Royal College of Anaesthetists

Core Training 3 (CT3) year equivalence survey report:

reviewing the impact of the introduction of the 2021 Curriculum and experiences of anaesthetists in training

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Contents

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Foreword

This report presents findings from a survey of a cohort of anaesthetists whose training was affected in the transition to the 2021 curriculum.

The survey was conducted by the College in partnership with the Association of Anaesthetists and the British Medical Association. Our aim was to understand more about the experiences of anaesthetists in training who completed core training on the 2010 curriculum and were required to obtain the remaining Stage 1 competencies outside of a training post, including those deemed 'CT3 equivalent'.

It is clear that, despite best efforts, the curriculum transition has negatively affected people both personally and professionally. On behalf of the College, I apologise unreservedly for that.

The findings provide important insight into the impact on the wellbeing, employment and salary of members who were affected, as well as on the educational quality of the posts themselves. I thank everyone who participated in the survey. As the report describes, many respondents experienced significant upheaval and stress, exacerbated by the impact of the pandemic. It is important for the College to acknowledge and understand that and to learn from it in the event of any future curricular transitions.

We are fully committed to implementing the report's recommendations, many of which are already in train. At the time of the curriculum transition we sought to support those in CT3 'equivalent' posts, including through the provision of a set of common standards for trusts and health boards to ensure the content of such posts provided doctors with a suitable level of training. As recommended, we will remind employers and departments of their responsibilities for ensuring these posts are fit for their intended purpose.

Many respondents noted the support they received from colleagues at the time, including from College Tutors and Regional Advisers. However, we fully accept the report's findings that the release of guidance and information may not have kept pace with the needs of anaesthetists in this position to adapt plans for their personal and professional lives. We will continue to support this cohort of anaesthetists in line with the recommendations made in the report.

We are also committed to increasing our support for anaesthetists in training more generally and this report will help inform that work. For example, we will work with Schools of Anaesthesia to try and avoid short, frequent rotations which we know can be detrimental to the work-life balance and life choices of anaesthetists in training. We will also provide additional support to recognise experience gained outside a training programme when people re-enter training.

Once again, I thank everyone who participated in the survey, including those involved in its design and delivery and everyone who has sought to support this cohort of anaesthetists to complete their training. The survey's findings and the personal accounts provided have helped us learn valuable lessons for the future.

Dr Fiona Donald, RCoA President

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The RCoA Anaesthetists in Training Committee

NOTE: the use of the term 'trainee' refers to a doctor in a formal training programme under the governance of the statutory education bodies

Introduction

The new 2021 Curriculum in Anaesthetics was implemented on 4 August 2021. The new curriculum describes the high-level outcomes, learning and capabilities required in anaesthetics in order to gain a Certificate of Completion of Training (CCT) or Certificate for Eligibility for inclusion on the Specialist Register (CESR). The review process of the curriculum began in 2015 and is aligned to the new GMC standards for Curriculum and Assessment – *Excellence by Design: Standards for postgraduate Curricula*.

The new curriculum includes changes to the structure of the training programme into three broad areas, namely Stages 1, 2 and 3. Training now includes the acquisition of high-level learning outcomes as defined in the GMC standards,[1] and embedding the GMC's Generic Professional Capabilities.[2] Anaesthetists are still expected to complete an indicative seven years of training to complete the programme.

In Stage 1 the core training period (previously two years) or ACCS (previously three years) were each expanded by a year to allow additional time for trainees to pass the primary examination and consolidate other elements of learning. In effect this moved anaesthesia from a '2 plus 5' year programme to a '3 plus 4' year programme. Within the new core programme, six months of ICM and three months of obstetric and paediatric anaesthesia experience are required. The changes to Stage 2 require recruitment via competitive selection directly into ST4 training for all trainees. Stage 2 training typically lasts two years, within which the Final FRCA Examination should be completed by the end of ST5, and single three-month blocks of neuro, cardiac and paediatric anaesthesia are undertaken. Stage 3 training also has an indicative timescale of two years, which is generally used to support generalist consultant on call skills and develop special interest areas.

The curriculum was approved by the GMC and implementation was originally planned for August 2020. Anyone on a core programme ending in August 2020 had been informed their programme would automatically be extended to three years. The COVID-19 pandemic overrode other timeline pressures and meant that implementation was delayed by a year and recruitment to ST3 continued.

