Association of Anaesthetists of Great Britain and Ireland – Written evidence (NHS0114)

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) is the professional membership organisation representing almost 11,000 anaesthetists, the largest speciality group of doctors in the NHS.

This response is submitted on behalf of the Board of the AAGBI as an overview. A separate and complementary response has been submitted by the GAT (Group of Anaesthetists in Training) Committee which represents over 3,500 anaesthetic trainees within our membership.

In preparing the responses, we have used both our professional experience and knowledge of relevant processes and data, our insight as members of NHS staff and also our experience as members of the public. We believe that all these perspectives are relevant.

Questions

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?

1.1. Medical innovation will continue both at home and abroad. Expectations from the public and patients will rise. Demographic changes will continue to impact on patients and the medical workforce.

1.2. The single biggest challenge facing the NHS is to respond to the vastly increased demands of an ageing patient population and workforce. Two thirds of patients staying in hospital have contact with anaesthetists, the specialist doctors who make up the largest group of hospital doctors (16% of NHS consultants). As well as anaesthesia for elective surgery, these doctors also deliver acute and emergency care to patients, particularly at night and weekends. A 28% increase in the number of consultants aged over 50 years is forecast. Adjustments in working patterns will be needed by an ageing NHS workforce. [see *Anaesthesia News* special issue: *Age and the Anaesthetist* August 2016 http://www.aagbi.org/AgeandtheAnaesthetist].

1.3. Life expectancy is continuing to rise resulting in an increase in the elderly population. With this the burden of long-term conditions will rise, such as diabetes, obesity and heart disease: there will be more older patients with multiple co-morbidities. It is unrealistic to expect to fund this within the current budget and without change and innovation in the way services are delivered.

1.4. These demographic changes will make a significant difference to the number of patients requiring the services of an anaesthetist. Healthcare systems should ensure that there are sufficient fully qualified specialists in anaesthesia and intensive care to deliver the amount of care needed. Pre-operative preparation, including exercise training, less invasive surgery,

early postoperative mobilisation, and rapid return to the familiar environment of home all make positive differences to patient outcomes.

1.5. As well as demographic changes, generational attitudes will have a significant impact. The baby boomer generation will soon become the 'old'. They will expect high quality care to be delivered quickly and efficiently and be less prepared to wait than are the current 'old' who were born before the inception of the NHS. In short they will be much more demanding as patients.

1.6. At the same time, within the medical workforce generation x and generation y are less likely to show the same level of loyalty to the service, more likely to work part time or to leave the service, and unlikely to stay on in organisations that value their contributions.

1.7. The ageing population will need better 'joined up' services, 'one stop' centres for the elderly, easily accessible, parking etc. Many large hospitals are difficult for elderly and infirm people to negotiate and should be re-designed to be easily accessible.

1.8. Integration of primary and tertiary care would remove many of the practical barriers encountered in providing sufficient beds for those needing tertiary care. For instance, patients who need social care services cannot be discharged at the weekend when there is no access to social care. If a general practitioner looked after a patient in their last few days of a hospital stay and in the first few days in the community, the patient's needs would be better managed. Currently, there are some intermediate care hospitals looked after by primary care physicians, which provide good quality care for those no longer needing the resources of the tertiary care environment, but these are by no means universally provided.

1.9. Another aspect of care in need of attention is the use of Accident and Emergency departments. Co-location of a GP surgery, fully staffed with a mixture of nurses and general practitioners might go a long way to reducing the almost overwhelming numbers of patients that A & E services are expected to manage.

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

2. To what extent is the current funding envelope for the NHS realistic?
2.1. The current funding is not realistic to meet the challenges outlined above. In order to continue the current scope of work of the NHS, and meet societal expectations, huge investment is needed. The NHS cannot continue to provide the service it does without this. The service is already under pressure from staff shortages and under-recruitment.

a. Does the wider societal value of the healthcare system exceed its monetary cost?
2.2. Yes, society places a high value on a healthcare system based on the principle that it should be free at the point of need and not dependent on an individual's ability to pay. There are wider economic and social benefits of investing in the nation's health; for instance, a healthier and more productive and economically active workforce.

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?
2.3. The status quo is not financially sustainable. There is a requirement for greater funding for both infrastructure and staffing. There is a choice to be made: dramatically increase funding of the NHS, invest in infrastructure and staffing and continue to provide all the services the NHS does or cut services to make the NHS more affordable. We need honest conversations with the public about this choice and what is affordable, and what options are available to fund our national healthcare services. A long-term financial strategy for a sustainable healthcare system should be created with cross party support. The NHS needs to be safeguarded from continual changes in government policy and incessant re-organisation with its associated costs.

c. What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?
2.4. Co-funding could allow patients and the public to value the treatment and engage better with it. An example would be better weight loss in bariatric patients with a gastric band performed privately rather than on the NHS.

2.5. Any increases in taxes would have to be met with a clear picture of how the money would be spent, and measurable, publicised outcomes demonstrating that the aims are being met or it will be seen as an underhand method by the government to fund other expenditure. Locally raised taxes for specific regional problems may be more acceptable to the population.

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?
2.6. Yes. High quality emergency care, free at the point of delivery, must remain at the heart of the NHS – something we are rightly proud of. But it is time for a rational, well conducted and researched public debate about other non emergency healthcare services. We need to challenge unrealistic expectations of what can be done, especially for the old and infirm, and about the extent and scope of what can be provided freely for all patients. Should we, for instance, be providing the more elective and to some extent cosmetic procedures for patients when we have long waits in emergency departments? Should we restrict cosmetic surgery on the NHS? Might we look for at least co payment for more elective procedures?

