Royal College of Anaesthetists

SAS Anaesthetists – Securing our Workforce

June 2017

Contents

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Introduction

The Royal College of Anaesthetists undertook a comprehensive workforce census in 2015.[1] It showed that SAS anaesthetists make up a significant part of the workforce (22%). The President was keen to explore how the College could best support these valuable colleagues.

The workforce census highlighted the likely shortage of anaesthetists in coming years. Many SAS anaesthetists are extremely competent, often coming to work in the UK with a wealth of experience gained abroad. They potentially offer a pool of talent to bring on to consultant level, especially since the numbers of trainees achieving their CCT is unlikely to meet the growing need forecast by the College and CfWI review.[2] Other SAS doctors are less experienced but might consider entering or returning to the training programme.

The recent Brexit vote has implications for the specialty, given that many of our colleagues are currently recruited from the EU. There is uncertainty over the future for these individuals, though it is unlikely they will be asked to leave their vital role in the NHS. However, some may return to their home country voluntarily or wish to emigrate to other countries. The junior doctors dispute raised the prospect of doctors leaving for Australia and New Zealand. Of course SAS doctors also have this option.

The last survey of SAS anaesthetists was undertaken in late 2009, jointly with the Association of Anaesthetists of Great Britain and Ireland (AAGBI). The results were published in the *Bulletin in* July 2010.[3]

The College seeks to engage more effectively with this group and celebrate their achievements. A new survey was designed to explore workforce challenges in particular, but we also wanted to understand better the issues that matter to SAS anaesthetists. Free text responses have provided rich and varied data. This has been shared with other interested parties, including the AAGBI and the British Medical Association (BMA) at a Joint Working Party, which aims to identify specific action points for each organisation to report on and take forward by the end of 2017, with a report due to be prepared by early 2018.

We are grateful to all of the SAS anaesthetists who took the time to complete the survey. We are also indebted to the College Tutor network, who forwarded the survey to all SAS doctors in their department.

Dr Lucy Williams

Dr Kirstin May

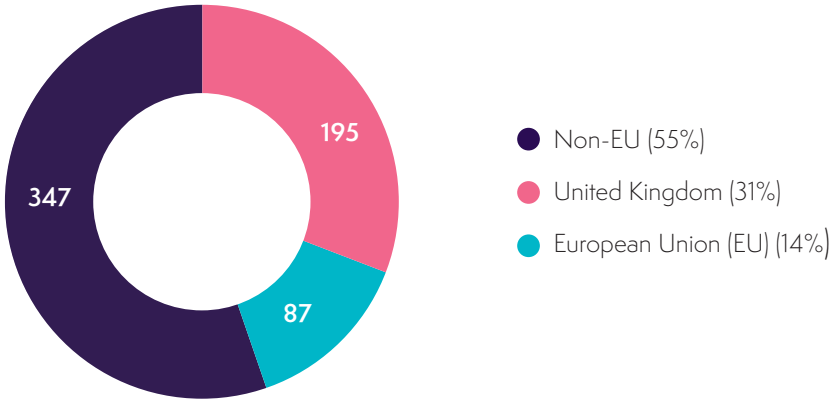
References

1 RCoA Medical Workforce Census 2015. (www.rcoa.ac.uk/census2015)
2 In depth review of the anaesthetic and intensive care medicine workforce – published February 2015. (bit.ly/2sd56w1)
3 The joint RCoA and AAGBI survey 2009. Roget Laishley. *Bulletin* 62 July 2010.

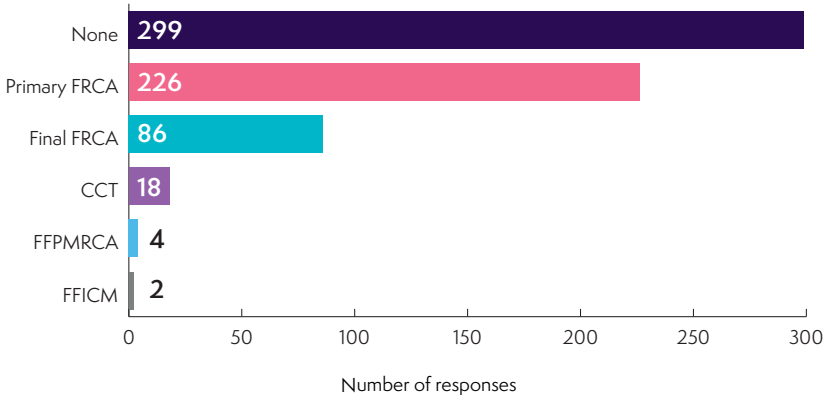
The SAS workforce

There were 634 responses to the survey. The 2015 census data identified 2047 SAS anaesthetists, giving a response rate of 32%. Coverage of the whole of the United Kingdom was achieved by disseminating the survey via the College Tutors' network.