As part of the process for development and subsequent implementation of the curriculum the College established committees representing a wide range of stakeholders including, anaesthetists in training, Regional Advisers in Anaesthesia, Training Programme leads, the lead Dean for Anaesthetics and including representatives from the four nations. In addition to this consultation the College engaged with external stakeholders such as specialist societies and medical organisations associated with anaesthesia.

In line with GMC rules, the College developed a plan to transition all anaesthetists in training from the 2010 curriculum to what was now the 2021 curriculum. Within this transition plan, the College proposed a series of measures to support anaesthetists in training and schools of anaesthesia in managing the training programmes.[3] The original transition plan was subsequently delayed due to the need for coordination and alignment of implementation with ACCS specialties; it was important to ensure that all ACCS specialties implemented their new curricula and training programmes at the same time.

During this implementation and transition, a cohort of anaesthetists successfully completed core training on the 2010 curriculum but were then required to complete a further year of out of programme work. These anaesthetists were undertaking this process of transition and gaining the necessary experience and capabilities to ensure that they were eligible for recruitment to higher specialist training at ST4 level. Some did this within locally employed doctor roles supported by anaesthetic departments across the UK.

The College and other stakeholders recognised that the provisions and requirements of these posts were less well-defined than the training posts overseen, governed, and managed under the auspices of the UK Statutory Educational Bodies (SEBs). There was not the implicit expectation that these posts would come with the same educational provisions such as a study budget, access to educational supervision or an environment geared to provide the necessary support to sign off CT3 equivalent competences. There was therefore a risk of inequity and that the absence of national oversight of these roles would lead to difficulties assessing the scale of the problem. The Royal College of Physicians had already made the move from a two-year core medical training (CMT)programme to a three-year internal medicine training (IMT) programme and as part of that move they had negotiated stand alone 'IMT3' years for those in a similar position during transition. The RCoA's request for such a solution was denied by the SEBs.

Historically not all anaesthetists progress directly from ACCS/Core programmes into Higher Specialist training. There are several reasons for this, including individual choice to spend time pursuing other clinical or non-clinical interests in the UK or overseas. Others have not completed core training successfully in-programme or have not successfully obtained the Primary FRCA examination in time to be eligible (prior to eligibility derogations brought in during the pandemic). Indeed, the change to the length of Core Training (Stage 1) was introduced to address these challenges. Accordingly, the College's Curriculum Development Group were aware there would be a cohort of anaesthetists who would have finished a core programme but would not fulfil eligibility criteria for ST4 application.

It was proposed that this could be addressed by spending 12 months whole time equivalent (WTE) in locally employed posts, with the College outlining what clinical opportunities would be necessary within such a post and what capabilities an anaesthetist would need to demonstrate, evidencing this via the Lifelong Learning Platform.

The College, alongside partner organisations such as the British Medical Association and the Association of Anaesthetists, designed a survey specifically tailored to gaining a better understanding of the experiences of this cohort of anaesthetists. The aims were to assess the educational quality of these posts and whether they were suitable for accessing the required experiences for CT3 equivalence training. It would also ask questions about impacts to employment, salary, and welfare.

