Royal College of Anaesthetists

Response to House of Lords Select Committee inquiry on the Long-Term Sustainability of the NHS

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The Royal College of Anaesthetists (RCoA) is the professional body responsible for the specialty throughout the UK, and represents a combined membership of 21,000 doctors who work in the NHS. The RCoA is committed to improving patients' safety, wellbeing and outcomes through the maintenance and advancement of standards in anaesthesia, critical care and pain medicine. Through our services, anaesthetists will be well trained and supported, and we continue to uphold a central role in the development and delivery of high quality healthcare.

Anaesthesia is the UK's largest secondary care specialty; 16% of all hospital consultants are anaesthetists and over two-thirds of in-patients will see an anaesthetist during their stay in hospital. Moreover anaesthetists play a vital role in the delivery of pre-hospital emergency medicine and the ambulance services.

We therefore welcome the opportunity to give evidence to the House of Lords Select Committee inquiry on the long-term sustainability of the NHS. We would be happy to supplement this written evidence with oral evidence, or answer any further questions, comments or queries in writing.

The future healthcare system

1. **Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?**

   The NHS is facing increasing pressures from a multitude of sources. Medical innovation brings with it increased costs of new treatments and therapies as well as the exciting potential of individualised treatment plans as genetic phenotyping continues to improve. An ageing population, multimorbidity and increasing patient expectations contribute to an increased burden on primary care and hospital services as well as increasing social care requirements and pressure on the health and social care budgets. The RCoA believes it is likely that multiple changes will be required to cope:

   - Increasing NHS funding from the UK Government.
   - Consideration of reorganisation of healthcare supported by greater investment in public health and public education which can support improved decision making between clinicians and carers.
   - An increased focus on the importance of the role of Perioperative Medicine and the importance of anaesthetists within this. Perioperative medicine describes the practice of patient-centred, multidisciplinary, and integrated medical care of patients from the moment of contemplation of surgery until full recovery.
   - Greater research and focus into the outcomes of patients who choose more conservative and less invasive treatment approaches. The development of perioperative medicine, which traverses the boundaries between primary and secondary care, and health and social care, provides an opportunity to address this through, for example:
     - Improved public health through support for primary care in optimisation of patients who are considering surgery (e.g. smoking cessation, interventions to reduce harmful alcohol consumption, weight loss, earlier identification of pernicious co-morbidities such as hypertension and diabetes mellitus). Optimisation leads to fewer complications and shorter length of hospital stays with better utilization of financial resources.
     - Improved resource utilisation through use of clinical decision aids and shared decision making which support patients in choosing less invasive treatment options which may lead

to better patient-centred outcomes.
    - Better supported follow-up to reduce the risk of prolonged (unnecessary) treatments which are both costly and potentially harmful (e.g. antibiotics and opioid analgesics).
    - New drug treatments and new surgical procedures are generally evaluated using a patient group that excludes older patients or patients with multiple medical conditions. We need to learn how to study the patient population that we have in the NHS.
- We need to know what happens to patients who decide not to undergo surgical procedures. There is a publication bias in surgical research in that few studies look at the outcome to patients who do not have surgery. This bias also exists in the national surgical audits for procedures such as Abdominal Aortic Aneurysm, Emergency Laparotomy, Hip Fracture and the Cancer Registries.
- Better patient reported or patient derived outcome measures need to be developed to evaluate the outcome from health care interventions. These outcomes need to be available in a timely manner to health care organisations at a local level to help prioritise spending.
- We need to know what patients want or value by improving shared decision making by all healthcare professionals. This may both reduce demand and develop rational allocation of spending without the unpopular need for rationing.
- The outcome measures and often tariffs we focus on in surgery are based on outcome measures determined by doctors many years ago and now accepted as a standard. For example this leads us to focus on how long a hip replacement lasts or 5-year cancer survival instead of quality and length of life.
- There is an overlap between health care and social care in keeping people healthy and well. Currently, there is a potential conflict between funding social care and funding health care, which needs to be addressed.

