RCoA response to HEE consultation: Facing the Facts, Shaping the future: A draft health and care workforce strategy for England to 2027

About the Royal College of Anaesthetists

- 16% of all hospital consultants are anaesthetists making anaesthesia the single largest hospital specialty in the UK[i,ii,iii]
- Anaesthetists play a critical role in the care of two-thirds of all hospital patients[iv] and 99% of patients would recommend their hospital's anaesthesia service to family and friends[v]
- With a combined membership of 22,000 fellows and members, representing the three specialties of anaesthesia, intensive care and pain medicine, we are the third largest Medical Royal College by UK membership.

Introduction

The RCoA welcomes the publication of a workforce plan for medical and associated staff in England. A transparent and practical plan that goes some way to respond to the changing and complex needs of the patients and the public is required [1],[2]. The Royal College of Anaesthetists is the professional body responsible for the specialty of anaesthesia throughout the United Kingdom. Its principal responsibility is to ensure the quality of patient care through the maintenance of standards in anaesthesia, pain medicine and intensive care.

Workforce planning is a collaborative process. It involves input from local providers – who can bring a detailed understanding of local circumstances – and from national organisations, to give a long-term view on the workforce required, now and in the future. The RCoA is supportive of effective regional engagement with national workforce planning, and we welcome your views, comments and contributions on how we can improve this area of work.

A summary of the key points of our response is provided below. Our response to the consultation questions, in full, is provided underneath the summary.

- The medical workforce in England will require new ways of working and new ways of tailoring investment to meet the future needs of patients and the public. Demand for anaesthetic and intensive care medicine services is expected to increase by 25% by 2033 and will require additional significant investment to meet this demand.

[1] NHS 5 Year Forward View. 2014 https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

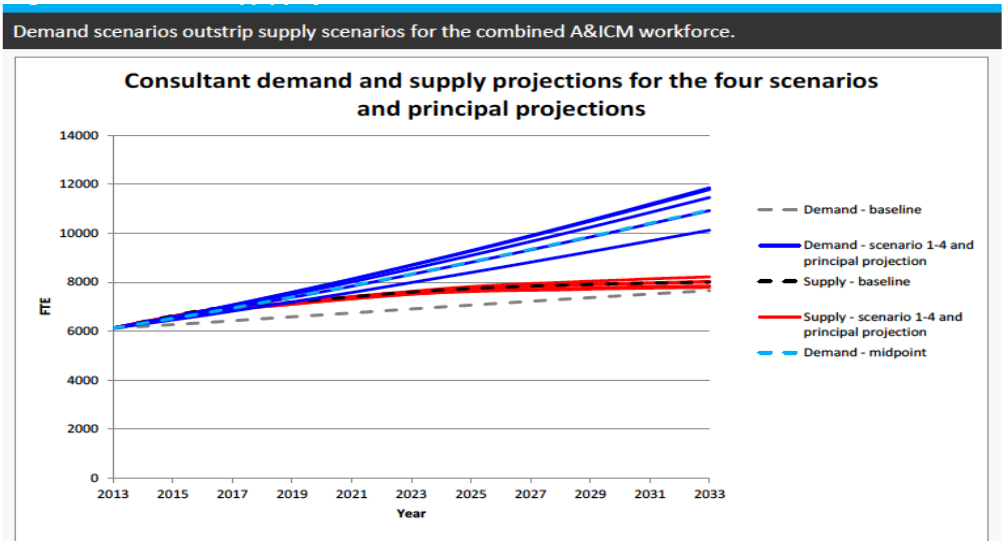
[2] Centre for Workforce Intelligence in-depth review of anaesthesia and intensive care medicine. 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/507348/CfWI_Anaesthetics_ICM_main_report.pdf

- The RCoA supports the 6 principles contained in the strategy as a framework for workforce development and investment for England.
- Workforce planning should be organised to achieve benefits at regional level and also support national workforce priorities. The RCoA supports the Faculty of Intensive Care Medicine (FICM) view that there is strong evidence[3] to support a further increase in the ICM workforce. However, any funding for ICM expansion should not be taken from anaesthesia budgets without a joint review and consensus from all relevant parties.
- Workforce planning in England should include considerations for consultants, staff working less than full time, SAS/trust grade doctors, trainees, non-medical professionals and the wider multi-professional workforce

General comments

The Centre for Workforce Intelligence (CfWI) in-depth review of anaesthesia and Intensive Care Medicine, published in 2015, reported that the demand for anaesthesia and ICM services is expected to exceed supply right up until 2033. The report also identified an existing unmet need of 15% in anaesthesia and 25% in ICM. The RCoA Workforce Census of 2015,[4] which received a 100% response rate from departments across the UK, corroborates the CfWI findings of the need for growth in consultant and SAS doctor supply, both to meet current service requirements and to accommodate predictable projected growth.