Methods

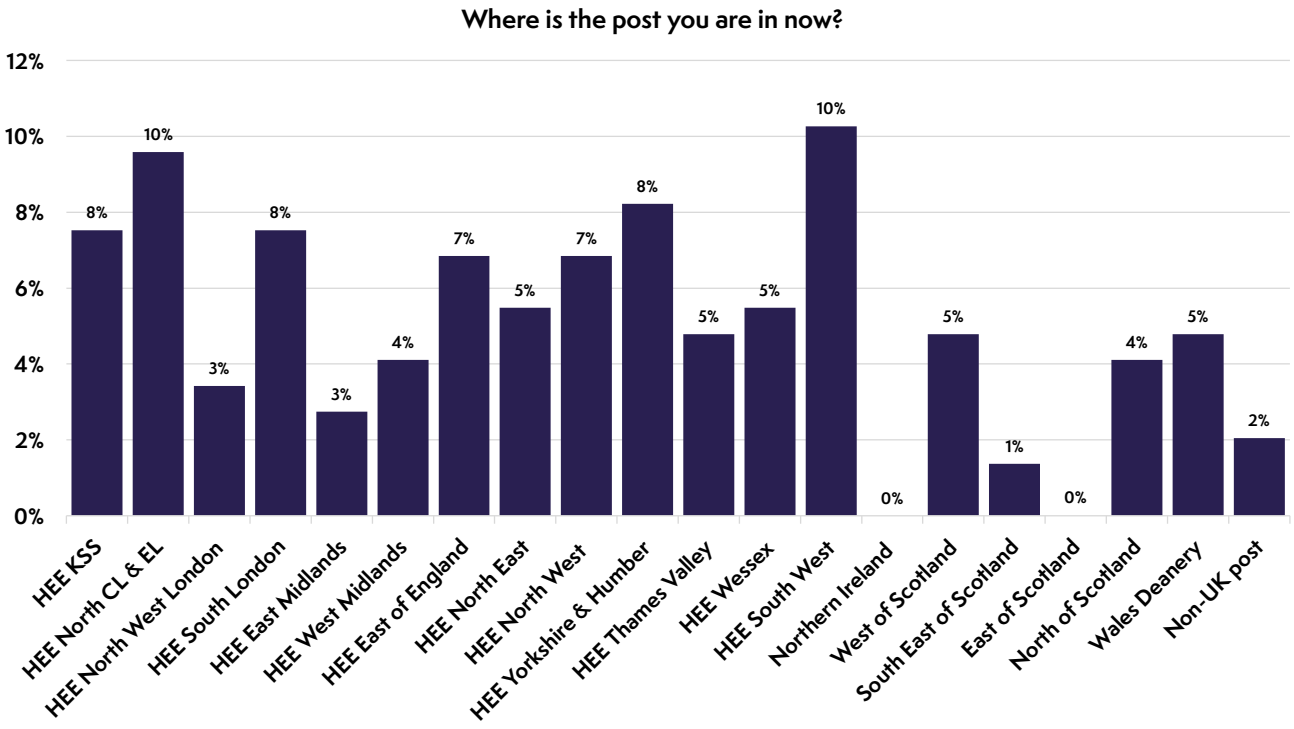
The survey was commissioned and undertaken by the College between November and December 2021. Survey questions were developed following a review of the existing research on the relative impacts of COVID-19 on anaesthetists in training.[4,5] Drafts of the questions were then shared with trainee representatives within the three organisations – the RCoA, Association of Anaesthetists and the BMA. The resultant feedback was incorporated into the final survey. Participants were notified via emails to anaesthetist in training members of the RCoA, Clinical Leaders in Anaesthesia, Core Anaesthetic Top Up Support (CATS) and the Anaesthetists in Training Representatives Group network. The survey was also promoted widely on social media (Twitter) and via the College's membership-wide President's email newsletter. Reminders were also sent out via all organisations to their membership networks.

Results

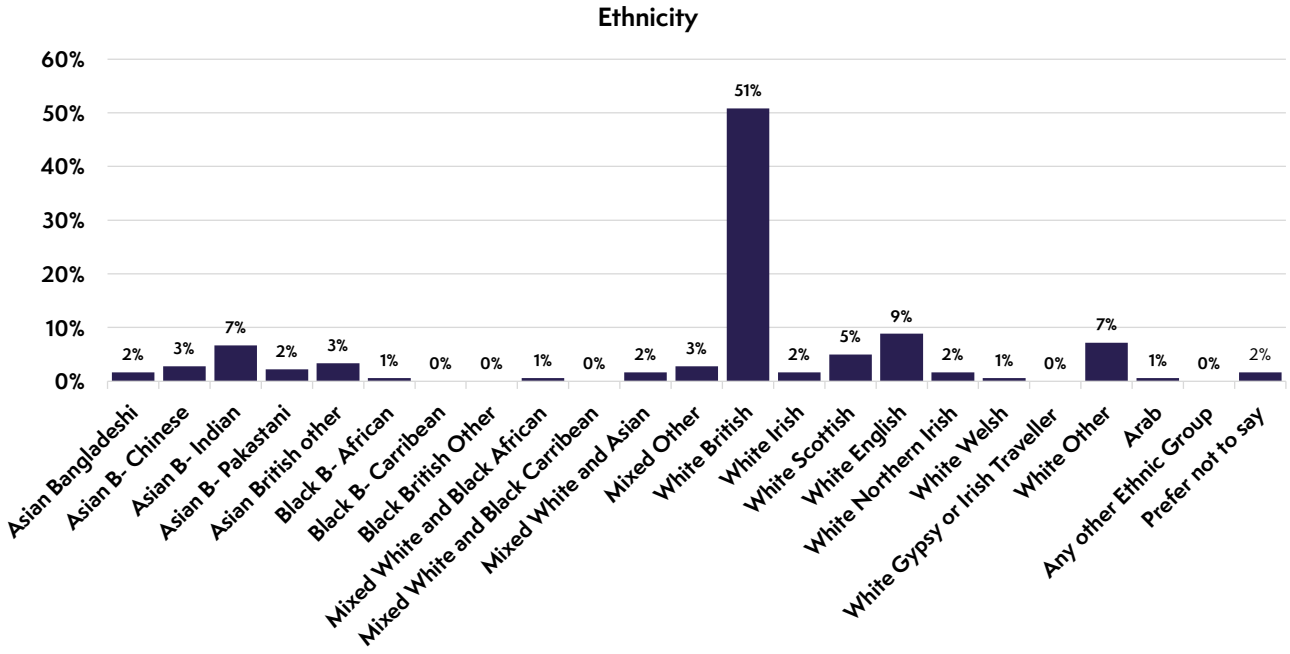
The survey received 183 responses from across the UK.

