HEE Workforce Planning 2014/15 – Call for Evidence

To submit your evidence please complete this form. Please make your submissions relevant to the categories provided in the boxes provided. We have categorised the known drivers of demand and supply under the following headings, and believe this to be a comprehensive description of the variable involved.

You can provide extracts of reports into the free text boxes below, or submit a whole report with this form by clicking on the email at the bottom of this form. Please mark clearly in the email which of the below categories the report/evidence relates to, including any relevant page numbers. Where an extract is provided, please reference the source.

Please use Part 3 to submit any information/evidence that does not fit the below categories. You can also leave any comments/observations in the free text box.

Before completing the form below please submit your contact details here:

Name: Miss Afsana Choudhury……..

Job title: Workforce Planning Co-ordinator, The Royal College of Anaesthetists……...

Organisation: Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain and Ireland

Contact email: achoudhury@rcoa.ac.uk……

Contact number: 020 7092 1652……

Form submission:

Once completed please submit the form via email to hee.workforceplanning1@nhs.net making sure all supporting documents are also attached to the email.

Please make the subject of the email: HEE Workforce Planning 2014/15 Call for Evidence-[Insert your organisation's name]

Data Protection and Freedom of Information

The information you send us may be made available to wider partners, referred to in future published workforce returns or other reports and may be stored on our internal evidence database.

Any information contained in your response may be subject to publication or disclosure if requested under the Freedom of Information Act 2000. By providing personal information for this review it is understood that you consent t its disclosure and publication. If this is not the case, you should limit any personal information provided or remove it completely.

If you want the information in your response to be kept within HEE's executive processes, you should make this clear in your submission, although we cannot guarantee to be able to do this.

PART 1 – Future Service and Workforce Models

1. Drivers of Future Service Demand

- Needs identified by patients and the public
- Activity and epidemiology

- Quality. Innovation, prevention and productivity
- Funding
- Other

2. Future Service Models

3. Future Workforce Models

- Associated knowledge and skills – and assessments of the supply and demand position*
- Associated values and behaviours – and assessments as above*
- Workforce structure, team structure, skill mix, new roles.
- Workforce performance and productivity

*NB: – this may include views on the efficacy and quality of education processes in equipping staff with these skills, knowledge, values and behaviours.

Drivers of Future Service Demand

- There is an increasing body of high quality evidence demonstrating better patient outcomes with improved efficiency of care delivery associated with a consultant delivered service.
- There is irrefutable evidence of the effect of future demography on demand for Anaesthesia care; demand that cannot be mitigated by a general policy direction to shift secondary (hospital) care to primary and community care.
- The CfWI In-Depth Review on Anaesthetics and ICM due to be published in September 2014 has identified a 15-25% baseline increase in demand.
- The College and the NHS support consultant delivered services and recognise the contribution that trainees make. However where the amount of time those consultants spend in service is increased in association with a reduction in training numbers, the ability to provide supervised quality training is compromised. This has become apparent following cuts to NTNs in Leeds where the reduction in trainee numbers is adversely affecting the frequency of trainee/consultant interactions, in both service and training with significant cost implications to the Trust. Such issues appear prevalent in other specialties, most notably Emergency Medicine where a crisis point has been reached and remedial action required. It is essential to avoid a similar situation occurring in anaesthetics.
- The GMC 2014 National Trainee Survey results record high outlier satisfaction for anaesthetics with overall satisfaction the highest for all hospital specialties (85.5/100). Clinical supervision is high at 92.7/100. Foundation trainees undertaking anaesthetic rotations recognise the high quality of training and supervision. http://www.gmc-uk.org/education/surveys.asp?WT.mc_id=MENE140618.

Seven Day Consultant Present Care http://www.aomrc.org.uk/projects/seven.html.

- Better care for patients over weekends and Bank Holidays to meet demand of 21st Century. Clinically led reconfiguration with involvement of patients and their families. The Academy of Medical Royal Colleges (AoMRC) encouraging NHS and DH to look at costs and benefits.
- Two recent audits have demonstrated that care delivered by consultants has a clear impact on patient survival rates, reduces complications and improves quality of care. There is an emphasis on two common procedures, emergency laparotomy and hip fracture fixation; outcome data for other procedures will become available through the PROMS program. Both are common in the elderly population, a group set to double in number over the next 20 years. These are The National Emergency Laparotomy Audit (NELA) and The 2010 National Enquiry into Perioperative deaths (NCEPOD) " An Age Old Problem".