The graph below is taken from the CfWI in-depth review. The black dotted line represents the current supply of training numbers, and the workforce behaviour with no changes to key modelling assumptions. The four blue lines represent the expected or most likely future demand according to the expert panel participating in the Delphi study on the four scenarios presented to them. All of the possible future demand scenarios are higher than the supply line.



[3] The Faculty of Intensive Care Medicine. Critical Futures. 2017. https://www.ficm.ac.uk/sites/default/files/critical_futures_2017_1.pdf
[4] Royal College of Anaesthetists. Medical Workforce Census. 2015. https://www.rcoa.ac.uk/system/files/CENSUS-REPORT-2015.pdf

To summarise, the CfWI Delphi process suggested that 15% of current anaesthesia need and 25% of current ICM need is unmet today. The baseline demand for anaesthesia services is expected to increase by 25% by 2033 due to demographic changes alone. The baseline supply of anaesthetists up to 2033, based on scenarios generated in the in-depth review, show an undersupply in the anaesthesia workforce.

There are a total of currently 7422 consultant anaesthetists in the UK – 6,019 in England. Staff and Associate Specialist (SAS) doctors are a heterogeneous group which includes associate specialists, specialty doctors and staff grade doctors. There are 2,033 SAS doctors working in anaesthesia in the UK - the CfWI projects that we will experience a shortage of anaesthetists over the next 15 years in England, and recommends an expansion of 30% of the workforce while taking likely workforce scenarios into consideration.

The draft strategy document rightly identifies that the current workforce growth has not kept up with the level of demand in the system. Faced with this challenge in developing a workforce to support healthcare services of the future, it is disappointing that the draft strategy document does not recognise the aging demographic of the medical and multi-professional workforce in England. There is a developing issue caused by the impending retirement dates among the consultant workforce, which couples with 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 of the consultant population[5]. 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[6]. While data shows 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[7].

This trend will undoubtedly require new ways of working and a different approach to planning new proportions of participation in the workforce and retirement. This trend has been modelled in the 2015 RCoA workforce census using the assumptions that those over the age of 50 would be likely to retire in the next 15 years – this pattern is consistent across England and all of the devolved nations. The table below outlines the age distribution of consultants in England and illustrates that there is a proportion of the workforce aged within the 50-64 bracket who may soon be thinking of retirement.

[5] The Association of Anaesthetists of Great Britain & Ireland. Anaesthesia News, August 2016 (no.349). ISSN 0959-2962

[6] General Medical Council. 2017 national training surveys summary report: initial results on doctors' training and progression. November 2017

[7] General Medical Council. Training pathways: analysis of the transition from the foundation programme to the next stage of training. Working paper 1 – November 2017.

Table 3 Age distribution of consultants (2015)

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[8] that will need to be taken into account and modelled when introducing new models of workforce planning and projections of participation rates.

CONSUTATION QUESTIONS

Question one: Do you support the six principles proposed to support better workforce planning; and in particular, aligning financial, policy, best practice and service planning in the future?

Yes. The RCoA is supportive of the principles outlined in the strategy. They represent an aspiration to develop the NHS in England as a model employer of people from all walks of life who would be able to develop their careers throughout their lives.

A framework for workforce planning that can both meet the national policy priorities but also be sufficiently flexible to respond to local need and requirements is a progressive step forward in guiding long-term investment decisions.

We do have concerns about how practical and realistic these principles are against a backdrop of current rules and regulations within the Gold Guide, the Medical Act (1983) and current training structures. We can see positives in the principle of greater flexibility in professions and careers from a morale & welfare point of view, and responding to the individual and system requirements. This could be envisaged for professionals in roles such as a healthcare assistant being given the ability and chance to train as an ODP as positive, however too much upward progression risks leaving the lower ranks denuded. Flexibility in medical roles and the training of generalists is difficult to envisage although transferable competencies during training

[8] Royal College of Anaesthetists Medical workforce census. 2015. https://www.rcoa.ac.uk/system/files/CENSUS-REPORT-2015.pdf

would be a very positive move and make medical careers more attractive, providing trusts and doctors greater flexibility to respond to changing a landscape[9] [10].

Sustainability and Transformation Partnerships (STPs) provide a significant opportunity for a range of organisations to work together to develop effective and sustainable plans for the workforce in England to improve health and support future models of service delivery.

The RCoA supports STPs in that they must be in the best interests of patient care and not have financial savings as their primary focus. RCoA also supports strong clinical engagement in the development, governance and delivery of STPs and there must be proper consultation with patients and patient groups to inform decision-making. These working arrangements will be key to ensuring that decisions on the future model of service delivery are in tandem and aligned to that of the workforce to deliver that service[11].