Location

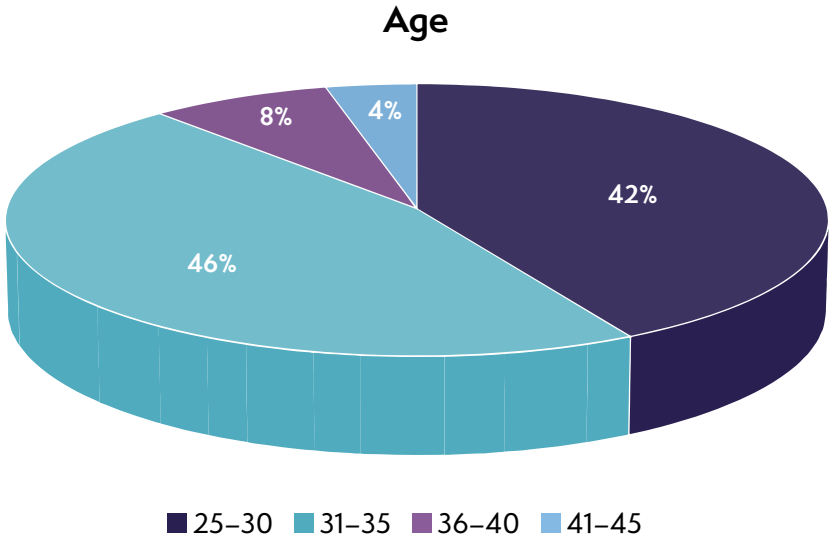
The table below shows where some of the respondents were located at the time of completing the survey. 146 respondents provided feedback to the question seeking their location. The highest response rates (10%) were from HEE North Central and East London and HEE South West.



The respondents were mostly White British (51%–92 respondents) followed by White English (9%–16), White other (7%–13) and Asian Indian (7%–12). This is broadly in line with the composition of the anaesthetist in training cohort.



The graph below shows the ages of the respondents. The majority of those in CT3 post are in the 25–30 (42%) and 31–35 (46%) age groups. It is noted that this age period is when many people choose to settle in one location, put down roots and for some this includes starting families.



