Our future anaesthetic workforce - pressures and opportunities

Nancy Redfern
Sarah Gibb
Kathleen Ferguson

AAGBI Linkman Tuesday 16 Sept 2014
Managing change

Current situation – pressures

What do we want?
- definitely changes afoot
- opportunity for us to decide what we would like and work towards getting it

how do we get there?
- what should the AAGBI/ departments/Trusts etc do to enhance our cause

Nancy Redfern Sept 14
Patient care

- How many people per year will need care from anaesthetists?
- What level and complexity of care will they need?
- Effects of an ageing population, new therapeutic interventions, more preventative care and better non-surgical treatments?
- Which service configurations provide the best quality care: small numbers of large hospitals; large numbers of smaller, local units; increasing proportion of private sector care?
- Who should provide anaesthetic care – consultants, trainees, staff grades, physician’s assistants?
Current Pressures

**Society**
- Ageing population
- 7 day working
- 24/7 expectations

**Specialty**
- ‘Over-recruitment’ & job security
- Ageing anaesthetists
- Fatigue
- Generation Y’s approach to work
- Training – impact of ‘Shape of Training Review’
2011 38 more trainees than posts
2013 67 more trainees than posts

BMJ adverts only; many only advertised on line e.g. NHS jobs

Nancy Redfern Aug 14
Oversupply?  2012/13

• Anxiety, Locums, left country
• Scotland attrition rate 34% (33 of 96 trainees)
  Of these, 42% moved abroad
  58% moved to rest of UK  Lynn Newman
  ? Impact of 9 + 1 contract
• ST3 fill rate Scotland 62% (53% if ICM posts not included)
• ST3 UK wide average 85%

• Pressure from Gov’t/HEE to move posts from specialty to GP
  – Chose unfilled posts in large specialties
### 2014 Fill Rate

<table>
<thead>
<tr>
<th>UoA</th>
<th>CT1 Posts</th>
<th>CT3 Posts</th>
<th>Fill Rate</th>
<th>Accepted</th>
<th>Fill Rate</th>
<th>Core/ST3</th>
</tr>
</thead>
<tbody>
<tr>
<td>HE East Midlands</td>
<td>30</td>
<td>18</td>
<td>72.22%</td>
<td>13</td>
<td>72.2%</td>
<td>1.7</td>
</tr>
<tr>
<td>HE East of England</td>
<td>56</td>
<td>8</td>
<td>100.00%</td>
<td>9</td>
<td>100.0%</td>
<td>7.0</td>
</tr>
<tr>
<td>HE Kent, Surrey and Sussex</td>
<td>44</td>
<td>23</td>
<td>91.30%</td>
<td>23</td>
<td>100.0%</td>
<td>1.9</td>
</tr>
<tr>
<td>HE North East</td>
<td>30</td>
<td>15</td>
<td>66.67%</td>
<td>10</td>
<td>66.7%</td>
<td>2.0</td>
</tr>
<tr>
<td>HE North West - Mersey</td>
<td>31</td>
<td>14</td>
<td>100.00%</td>
<td>14</td>
<td>100.0%</td>
<td>2.2</td>
</tr>
<tr>
<td>HE North West - North West</td>
<td>40</td>
<td>24</td>
<td>100.00%</td>
<td>24</td>
<td>100.0%</td>
<td>1.7</td>
</tr>
<tr>
<td>HE South West</td>
<td>45</td>
<td>26</td>
<td>88.46%</td>
<td>26</td>
<td>100.0%</td>
<td>1.7</td>
</tr>
<tr>
<td>HE Thames Valley</td>
<td>12</td>
<td>12</td>
<td>91.67%</td>
<td>12</td>
<td>100.0%</td>
<td>1.0</td>
</tr>
<tr>
<td>HE Wessex</td>
<td>13</td>
<td>9</td>
<td>100.00%</td>
<td>9</td>
<td>100.0%</td>
<td>1.4</td>
</tr>
<tr>
<td>HE West Midlands</td>
<td>46</td>
<td>19</td>
<td>78.95%</td>
<td>16</td>
<td>69.6%</td>
<td>2.4</td>
</tr>
<tr>
<td>HE Yorkshire and the Humber</td>
<td>32</td>
<td>30</td>
<td>86.67%</td>
<td>27</td>
<td>90.0%</td>
<td>1.1</td>
</tr>
<tr>
<td>London Recruitment</td>
<td>94</td>
<td>102</td>
<td>77.45%</td>
<td>78</td>
<td>77.5%</td>
<td>0.9</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>20</td>
<td>10</td>
<td>90.00%</td>
<td>10</td>
<td>100.0%</td>
<td>2.0</td>
</tr>
<tr>
<td>Scotland</td>
<td>66</td>
<td>43</td>
<td>74.42%</td>
<td>32</td>
<td>74.4%</td>
<td>1.5</td>
</tr>
<tr>
<td>Wales</td>
<td>34</td>
<td>18</td>
<td>100.00%</td>
<td>18</td>
<td>100.0%</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>593</strong></td>
<td><strong>371</strong></td>
<td><strong>321</strong></td>
<td><strong>85.6%</strong></td>
<td></td>
<td><strong>1.85</strong></td>
</tr>
</tbody>
</table>
Leeds December 2013