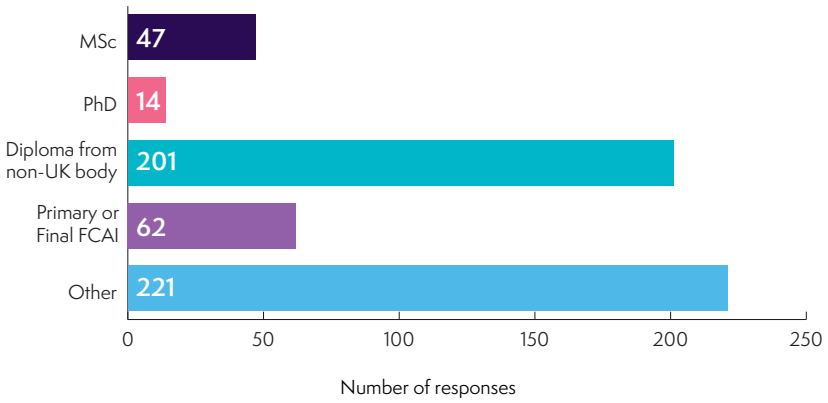
Country of primary qualification



Which stages of qualification in anaesthesia, pain medicine and intensive care medicine in the UK have you completed?

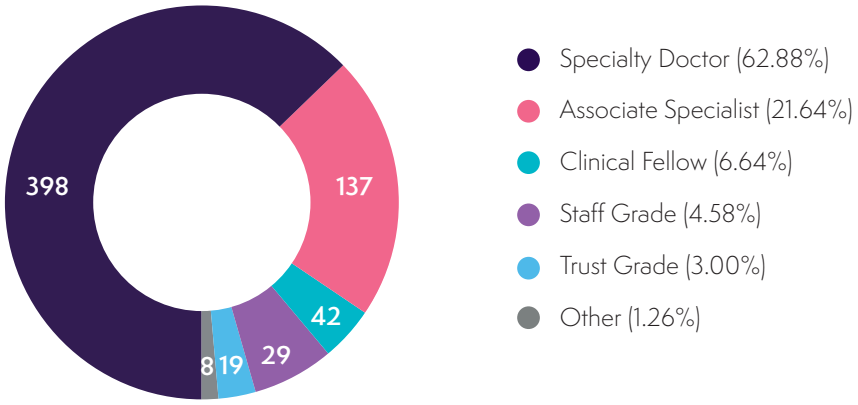


Do you have any other qualifications, diplomas or exam passes relevant to anaesthesia, pain medicine or intensive care medicine?

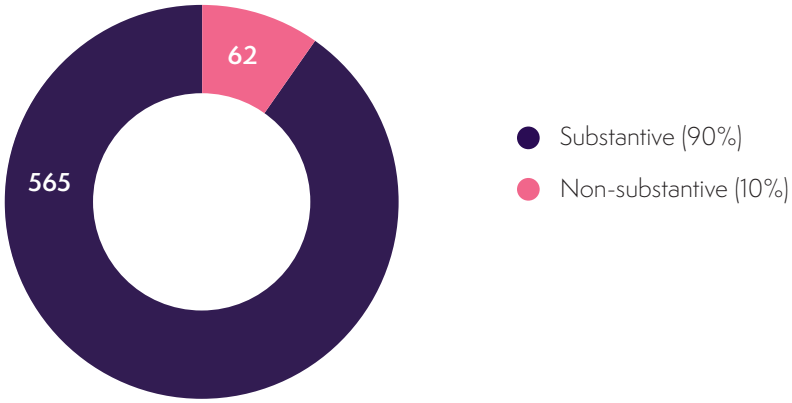


18% of respondents were on the Specialist Register. Doctors from the European Economic Area (EEA) are entitled to this under EU legislation if they are on the Specialist Register of their home country. Currently the General Medical Council (GMC) is not permitted to make any formal assessment of fitness to practise for EEA doctors, but this may change with Brexit.