Training status

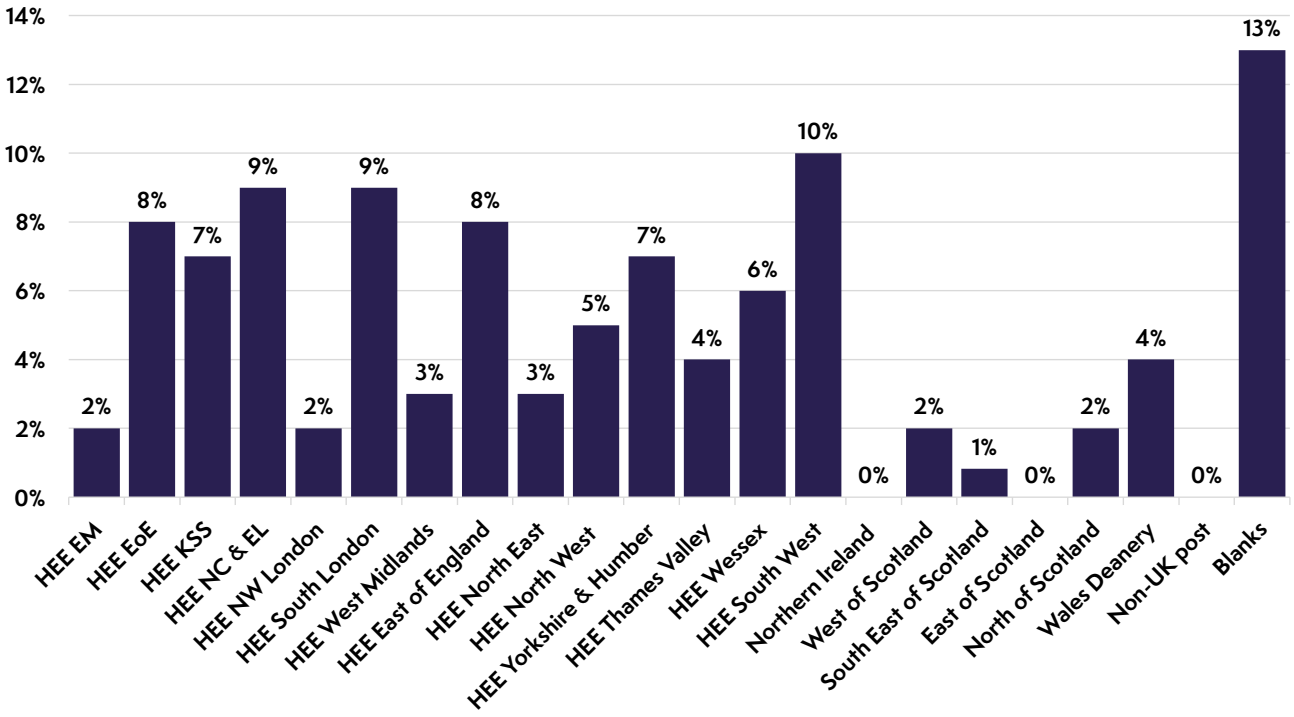
The majority of respondents (68%) had successfully completed core training whilst within a standard length core post, with a further group completing after an extension.

80% of respondents had passed both parts of the Primary FRCA examination, the majority (73%) within their CT2 year. 57% had both parts of the exam when applying for specialty training ST3 posts for Aug 2021. 47% of respondents reported that the COVID-19 pandemic had delayed them successfully passing the FRCA primary examination; 14% thought it partly delayed them.

71% applied for an Aug 2021 ST3 post (121). 65% of respondents were appointable but not offered a post. The majority had not been eligible to apply at previous rounds (67%).

56% applied for February 2022 posts and 29% were offered a post.

Regional Breakdown of applicants for August 2021 ST3 posts



CT3 'equivalent posts'

65% were in posts that were advertised as CT3 equivalent, with most advertised through NHS Jobs. 78% applied with the intention of achieving CT3 competencies, and of these 49% were confident and 30% partly confident the post would help them achieve this aim.

Quality of the posts

Only 50 people answered the question 'has this post met your expectations?' – 70% said yes. 70% said they would recommend the post to others.

When answering questions about the quality of their post, 67.6% of respondents noted that the post met their expectations, and a further 10.6% reported that it exceeded expectations.

95% of respondents had a named Educational Supervisor. 85% had access to study leave, 46% said it was equivalent to what a trainee would have access to. 65% had access to study budget, only 15% were given the same as a trainee. 75% worked the same hours as a trainee. 58% felt they had the same educational opportunities as a trainee.

Salary

In England, 15% reported a pay cut. 31% reported pay had stayed the same, 22% reported an increase equivalent to a trainee, 14% had an increase not equivalent to a trainee.

In the devolved nations, 39% had a pay rise in line with a trainee, 15% a less generous pay rise, 33% had pay stay the same, with12% experiencing a pay cut.

