even over the period (2008, 14% / 2009, 29% / 2010, 29%).[15]

Further analysis of data from the Anaesthetic National Recruitment Office over the period August 2014 to February 2017 suggests that this attrition observed in Scotland is comparable UK-wide, where there has been an attrition rate of 27% in the transition from CT to ST.[16]

We have welcomed the UK Government's plan for up to 1,500 extra medical training places from September 2018.[17] However, the increased cohort of medical students will not graduate until 2023 and would not be 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.[18] The House of Commons' Public Accounts Committee estimates that the NHS is short at least 50,000 staff.[19]

For the specialties of anaesthesia and ICM, a 2015 report by the Centre for Workforce Intelligence (CfWI) found that the number of anaesthetists and intensivist certificate of completion of training (CCT) holders needed to meet demand by 2033 would be 11,800 full-time-equivalents: nearly double the current level of around 6,100 and a 33% shortfall of the 8,000 projected to be trained by this date.[20]

Retention of the anaesthetic workforce

There is a developing issue caused by the impending retirement dates among the consultant workforce which couples the recruitment challenges outlined above. 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.[21] Due to contractual changes, all consultants starting in post today will be expected to work until they are at least 68 years old, which may demand adjustments in rotas and shift work to accommodate the later part of their career.

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[22]. While data show that the majority return to training - with 93% of the 2012 F2 cohort in speciality or GP training within five years - more than one in 20 (7%) have not returned to training at all.[23]

Physicians' Assistants (Anaesthesia) and Advanced Critical Care Practitioners

The changing demographics of the UK indicate a need for a 25-40% expansion in the anaesthetic workforce by 2035.[24] The RCoA believes that 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, but only if these roles are properly regulated. Therefore, we strongly support the introduction of statutory regulation of PA(A)s, ACCPs and other MAPs.

The RCoA currently administers a voluntary register and only recognises those PA(A)s who have qualified, having completed the approved UK training programme, and have subsequently been entered on the voluntary register. We would not support any advancement of the role without statutory regulation in place. While there is no voluntary register for ACCPs, the Faculty of Intensive Care Medicine (FICM) provides an Associate membership for this group and believes that around 80% of practicing ACCPs are members of the Faculty.[25] The development and expansion of MAPs is limited by the absence of statutory regulation.

Staff morale, welfare and fatigue

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. [26,27] Overworked doctors, demoralised staff and under-resourced hospitals can also undermine the quality of patient care and safety - themes which were interrogated in the *Francis Report* which followed the Mid-Staffordshire NHS Foundation Trust Public Inquiry in 2013.[28]

Between December 2016 and January 2017 the RCoA conducted a survey which received responses from over 2,300 anaesthetists in training. The results of the survey were reported in the *Observer* in February 2017.[29] The survey revealed that 85% of anaesthetists in training are at risk of becoming burned out (as measured on the Oldenburg Burnout Inventory). Long hours, concerns over patient safety, the disruption caused by working night shifts and long commutes were identified as major reasons for growing fatigue and disillusionment.

The survey also highlighted that:

- 61% of respondents felt their job had detrimentally affected their mental health and 64% felt their job had detrimentally affected their physical health
- 75% of respondents reported working a shift without adequate hydration.

In June 2017 the results of a separate survey concerning the impact of fatigue among anaesthetists in training were published in the journal *Anaesthesia*.[30] The survey which was led by members of the RCoA Council and the Association of Anaesthetists of Great Britain and Ireland (AAGBI), revealed the following key findings from the 2,170 respondents:

- 75% of anaesthetists in training drive to work and 60% have a commute of 30 minutes or more each way, and more than half of applicable respondents (57%) have had an accident or a near miss
- Less than two-thirds of respondents (64%) have access to rest facilities in the hospital where they work.

We believe that there is an urgent need to respond to the issues raised by anaesthetists in the recent RCoA surveys to address the reasons why these doctors are at a higher risk of burnout, are feeling undervalued and that their job is negatively impacting their physical and mental health. [31,32]

Under schedule 5 of the Terms and Conditions of Service for Doctors and Dentists in Training (England) 2016[33], junior doctors may now file exception reports about excessive hours or inability to take rest breaks. The new Guardians of Safe Working Hours[34] could 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 Guardians are accountable.

Considerations of the implications of Brexit on the health and social care workforce

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. [35]

The General Medical Council (GMC) Working Paper on doctors with a European Primary Medical Qualification (PMQ)[36] shows that for the specialty of anaesthetics and intensive care 12.6% of doctors on the UK Specialist Register are European Economic Area (EEA) graduates. The same paper shows that across the UK 9.9% of registered anaesthetists and intensivists in Northern Ireland graduated in the EEA, in Scotland 9.4%, in Wales

14.5% and in England 11.8%. Among RCoA members who are SAS doctor grades 14% gained their PMQ in the EU.[37]

There are indications that the uncertainty created by Brexit is undermining the position of health and social care staff. Surveys conducted by the GMC and the British Medical Association (both in 2017) reported that over 40% of surveyed doctors from the EEA are considering leaving the UK in the near future.[38,39, 40]

NHS hospitals rely on accessing the EEA recruit porters, cleaners, doctors, nurses and technicians. Without this range of support staff, a hospital simply cannot operate. As the Home Office begins exploring possible immigration models post Brexit, the RCoA recommends that a new tier with a lower salary threshold than is currently stipulated at the existing Tier 2, should be agreed to ensure that non-clinical staff will not be discouraged from migrating to the UK to contribute to the health and social care workforce.[41]

Currently doctors from EEA countries wishing to practice in the UK are not required to meet a common threshold for entry onto the UK medical register, or to pass a standard assessment to test their skills and competence, this is instead left to local clinical governance. We support GMC proposals for a Medical Licensing Assessment which would provide 'definitive' generic standards to be met by all doctors in the UK.[42]

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