Research from the Nuffield Trust found that some STPs are targeting up to 30 per cent reductions in selected areas of hospital activity, including outpatient care, A&E attendances and emergency inpatient care[12]. These reductions are being planned in the face of steady growth in all areas of hospital activity, including the doubling of elective care over the past 30 years. It seems clear therefore that maintaining the required levels of patient care in parallel to the pursuit of a reduction in activity, will require a major overhaul of how patient care is delivered – and the layout of the care pathway.

The RCoA introduced its Perioperative Medicine Programme at the beginning of 2015. A document entitled Perioperative Medicine: The Pathway to Better Surgical Care,[13] describes the vision for this emerging multidisciplinary approach, and outlines the improvements to patient outcomes that could be achieved by developments in perioperative medicine, as well as setting out how the anaesthesia profession could achieve these goals.

There are a multitude of drivers behind this work, including:

- a growing elderly population, undergoing more and more complex surgical procedures
- increasingly complex medical co-morbidity at the time of surgery
- strong evidence that preoperative and postoperative interventions can improve outcomes, reduce complications and decrease length of stay
- an underlying requirement to use resources such as high-dependency and critical care facilities as efficiently as possible
- a loss of considerable numbers of junior surgical training posts to support the 'Broadening the foundation programme' initiative, and increased recruitment into primary care necessitating changes in the way that perioperative care is provided.

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[9] Health Education England, Enhancing junior doctors' working lives. https://hee.nhs.uk/sites/default/files/documents/Enhancing%20junior%20doctors%20working%20lives%20-%20a%20progress%20report.pdf

[10] Royal College of Anaesthetists, A report on the welfare, morale and experiences of anaesthetists in training: the need to listen. 2017. https://www.rcoa.ac.uk/document-store/welfare-morale-report-2017

[11] Royal College of Anaesthetists. Sustainability and Transformation plan policy briefing. 2017. https://www.rcoa.ac.uk/sites/default/files/RCoA-STPsBriefingMay2017.pdf

[12] Imison, et al. 'Shifting the balance of care: Great expectations'. Nuffield Trust. March 2017

[13] Perioperative Medicine: The Pathway to Better Surgical Care https://www.rcoa.ac.uk/perioperativemedicine

There are approximately 250,000 patients undergoing surgical treatment each year who are identified as being at high risk of complications, and this number is set to increase in the future. Anaesthetists have always possessed many of the professional skills and qualities required to contribute to perioperative care, with more and more anaesthesia skills and capabilities being used in an 'out-of-theatre' environment. This is a trend that is increasing across the UK, and it will continue to do so over the coming decades in order to meet the demands of patients presenting for surgery with increasingly complex co-existing medical conditions.

Developing perioperative services can also make a considerable contribution to the efficiency of NHS care by reducing complications and lengths of stay in hospital. There are already units that are able to show cost savings as a result of careful patient selection, preoperative optimisation, and the appropriate use of hospital facilities. The knowledge and skills required to undertake perioperative roles are considerable, and this work represents a natural extension to the role that consultant anaesthetists play in the care of patients. However, there are significant workforce requirements associated with this expanding area of work and, given the complexity of this care, much of it will need to be delivered by consultants.

In 2014 the RCoA published its vision for the development of perioperative medicine - 'Perioperative medicine: The pathway to better surgical care' (hereafter referred to as the *vision document*)

- Reduce variation
- Improve patient outcomes
- Around 250,000 high-risk patients undergo surgery in the NHS – approximately 15 per cent of hospital inpatients with surgical needs
- Encompassing the principles of enhanced recovery
- Prevention and treatment of medial complication
- Multi-disciplinary perioperative medicine team (which may be led by an anaesthetist). This team provides a single point of contact for surgeons and GPs coordinating the care of these complex patients

There have also been considerable developments in the provision of perioperative medicine services over the last two years. A network of perioperative leads has been established, and is led by two RCoA-sponsored national perioperative medicine leads, Dr Mike Swart and Dr Chris Snowden.

What data do we need to ensure we can plan effectively, and how do we align across workforce, finance and service planning?

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

1. 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.
2. The true impact of winter pressures in terms of staff time and rotas[14]. 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.

[14] 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

The RCoA workforce census shows that nearly three-quarters (74%) of consultant anaesthetists currently work more than 10 Programmed Activities (PAs), and of these 75% are male and 25% are female. 8.5% of consultants work nine or fewer PAs, and there are more female consultants than male in this group (5.4% vs 3.1%).