The National Emergency Laparotomy Audit (NELA) http://www.nela.org.uk/reports. On-going audit which has identified the need for better quality of care in increased standards in emergency laparotomy to reduce the current 15% mortality rate. NELA has published a variety of multidisciplinary recommendations and

standards that are intended to improve and safeguard the quality of care of all patients undergoing emergency laparotomy. These include surgery performed under the direct care of a consultant surgeon and consultant anaesthetist, prompt access to an operating theatre and admission of high-risk patients to intensive care following surgery. Many hospitals do not meet current standards in respect of essential facilities and consultant staff required to provide an acceptable standard of care for patients requiring emergency laparotomy. NELA make 11 recommendations made including 24hr access to fully staffed operating theatres, direct care by consultant anaesthetists and increased support to elderly patients. NELA includes the following standards for anaesthetic provision:

- A consultant surgeon (CCT holder) and consultant anaesthetist are present for all cases with predicted mortality
- All patients undergoing emergency surgery requiring anaesthesia should be seen by an anaesthetist for assessment and pre-operative optimisation; the exact timing of this visit will be dependent upon the urgency of surgery (RCoA GPAS)
- The peri-operative anaesthetic care of ASA3 and above patients requiring immediate major surgery (and therefore with an expected higher mortality) is directly supervised by a consultant anaesthetist (RCS USC). *When this happens out of hours, consultants are spending significant amounts of time working at night. Consideration will have to be given either to time off the day after or full shift working. Both require an increase in numbers.*

(This first stage NELA report investigated the structures and processes in place for emergency abdominal surgery at 190 hospitals in England and Wales, with patient-level data to be reported for the first time in summer 2015.)

The 2010 National Enquiry into Perioperative deaths (NCEPOD) " An Age Old Problem"
http://www.ncepod.org.uk/2010eese.htm looked at surgical deaths in those aged 80 and over. 75% of these were emergency admissions, with 40% of the deaths from acute laparotomy and 40 % from hip fracture. Consultant presence in theatre delivered better outcomes, especially in this age group.

- The National Hip frature Database Anaesthesia Sprint Audit of Practice reviewed 16,904 patients treated for hip fracture in 182 hospitals in England Wales and Ireland in 2013. These are usually frail elderly patients; the average age of those recruited to this audit was 83 years. The audit demonstrates a considerable variation in the seniority of surgeons and anaesthetists present during theatre, from 18% in one hospital to 100% in the best institutions.
- The Office for National Statistics report September 2012 identifies 500,000 over 90s in England and Wales, a three fold increase since 1984. The number of hip fractures may double from 2009 to 2030, by which time we will be required to care for 130,000 such patients per year in England and Wales.

Birth Rate and Obstetric Care

- The birth rate in the UK is increasing and a higher percentage of mothers have Caesarean Sections. Over the past 10 years the Caesarean Section rate has increased from 22% to 25.5% and the birth rate has increased by over 120,000 from 548,000 (2002-03) to 671,255 (2011-12). This represents a significant increase in workload for anaesthetists. With advances in medical care and with fertility treatments (e.g. IVF), there are an increasing number of parturients with complex health issues, such as patients with adult congenital heart disease and cyctic fibrosis. Such patients need the expertise of a specialist obstetric anaesthetist and consultant obstetrician.
- In their document entitled Labour Ward Solutions http://www.rcog.org.uk/files/rcog-corp/LabourWardSolutionGoodPractice10a.pdf, the Royal College of Obstetricians & Gynaecologists suggest that all units delivering over 4000 babies per year should have a consultant present for 16 hours per day, 7 days per week on labour ward Consultant obstetricians are quick to recognise when an emergency situation is developing. There is a clear correlation between

consultant presence and good neonatal outcome. These units are requiring the presence of a consultant anaesthetist as well as a consultant obstetrician. Some obstetric anaesthetists currently work 12 hour days from Monday to Friday and there is constant pressure to increase these hours to match that of obstetricians and to provide the same level of service at the weekend as during the week. With current projected recruitment it is impossible to match this with consultant anaesthetist 7 day working even in the biggest units.