Career intentions and personal wellbeing

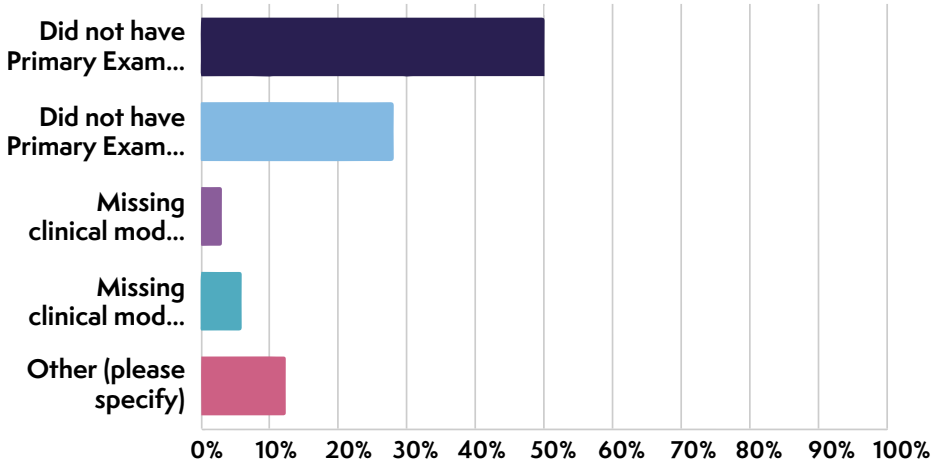
The majority of respondents to the survey intended to pursue Higher Specialist Training in the future – 15% had secured a post, 52% would apply at the next available round, and 23% at a future recruitment round.

58% felt less positive about obtaining an ST4 post compared to before. The majority of free text comments submitted made references to a bottleneck in training, lack of posts, and a feeling that the College had been changing the person specifications and moving the goal posts. There were further comments about the demands of COVID-19 and clinical work whilst training, the hardship of completing the exam, and maintaining a competitive CV for recruitment.

More than 60% felt negative or somewhat negative about life, and about their future in anaesthesia.

What prevented you from achieving your CLTC or equivalent within your Core or ACCS Program?

Answered: 32 Skipped: 151



Obtaining the full Primary Examination within two years of a core programme (or three for an ACCS programme) was the most common barrier to the respondents achieving a core level training certificate or equivalent.

There were a number of respondents who reported that the clinical exposure of the posts and educational opportunities did not mirror their colleagues locally on training programmes.

Discussion

The authors would first like to offer our unwavering gratitude to all anaesthetists who took the time to complete this survey, without your insight and lived experience, we would not have had the opportunity to learn as richly as we have about the process of curriculum transition. In particular, we would like to acknowledge the extremely moving personal accounts in the free text submissions which have left their mark on many of us.

The implementation of the curriculum came at a very challenging time for the profession and particularly to those working within anaesthesia and critical care. Changes in policy and guidance were implemented in an attempt to support anaesthetists who found themselves in CT3 posts and had or have the intention of joining the training scheme at ST4 at a later date. This was a complex and evolving process, and the release of key guidance and information may not have kept pace with the needs of anaesthetists in this position to adapt plans for their personal and professional lives.

The information gathered about respondents to this survey indicates that the anaesthetists who were in post as 'CT3 equivalents' were diverse in terms of their spread across the UK and were from a variety of backgrounds. This undoubtedly made policy and guidance harder to craft and implement and one size fits all solutions were not found. It is however notable that the College sought an 'IMT3 like' solution similar to the RCP but this was denied on several occasions.

CT3 posts were advertised predominantly at a local level and required anaesthetists to seek out such posts and advocate for themselves in ways that many in formal training programmes would not usually need to do at this point in their careers. The evidence from our survey showed that, Regional Advisers, College Tutors, Clinical Directors, anaesthetist in training networks and SAS/Consultant colleagues on the ground stepped up where they could to support this group of doctors and we want to extend our thanks for their efforts to provide these posts during exceptionally challenging times.

It was clear that in addition to the challenges of obtaining a post, anaesthetists in training also had numerous other stressors, including but not limited to examinations, upheaval in their personal lives and the wide-reaching impact of the COVID-19 pandemic. This is likely echoed in the experiences of their SAS and Locally Employed anaesthetic colleagues.

Recommendations

The following recommendations have been made in order to address the current issues faced by this cohort of anaesthetists, and to ensure that enhanced processes will be in place to mitigate the unintended consequences of any future curricula transitions. It is important to emphasise that none are currently planned.

This is not an exhaustive list, and not all will be applicable to all anaesthetists. Additionally, some will become less relevant over time, as the cohort diminishes in size owing to successful application or alternative career pathways.