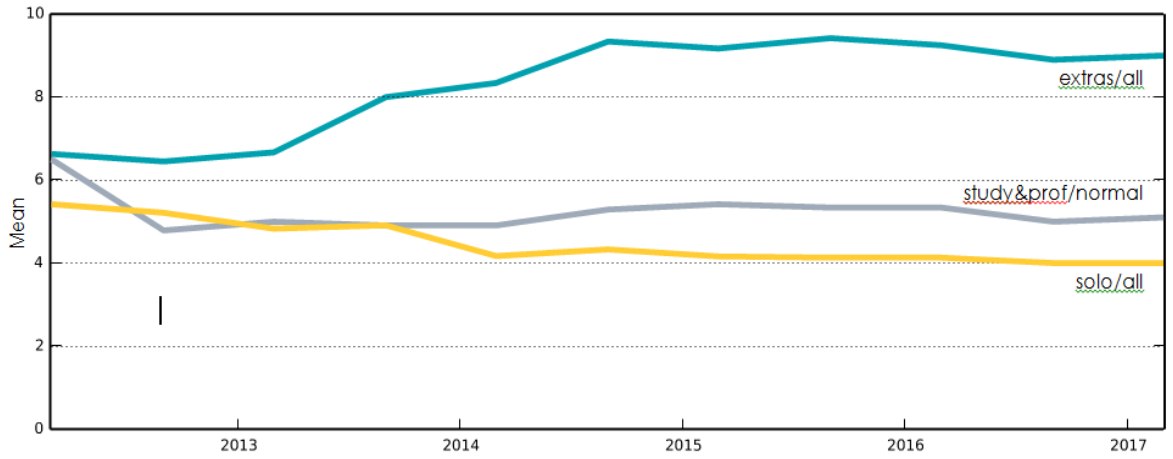
The traditional ways and patterns for how consultants are working is changing more and more. The RCoA workforce census data shows that around 40% of departments reported they are participating in both elective and emergency evening and weekend sessions.

Data on additional sessions

The Rotamap system helps NHS departments plan and report on anaesthesia activity. Rotamap manages over 10,000 NHS anaesthetists (including anaesthetists in training) around the UK, with 102 trusts using the system.[21]

The graph below shows averages taken from cross-departmental benchmarking conducted at six monthly intervals. The data shows that the dependence on extra sessions has been growing over the last four years. It also shows that, although there was a slight decline in the number of extra sessions at the end of 2016, it continued to rise again in 2017.

Extra, study and professional leave and solo as a percentage of all activity



It can be seen from the graph that, in order to cover list-work, departments rely much more heavily now than they did four years ago on doctors undertaking additional sessions above and beyond their job plan, for which they are paid extra. Despite the fact that this is paid work, this cover does, nonetheless, depend heavily on the goodwill of doctors; the more doctors feel burnt out, pressurised and undervalued, the less effective this measure becomes as a way of meeting patient need.

There has been an increase in the need for three-session days and weekend work, much of which is being provided as extra sessions worked by existing anaesthetists or by consultants on the retire-and-return scheme.[22] Therefore, although there is a rise in activity resulting from three-session days and from extra paid list-work, this is being achieved without a corresponding significant increase in the number of anaesthetists.

The Rotamap system supports the management of rotas in two-thirds of UK anaesthesia departments. The crucial point about the data we have from Rotamap is that it reveals a significant increase in extra work undertaken beyond full-time contracts. This is a strong consolidated measure of unmet need and of the corresponding increased pressure on existing staff.

For what sort of measures/plans/proposals should the Workforce Impact Assessment be used?

There continues to be growing concern over the inconsistent specialty-training fill rates, and these have been highlighted to HEE. Although there has been an increase in the number of training posts in some years (2015 and 2017), nationally we are not achieving 100% fill rate. Furthermore, since 2015 the fill rate has fallen by more than 7.5%, suggesting a more concerning trend. Reduction in the number of posts offered on a regional/ local level, and which is contrary to a national policy agenda should only be done following a workforce impact assessment of the likely impact on the future of that specialty and associated specialties. For example, the RCoA support the Faculty of Intensive Care Medicine (FICM) view that there is strong evidence[15] to support a further increase in the ICM workforce. However, any funding for ICM expansion should not be taken from anaesthesia budgets without a joint review and consensus from all relevant parties.

Question two: Do you feel the measures to secure the staff the system needs for the future can be added to, extended or improved, if so how?

Are there any fresh ideas for attracting more people to work in the NHS, either as new recruits or returners.

While we have welcomed the plans to increase medical school places,[16] this new cohort of medical students will not graduate until 2023, and those who go on to opt for specialist training in anaesthesia are anticipated to complete training in 2032; they cannot, therefore, be considered as a short-term 'auxiliary' in the immediate post-Brexit period after 2019. Furthermore, it is unknown whether additional medical school places will be enough.

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, as gender demographics change, 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.

It is likely that many more doctors will work what is now 'part time'[17], 35 hours per week. This trend will need to be factored into workforce planning for anaesthetic and perioperative care services for the future.

