

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) Group of Anaesthetists in Training (GAT) – Written evidence (NHS0115)

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) is the professional membership organisation representing almost 11,000 anaesthetists, with the GAT (Group of Anaesthetists in Training) Committee being the directly elected representative body for over 3,500 anaesthetic trainees. This response has been prepared by the elected members of the GAT Committee. 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.

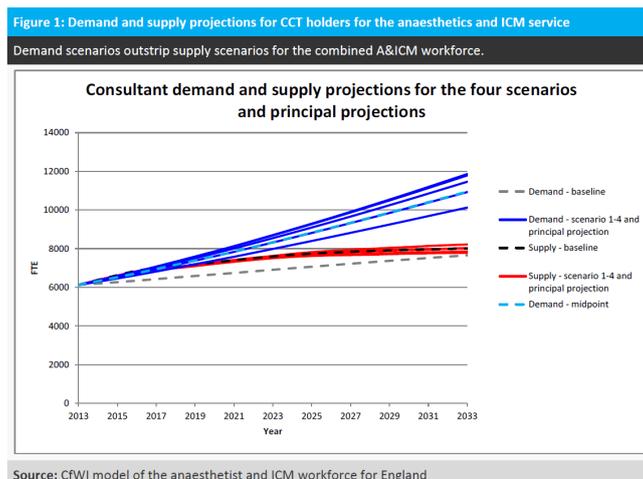
Submitted by Dr Emma Plunkett, GAT Chair

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. The NHS is constantly adapting to meet the needs of the population. New technologies and therapies are regularly introduced and staff adapt to these changes. We can predict some “knowns” about the future needs of the population – increased longevity and increased co-morbidities, such as obesity for example. However, there are likely to be “unknowns” that appear and we need to encourage innovation, recognise and value the expertise and diligence of NHS staff, and empower them to be able to do their best and adapt to changing conditions. Well-trained, resilient staff with appropriate resources will ensure sustainability of our world-class healthcare system.

1.2. In terms of the specialty of anaesthesia and intensive care, the Committee Centre for Workforce Intelligence (CfWI) predicted that an increasing demand for healthcare indicated a need to expand numbers of anaesthetists to meet this.



1.3. As staff working in anaesthesia in the NHS, it feels like theatre efficiency is hampered by lack of available hospital beds. Despite efforts to focus on this, there remain a proportion of patients within each hospital who are awaiting discharge due to lack of social care packages or placements. Efforts to reduce this bottle-neck will become more important in the future

with increased longevity of the population.

1.4. We also need better communication between all aspects of health and social care. This will be helped by the introduction of electronic records, available at all times but more work needs to be done to link primary, secondary and social care.

1.5. Increasing involvement of patients in decisions affecting their health has to be central to the future NHS. This should be on both a population basis, with continued work on public health and primary prevention initiatives, and also on an individual basis. We need to make it easy for the population to make sensible health choices.

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

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

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

2.1. Yes. One of the defining characteristics of our nation is how we care for sick and vulnerable members of society. Accessible, high quality healthcare is a key priority for everyone and the NHS provides us with an unrivalled system that gives universal access to healthcare. We firmly believe that the value of the NHS lies in removing personal finance from any decision regarding the healthcare of one's family. The importance of a healthcare service that is free at the point of delivery should not be underestimated. GAT holds the view that the value of this certainly outweighs the cost.

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?

2.2. Our current NHS funding sources comprise general tax, National Insurance and a much smaller proportion from patient payments (<http://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/how-nhs-funded>). A funding system that is consistent and protected from macroeconomic fluctuations would be ideal.

2.3. Governments are under constant pressure from increasing health expenditure. There are 3 options: containing costs (by reducing services or creating efficiency savings), increasing expenditure or a combination of both. If expenditure is going to increase, the Government will have to raise available revenues.

2.4. Revenues can be sourced from taxation, compulsory insurance contributions, voluntary insurance premiums, individual savings and out-of-pocket payments. Quite often the source of revenue is a combination of the above. We realise the challenges for the Government but we believe that the public healthcare system funded principally via taxation should continue.

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)?

2.5. Hypothecated health tax: Overall, we think that a hypothecated health tax is a good idea, specifically as a way of reconnecting taxes and services. We agree with the benefits as outlined by the World Health Organisation:

2.6. Accountability and trust: Rather than paying taxes into a perceived black hole, hypothecated taxes provide taxpayers with in-built accountability for public spending. At times when a government is suspected of following its own agenda, this can help to restore trust between it and its citizens.