Table 1. Hours of consultant presence on the labour ward

Category	Definition (births/year)	Consultant presence (year of adoption)			Specialist trainees (*n*)
		60-hour	98-hour	168-hour	
A	< 2500	Units to continually review staffing to ensure adequate based on local needs			1
B	2500–4000	2009	–	–	2
C1	4000–5000	2008	2009	–	3
C2	5000–6000	Immediate	2008	2010	
C3	> 6000	Immediate	Immediate if possible	2008	

Future Service Models

- There is an expectation that the NHS will move to seven day working with Seven Day Consultant Present Care http://www.aomrc.org.uk/projects/seven.html; http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf. The quality of care delivered to patients admitted at weekends and on Bank Holidays needs to match that delivered during the week. The AoMRC is encouraging NHS and DH to look at the costs and benefits of maximising involvement of consultants in emergency work and at at a full 7 day service for elective work.
- Clinically led reconfiguration, in which services are provided in fewer larger hospitals, may produce some efficiency savings with fewer on call rotas requiring cover. However this would be at the expense of more locally delivered care. Public, patients and their families will need to be fully involvement in the planning of any service reconfiguration. Current DH commentary indicates an emphasis on care closer to home. If we are to provide seven day working with no rationalisation of the overall number of hospitals providing care, this will require a very significant increase in numbers of fully trained anaesthetists.
- The proposed rationalisation of acute hospital services to provide fewer larger units, may be beneficial for some specialist aspects of service. However, if units which undertake common procedures, such as emergency laparotomy and hip fractures, are closed, those left will require increased medical staffing to support the increased demand. While some 'economies of scale' may result as noted above, evidence suggests that these are limited and the likely overall effect is increased demands on medical/ consultant time. Each unit will require sufficient fully trained staff to provide the appropriate level of care to a population requiring about twice the current number of procedures. The move to full service delivery on 7 rather than 5 days per week will inevitably require 7/5 of the number of fully trained anaesthetists. The requirement to move critically ill patients to large centres requires skills in patient transfer and as such, usually requires anaesthetists.

Physician's Assistant (Anaesthesia) (PA)(A)s

- PA(A)s can provide excellent service when appropriately employed and properly supervised. They are not equivalent to an anaesthetist at any grade and cannot be used to replace NTNs. But by engaging clinical directors in planning service delivery there may be a role for PA(A)s to support consultants and trainees during elective surgery. The College is aware of 125 PA(A)s UK wide (147

by 2016) but only 60 UK wide are registered with the Association of PA(A) http://www.anaesthesiateam.com/images/download/mvrlist.pdf which leaves 65 (125 completed course) who have chosen not to register themselves on the APA(A)S Managed Voluntary Register (MVR). Latest numbers suggest there are 42 registered working PA(A)s in the NHS in England. The RCoA are willing to look at the options for effective employment of PA(A)s and consider strategies alongside HEE taking into consideration the total anaesthetic workforce.

- The Association of Anaesthetists reviewed the roles of 100 PA(A)s working in the UK in 2011, and concluded that they work well as part of the theatre team, providing consultants with better opportunities to teach and increasing list turnover, and have a role to play in regional anaesthesia and sedation. However they found that they are not able to replace a fully trained anaesthetist. (http://www.aagbi.org/sites/default/files/PA%28A%29%20Review_FINAL%2016MAR2012.)