- “14 trainees down from 5th Feb”
- Loss of most of 2 rotas
- Possible replacements:  
  - Locums  
  - Anaesthetic practitioners  
  - Fellows  
  - Speciality doctors  
  - Consultants

*How do we get consultants to cover nights?*

*How do we backfill the daytime elective work?*
Impending cut in NTNs
RCoA CD Discussion Forum

In September the Deaneries are expected to cut NTNs for anaesthesia. This is in the face of evidence from various bodies including RCoA that reducing NTNs will impact negatively and significantly on future workforce and therefore capability. Documents being added in the CD forum library from HEE MWAG and CfWI refer and add detail. ICM requirements are increasing. Anaesthetic trainee posts are already unfilled. There are nationally fewer SAS grades to cover gaps. Consultants are expensive and have a requirement for SPA which impacts on availability for DCC. Demographic (age and gender) factors are creating an impending workforce liability. RCoA is representing back to the Deaneries in September. YOUR VIEWS WILL ADD WEIGHT. Please log in and post your response.
Ideas - Funding or NTNs

• Separate NTNs from funding
• Offer areas with low weighted capitation the opportunity to ‘self-fund’ NTNs – cheaper than current arrangement
• MUST deliver the curriculum – not ‘rota fodder’

• More cost-effective than having consultants resident first call
• Use consultants to teach & to lead service development
• Less fatigue / burnout amongst older staff (consultants)
• Better quality patient journey, better outcomes
• More engagement in workforce planning – would not wish to see ‘their funded trainee’ without future employment

Nancy Redfern Sept 14
Impending cut in NTNs

• Do you know how many trainees are being recruited in your area?
• Have you had trainee numbers reduced already?
• Have you engaged on this matter with your LETB and or Deanery?
• Would a reduction in trainees trouble you? What would be the impact on your Trust (financial and service delivery)?
• Do you avoid trainees providing service lists already?

Potential solutions

• Would your Trust fund some NTNs? (ratio 1.4 core to 1 ST3, i.e. 2 core, 1 ST3)
• Managing gaps in your rota? What has worked?
• How would you use 'credentialled' doctors?
Our future anaesthetic workforce - pressures and opportunities

Nancy Redfern
Sarah Gibb
Kathleen Ferguson

AAGBI Linkman Tuesday 16 Sept 2014
Shape of Training Review

• Aims “.. to make sure we continue to train effective doctors who are fit to practise in the UK, provide high quality care and meet the needs of the patients and public. As part of this review, we looked at the desired outcome of training – what kinds of doctors are needed, and the means by which we get there.”
Shape of Training Review

Five key themes considered by the review:

• Patient needs
• Workforce needs: specialists vs. generalists
• Breadth and scope of training
• Training and service needs
• Flexibility of training

AAGBI Linkman Tuesday 16 Sept 2014
Shape of Training Review

Securing the future of excellent patient care

Final report of the independent review
Led by Professor David Greenaway

AAGBI Linkman Tuesday 16 Sept 2014
Shape model for the future structure of postgraduate medical training:

<table>
<thead>
<tr>
<th>Undergraduate degree</th>
<th>FOUNDATION PROGRAMME</th>
<th>Postgraduate medical training</th>
<th>Professional practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BROAD-BASED SPECIALTY TRAINING</td>
<td></td>
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<tr>
<td></td>
<td>Clinical academic training</td>
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<tr>
<td></td>
<td>Academic training focused on a particular research area combined with broad-based specialty training. Doctors can move in and out of academic training at any point.</td>
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<tr>
<td></td>
<td>All doctors develop generic capabilities in key areas, including:</td>
<td></td>
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<tr>
<td></td>
<td>- patient safety</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- communication with colleagues and patients</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- teamwork, management and leadership</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- evaluation and clinical application of research</td>
<td></td>
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<tr>
<td></td>
<td>Optional year spent working in a related specialty or undertaking leadership or management work that can be taken at any time during broad-based training.</td>
<td>4-6 years (depending on specialty requirements)</td>
<td>Rest of career</td>
</tr>
<tr>
<td></td>
<td>Doctors are able to practise with no clinical supervision within multidisciplinary teams and networks. They are able to make safe and competent judgements in broad specialty areas.</td>
<td></td>
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<td></td>
<td>With further opportunities to:</td>
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<tr>
<td></td>
<td>- maintain capabilities and develop practice through CPD</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- enhance career and gain additional expertise through orientating in special interest areas</td>
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<td></td>
<td>- develop depth of knowledge by learning through experience and reflecting on their practice</td>
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<tr>
<td></td>
<td>- move into education, management and leadership roles</td>
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</tr>
</tbody>
</table>

Training duration:
- 2 years
- 4-6 years (depending on specialty requirements)
Shape of Training Review

GAT involvement with review process:

• Provision of written evidence (as did AAGBI)
• Provision of oral evidence
• Attendance at workshop for doctors in training
• Responded to final report
• Engagement with ongoing work

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Shape of Training Review

Current work: Four nation approach

- Steering group
- Six seminars/workshops:
  - General themes and progression to CST*
  - Interaction with employers*
  - Blurring the primary and secondary care interface*
  - Issues relating to SAS doctors*
  - Academic training pathway
  - Credentialing
Shape of Training Review

Credentialing:

• Not necessarily post CST
• Multiplicity of routes to credentialing
• Accessible to SAS doctors and allied professionals
• Flexible to respond to service needs
• Proleptic appointment
Shape of Training Review: Questions

- What types of doctors do you think are needed and how do we get there?
- Can we shorten training in anaesthesia to 4-6 years? How?
- What would you expect from a CST trained doctor? Are they the consultant on-call?
- What areas of practice should become credentialed?
Our future anaesthetic workforce
- pressures and opportunities

Nancy Redfern
Sarah Gibb
Kathleen Ferguson

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Ageing

From aged 50 onwards, declines in processing speed, working memory, episodic memory encoding. Semantic memory (recall of facts) doesn’t alter.

Impact on work
- vigilance variable
- slower to deal with new information

Normal pension age - 66 by 2020 - 68 by 2046

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Ageing anaesthetists - tiredness

- tiredness affects older doctors’ performance and mood
- quality of sleep worsens with age; sleep becomes shorter
- reduced capacity to adapt to shift work with increasing age
- cognitive performance of older shift workers more impaired during night work but may be less aware of their degree of impairment than younger shift workers

- Canadian study: rate of successful claims against anaesthetists aged > 65 yrs 1.5 times anaesthetists < 51 yrs, led to more severe injuries, despite the older anaesthetists’ being involved in fewer complex cases

Normal pension age - 66 by 2020 - 68 by 2046

Redfern & Gallagher Anaesthesia 2014
Baby Boom (1945-1962)
- Optimistic, ambitious, permissive, rebellious
- Value - youth, personal success, wealth
- Workaholics; work is part of your identity

Generation X (1963-1981)
- Independent, resourceful, entrepreneurial
- Alienated & misunderstood
- Don’t have same levels of allegiance
- Will go abroad, change jobs

- Co-operation, communication, conformity, perfection
- Don’t stay long in bad jobs
- Want to get job done & have fun
- Relationship with employers – expect to be trained, have positive bosses and encouragement
- Like a consensus view
- Want good working atmosphere & family friendly
- Sense of civic responsibility
- Location of job important