2.7. Transparency: Hypothecated taxes can educate people about the cost of particular services, such as healthcare. Taxpayers can then make better-informed decisions about the balance between tax burden and level of services provided. Health spending, in particular, has grown faster than GDP in many countries and the decision whether to go on spending ever more on health or whether to cut back on these services can be a tricky one for politicians. Paying for health through hypothecation allows governments to explicitly hand back that choice to the electorate and escape a potential political fallout.

2.8. Public support: In some cases, hypothecation can generate public support for tax increases. This is highly dependent on whether the service set to benefit from the earmarked tax is perceived to merit it. Education and health have consistently, and internationally, shown this potential and we believe that the public would likely respond to general tax increased more favourably if they had a guarantee that tax was being direct towards the NHS.

2.9. Protecting resources: Because of the relative public support for such spending, ministries of health are often in favour of hypothecated taxes for health. They see it as a way to ring-fence their resources from competing political interests and a way to by-pass budgetary constraints mandated by ministries of finance.

2.10. We also appreciate there are disadvantages, which include:

Exemption from review: Unsurprisingly, ministries of finance rarely endorse hypothecation as it undermines their mandate to allocate budgets as they see appropriate. It exempts the tax revenues in question from scrutiny and potential cuts that others are subjected to. There is also no obvious answer as to who should set rules on the level of hypothecation. Furthermore, when the hypothecation affects a large amount of public expenditure, as is typical for health, it can severely impact on other public spending should cuts be necessary.

2.11. Undermining solidarity: Financing from tax revenue is one of the major mechanisms allowing governments to achieve a fair distribution of the cost of healthcare. Some fear that specifying each individual's share of the cost vis-à-vis services received could undermine this solidarity.

2.12. Inappropriate funding levels: Hypothecated taxes are accused of linking spending not to the requirements of the services but to unrelated macroeconomic circumstances. Rather than determining health spending by how much a tax raises, it should be based on the health needs of the population. Severing this link between need and provision risks wasteful spending when the tax base is buoyant and insufficient budgets when it is depressed.

2.13. Tying the hands of government: By taking decisions on spending levels out of government discretion, hypothecating tax revenues constrains its ability to deal with economic cycles.

2.14. **Sin taxes:** The continuing decline in smoking has been in part attributed to the effect of the tax on tobacco. There have also been calls to increase the taxation on alcohol to go some way to cover the estimated social cost of £21 billion. Sin taxation has also recently been extended to drinks with high sugar content. Whilst the idea of sin taxation is appealing with the dual effect of generating revenue and discouraging harmful behaviour, care has to be used, as they can be regressive. In addition, other activities which are deemed to be 'healthy' can also lead to increased healthcare resource use. For example, road running can lead to osteoarthritis necessitating a total knee replacement, or road cycling accidents leading to broken bones. Should these habits also be taxed? Overall, we think sin taxes are a good idea and could be extended within reason.

2.15. **Inheritance taxes:** Whilst the public might be willing to give up more of their inheritance if they knew it was going towards healthcare, it would be very difficult to create an accurate budget around this due to the fluctuating nature of inheritance.

2.16. **Co-payments:** Co-payments are a useful way of limiting inappropriate overuse of healthcare systems. However, if set too high they may also discourage people from accessing healthcare when genuinely necessary. As such, increasing co-payments would be an appropriate way of raising more revenue, but the targets for co-payment would have to be very carefully selected.

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?

2.18. A King's Fund report from 2013 suggests that the public still value the key NHS principles of high quality comprehensive care free at the point of use and would be somewhat resistant to limitation of services and means testing.

http://www.kingsfund.org.uk/sites/files/kf/field/publication_file/how-should-we-pay-for-health-care-in-future-kingsfund-apr13.pdf. However, limiting the services that the NHS offers is one way to continue to fund the NHS.

2.19. Consideration has been given in the past to restricting access to services where a patient's lifestyle choice has been implicated in their disease (e.g. smokers, obesity, and illicit drug use). However, delineating causation and denying care makes for uncomfortable denial of services for healthcare professionals within the NHS as it seems contrary to the fundamental principle of universality. Ethical debate about new treatments as they become available must continue and the threshold used by the National Institute of Health and Care Excellence to assess cost effectiveness of services could be increased to achieve this.

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. Please see the graph above (Q1) from the CfWI report regarding future requirements for anaesthesia and intensive care medicine. The full report can be found here: <http://www.cfw.org.uk/cfw-work/medical-and-dental-workforce-reviews/medical-specialties/anaesthetics-and-intensive-care-medicine-in-depth-review>. We need adequate numbers of junior doctors to meet this need and we also need adequate numbers to staff on call rotas and provide 24-hour care. The optimum situation would be a reduced reliance on locums, which are not cost effective, but are being used more frequently to meet gaps on rotas.

3.2. We also need to consider the implications of increased longevity on the workforce itself. This is discussed in depth in the latest edition of Anaesthesia News; "Age and the Anaesthetist".