2.7. From our clinical experiences these sorts of questions must be asked if the scope of what is provided is to be limited. Overall, we would favour consideration of patient need rather than financial means testing of individuals.

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?
3.1. The recent RCoAs' Workforce Census indicated insufficient new consultant

anaesthetists joining the NHS anaesthetic workforce to meet the future patient demand predicated by the Centre for Workforce Intelligence. Unless this is addressed by 2033, there could be a shortfall of 33% in the consultant anaesthetist numbers required to maintain expected levels of safe and effective healthcare.

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

3.2. Entry into medical school remains fiercely competitive. Many UK students who do not meet the stringent UK entry requirements undertake courses abroad, and yet make good UK doctors. A 10% increase in medical student places would broaden opportunity.

3.3. Recently, a medical school has opened in the UK which will only take non UK entrants due to the way that UK medical school places are funded. What is the scope for introducing 'private' medical schools for those who can afford to pay?

3.4. Overseas recruitment is likely to become increasingly problematic. Many more medical graduates from the Indian subcontinent and South East Asia elect to remain there – indeed several UK universities have campuses in South East Asia. What is needed is a much better understanding of the true future need for healthcare professionals – worked out on a sessional basis and not on a 'full time equivalent headcount'. It is likely that many more of generation X and Y will work what is now regarded as 'part time'.

3.5. The NHS will need to retain older workers in order to have sufficient staff to meet ever-increasing demands.

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

3.6. With 'Brexit', working in the UK may become more difficult. About 10% of doctors come from the EU. Furthermore, some who do not get into medical school in the UK do their primary degree in English, but in an EU country. If fees go up to a point where this becomes prohibitive [they are currently in the range of 1,500 – 9,000 Euros], this supply of doctors will dry up. In the event of leaving the EU we may be able to attract back doctors from the Indian sub continent who left when EU workers gained priority over them regardless of qualifications. Many will now be working in other countries with similar health care systems.

3.7. Visa restrictions have made if more difficult for non-EU staff to work in the NHS, resulting in problems; overseas staff may wish to work for short periods in good, well regulated jobs, with appropriate supervision and training, to enhance their skills and career opportunities at home. In the past, this both helped our workforce and enhanced our knowledge of overseas practice. With so many gaps in rotas throughout NHS, this supply of overseas, often temporary, workers has been lost. The alternative is to train more staff: doctors, nurses etc in the UK, which may cost money, but is a more permanent solution.

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

3.8. Retention is crucial, associated with this is maintaining good staff morale. Recent contract disputes, and the increasing workload with no extra resource have impacted on

morale. This will make it more difficult to recruit and retain staff: junior doctors may go abroad and senior doctors may retire early. Being valued at work and having a sensible work-life balance are key issues for doctors, particularly from generations x and y.

3.9. Current workforce planning is largely done by the 'baby boomer' generation, for whom hard work, ambition and loyalty were key career drivers. Yet the people involved in delivering these plans are generations x and y, for whom loyalty is not important. This generation does not stay long in bad jobs, want a good working atmosphere & a family friendly environment and value co-operation, communication and encouragement. Consultant jobs as they are currently arranged may not, in the long term, be attractive to the next generation of doctors. What is needed is a review of the amount of healthcare likely to be required not in terms of 'whole time' jobs, but in terms of 'days worked'.

3.10. Training 10-20% more doctors, more of whom work part time, is more likely to provide the quality of life that generations x & y expect.

3.11. For more senior doctors, there is expected to be a significant impact from the lowering of the lifetime pension allowance to £1million. With the current contract, many people will reach this level of contribution in their mid to late 50s. Some may stay on and just leave the pension scheme; others may elect to retire at this point and yet others may move to working part time. Depending on the outcome of contract negotiations, the combined impact of the lowering of the lifetime allowance and of the annual allowance could lead to a significant diminution in the number of sessions worked [see Pandit, J.J. 'Pensions, tax and the anaesthetist: significant implications for workforce planning'. In *Anaesthesia* 2016,71,883-891].

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

c. What investment model would most speedily enhance and stabilise the workforce?
4.1. A mix of pay and benefits, which should include training packages, would be effective. Reward clinical work above managerial to keep experienced staff working in clinical areas. It would help if the Government were more respectful of NHS workers; at present ministers seem quick to criticise, slow to praise. A feeling of being valued would mean more staff stay in the UK.

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?
6.1. Better engagement in management of obesity, the importance of exercise and of a healthy diet. Incentives that encourage employees to take time out of their working day to do exercise, even if only for those working in healthcare settings and in the civil service,

would be one way of demonstrating the government's commitment to this agenda. In the UK public health measures are sometimes criticised as the behaviour of a 'nanny state'. This attitude may have to be challenged. Health inequality is a reality. Some families have problems raising children in a way that offers them reasonable opportunities in life. Directing more resource to disadvantaged families, particularly in the early years from birth, is crucial for lifetime health.

Digitisation of services, Big Data and informatics

8. How can new technologies be used to ensure the sustainability of the NHS?

b. What is the role of 'Big Data' in reducing costs and managing demand?

8.1. 'Big data' in terms of national audits has been very effective in informing a more consistent and more effective approach to management of patients undergoing emergency laparotomy and those with fractured neck of femur. Attention to detail, good technique and facilities and resources to promote rapid mobilisation and recovery will, over time, lead to a reduction in costs from longer term care and rehabilitation.

c .What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?

8.2. The NHS is a professional bureaucracy, where frontline staff has control over work content, and more influence than those in authority on day to day decisions such as how to treat a particular patient. In this context, leaders have to negotiate changes rather than impose them, hierarchical directives have little impact. Factors influencing change are:

- Positional power is not always followed or respected
- Influence is more significant in achieving change
- Professional networks & peer pressure are important
- Professional credibility is important

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