NHS hospitals rely heavily on free movement within the EEA to facilitate the recruitment, not only of clinicians, but also of non-clinical staff, such as nurses, porters, cleaners and technicians. Without this range of support staff, a hospital simply cannot

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[15] The Faculty of Intensive Care Medicine. Critical Futures. 2017. https://www.ficm.ac.uk/sites/default/files/critical_futures_2017_1.pdf

[16] Medical places to increase next year. *BBC Health,* August 2017

[17] British Medical Association. Understanding trends among current doctors in training. 2018. https://www.bma.org.uk/-/media/files/pdfs/collective%20voice/policy%20research/education%20and%20training/junior-doctors-career-trends-survey.pdf?la=en

operate. A flexible immigration system is required post Brexit that will allow UK healthcare providers to continue to attract talent from outside the UK in response to skills shortages, rather than being based on salary thresholds and complex visa systems.

As we leave the EU, there may be an opportunity to attract back a number of people who are doing medical qualifications in Europe. Each year, a number of UK students who want to study medicine, but who are unsuccessful in gaining entry to UK universities, go to study in places such as Holland, Czech Republic and Hungary. Many come back to the UK to work as doctors. It might be possible to establish a few university courses to support these people to return and complete their degrees in the UK. Currently some European countries charge 1,500 Euros per year for these courses, but they may become much more expensive to UK students as they become non-EU citizens.

As the effects of night shift work are better understood, it is likely that people will no longer accept the impact this has on their own health. Between December 2016 and January 2017, the RCoA conducted a survey of anaesthetists in training on the issues of morale and welfare, and this received more than 2,300 responses. The report of the findings was published in December 2017.[18] The survey revealed that 85% of anaesthetists in training are at risk of becoming burnt 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 the findings that:

- 61% of respondents felt that their job detrimentally affected their mental health
- 64% felt that their job had detrimentally affected their physical health
- 75% of respondents reported working a shift without adequate hydration
- 95% of respondents had stayed on after their shift

In June 2017, the results of a separate survey concerning the impact of fatigue among anaesthetists in training were published in the journal *Anaesthesia*[19]. 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
- more than half of respondents (57%) have had an accident or a near-miss
- 84% of respondents have felt too tired to drive home after a night shift
- 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 training in the recent RCoA surveys, and to address the reasons why these doctors are at a higher risk of burnout, why they are feeling undervalued, and why they feel that their job is negatively impacting on their physical and mental health.

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[18] Royal College of Anaesthetists. A Report on the Welfare, Morale and Wellbeing of Anaesthetists in Training; The need to listen. 2017. https://www.rcoa.ac.uk/system/files/Welfare-Morale2017.pdf

[19] McClelland L *et al.* A national survey of the effects of fatigue on trainees in anaesthesia in the UK. *Anaesthesia* 2016; **72(9)**:1069–1077

What scope is there to extend workforce flexibility using ideas such as credentialing, transferable qualifications, scope of practice and others?

The RCoA believes that non-medically-qualified staff can make a valuable contribution towards a sustainable anaesthesia workforce, but only if these roles are properly regulated. Therefore, the RCoA strongly supports the introduction of statutory regulation of Physicians' Assistants (Anaesthesia) (PA(A)s) and Advanced Critical Care Practitioners (ACCPs). Such regulation will facilitate augmentation of the anaesthesia and critical care workforces respectively.

The RCoA currently administers a voluntary register for PA(A)s, and only recognises those who have qualified by completing the approved UK training programme, and who have subsequently been entered on the voluntary register. We would not support any advancement of the role without statutory regulation being in place.[20] There are currently 179 qualified PA(A)s in the UK. These numbers are small and pending statutory regulation the numbers are unlikely to grow substantially.

Credentialing needs to be fully clarified in order for this issue to be properly considered and responded to. The terminology, entry criteria, quality assurance, funding and exit criteria need to be fully articulated and agreed by all relevant stakeholders following consultation, as the current concept is open to misinterpretation and confusion. The RCoA welcomes work from the GMC on clarifying credentialing however, it is important that this work is not conducted in isolation from Shape of Training developments.

Currently Pre-Hospital Emergency Medicine (PHEM) is the only GMC recognised subspecialty programme in Anaesthetics. PHEM is a new area of practice focusing on the specialist provision of on-scene and in-transit critical care. However, there are increasingly more practitioners and specialists becoming engaged with and inputting into PHEM care. General practice is a specialty which has significant exposure, history and presence in this area of practice and yet cannot be recognised due to no sub specialisation in general practice. Therefore PHEM would lend itself to being considered as a possible post CCT credential, or possibly within CCT if this concept were to be adopted.

The question of possible areas suitable for pre-CCT credentialing or whether it should just be a post-CCT concept is dependent upon concept being defined and clarified by the regulator and associated organisations.