Richard Marks Learn@AAGBI WSM 2014
Out-of-hours working

Dr Kathleen Ferguson AAGBI
Dr Anne-Marie Rollin RCoA

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OOH working and anaesthesia

- Priorities
  - Quality
  - Patient safety
  - Anaesthetist well-being
  - Sustainable services

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Definitions

- Out of hours
- Emergency – immediate and urgent
- Expedite
- Elective

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The drivers

- The 7-day NHS
- Patient outcomes
- Efficient use of resources
- Ageing population
The risks

Patients
• Senior medical presence
• Support services

Staff
• Sleep disturbance
• Fatigue
• Wellbeing

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Considerations

• Patients
• Anaesthetists
• The service
Draft recommendations

• Agreements about start and finish times of operating sessions that extend into OOH periods must take into account human performance factors.

• Theatre sessions should be staffed appropriately with cover for breaks. This is particularly important if sessions extend beyond normal working hours, i.e. last for more than 8 hours or extend into OOH periods.

• Anaesthetists should only work for more than 12 hours in any 24-hour period under exceptional circumstances.

• Only immediate or urgent procedures should be conducted at night.
• Planned OOH sessions during which expedited or elective cases are performed must have similar levels of staffing, consultant supervision, support and laboratory services, and critical care facilities as sessions done during working hours.

• Special consideration should be given to the very young and the very old, who should be operated on during the day where possible.

• There must always be sufficient backup and additional facilities to deal with any life or limb threatening emergency without delay.
• Audit of the outcome and productivity of OOH operating sessions must be conducted and compared with sessions done in normal working hours.

• Extending planned surgery into OOH periods will demand more financial and human resources if patient safety is to be maintained. Clinical Directors of Departments of Anaesthesia must work with clinical governance systems within hospitals to ensure that patient safety is put first and is not compromised.
Questions

• Do the OOH working recommendations cover the issues?
• Will they be of use to anaesthetists / departments?
• What else might be done to help?
• What impact will having a larger group of ageing anaesthetist have?
• Is your department managing this well?
• What are they doing?
• If the AAGBI working party document on “The Ageing Anaesthetist” is really good what will it contain?
Calculating supply & demand

• What human resource do we have to deliver the service?

  • Not just numbers of staff (Consultants, SAS, trainees) but accurate reflection of DCC delivered
  • Subtract leave allocation (42 weeks, 39 weeks)
  • Need to consider 2-4% sick leave rate
  • Subtract payback for on call (all grades)
Calculating supply & demand

• What services are we required to cover?
  • Average month of list covered including all compulsory double-ups
  • Exclude ICM but remember to include this in trainee payback calculation

• What is the balance of resource to service?

• How to manage the deficit?
  • Decide on how OOH will be delivered – types and grades of staff
  • Agree payback

• What’s left is the elective resource
Making a calculator - excel
AAGBI activity to date

• Response to HEE’s call for evidence
• HEE spoke at AAGBI council meeting
• GAT gave evidence to ‘Shape of Training Review’
• Hamish McLure spoke to CDs and trainees about the Leeds situation
• Position statement on N + 1 – raised by GAT

In development
• Position Statement on Out of Hours working
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Impending cut in NTNs
RCoA CD Discussion Forum

Asked

• How do you mitigate gaps in your rota?
• Do you avoid trainees providing service lists already?
• Would a reduction in trainees trouble you? What would be the impact on your Trust (financial and service delivery)?
• Have you experienced trainee number reduction already?
• Have you engaged on this matter with your LETB and or Deanery?
Our responsibility?

What do we want to achieve?
- there are definitely changes afoot - this is an opportunity for us to decide what we would like and work towards getting it

Right number of people with the right skills in the right place at the right time
- What would this look like in your own department?

How do we get there?
what should the AAGBI/ departments/Trusts etc do to enhance our cause

Can’t afford it?
- Follow politicians lead or find ways of funding this

Nancy Redfern Sept 14
• Do you know how many trainees are being recruited in your locality?,
• Is your department involved in discussions with LETB?
• What impact does it have on your department?
• What impact does maternity/sick leave & out of programme leave have on your department?
• **Potential solutions** - have you had trainee numbers cut? How have you managed? What has worked?