Less Than Full Time (LTFT) and Feminisation

- Anaesthetics has seen a gradual increase in female recruitment to around 50%, matched by an increase in demand for LTFT training opportunities especially during the latter years of training. The 2013 GMC trainee survey data and figures from the RCoA have 11% training LTFT. Central support for this way of training needs to be addressed, as only offering 50% in a slot share is not the best way forward. The matter has been further complicated by the 2014-15 Education and Training Tariff arrangements (www.hee.tariffs@nhs.net Education and Training Tariffs) which state that slot shares and any supernumerary posts should be excluded from tariff but with no further advice currently available. Our speciality is a craft skill based area of medical practice and requires a minimum of LTFT @ 60-70% to consolidate new skills, maintain confidence and demonstrate progression – RCoA 2010 LTFT survey. Trainees will be deterred from a career in anaesthesia if there is not greater flexibility in funding allocation to promote LTFT training.
- LTFT trainees continue to make a considerable workforce contribution, as shown by the current RCoA outcome from training analysis. This piece of work specifically focused on those who chose to train LTFT and demonstrated that most only require the option of LTFT for part of the training programme, not for the duration of training – LTFT complete the nominal 7 year competency based training programme in 10yrs 8months as compared with FT trainees who average 8 years and 5 months. Significantly, outcome analysis showed those who had been LTFT at some point during the training programme were just as likely to take a FT consultant post after being awarded their CCT as those who had been FT. This needs to be viewed in the context that for the period being analysed 2009-2012, the majority of 10 PA consultant posts were a 7.5/2.5 split. The current move to offer 9/1 PA for new consultants may influence the choice of FT working arrangements post-CCT for those who have been LTFT. **Data submitted for publication May 2014 : "Does Part-Time Work? The impact of LTFT Training on training time and consultant posts in anaesthesia*".
- The number of trainees on Maternity Leave leaves a significant gap in rotas, compounding the difficulties in staffing doctors on a given tier of on-call. Maternity leave and LTFT working prolongs training, so output of training is less than planned. The continued use of LAT recruitment to cover these inevitable gaps is essential.

Clinical Directors and trainees in many units throughout the UK report that it is difficult to run rotas that comply with the European Working Time Regulations, with the current complement of staff. No allowance is made for maternity leave, or sick leave, despite the fact that the average age of trainees is 28-35, the time at which most professional people have families. Hence, units rely on people doing 'internal locums' and hence working for more than 48 hours, or on external locums, who do not know the hospital and can be of variable quality. Lack of familiarity with the work environment is known to be associated with an increased incidence of adverse events.

- When locums are not available, many units report that pressure to provide service and meet waiting list targets, e.g. for patients having cancer operations, means they run whole theatre suites with no anaesthetist 'doubled up' and therefore immediately available to assist a colleague should

an emergency arise. Although relatively rare, anaesthetic emergencies such as being unable to oxygenate a patient or a serious anaphylactic reaction, have potentially life threatening consequences for patients, and are often difficult to manage effectively with only one anaesthetist. Moreover, surgical complications such as major haemorrhage, also require the presence of two (or sometimes more) anaesthetists. The Group of Anaesthetists in Training (membership 3,000) has examples of such difficulties in many regions including Oxford, Yorkshire & Humber, East Midlands.

- Consultants also play their part in supporting service delivery in units with insufficient staffing levels. It was common to hear comments such as 'There are roughly 100 extra sessions per week covered by the consultants.' Again the consultants are working well over 48 hours per week with long periods of continuous work.
- Fatigue is known to have a serious impact on performance, vigilance and hence safety. Cognitive function is impaired, with slower response times, more frequent lapses in attention, impaired memory and poorer ability to do simple calculations (e.g. drug doses) and poorer decision-making. Working continuously for 20 hours has the same impact on performance as being over the alcohol limit for driving. (ref http://www.aagbi.org/sites/default/files/fatigue_and_anaesthetists_v6_for_members%5B2%5D_0.pdf)

PART 2 – Forecast of future supply and demand – volumes

If you want to input evidence into the forecasting of future numbers you can report your perspectives on either;