Sedation would be a useful skill that could be shared more with professions such as dentists, endoscopists etc. The Academy of Medical Royal Colleges has produced standards and guidance on safe sedation practice for healthcare procedures[21].

Pain Medicine benefits from being part of the overall training programme for anaesthetics, bringing skills in pain management that benefit a generalist. As pain medicine is a cross cutting and a common medical presentation there is a case for pre CCT credentialing for other specialties which effectively would be based on current content and methods of delivery of advanced pain medicine training.

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[20] Joint statement from the RCoA and AAGBI on the Scope of Practice of Physicians' Assistants (Anaesthesia). 2016. https://www.rcoa.ac.uk/sites/default/files/JointStatementPAA2016.pdf

[21] The Academy of Medical Royal Colleges: Safe Sedation Practice for Healthcare Procedures Standards and Guidance (2013) http://www.aomrc.org.uk/doc_view/9737-safe-sedation-practice-for-healthcare-proceduresstandards-and-guidance

Question three: Do you have comments on how we ensure the system is effectively training, educating and investing in the new and current workforce?

Are there any specific areas of curricula change or new techniques such as gamification or new cross cutting subjects like leadership, public health or quality improvement science that should be taught to all clinicians?

As outlined in the RCoA's recent report into morale and wellbeing, people should learn about ways of managing their own and their team's wellbeing. All health professionals should understand the impact that fatigue has on performance and be equipped with ways of mitigating this. They should also understand how to recognise colleagues who might be burned out, at risk of burnout and be skilled in supporting those with mental health issues on how to seek the support they need.

Quality Improvement (QI) is a fundamental part of a doctors duties[22] and vital to grow and develop services to meet the financial and demographic challenges of the future[23]. Doctors and other healthcare professionals must be able to learn improvement skills including collaboration and team working, best taught in a multidisciplinary environment, including with managers as all improvement work will include collaboration, often across professional and sometimes organisational boundaries.

It is increasingly clear that the 'soft' skills are vital for improvement (and leadership), and so curricula will need to include negotiation, collaboration, dealing with conflict and the Academy of Medical Royal Colleges is developing guidance on how this can be achieved in curricula.

The most effective way of becoming skilled in the above is to participate in improvement work during clinical placements, rather than out of programme or on external courses etc. Facilitated/coaching of trainees and colleagues conducting projects during placements is best. However the issue that limits this is time to complete something, and unconducive rota structures commonly act as a barrier.

Therefore sufficient time must be allowed to undertake and participate in QI work alongside clinical work - high functioning US hospitals give clinicians 15% of their paid time dedicated to leadership/QI. 15% might be aspirational, but some capacity over clinical requirements for doctors to undertake leadership/ improvement roles must exist when planning the workforce.

How does the system ensure it spends what is needed on individual CPD and gets the most effective outcomes from it?

Participation in CPD is one of the annual supporting information requirements for revalidation. Another important requirement for revalidation is an annual appraisal meeting during which the doctor's CPD will be reviewed and their future personal development activities established during their Personal Development Plan, so there will be this verification done on an individual basis. These important aspects of professional development should be extended to a wider range of professional groups to ensure people remain in up to date and to promote equity of access.

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[22] Generic Professional Capabilities. General Medical Council. https://www.gmc-uk.org/Generic_professional_capabilities_framework__0817.pdf_70417127.pdf

[23] Quality Improvement – training for better outcomes. Academy of Medical Royal Colleges. http://aomrc.org.uk/wp-content/uploads/2016/06/Quality_improvement_training_better_outcomes_140316-2.pdf

Question four: What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?

What more can be done to create careers not jobs for all staff, regardless of qualifications, entry level and current skills?

The draft strategy document comments that some of the increase in people leaving the NHS and related careers may be due to pressure of work, some because of lack of flexibility, some due to pay, and some because people feel they are not getting the career development they want. This is reflected within the RCoA work on career pathways in anaesthesia and our work on morale and wellbeing.

One reason for this is organisational culture. Organisations that pay attention to the wellbeing of staff, with good working relationships, well-designed jobs good support and health-related initiatives such as sensible work-life balance, do better [24]. However in working conditions where committed professionals become burned out and the organisation becomes a harder environment to work within, commonly targets and financial sanctions become priority areas. It would be better to emphasise the approach of appreciative inquiry, praising the good, in the way Don Berwick described in his 2012 report[25].

What reforms are required to medical education and training to deliver the doctors the system needs in the future but also supports the needs of the system now?

Training, working patterns and careers need to become more flexible as the working environment and societal approaches to change[26]. The RCoA have already started this approach by reviewing the training curriculum and associated assessment framework in order to ensure the curriculum continues to allow the system to develop careers and roles that are general enough to provide anaesthetic and perioperative services in district general hospitals, but also to allow individuals to tailor, switch and evolve their careers in a flexible way.