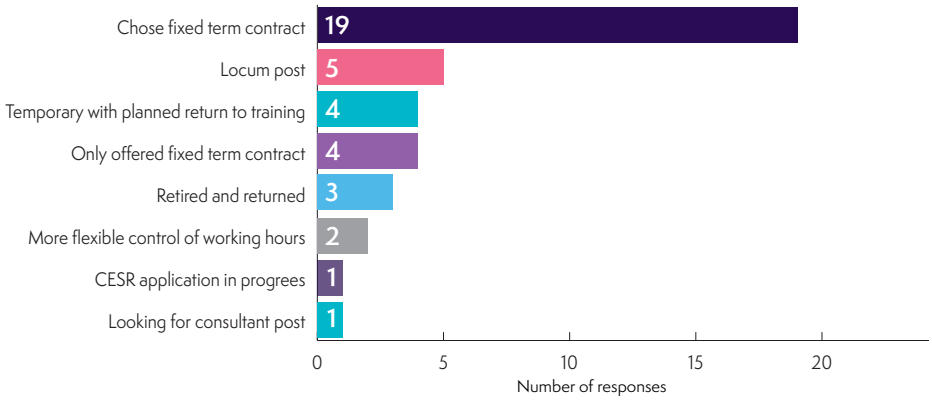
Grade of contract



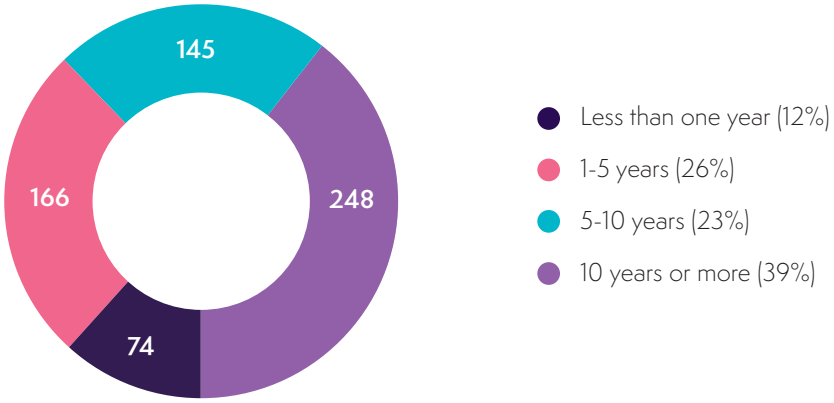
Type of contract



Reason for non-substansive contract

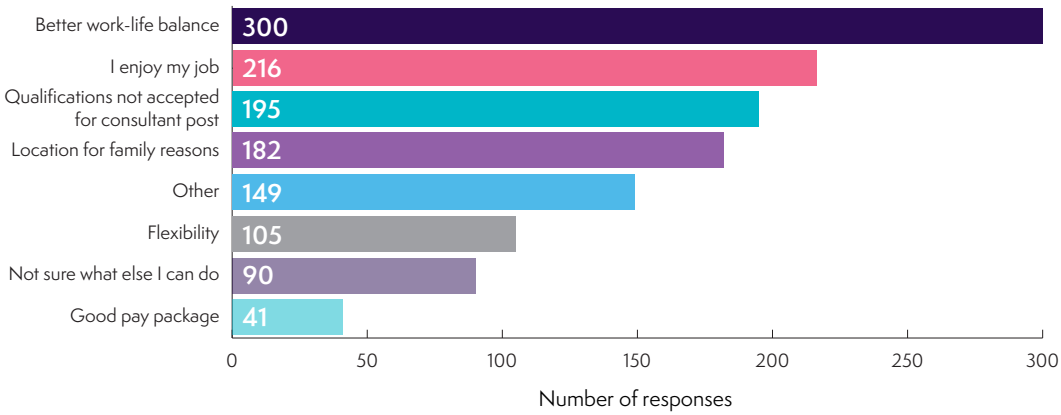


How long have you been an SAS doctor?



62% have been an SAS doctor for at least five years, with 39% having more than 10 years in the grade. These are experienced senior doctors. Data from the 2015 Census shows that the age profile is very similar to the consultant workforce and there will be implications arising from the retirement of these anaesthetists over the next 10 years. New doctors are coming into the grade but evidence from the 2015 Census suggests that recruitment does not meet demand.

Why have you chosen to be an SAS doctor?

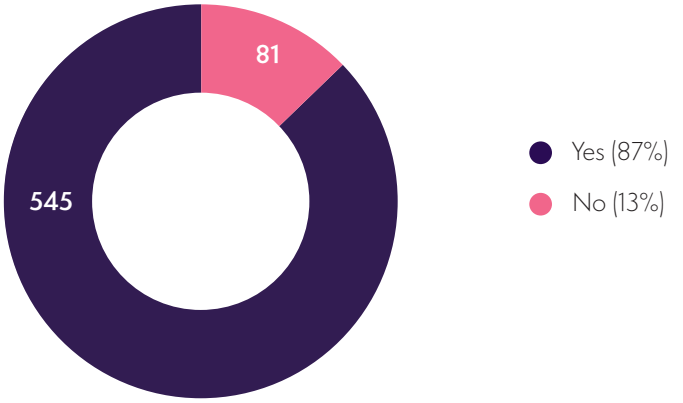


It is encouraging that a substantial number enjoy their work and feel that it gives them a better work-life balance than alternatives. Many are ineligible for consultant posts or seem unsure of other ways of working. Few felt the pay package was a reason to be an SAS doctor. Flexibility is valued by a significant number.

Job plans and career development

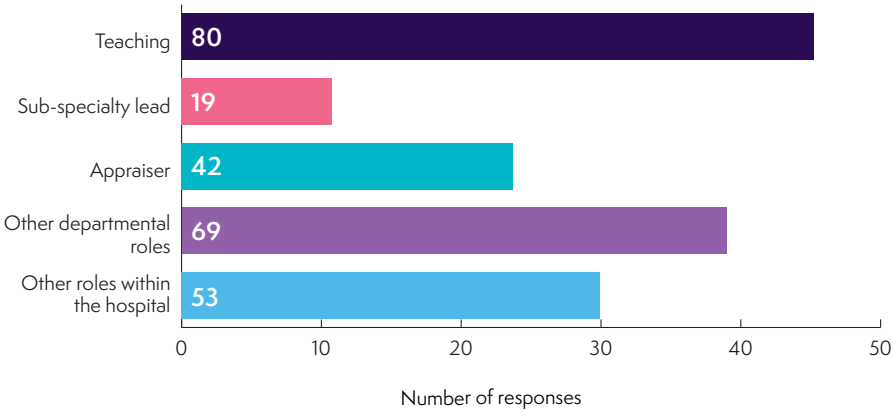
Nearly three-quarters (73%) of SAS anaesthetists have on-call commitments, with a significant proportion being resident on-call. (It should be noted that the responses suggest the question may have been misunderstood and the exact figures are unreliable.) They cover all areas of theatres, maternity, ICU and pain medicine. Another common out-of-hours commitment is weekend trauma lists.