3.3. <http://www.aagbi.org/sites/default/files/AUG%20Anaesthesia%20News%20web.pdf>

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

3.4. Removing the pre-conditions for trainees applying to core training. (e.g. trainees who have 'too much' experience to apply to be a core trainee).

3.5. Increasing the number of trainees taken at core training level to account for the poor attrition rate at specialty training.

3.6. Improving morale amongst the junior staff already in the workforce, which will attract people into the profession as well as decrease the numbers of junior staff leaving the NHS.

3.7. Removing the barriers for less than full time training.

3.8. Given the large number of rota gaps, offering an attractive fee for additional hours may help bridge the gaps'.

3.9. Removing minimum salary requirement for overseas workers, as those in the nursing profession/LTFT doctors may not earn above the threshold to remain in the UK.

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

3.10. Whilst there are some overseas EU trainees, the main supply of overseas workers are for locum provision, nursing and Healthcare Assistant (HCA) posts. The supply of overseas doctors will be affected by decreasing locum rates as current rates may be unappealing, which will be compounded by the fall in value of sterling against the Euro. The nursing and HCA supply may decrease due to minimum salary requirements for immigrants.

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

3.11. The **attrition rate** from Core Trainee year 2 (CT2) to Specialty Trainee year 3 (ST3) in anaesthetics is of major concern.

3.12.

http://www.aagbi.org/sites/default/files/Anaesthesia%20News%20JAN%202016web_0.pdf

(page 12-13) According to Royal College of Anaesthetists figures, there is around a 37% difference between trainees being appointed to core training posts in 2013 and those taking up ST3 posts in 2015. As to how this should be addressed, would depend on why we are failing to retain these trainees in Anaesthesia. It is currently unclear why these trainees are not taking up ST3 posts, whether they have gone abroad, doing a non-recognised training post due to lack of primary FRCA (an essential requirement) or whether they have decided to change specialty. The only accurate way to track this would be through the GMC database. Clearly, currently all trainees are under stress due to rota gaps throughout the UK and this may influence a trainee's decision to work abroad. At least part of the reason for the poor CT2-ST3 progression is likely to be exam failure, as this is a necessary component. So, increasing study leave budget and deanery support may help. Improving the terms and conditions for medical staff will help with retention, for e.g. providing workable rotas well in advance and honouring rota requests.

3.13. The increased **feminisation** of the medical workforce but the lack of support for and availability of flexible or part time working options is another key concern. The new junior doctors' contract is known to disadvantage this group of doctors and this is likely to hamper future recruitment and retention.

3.14. Finally, we need to address the issue of an **ageing** workforce and how we can support older consultants to continue to work, whilst protecting them from the effects of fatigue. Changes to the NHS pension scheme, with limits on the tax free lifetime allowance, will impact on the financial viability of people working later in life and have significant implications for the NHS consultant workforce. This editorial in Anaesthesia explains the issue: <http://onlinelibrary.wiley.com/doi/10.1111/anae.13579/full>

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?

4.1. With regard to anaesthesia, there are clear training objectives to be met at each stage of training, including Royal College of Anaesthetist examinations that are required to be passed. The curriculum provides a broad training with flexibility to produce both general and specialist anaesthetists. We believe that it is fit for purpose. Increasing amounts of education and training could be delivered remotely, via webinar or webcast. However, many departments have inadequate IT support available to trainees and the availability of computers and printing facilities can be extremely variable.

4.2. There are various online tools available to help with rota planning, potentially these could be used to identify rota gaps early and help the workforce by providing early information about on call requirements.

b. What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?

4.3. According to data recently published by the Royal College of Anaesthetists this year, for

the first time, Anaesthesia had a 90% fill rate. This means that 10% of posts were not filled. These rota gaps will have to be filled by locum doctors. By making the training posts more attractive to trainees, the rota gaps created by this lack in recruitment would not exist. As locum doctors cost more than those in a training post the NHS would be better to invest money in recruitment of trainees, and making the NHS an attractive place to work, which may make emigration a less attractive option.

c. What investment model would most speedily enhance and stabilise the workforce?

4.4. Investing in a stable junior doctor workforce in order to ensure supply of consultants in the future both costs less than reliance on locums to fill rota gaps and ensures future sustainability. This means expansion of the numbers of anaesthetic training posts.

Models of service delivery and integration

5. What are the practical changes required to provide the population with an integrated National Health and Care Service?

5.1. A high quality, integrated and efficient health and care service will improve care for patients. Organisations will work better together if they understand each other's perspective and roles and see that working together provides mutual benefits.

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. Engage with schools and do more to tackle obesity, prevent smoking and stress the dangers of drugs and alcohol.