Resource issues, including funding, productivity, demand management and resource use

2. **To what extent is the current funding envelope for the NHS realistic?**

The current funding envelope for the NHS is not realistic. NHS activity is expected to increase by 3% a year.[1] However in real terms, NHS funding will increase by only 0.2% a year to 2020.[2] This will cause a budget shortfall. Although the health system is looking at ways to implement the Five Year Forward View within the current cost envelope, and Sustainable Transformation Plans are looking at how to bridge the funding shortfall, a subsequent shortfall in care is highly probable. Modelling suggests that an annual increase in funding of 3–6% in real terms would enable the NHS to meet increased demand.[3]

Along with workforce issues and spiralling service pressures, the consequences of reduced health spending at this time could not be more severe. At the current trajectory, we are heading for a perfect storm with implications for the welfare of both patients and clinicians.

We have known for a number of years that the squeeze on public spending has hit the health sector particularly hard. The UK is committing a smaller proportion of its GDP to healthcare provision than many of its peer group of G20 nations, and the significant majority of NHS trusts are in deficit. Anaesthesia and intensive care medicine are specialties that have felt the impact of these cuts.

The RCoA 2015 Medical Workforce Census revealed a significant shortfall in the anaesthetic workforce required to meet the need identified by the 2015 Centre for Workforce Intelligence (CfWI) review, with challenges including increases in staff rota gaps, high vacancy rates and an ageing anaesthetic workforce.[4] The Census shows that numbers of consultants will need to double by 2033 to maintain the levels required to deliver safe healthcare as identified by the 2015 CfWI review.[5]

As doctors, anaesthetists possess a unique skillset essential to maintaining core hospital services including surgery and intensive care. The potential impact of reduced health spending would exacerbate existing issues and have serious implications for the anaesthetic workforce and therefore patient safety across the NHS.

Results from the RCoA's 2016 membership survey shows the impact of the current lack of financial resource on the ability to deliver safe and effective patient care.[6] Over a third of all anaesthetists in the RCoA survey indicated that a chronic lack of resources is impacting on their ability to deliver safe and effective patient care, citing a lack of qualified staff, inadequate facilities, disengagement and lack of

co-operation by management and a demoralised workforce.

a. **Does the wider societal value of the healthcare system exceed its monetary cost?**

Yes - the basic founding principles of the NHS should be maintained: healthcare free at the point of delivery to all citizens irrespective of wealth or ability to pay and based on need.

b. **What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?**

Commitment from the government to increase NHS funding as a proportion of GDP. Modelling suggests that an annual increase in funding of 3–6% in real terms would enable the NHS to meet increased demand.

d. **Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?**

Charging any fee for GP and hospital attendances or rationing of healthcare services are not recommended and could increase healthcare imbalances for vulnerable adults and children. Some interventions, such as non-scientific medicine, e.g. homeopathy and some plastic surgery procedures should be removed from the list of NHS treatments offered at no cost.

Access to ambulance services to drive patients home could be more tightly regulated to prioritise transporting those patients who need it most.

Workforce

3. **What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?**

a. **What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?**

The 2015 report by the Centre for Workforce Intelligence, which is part of Health Education England, showed that demand for anaesthetic services would grow by 25% by 2033 because of the ageing and growing population. That would require the number of anaesthetists to grow by 300 a year to keep up. However, findings from the RCoA's 2015 Medical Workforce Census show that only 130 more a year were added between 2007 and 2015, leading to a significant gap that on current trends is set to continue widening. The RCoA's Census also showed that by 2033 every hospital trust will have 10-20 fewer consultant anaesthetists than they will need to meet rising patient demand. The research estimates that, while the NHS has agreed that its total of anaesthetists should expand to 11,800 by that date, on current trends it is likely to reach only 8,000 – a shortfall of 3,800, or about 33%.

The recent publication of recruitment data by Health Education England reflects the difficult financial climate in which we are operating, with anaesthesia among other specialties continuing to experience problems in filling posts in parts of the UK. With entry at ST3 level dropping to 90 percent for anaesthesia and fill rates for intensive care medicine lower still, at 89 percent, the RCoA believes that one of the fundamental causes of the failure to fully recruit at these levels is an inadequate supply of suitably qualified trainees, which could be attributed to insufficient funding of new trainee posts. Coupled with the data from our 2015 medical workforce census, the RCoA believes there is a strong case for an increase in Core/Acute Care Common Stem (ACCS) trainee posts, in order to secure a sustainable anaesthesia and intensive care workforce.