Question five: Do you have an comments on how to better ensure opportunities to; and meets the needs and aspirations of; all communities in England?

What more can be done to attract staff from non-traditional backgrounds, including where we train and how we train?

One area that we could attract more people to medicine from are lower socio-economic backgrounds. Like anywhere they have pupils who have the innate ability to work in the NHS; what they lack are role models and the self belief that they can

[24] The Wellness Imperative: Creating More Effective Organisations, 2010 The World Economic Forum

[25] A promise to learn – a commitment to act: Improving the Safety of Patients in England National Advisory Group on the Safety of Patients in England. 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

[26] Adapting for the future: a plan for improving the flexibility of UK postgraduate medical training. General Medical Council. 2017. https://www.gmc-uk.org/Adapting_for_the_future__a_plan_for_improving_the_flexibility_of_UK_postgraduate_medical_training_FINAL.pdf_69842348.pdf
uk.org/Adapting_for_the_future__a_plan_for_improving_the_flexibility_of_UK_postgraduate_medical_training_FINAL.pdf_69842348.pdf

get there. In medicine, it would be possible to encourage a group of medical students and trainees [and indeed consultants] to train as mentors and then use their skills to support such individuals to achieve their full potential. There is currently a differential attainment in relation to ethnic background that is apparent both in medicine[27] and also experienced within anaesthesia[28] . The issues this raises in the context of a curriculum designed to develop capabilities of doctors for UK practice and the complex sociological, cultural and behavioural issues which will need to be studied in more detail. Further insights and understanding into equality and diversity and cultural differences are required to ensure staff from non-traditional backgrounds have access to careers within the NHS.

How we better support carers, self carers and volunteers?

The report comments that 'HEE is announcing a series of workstreams and reviews to look at how we can better support the education and training needs of volunteers, carers and patients.' Some volunteers, carers and patients have a much deeper understanding of managing an individual's health than do doctors and nurses, who are experts on the disease and not the impact a disease has on a particular individual. However, too often carers do not receive the recognition and support that they need and deserve. [29]. Providing resources, guidance and toolkits for carers around providing care, information on support networks and some of the principles of patient care and rehabilitation. Some volunteers, who work with charities concerned with a particular disease [e.g. breast cancer or diabetes] also bring a vast array of knowledge, which is less well used than it might be by the professionals.

Question six: What does being a modern, model employer mean to you and how can we ensure the NHS meets those ambitions?

What more would make it more attractive to work or stay in the NHS as you progress through different careers stages?

One aspect that doesn't get sufficient mention is staff well-being. There have been significant reports into the health and well-being of NHS staff[30] [31]which set out aspirations for the NHS to be a beacon for exemplar service, excellence in developing staff and embedding wellbeing. The workforce strategy presents an opportunity to take these ideas forward, for instance one of the 6 principles [page 19]:

> *'Ensuring the NHS and other employers in the system are inclusive modern model employers with flexible working patterns, career structures and rewards. These need to support staff and reflect the way people live now and the changing expectations of all the generations who work in the NHS. To retain dedicated staff now and in the future requires employment models that sustain the values which drive health professionals every day whilst protecting*

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[27] Independent research for the GMC shows ethnicity still a factor in future doctors' prospects. General Medical Council. https://www.gmc-uk.org/news/27480.asp

[28] Differential pass rates in the FRCA. The Bulletin92.2015. Royal College of Anaesthetists. https://www.rcoa.ac.uk/system/files/CSQ-Bulletin92.pdf

[29] NHS England's Commitment to Carers. 2014. https://www.england.nhs.uk/wp-content/uploads/2014/05/commitment-to-carers-may14.pdf

[30] The Boorman Report on the Health and Well-Being of NHS Staff: Practical advice for implementing its recommendations. 2010. https://www.robertsoncooper.com/files/boorman_download.pdf

[31] Eight high impact actions to improve the working environment for junior doctors. https://improvement.nhs.uk/uploads/documents/NHS-8-high-impacts-A4v5Bm_with_stickynotes_5_7dglFbL.pdf

against burnout, disillusionment or impossible choices between work and home life.'

could be re-framed to also include an emphasis on well-being. For example: "Ensuring the NHS and other employers in the system are inclusive modern model employers with flexible working patterns, career structures, an emphasis on individual and team well-being and rewards.

What should the system do to ensure it is flexible and adaptable to new ways of working and differing expectations of generations?

The document states that NHS staff remain respected and admired, yet more staff are leaving, and increased part-time working among certain staff groups adds to the challenge of maintaining growth.