Do you have at least 1.0 SPA in your job plan?

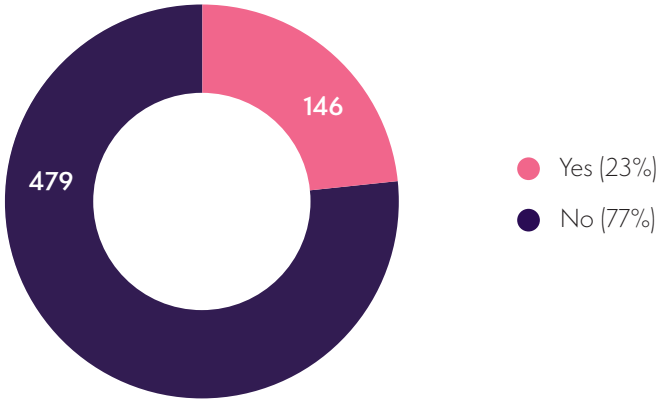


87% of respondents have at least 1.0 Supporting Professional Activities (SPA) in their job plan. This compares with 89% who are on Specialty Doctor, Associate Specialist or Staff Grade contracts. All of these national contracts should have a minimum of 1.0 SPA to support appraisal and revalidation. Non-standard Trust appointments have no such requirement and are not protected by national terms and conditions.

Additional SPA activities

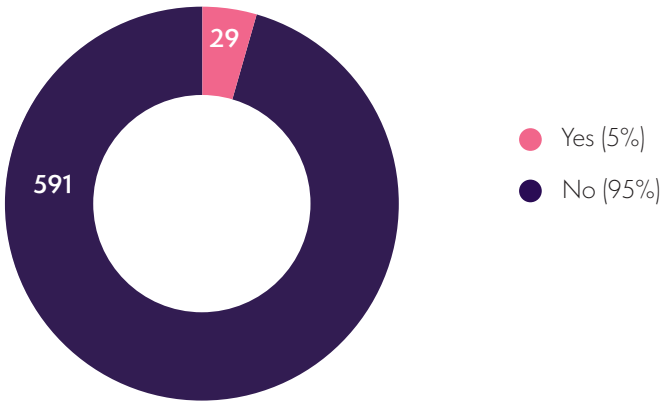


Do you have any plans to enter/re-enter the training programme

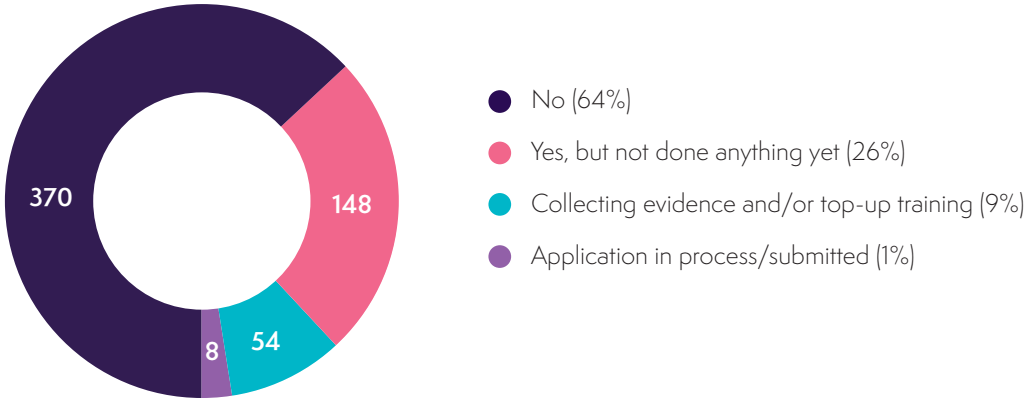


Some SAS anaesthetists enter the grade temporarily with the intention of returning to training. In Scotland LAT (locum appointment for training) jobs are still available, but not in England. An SAS post can provide an opportunity to pass the Primary and apply for ST3 training. Other doctors from abroad may wish to enter training in the UK to achieve a CCT. An alternative route to the Specialist Register is to apply for a Certificate of Eligibility for Special Registration (CESR). Many foreign doctors come with a lot of experience.

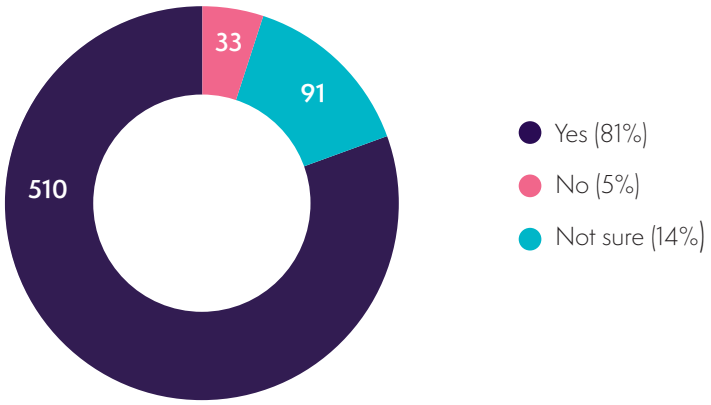
Do you have a CESR?