1. The RCoA should have a formal, internally constituted body to manage a programme of engagement and support for anaesthetists working in 'equivalent posts'. This should include periodic snapshots of this workforce and identification of common barriers to completing their competencies as well as individual tailored support to those in unique situations.
2. The RCoA should, with relevant stakeholders, reaffirm the principles of the jointly badged best practice document for these posts, reminding employers and departments of their responsibilities for ensuring these posts are fit for the intended purpose.
3. The personal impact on anaesthetists in training who do not achieve their primary FRCA in time for higher specialty training applications should continue to be seen as a matter of extreme importance in the review of college examinations.
4. The RCoA should actively consider these anaesthetists when changes or submissions are made to the Medical and Dental Recruitment and Selection group – being mindful of not placing additional burdens of evidence or educational experiences that may be harder to demonstrate or accrue outside of formal training programmes.

5 When designing future curricula or instigating significant curricula change, the RCoA should conduct an enhanced impact assessment, utilising skills and experience both in and outside the College. This would crucially include a comprehensive consideration of the effects on the terms, conditions, and financial security of trainees in anaesthesia. It is important to note that no substantive change is on the horizon, and this will not affect any current anaesthetist.

6 In future representative groups, the RCoA should seek a wider reference base, focusing particularly on those who are more vulnerable to training programme changes such as those with disabilities, from minority backgrounds as well as those already between stages of training at times of transition.

7 The RCoA should continue to provide educational and pastoral support in the form of online guidance and periodic events such as webinars to answer relevant inquiries and foster a sense of community amongst not only this cohort but the SAS and Locally Employed doctors who are also challenged by these issues. This may also involve liaison with Professional Support Units and equivalents which are already established within NHS England Education footprints.

8 The RCoA should acknowledge the discontent of this group publicly and seek to restore confidence by way of an apology and commitment to additional safeguards in the future. It is vital these doctors feel supported and valued within the specialty.

Additionally, other organisations must also take steps to address the persistent and harmful shortfall of trained anaesthetists. Specifically we call for:

1 Urgent action by the UK and devolved governments to increase the number of higher anaesthetic posts across the UK to cope with this group of trained anaesthetists seeking consultant roles, and to meet the current and future patient demand for anaesthetic services (as referenced in the RCoA census and State of the Nation report).

2 The NHS across the four nations must redouble efforts to support flexible career pathways that exist outside of NTN training. This should include considerations around study leave, education, supervision, health and pastoral support.

Conclusions

The findings of this survey of anaesthetists working in CT3 equivalence posts demonstrate a wide variety of experiences across the UK.

Many have been fortunate to find supportive departments with favourable employment terms to help them complete their required competencies and remain able to progress in their career on a national training programme if so intended.

Unfortunately, this experience was not universal, and many experienced a more arduous period, with salary loss and a lesser exposure to the educational opportunities they may have had if in a funded training post.

The rationale for curricula change has been summarised in this report. Alongside the need for educational evolution is the need to consider the human impact of what is well intentioned change.

Standardised employment terms, or educational experiences for those not in training programmes are not within the gift of the College but it can lend its support to anaesthetists in their pursuit of these, including closer collaboration with the Association of Anaesthetists and the BMA.

Although the numbers of anaesthetists affected in the context of the national workforce is small, any loss, of even a single anaesthetist is a disaster. It is a tragedy for their professional and career aspirations as well as a blow to the individual and those close to them. A number of those surveyed in this report will now be back in training programmes within anaesthesia, intensive care medicine, or both, yet ongoing work will be essential in supporting those not yet successful and restoring confidence in all those affected.

It is encouraging to note that since the survey was conducted, the College has already taken steps in other areas, notably in its reviews of its examinations, to address the issues affecting members' experience of training and assessment. Acknowledging wider concerns and acting on them in an open, thoughtful and transparent way is essential and the College has shown it has the capacity to do just that.

References

1 Excellence by design: standards for postgraduate curricula. *GMC*, 2017.

2 Generic professional capabilities framework. *GMC*, 2017.

3 Curriculum implementation and transition. *RCoA*, 2021.

4 The impact of the COVID-19 pandemic on training: a national survey of UK anaesthetic trainees. *Association of Anaesthetists*, 2021.

5 Subramaniam J et al. (2022). Recruitment to higher specialty training in anaesthesia in the UK during the COVID-19 pandemic: a national survey. *Anaesth* 2022;**77(5)**:538–546 (doi:10.1111,anae.15660).