Although this is factually correct it could be interpreted as negative towards part-time working. The opportunity to work part time offers a good opportunity to retain experienced staff, so enhances rather than detracts from maintaining staff numbers and skill sets. However there are not enough role models in senior NHS staff who work part time. It is clear that excellent senior women have been 'passed over' for promotion in other areas of industry and services sometimes because they have worked part time. To be the employer of choice, the NHS would benefit from having part timers in all senior roles perhaps with job shares becoming more the norm.

Question seven: Do you have any comments on how we can ensure that our NHS staff make the greatest possible difference to delivering excellent care for people in England?

What opportunities are there for making a difference through skill mix changes, staff working flexibly across traditional boundaries, and enabling staff to work as the top of their professional competence?

Perioperative medicine also provides significant benefits to new ways of thinking about the way in which anaesthesia works alongside and integrates with other specialties and areas for example:

The document comments [p 39]:
Medical Associate Professions (MAP) roles are trained to the medical model to augment service delivery alongside doctors. They are competent to practise in a range of specialties and can offer continuity of care, particularly in acute settings and GP practices.

The RCoA believes that registered, regulated PA(A)s and ACCPs supervised by medically qualified consultants, can make a valuable contribution towards a sustainable anaesthetic and intensive care workforce as part of integrated professional teams. A PA(A) is able to help with a range of clinical services, including improving the throughput and efficiency of theatre environments. However, PA(A)s do not replicate the same breadth and depth in their scope of practice that a fully trained anaesthetists provides.

The postgraduate diploma from the University of Birmingham is workplace-based and completed over 24 months with an additional three months probationary period served in clinical practice. The course comprises 12 modules which introduce trainee PA(A)s to the clinical practice of anaesthesia, the use of anaesthetic equipment, monitoring principles and relevant applied basic sciences. PA(A)s provide support in a range of hospital settings across the perioperative pathway, including:

- Preoperative assessment and planning anaesthetic care
- Intraoperative environment including regional anaesthesia
- Vascular access
- Procedural sedation
- Recovery from general and regional anaesthesia
- Membership of the resuscitation team

What more should we do to help staff focus on the health and wellbeing of patients and their families?

In the RCoA's 2017 report in to the morale, wellbeing and welfare of anaesthetists in training, we presented a key recommendation for government to establish a national strategy that makes practical recommendations for the working conditions for staff and identifies the facilities necessary in order to provide safe and sustainable patient care.

One way of addressing this would be to establish the idea that every employing organisation focuses on the health and wellbeing of its staff, as a cultural norm in the NHS and social care. NHS staff could be given the opportunity, during working hours, to take positive steps to improve their own well-being. Simple steps would be to allow only the shops that sell healthy food to be within hospital grounds.

The impact that night shift work and chronic fatigue has on older workers is profound. As people age, their processing speed, short-term memory and ability to retain new facts all fall - tiredness worsens this[32] [33]. Night shift work is also associated with high rates of chronic diseases such as diabetes and hypertension and also with cancer. If the health service is to retain an effective workforce, this must be taken into account in workforce planning.

What are the most productive other areas to explore around management and leadership, technology and infrastructure?

The strategy document states the following:
'*Core NHS values need to resonate in organisational culture. Leaders must be committed to doing the right thing for patients and staff within a culture of equality and diversity*.' [p 45]

Whilst this is a valid and good commitment, we feel that this could perhaps should go further by embodying such a culture. The Faculty of Medical Leadership and management [FMLM] states that:

> *'The team should ensure all team members hold themselves and each other to account for behaving according to the team's values and their own professional standards, with systems in place to allow concerns to be escalated appropriately when they arise.'*[34]

This statement addresses and encompasses leadership and vision, people, relationships between multidisciplinary teams, the organisational culture all of which are integral to effective leadership and team working.

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[32] Time to change the culture of fatigue in hospitals. AAGBI fatigue resource pack. https://www.aagbi.org/professionals/wellbeing/fatigue
[33] Fatigue education resources. AAGBI. https://www.aagbi.org/professionals/wellbeing/fatigue/fatigue-resources
[34] Leadership and management standards for healthcare teams. FMLM. https://www.fmlm.ac.uk/team-standards

Shared decision-making between clinician and patient is seen as vital. There is clear data from other industries showing that shared decision-making between employers and employees leads to better staff morale (and in healthcare settings, a more patient-centered approach). Yet the common style in the NHS is to state what the problem is and then state the organisational plan to address this. Unfortunately in many circumstances, the analysis of the problem is limited, the 'solution' has unintended negative consequences and implementation is by mandate rather than engagement.

One way of addressing this would be to include training on managing dilemmas and problems in the curriculum, with the expectation that each person would be involved in leading and managing a change in their own clinical area. Gerard Egan's Skilled Helper model is a useful framework for learning, and there are examples of this being effectively taught and used e.g. Leicester Medical School, Association of Anaesthetists of Great Britain and Ireland.

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[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