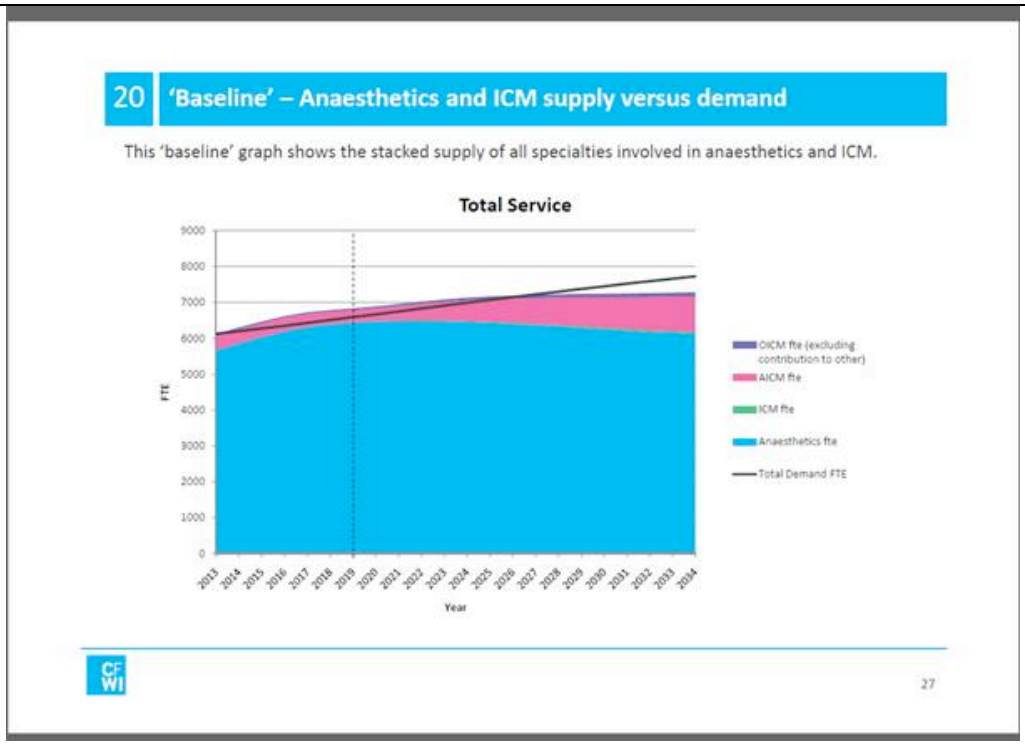
i) the high level indicators; supply, demand, and any forecast under / over supply, or if available - Part 2.1

ii) the more granular components of these three components e.g. retirement rates, output from education relative to attrition – Part 2.2

2.1 Summary forecasts

- Forecast Workforce Demand
- Forecast Workforce Supply and Turnover
- Forecast Under / Over Supply

Forecast Under/Over Supply
Centre for Workforce Intelligence (CfWI) in-depth review into anaesthesia and intensive care medicine predict a baseline increase in demand by 25%:



Graph from CfWI, to note preliminary modelling results may change

- The College recognises the need for an increase in ICM numbers and supports the FICM CfE submission. However, as noted in the FICM CfE response, an increase in ICM numbers should not be at the expense of anaesthetic numbers as this is unsustainable.
- The CfWI In-Depth review will be published in September 2014 but the initial findings are as follows:
- The number of anaesthetists that the CfWI is using for England is 5,833.
- There has been a steady workforce supply increase since 1998, this is a higher overall growth than the consultant workforce in the NHS.
- Proportion of women in the workforce has increased since 1998 and the participation rate for both male and female remains constant and high.
- Perioperative medicine has meant an increase in activity which would increase demand for anaesthetists but it is not clear how much perioperative medicine is already undertaken and therefore included in the demand calculations.
- The Delphi process has suggested that 15-25% (anaes-ICM) of need for services is unmet.
- Demand will rise due to a growing and ageing population and baseline demand for anaesthetic services is expected to increase by 25% by 2033 due to demographic changes alone. Baseline demand does not take into account any other changes in the need for anaesthetic services.
- Baseline supply of anaesthetists up to 2033 show an undersupply, although there is slight over supply in 5 years. The contribution to ICM from other medical specialties mean that this number could be underestimated.
- The scenario projections all suggest an increase in demand from 2013-2035.
- The previous assumption was that there was a 5% oversupply of anaesthetist FTE. It will be difficult to ask LETBs to reduce anaesthetic NTNs for 2015 on the basis of the information provided.
- Agreement for the need to increase the ICM workforce but it must be emphasised and accepted that this must not be to the detriment of the anaesthetic workforce, particularly in the light of the findings presented by CfWI. This is a joint RCoA and FICM position.
- Further work is needed to identify the volume of extra perioperative medicine work, the

number of ICU level two and three patients. In addition the number of non-anaesthetists providing ICM service needs to be considered as this will have an impact on the number anaesthetists able to meet service need. The impact of 7 day acute care, anaesthetic rotas, WTR was also important factors which require further consideration.