Do you have plans to appy for a CESR?



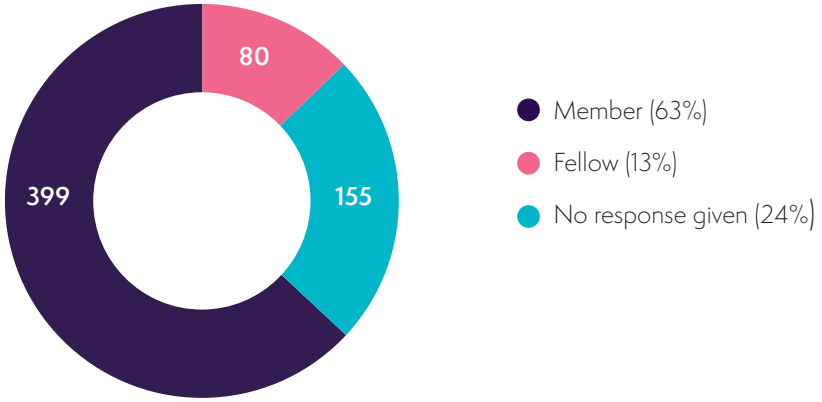
Do you plan to remain in practice in the UK?



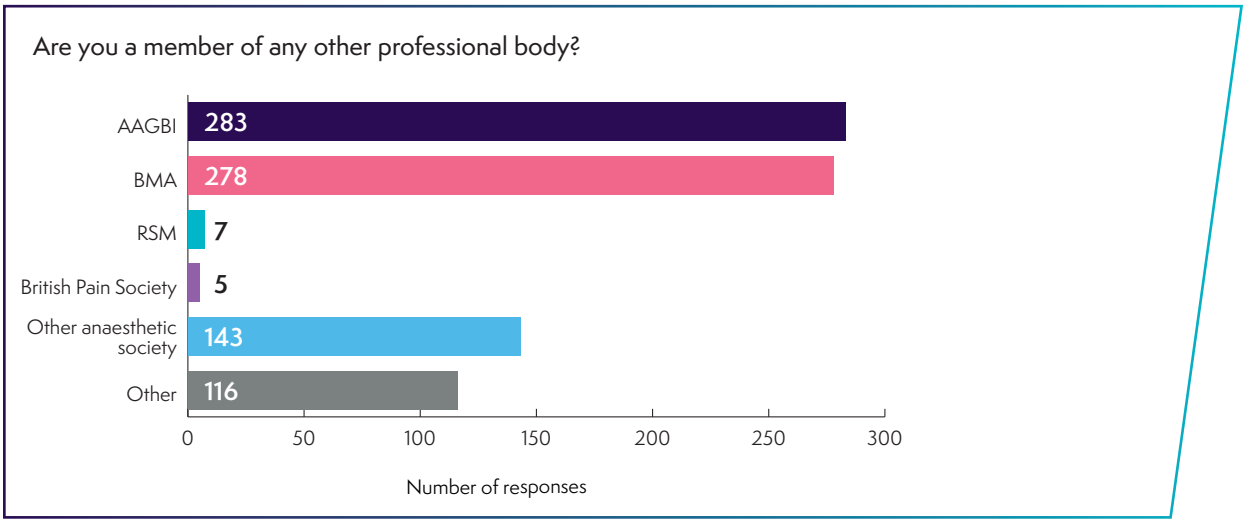
10% of survey respondents had not been appraised in the last year. 35% had not had a job plan review in the last year. Appraisal is mandatory for revalidation; SAS doctors must seek it and employers must offer it. Job planning should ideally occur on an annual basis as a separate process. 51% of respondents said job planning was included in their appraisal.

Affiliation to professional bodies

Are you a fellow or member of the RCoA?



Of the 479 respondents, 83% were College members and 17% were fellows. Although it is possible that some or all of the 155 respondents who skipped the question are Associate Members, it is perhaps more likely that they are not linked to the College in any way.



Free text responses

Several questions in the survey were designed to allow free text answers. This provided opportunities for individuals to expand on subjects that they feel are important. Some of the major themes that emerged, and a selection of verbatim comments, are included below.

Reasons for being an SAS doctor

- Exam difficulty
- Availability of training places
- Choice/career development
- Other
- Visa/work permit
- Lack of career guidance
- Uncertainty about consultant role
- Personal/family
- Unsuccessful consultant application
- Did not complete training
- Medical Training Application Service (MTAS)
- Modernising Medical Careers (MMC)

'Could not get SPR job for continuation of training'

'Contract issues not compatible with good quality family life'

'Not achieved final FRCA'

'Failed primary exam hence unable to progress'

'Health issues'

'Time to consider career options/decide whether to proceed with training'

'Came specifically for a year to get more experience'

'Doing a PhD'

'No Deanery stress'

The two main themes were failure to pass examinations (either Primary or Final FRCA) and inability to secure a training number. Career breaks or access to less than full time training were specific reasons for being unable to continue training. Health issues and family commitments were also cited.

Some enjoy the ability to work independently while still knowing that there will always be someone to turn to for advice or assistance. A couple saw the consultant post as unattractive because of its paperwork and administrative responsibilities. Two more mentioned visa problems.