6.2. More programmes such as vaccinations for babies and children and dispel myths regarding the dangers of vaccines which have since been disproven.

6.3. Increase taxation on cigarettes, alcohol and unhealthy food.

6.4. clearer labels on packages regarding the salt, sugar and fat content – penalties for company who fail to engage with this and rewards such as tax relief for companies that show willingness to engage.

6.5. Less appealing packaging for cigarettes, alcohol and unhealthy foods, with more stringent rules for advertising on posters/TV.

6.6. More emphasis on screening – both encouraging public to engage with screening programmes and more money to develop more screening programmes.

6.7. Contacting patients regarding screening programmes etc with different methods of communication e.g. post, text and email.

6.8. Emphasis on allowing local authorities to use money from government to develop health schemes that are more relevant to the local population e.g. if high population of diabetic patients, use local money to focus on management of diabetic patients.

6.9. Subsidise gym memberships for those overweight and obese; continue to subsidise in those who engage.

6.10. Companies having to provide information to new employees regarding the health benefits they provide

6.11. Provide patients when discharged from hospital and A&E or when seeing GP, a bill with how much the visit costs so patients have a better idea/understanding of how much healthcare costs.

6.12. More advertising and use of social media to increase public awareness regarding important health issues and health websites approved by NHS e.g. Change4Life etc.

6.13. Organising local discussion groups to see what patients in the local community want from their local health care services.

6.14. Funding for and emphasis on looking after patients with chronic illness in the community and within primary health care e.g. using COPD nurses, diabetic nurses etc. so there is less pressure on the OPA within the hospitals – regular follow ups will help to prevent disease progression.

Digitisation of services, Big Data and informatics

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

a. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

8.1. Telecare (network devices to monitor patients in their own home, connected to centre via call system)

- Reminders for patient medication administration, for example pre-operative medication or fasting guidelines may prevent cancellations of surgery, and post-operative analgesia reminders may help patients to get home more quickly after surgery. This would improve efficiency.
- Telecare systems may allow patients to remain in their home and reduce the cost and demand for social care provision. If social care is required, it can be more efficiently tailored to individual patients.

8.2. Telehealth (ability to measure patient vital parameters whilst at home)

- The use of telehealth devices may allow earlier assessment/triage prior to admission including early assessment at home and prevention of the need for admission.
- If hospital admission is required, potential for early treatment and avoidance of higher levels of care.
- Earlier discharge may also be possible, if remote follow up using telecare is possible.

8.3. Wearable tech (any wearable piece of technology inc. fitness trackers)

- Increase in availability of activity trackers may lead to increased activity levels and reduced burden of obesity related issues
- Ability to non-invasively measure health parameters such as blood glucose may improve stability and efficacy of chronic illness therapies, thus improving general health.
- Devices may be instrumental in habitual activities e.g. smoking cessation, diet control, physical activity – this may help with pre-optimisation for surgery and reduce postoperative morbidity.

8.4. Genetic medicine

- Potential for early identification of disease risk and preventative management in a targeted manner
- Potential for reduction in cost of disease treatment due to prevention
- Ability to plan services around specific requirements of local population, many years in advance.

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

8.5. There is an incredible volume of data (patient vitals, disease progression, surgical procedures, and consumable usage) collected in the NHS on a daily basis, which has the potential to be used to shape the future care of individual patients. At present, we lack structure for much of the data collected, which can be problematic. Data use is mostly restricted to within the institution it is collected and increasing data sharing within the NHS (not with private entities) on a national scale may allow more efficient treatment of rare, but expensive, conditions.

8.6. Integration of data collection and display systems throughout the NHS will allow development of specific services in particular areas relative to demand. Clinical risk intervention and predictive analytics will allow individualised treatments and more rapid assessment/resolution of chronic disease.

8.7. Electronic data collection and storage, including in the cloud, will reduce the environmental burden of the NHS, reducing paper and stationary usage

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

8.7. Cost; information governance / law; data quality, inaccuracies are magnified as dataset size increases; structure of datasets, intelligent tools are required for verification of data accuracy and believability.

d. How can healthcare providers be incentivised to take up new technologies?

8.8. Increased funding for new technologies

8.9. Positive publicity if provider uses technology

8.10. Internationally recognised research to show benefit

8.11. Grass roots action – get junior doctors/nurses on side with new technology

8.12. Streamline processes, increase availability of new tech vs old tech

8.13. Remove barriers to using/applying new technology

e. Where is investment in technology and informatics most needed?

8.14. Social care / care in the community

8.15. Hospital / GP record keeping

8.16. Anaesthetic / Peri-operative record keeping including pre-op assessments

8.17. Making this information easily accessible to the staff who needs it (who may work in different organisations) and yet maintaining security is crucial.

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