Scotland's Justification for increase in CT1 numbers

- Scotland have conducted detailed modelling on their workforce numbers and as a result identified a need for an increase in CT1 numbers to support workforce need and to provide a sufficient pool for recruitment into ST3.
- Fill rates at ST3 in Scotland have been low for a number of years and supply does not meet current demand. Previous work confirmed a consistent level of attrition at core training level of around 25%. Of those trainees who enter core training, 50% will complete as planned, 25% will require additional time to complete and 25% will leave the programme. Core numbers were thus too small to reliably feed the required intake at ST3 level leading to failure to fully recruit in 2011, 2012 and 2013.
- In recent years it has had a year on year expansion of 2-5%, despite challenging financial circumstances, but still finds itself short of anaesthetists.
- The additional 10 core posts added to this year's core intake in Scotland, following specialty input to workforce planning are thus welcomed.
- The specialty in Scotland will continue to make the case around workforce numbers based on reasonable projections.
- The RCoA considers similar increases in CT1 numbers are required in England. Specifically in ACCS. The increase in numbers to support a broad based training theme will be of benefit to all four specialties involved. A reintroduction of CT2 recruitment for all ACCS streams will enable a more flexible and experienced workforce and better supply at ST3 and an ability to transition more effectively to changes implemented as a result of the Shape of Training.

Working Time Regulations (WTR). Pressures of paper only compliant rotas such as in HEEoE:

- *"…whilst we aspire to a 1 in 8 rota in Norwich this is usually not achievable. We run 4 parallel rotas all of which are each published as a 1 in 8 rotas with gaps for locum sessions. We do not have 32 trainees to run these rotas and although we have some staff grade contribution this does not bring us up to the full complement even before novice trainees, maternity leave etc come into force. Trainees are asked to cover these shifts as internal locums but they are increasingly reluctant to do so and we occasionally find ourselves with a gap on the rota."*
- **Paul & Fauvel** (ref Paul RG, Bunker N, Fauvel NJ and Cox M. The effect of the Working Time Directive on anaesthetic working patterns and training. *Anaesthesia* 2012; **67**: 951-56.) http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2044.2012.07227.x/full demonstrated that the workload delivered by one typical teaching hospital grew by 50% between 2000 & 2010. Financial pressures made no difference to this growth, which was a response to an increase in both elective and emergency work.
- A survey of surgeons demonstrated that 61% of consultants and 72% of trainees are working in excess the European working time regulation of 48 hours per week. If this is to be addressed, more consultants surgeons will be needed, and they will inevitably take on an increasing proportion of out of hours work. Both patients and surgeons will expect to work with fully trained anaesthetists – an effective and safe surgical service depends on the whole surgical/anaesthetic/theatre team.
  http://www.rcseng.ac.uk/news/docs/rcs_ewtd_survey_results_jul_2010.pdf

Forecast Workforce Supply and Turnover

RCoA/Group of Anaesthetists (GAT) Trainee Survey (See attached Trainee Survey)

The RCoA Trainee Committee and the Group of Anaesthetists (GAT) in Training carried out a survey– open to all UK anaesthetic trainees and recently qualified consultants in Autumn 2012. The results from this give some indication of the current cohort of trainees' hopes about their future working lives.

- Approximately 11% of the trainees who responded to the survey worked LTFT. More female respondents worked LTFT than men (approx 20% vs 1%). Older respondents (>30 years of age) who were mostly in the later years of specialty training comprised the bulk of those who worked LTFT. There was also significant regional variation in LTFT working 11.7% and 8.5% of English and Scottish respondents worked LTFT compared to 4.3% and 3.8% of Northern Irish and Welsh respondents. The reasons for this are unclear – it may be survey bias or it may reflect the relative difficulty in obtaining agreement to train LTFT in those locations.
- Future intentions with respect to working patterns. 38% of those who currently worked LTFT wished to remain LTFT but 62% aimed to return to full time practice in the future. The 90% of the cohort who currently worked full time expected to remain full time. Female respondents were much more likely to aspire to a part time role in the future (25% wanted a part time role) compared with only 2% of male respondents. Therefore it can be anticipated that as the future workforce feminises more consultants will be required to compensate for a decreased participation rate by each consultant.
- Geographical Location- Survey highlighted importance placed upon geographical location by respondents. This is backed up by anecdotal evidence of consultant posts in more remote (but not necessarily undesirable) locations being significantly more difficult to fill than those in areas with a ready pool of locally established trainee anaesthetists. About 40% of FT respondents indicated that they would be unwilling to move to take up post CCT employment in their non-preferred geographical area. Amongst the LTFT respondents this increased to around 50% who would be unwilling to move.
- LTFT respondents were much more likely to already work within their preferred geographical location – (94%) versus the FT respondents (84%). This increasing lack of flexibility in the workforce will need to be considered when allocating training posts in the future – it may well be that training posts need to be redistributed so that areas of predicted need for future consultants train more people.