Other positive reasons for choosing an SAS contract include the opportunity to pursue other career interests such as research or non-medical work. One respondent chose an SAS contract as it offers unpaid leave to undertake foreign aid work.

Professional support for SAS anaesthetists

The final survey question was, *"What should the College do for SAS anaesthetists?"* and was deliberately very open to encourage a broad range of suggestions. 343 free text responses were collated. There was great strength of feeling from many, with a lot of frustration expressed.

A consistent theme was a strong desire for recognition of skills and clinical competence as well as clear career progression pathways. Re-opening of the Associate Specialist grade was a recurring priority. Many felt that the new Specialty Doctor contract did not allow sufficient distinction between those early in their career and those effectively working at consultant level in the clinical setting. It is also preventing current Associate Specialists from moving posts because any new appointment would be on the Specialty Doctor contract.

> *'Increase recognition of the work they do'*
>
> *'Restart the Associate Specialist post... so people can move around if they need to'*
>
> *'... to be recognised officially that I work completely independently at consultant level'*
>
> *'See about career progression'*
>
> *'Trying to get rid of the specialty doctors grade. It has no distinction between a few or multiple years of experience'*

There was concern over whether job plans and on-call commitments could change with age. Some wanted the College to produce specific guidance on this.

> *'Has anyone thought about an optional time in which these doctors could come off resident on call, can't believe I will be doing a resident ITU on call at 60 especially nights'*
>
> *'Could the college offer guidance on age and on call work for SAS doctors?*

There was dissatisfaction expressed regarding access to, and support for, training opportunities to progress towards CESR, or for examinations. Some complained that they had been informed they were for service only and were not entitled to any training. Entry to the training programme was seen as too inflexible, taking no account of prior qualifications and experience, especially from abroad.

'Have an alternative teaching plan for SAS to upgrade them professionally'

'More training opportunity, just not a service oriented post'

'I was told by consultants several times that I'm here for service only. That leaves the SAS body separated from the consultant-trainee family'

'Providing more opportunities to enter training'

'Recognise overseas qualifications... and help with CESR entry'

Some SAS doctors commented that they wanted their non-clinical skills to be appreciated and developed so they could make a full contribution at both departmental and wider levels. Some suggested that the College could lead the way by making sure that opportunities for College work are open to SAS fellows and members as well as to consultants.

'Recognise our wider roles and responsibilities in healthcare'

'Some senior colleagues have no idea about what we can do and our SPA time should be equivalent for revalidation purposes'

'Involving them more in management and teaching roles'

'Real opportunities to develop to their maximum ability'

The CESR process was felt to be too onerous and over-complicated. Specific guidance and support for this, both locally and from the College, locally was requested. Many wanted recognition for time spent working abroad as well as in non-training posts in the UK. Significant numbers aspire to a consultant post but believe that the system is stacked against them. Some asked for an organised scheme providing access to top-up training and similar educational supervision and mentoring as that given to trainees. Access to the e-portfolio was mentioned.

'As much specific guidance on CESR as possible and routes to gain equivalence training especially in the subspecialties (neuro/cardiac/paeds) which are harder to arrange'

'Provide equivalent of e-portfolio for those wishing to go for CESR'

'For any SAS doctor who has been in their post for 5 years or more, it will be almost impossible to get the necessary paperwork completed (for CESR)'

Courses and educational events run by the College were felt to be expensive for SAS doctors who are usually required to pay the same registration fee as consultants while earning considerably less. Several requested more meetings or online e-learning modules that are specifically targeted at SAS anaesthetists. There was also a request for more SAS representatives on the faculty for educational meetings.

> *'Cheap CPD courses'*
>
> *'Many of us don't earn as much as trainees let alone consultants'*
>
> *'College should involve SAS doctors in teaching roles for example as faculty in courses'*
>
> *'Providing meetings to help with clinical and non-clinical challenges of a non-training anaesthetists'*

The cost of College affiliation was mentioned. Not many SAS doctors are fellows but the subscription rate is the same, whatever the doctor's contract or pay-scale. Several said that they did not see what the College could do for them.

> *'After 14 years working in the UK I do not believe that the College would do anything for SAS anaesthetists'*
>
> *'The college currently does very little (?anything) for SAS grades and the general perception held by most of my colleagues is that we are merely an afterthought'*
>
> *'Reduce membership fee'*

Some respondents said they had experienced discrimination or bullying during their career. A specific claim of bias in the exam system was made. Many foreign doctors had no previous experience of keeping a logbook and felt the College should make allowances for this when assessing previous clinical experience. Several felt that the College and anaesthetic consultant body undervalue SAS anaesthetists and look on them as 'failed' in some way.

> *'SAS doctors should not be looked down upon (which unfortunately still happens)'*
>
> *'Sometimes we feel that we are discriminated a bit especially when it comes to teaching'*
>
> *'Subject to constant bullying'*
>
> *'Preventing discrimination. Stopping the 'dead end' posts'*

SAS anaesthetists want robust representation of the grade at the College. Some felt there should be increased representation, to reflect the number of SAS anaesthetists in the UK workforce. They would like College support on contractual issues such as the Associate Specialist grade, rota gaps and on-call commitments. They want to be valued and supported to reach their full potential.