Equipping the existing non-medical workforce – nursing, community and support staff – with additional skills may be one way to develop the capacity of the health service workforce, but this

sort of reshaping is not without challenges. New or extended roles could lead to an increase in demand, more rather than less cost, fragment care and compromise quality.

For our own specialty, Physicians' Assistants (Anaesthesia) - PA(A)s - are an established group of healthcare professionals, currently numbering about 150 across the UK. The current lack of statutory regulation of PA(A)s is a major obstacle to new ways of working. Development of PA(A) enhanced roles is taking place and this remains a controversial issue. The RCoA and The Association of Anaesthetists of Great Britain and Ireland (AAGBI) would only consider supporting role enhancement when statutory regulation is in place. Responsibility for such role enhancement, where it exists, currently remains a local governance issue. Patient safety remains the priority of the RCoA and we will continue to press for statutory regulation of PA(A)s.

b. **What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?**

The UK is currently heavily dependent on the invaluable contribution EU migrants make to staffing the NHS and social care sectors. 130,000 people from the EU work for the NHS or in social care, including 10% of doctors, 5% of nurses and 5% of the social care workforce.

The RCoA's 2016 membership survey of our 21,000 members showed that of the current workforce, 70% received their Primary Medical Qualification in the UK, 7% from a European Economic Area (EAA) country and 23% from a non-EEA country. The NHS could not deliver a safe and sustainable anaesthetic, pain medicine and intensive care service without the pivotal contribution of EEA colleagues.

What is unknown at the moment are the implications of the EU referendum outcome on key policy areas affecting our specialty, including free movement of the workforce, which is a cornerstone of EU membership, and the European Working Time Directive (EWTD). The EWTD has been a controversial issue in healthcare, and for the medical profession for many years. EWTD has been welcomed for the protection it brings for doctors and their patients from working excessively long hours. However others express concern that doctors in training are denied the opportunity to gain valuable clinical experience and to maintain continuity of patient care.

c. **What are the retention issues for key groups of healthcare workers and how should these be addressed?**

The impact of cumulative issues for doctors on retention of the workforce cannot be underestimated. Results from the RCoA's 2016 membership survey show that a third of anaesthetists indicated that a chronic lack of resources was causing a lack of qualified staff, inadequate facilities, disengagement and lack of co-operation by management and a demoralised workforce.

Some of these issues could be addressed by:

- An increased recognition by senior managers within hospitals of the importance of anaesthetists in service delivery and the need to involve them in decision making at an executive senior level.
- An increase in the number of Core Anaesthesia and Acute Care Common Stem (ACCS) trainee posts in order to secure a sustainable anaesthesia and intensive care workforce.
- Offering flexible working patterns to increase access to training in medicine.
- Supporting the physical health of the workforce by giving doctors rapid access to healthcare for personal use if needed, such as fast-tracking of referrals and procedures to minimise time spent off work. This would reduce the amount of time spent on sick leave awaiting procedures and investigations. It would also reduce strain on remaining healthcare workers as staffing levels would be better.

4. **How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?**

a. **What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?**

Ways to encourage lifelong learning should be explored where different professional groups learn in partnership.

Prevention and public engagement

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

a. What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

Targeting at risk populations with strategically developed policies. This could include incentivisation for healthier behaviours, rather than just financial penalties for unhealthy behaviours (such as tobacco tax).

Targeting children and young adults to enhance healthy behaviours which may be sustained into adulthood.

Incentivisation for employers to promote healthier lifestyles – e.g. tax breaks, opportunities to use pre-tax income of employees to fund contribution to workplace fitness programmes etc.

d. Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?

The RCoA is a member of the Obesity Health Alliance (OHA) - a coalition of organisations committed to share expertise and support Government to tackle the issue of overweight and obesity in the UK.[7] We call for:

- Government to take action to reduce the consumption of sugar-sweetened beverages (SSBs) by introducing a 20% tax on SSBs.
- Targets for retailers to improve in-store architecture to reduce the display of unhealthy foods in areas such as checkouts and end of aisle displays and increase price promotions of healthier alternative products.
- Government to develop an independent set of incremental reformulation targets for industry, backed by regulation and which are measured and time bound. These targets should address salt, sugar and saturated fat levels. Compliance with these targets should be monitored and non-compliance should be backed by meaningful sanctions.

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