2.2 Detailed / Component forecasts

Forecast Workforce Demand

- Service Demand drivers
- Change in use of temporary staff
- Addressing historic vacancies
- Skill Mix / New Roles
- Workforce Productivity

Addressing historic vacancies

- The regional distribution of training numbers in Anaesthesia does not reflect regional requirements for anaesthetic services. Approximately 25% of training numbers are within the M25, whereas other areas with poorer weighted capitation have fewer anaesthetists in training. Several surveys of trainees, including longitudinal studies of career progression (BMA cohort study) demonstrate that trainees do not relocate for consultant posts [e.g. 90% of trainees in Yorkshire and the Humber are recruited to local posts.]
- Many hospitals have funding and service requirements for more anaesthetists. The 2010

RCoA Census http://www.rcoa.ac.uk/node/1472, identified 197 consultant gaps and 236 gaps in other grades in England. Current unfilled consultant posts gaps in Leeds and Hull are 13 and 10 respectively.

Workforce Productivity

- The NHS has a responsibility to train sufficient anaesthetists to remain productive, not only in terms of direct clinical care, but also in the wider field of teaching, quality improvement and innovation.
- Changes to working patterns e.g. laparoscopic colorectal surgery replacing open bowel surgery reduces the number of patients on a routine list.
- Anaesthetists contribution to service is much wider than clinical activity within theatre and ICU, chronic pain clinics. This includes acute services, perioperative medicine, pre-operative medicine, prehabilitation as well as input into medical leadership, management, training and research. The College provides support through the Clinical Directors network to those in management and leadership positions.

Forecast Supply from HEE commissioned education

- Assumed training levels
- Under recruitment
- Attrition
- Employment on completion of training

Under Recruitment

ST3 Fill Rate There has been growing concern over the inconsistent fill rate at ST3 for two consecutive years. The College is increasingly aware that this is having an impact at departmental level with an increase to consultant workloads and gaps in rotas.

ST3 Fill Rate August 2013

UoA	Candidates	AppointAable Candidates	Posts	Accepted	Fill Rate
East Midlands North	17	14	9	9	100.00%
East Midlands South	7	6	12	12	100.00%
East of England	8	8	11	11	100.00%
Kent, Surrey & Sussex	25	20	21	21	100.00%
London	128	110	103	103	100.00%
Mersey	15	13	12	12	100.00%
North Western	26	22	20	20	100.00%
Northern	15	13	20	10	50.00%
Northern Ireland	11	9	10	9	90.00%
Oxford	12	12	12	12	100.00%
Scotland	46	40	50	30	60.00%
Severn	22	19	11	11	100.00%
South West Peninsula	9	9	11	11	100.00%
Wales	22	17	20	19	95.00%
Wessex	16	11	10	10	100.00%
West Midlands	37	33	30	30	100.00%
Yorkshire and the Humber	27	20	28	20	71.43%
Totals	**443**	**376**	**390**	**350**	**89.51%**

ST3 Fill Rate August 2014

UoA	Appointable	Posts	Accepted	Fill Rate
HE East Midlands	17	18	13	**72.2%**
HE East of England	15	8	8	**100.0%**
HE Kent, Surrey and Sussex	27	23	23	**100.0%**
HE North East	11	15	10	**66.7%**
HE North West - Mersey	16	14	14	**100.0%**
HE North West - North West	25	24	24	**100.0%**
HE South West	32	26	26	**100.0%**
HE Thames Valley	17	12	12	**100.0%**
HE Wessex	16	9	9	**100.0%**
HE West Midlands	19	23	16	**69.6%**
HE Yorkshire and the Humber	34	30	27	**90.0%**
London Recruitment	83	102	79	**77.5%**
Northern Ireland	10	10	10	**100.0%**
Scotland	38	43	32	**74.4%**
Wales	24	18	18	**100.0%**
Totals	**384**	**375**	**321**	**85.6%**

Will not fill- Red, Filled- Green, Appointable candidates remaining- Black

Attrition

- Attrition from core training to ST3 training is known to be at about 30%. To be confident of having sufficient UK trainees to fill ST3 posts the ratio of core to ST3 should be 1.4 : 1. Yet many LETB programmes have a lower ratio, inevitably resulting in gaps in rotas.