'Our rota is very short because we cannot recruit SAS anaesthetists putting all of us under pressure to do extra hours'

'Representation of our rights, help our SAS representative on Council'

'Restart associate specialist or equivalent grade again'

'Recognition & respect'

'Encourage SAS doctors in leadership roles both at college level and local departmental level'

A few said that they saw the College as already active in its support of the grade. Some suggested that SAS grades should be promoted as a positive career choice. Even in those instances where failure to progress with training is the reason for being in an SAS post it can still be a satisfying and enjoyable job.

'Promote the role to Core Trainees as a viable, long term alternative to SpR training, which may not suit everyone'

'Promoting the grade as a valid career choice'

'College is very supportive to SAS doctors'

'It has been very proactive in helping SAS anaesthetists improve their profile'

Where are we now?

The Royal College of Anaesthetists, and the NHS more widely, recognises that SAS doctors are a vital part of the medical workforce. Several relevant documents have been published, including:

- an updated SAS Charter for each nation[1]
- BMA guidance on developing autonomous practice[2]
- RCoA guidance on supervision of SAS anaesthetists[3]
- AAGBI revised SAS Handbook[4]
- a joint document from the Academy of Medical Royal Colleges, BMA, Health Education England and NHS England on SAS doctor development was published in late 2016.[5]

Many hospitals now have an SAS tutor and Deaneries may have an Associate Dean with responsibility for this part of the workforce but this varies around the country. These individuals are responsible for promoting the education and development of SAS doctors across all specialties. There has been some additional SAS development funding but this looks increasingly threatened as budgets are squeezed.

As in the joint RCoA/AAGBI survey in 2009, the majority of issues raised in the recent survey were contractual. In 2009 only 15% of SAS anaesthetists were on the Specialty Doctor contract, compared to 63% now. The age profile is similar but absolute numbers have grown. However, rota gaps and workforce problems have increased and SAS doctors are a scarce commodity, with the 2015 Census identifying unfilled posts across all four nations.

In 2009, 32% of respondents obtained their primary medical qualification in the UK. The recent survey shows an almost identical proportion, of 31% of the grade consisting of UK graduates. It is not possible to compare the origin of foreign graduates because this was not asked in 2009. It is likely to have changed in the intervening years due to visa restrictions for non-EU doctors and freedom of movement for doctors within the EEA. 14% of 2016 survey respondents were EU graduates. There is uncertainty about the Brexit negotiations. If the survey is representative of all SAS anaesthetists, it could affect approximately 280 individuals.

In 2009, there were concerns about the impending retirement of older SAS doctors but it seems that their roles were filled by younger colleagues. We must continue to attract new SAS anaesthetists to work in the NHS, from the UK and abroad. Consideration should be given to managing the job plan of aging SAS anaesthetists, especially with regard to their on-call commitment.[6]

The SAS Committee at the College has recently been reinvigorated and now includes SAS representation from all four UK nations. There is an SAS member on the Board of each devolved nation. The two elected SAS positions on Council are filled by Dr Kirstin May and Dr Lucy Williams. These individuals have seats on other College committees and represent the interests of SAS doctors as well as being involved in all aspects of College business; they and the College will draw on the wealth of data provided by this survey to promote the SAS agenda at all levels. Dr May also chairs the SAS Committee of the Academy of Medical Royal Colleges.

The RCoA President has set up a Joint Working Party and invited interested organisations to join. The AAGBI and BMA are working with the College and each organisation will lead on different areas of importance to the survey respondents. The Working Party will produce a report early next year with action plans for each organisation to take forward.

The College is primarily responsible for education and training, examinations, professional standards and patient safety. However, the College must work within strict regulation from the GMC. This fact is poorly understood by many SAS anaesthetists. It particularly affects points of entry to the training programme and recognition of alternative qualifications and experience. For CESR applications, the College examines documentation on behalf of the GMC to confirm that there is sufficient evidence to demonstrate equivalence to a new CCT holder in the four domains of Good Medical Practice. Comprehensive guidance on the process is available on the GMC website[7] and the College website.[8] Specific queries may be addressed to equivalence@rcoa.ac.uk.

The College has reviewed the role of the Regional Advisers Anaesthesia and identified them as a key contact for career guidance. The College already recommends that anaesthetic departments have a designated educational supervisor to support SAS doctors. Many SAS doctors hope to return to training or would like to achieve CESR as a route to the Specialist Register. Both may be challenging and a frank discussion about prospects of success would be helpful at an early stage. Alternatives for career progression should be considered.

The College has recently updated GPAS and it is now more inclusive of SAS doctors.[9] The College recognises that SAS doctors should be considered alongside consultants for clinical and non-clinical work if they have appropriate skills and expertise. Dr Emma Stiby, an SAS Committee member, has recently joined the editorial board of the Bulletin. The College will ensure that all its communications and publicity distinguishes appropriately between, and is inclusive of, SAS, consultants and trainees.

1 A charter for staff and associate specialist and specialty doctors (www.rcoa.ac.uk/sas)
2 Guidance template for the development of autonomous practice for SAS doctors and dentists. BMA 2015. of SAS and other non-consultant anaesthetists in NHS hospitals. (http://bit.ly/2rAy783Supervision)
3 Supervision of SAS and other non-consultant anaesthetists in NHS hospitals (bit.ly/2cPDcxl)
4 SAS Handbook. 3rd Edition. (www.aagbi.org/professionals/sas)
5 SAS doctor development. AoMRC/BMA/HEE/NHSE 2016. (http://bit.ly/2rAsGpv)
6 Age and the Anaesthetist. AAGBI 2016. *Anaesthesia* News 349 August 2016
7 Evidence for CESR/CEGPR applications (www.gmc-uk.org/doctors/24769.asp)
8 CESR and Equivalence (www.rcoa.ac.uk/careers-and-training/cesr-and-equivalence)
9 Guidance on the Provision of Anaesthetic Services (www.rcoa.ac.uk/gpas)

Next steps

Data from the survey is being presented to all the relevant committees of the College, in order to build an action plan to take forward. This will be included in the report of the joint SAS Working Party which should be prepared by early 2018.

Survey data has been presented to meetings of Regional Advisors and Clinical Directors with a very positive response. Workforce is a major problem for CDs. Many are considering innovative solutions to recruitment difficulties. Attracting and retaining high calibre staff is a priority. Offering new posts with real development opportunities would be one option. Supporting existing staff to sit examinations or work towards CESR may improve retention and job satisfaction. Motivated and engaged staff provide better care for patients.

A survey generates as many questions as it answers and College representatives need to get out and speak to SAS doctors. SAS-specific sessions have been held at all the major College meetings for the last 18 months and this will continue. Listening Events have been held for trainees and similar events could be held for SAS doctors. The College will be reaching out to SAS doctors and will work to be seen as an advocate for them, not an irrelevance.

The College published its five year Strategic Plan in 2016.[1] The first three of the strategic aims are directly relevant to SAS anaesthetists.

1. Supporting anaesthetists throughout their career

The plan explicitly states that 'The College supports and develops doctors through all stages of their career, and at all levels and grades.' The Regional Adviser has been identified as the key individual for career advice. SAS doctors can contact the relevant College department with specific questions regarding examinations or the training programme. There is a designated e-mail address, sas@rcoa.ac.uk, for general queries.

2. Setting and maintaining the highest standards for anaesthesia and delivering healthcare improvements to secure the best outcomes for patients

SAS anaesthetists can get involved in updating GPAS chapters, can work within their own department to meet ACSA standards and can participate in National Audit Projects and research such as the Perioperative Quality Improvement Programme (PQIP). SAS doctors can apply to be examiners if they have the Fellowship. The College will work to make these opportunities more widely known.

3. Promoting anaesthesia by engaging members and informing the public.

The College wants to be relevant to its members and communicate more effectively with them. This will be facilitated by the delivery of the Technology Strategy Programme over the next two years. Platforms such as e-portfolio, logbook, CPD portfolio and the data systems of the College are being redesigned with input from fellows and members. The new e-portfolio system will be available to SAS fellows and members as (unlike the previous version) there will be no limitation on the number of users. This has been a frequent request at meetings with SAS colleagues and in the survey.

'We provide our specialty with a powerful and collective voice that influences the health sector. We will continue to increase our profile with governments, regulators, hospitals and the media.'

The RCoA represents the largest single hospital specialty and, in its 25th Anniversary year, is extending its influence far beyond the confines of training and standards. The College has significantly raised its media profile and has been building links with the Department of Health, health ministers and other NHS bodies. Many SAS concerns are not under the control of the College, but the College can and will raise these concerns with other relevant agencies.

1 The RCoA Strategic Plan 2016-21. (http://bit.ly/rcoa-strategic)

Conclusions

SAS anaesthetists are a diverse group of doctors providing substantial anaesthetic services. Many are happy with their job, but some are not. We need to explore this dissatisfaction through further conversations with colleagues, and, identify specifics that the College can address directly or through its influence with other agencies. This is ongoing work throughout the College via the relevant committees.

An SAS post should be seen as an attractive career option for those who leave training through choice or due to failure to progress. There are some very good anaesthetists who struggle with exams. They must feel that a satisfying career is still available to them within the specialty, with alternative ways of developing and making a contribution.

It is vital that the NHS continues to recruit foreign graduates and incorporate them successfully into the anaesthetic workforce. This is supported by the annual RCoA 'New to the NHS' Day. These doctors often need support with mentoring, educational supervision and comprehensive induction. There will be examples of excellent practice in these areas which we would like to hear about.

There needs to be a cultural shift away from SAS doctors being seen as purely for service. SAS grades have an even bigger contribution to make if they are given the opportunity. Cultural change takes time and the College is leading on this. But the culture needs to change within the grade as well as in the wider community of anaesthetists. SAS doctors need to get involved and engaged within their own department to show what they have to offer. The opportunities are there for participation in College business and national activities through a variety of bodies.

Concrete proposals for action will be put forward from the RCoA, AAGBI and BMA. Continued dialogue between the College and SAS doctors is vital to inform these proposals. Further SAS sessions will be offered at big College meetings and smaller events regionally would be desirable.

Contact the College via e-mail at sas@rcoa.ac.uk to let us know what you think, especially if you would like us to visit you. This document is the beginning and progress updates will be published in the *Bulletin* and on the College website.

NOTES

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