Emigration & Attrition

- The 2012 trainee survey showed that trainees do not demonstrate geographical flexibility when choosing consultant posts. The free text comments revealed a workforce who would rather leave the UK than work in jobs that are distant from their established social network.
- However, some regions are very short of applicants for consultant posts. Surveys of trainees (BMA) show that a majority of people will not move region to take up consultant posts; they would rather retrain in another discipline or leave medicine altogether. In areas where there is a relative over-supply, such as London & the SE, there is attrition. This matter could be solved with a redistribution of NTNs to reflect weighted capitation.

Attrition from changes to pension arrangements

- Recent changes in pension arrangements have seen an exodus of consultants in their late 50s and early 60s. Some have taken up opportunities to 'retire & return' but others have left the service.

Forecast Supply – Other Supply and Turnover

- From other education supply
- To/from the devolved administrations
- To/from private and LA health and social care employers
- To/from the international labour market
- To/from other sectors / career breaks and 'return to practice'
- To/from other professions (e.g. to HV or to management)
- Increased / decreased participation rates (more or less part time working)

- Retirement

To/from the international labour market

- In the past the UK has relied heavily on doctors from outside the EU, with many anaesthetists coming from the Indian subcontinent, South Africa and South East Asia. We also have a number of doctors from emerging economies in Africa and from the Middle East. The decision was made to increase the number of medical school places to ensure the UK produces sufficient doctors to meet national demand. However if these doctors are not able to train in the specialties in which patient care is needed, Trusts will continue to rely on overseas doctors to provide service.
- The 2012 trainee survey identified 2% of respondents who had secured permanent posts overseas at the end of their training.
- Also Locums appointed from the rest of the European Union and elsewhere are assumed to have the same level of training as UK CCT holders, but in reality take time to acclimatise to the NHS organisational culture.

Retirement

- The current normal pension age is now 65 years. Many consultants are retiring earlier than this. The reasons are multifactorial, but factors such as increasing evening and night work and the pressure to deliver more direct clinical care, often single handed, as a percentage of overall workload have been cited (Redfern N Gallagher P The Ageing Anaesthetist Anaesthesia. 2014;69(1):1-5. It is well-known that older people take longer to recover after overnight work (Fatigue and the Anaesthetist 2014 AAGBI).
- Current pressures for increased utilization of NHS resources through evening and night time work are unattractive to many doctors and particularly those in front-line service specialties such as anaesthetics, and have the potential to be unsafe for older anaesthetists and their patients. A Canadian study found that anaesthetists aged 65 and older had 1.5 times the number of successful claims against them compared with anaesthetists < 51 years, leading to more severe injuries, despite the older anaesthetists' being involved in fewer complex cases. [Tessler MJ, Shrier I, Steele RJ. Association between anaesthesiologist age and litigation Anesthesiology 2012; 116: 574-9]

PART 3 – General / Other Evidence not included elsewhere

Generation Y

The current elderly population were born before the NHS, are grateful for the treatment they receive and very unlikely to complain. The next generation will be different. They will know the evidence – tired doctors are not safe, better results are achieved by fully trained doctors – and they will demand that the NHS provides the high quality of service for which they pay through taxation. Workforce planning must ensure that sufficient UK doctors are trained to deliver this. Older and more vocal taxpayers vote – votes get politicians elected – elected politicians have a vested interest in an NHS that works. To work the NHS needs the right staff in the right place at the right time.

Trainee Satisfaction

The GMC 2014 National Trainee Survey results record high outlier satisfaction for anaesthetics with overall satisfaction the highest for all hospital specialties (85.5/100). Clinical supervision is high at 92.7/100. Foundation trainees undertaking anaesthetic rotations recognise the high quality of training and supervision. http://www.gmc-uk.org/education/surveys.asp?WT.mc_id=MENE140618.