Royal College of Anaesthetists

The 10-Year Health Plan for England: RCoA Submission

November 2024

1. What does your organisation want to see included in the 10 Year Health Plan and why?

Currently, patients are experiencing excessively long wait times for operations and procedures, with the waiting list in England standing at over 7.6 million. The key for the Government to achieve its objectives – increasing NHS productivity, clearing waits of over 18 weeks, and reducing waiting lists by 'millions' by the end of this parliament – is to address the significant shortfall of anaesthetists.

Anaesthetists are vital to bringing down elective waiting lists, as most operations and procedures cannot take place without them. However, there is a chronic shortage of anaesthetists. In England alone, as of 2022 the anaesthetic workforce fell short by roughly 1,600 anaesthetists (around 1,200 consultants and 400 SAS doctors). This is 15% lower than what is needed.

As a result of this, we estimate that around 1.17 million operations and procedures are unable to take place each year in England. If the 10 Year Health Plan doesn't include clear directives placing workforce at the forefront of NHS planning, these issues are set to worsen in years to come.

We commissioned the York Health Economic Consortium to produce projections on future demand for anaesthetists and how that would compare to the supply if historic rates of growth were maintained. The projections suggest that the gap between the supply and demand of anaesthetists is set to grow considerably due to factors such as population growth and ageing, increasing numbers of surgical interventions on offer and the expansion of the anaesthetists' role, particularly through their involvement in perioperative care. These factors together will increase the demand for anaesthetists by 3.85% per year. However, from 2010 to 2020, the supply of anaesthetists increased at a compound annual rate of just 1.54%. If this trend continues, the demand for anaesthetists will considerably surpass the available supply in future.

It is key that issues within the NHS workforce are not overlooked. In September, Lord Ara Darzi's comprehensive review of performance levels in the NHS provided a strong direction for the basis of the 10 Year Plan. However, within his diligent analysis lay the suggestion that the NHS workforce 'appears to have expanded to amongst the highest levels in the world'.

Although this may be true of certain specialties, it is definitely not true in anaesthesia, where workforce numbers lag significantly behind other European nations. In 2024, the results of 'The Global Anaesthesia Workforce Survey' revealed that the UK has 14.23 anaesthetists per 100,000 people. This is considerably lower than other large high-income European nations such as Germany (37.37), Italy (25.34), France (17.02) and even lower-income European nations such as Moldova (16.12).

The NHS Long Term Workforce Plan (2023), made a significant and welcome commitment to double the number of medical school places to 15,000 by 2031/32. However, medical school, which currently constitutes the first 5 years of a doctor's medical training, is not the key hinderance to the numbers of anaesthetists in post today.

Following undergraduate training, a doctor in training will complete two years of 'foundation training', where they are offered experience in a range of medical specialties. After this, doctors in training will choose an area of medicine to specialise in, such as anaesthesia, subsequently applying for what's often called 'core specialist training' in this field. Once they have completed their core training, they then may apply for 'higher specialist training' in their field, commonly the final stage of the training pathway.

Throughout the whole medical training system, there exists a huge bottleneck between foundation and core specialist training. In 2024, in England alone, there were roughly 26,000 individual applicants for just 9,000 specialty training places.

In anaesthesia, there were roughly 3,500 applications for an available 500 core anaesthetic training places, representing a competition ratio of 6.5:1. This demonstrates that we are not short of interested applicants, but short of posts for them to go to. Also in anaesthesia, there is a second bottle neck between core and higher training. While this was particularly high a few years ago, through the work of the College and NHSE, it has now come down to a more acceptable 1.6:1 ratio.

What is needed

The NHS has already made some moves towards increasing the anaesthetic workforce. In 2022, Health Education England (now NHS England) granted funding for an extra 70 higher anaesthetic training places for that year as well as subsequent years 2023 and 2024. However, it has not yet been confirmed that these additional posts will be made permanent. Even so, these additional posts are not enough to train the numbers of anaesthetists needed in future. Investment at core level is needed immediately to allow more doctors to start their anaesthestic training, this should be matched with investment at higher level to prevent the re-emergence of an unacceptable core : higher bottleneck.

We know that there is immediate capacity in the system to train extra anaesthetic doctors. Our survey of college tutors and heads of school in 2023 revealed, at a conservative estimate, space for at least 59 extra core training places per year, and 81 extra higher training places.

We believe that the 10 Year Health Plan must make reference to anaesthetic workforce shortages and include commitments to address them. Without this, it will be extremely difficult to improve NHS productivity, or for the Government to meet its commitments to clear waits over 18 weeks and reduce waiting lists by 'millions' by the end of this parliament.

Retention issues

In addition to the challenges surrounding the pipeline into anaesthesia, we must also consider the current and future exists from the profession caused by the ageing anaesthetic workforce and retention issues in the specialty.

Our 2021 report 'Respected, valued, retained – working together to improve retention in anaesthesia' revealed that 1 in 4 consultants and 1 in 5 SAS anaesthetists were planning to leave the NHS within the next 5 years, due to a range of issues.

In part this is explained by the ageing anaesthetic workforce, leading to higher levels of retirement. GMC data shows that the percentage of licensed anaesthetic and intensivist consultants aged over 60 has risen from 8.2% in 2014 to 11.9% in 2022. Similarly, the percentage in the 50-59 age group increased from 28.4% of the workforce in 2014, to 33.5% in 2022.

There are also other reasons why anaesthetists are retiring or leaving the profession early. Our survey work showed that 42% of those who retired from the profession felt undervalued and unsupported at work. Furthermore, 25% who retired or left early did so to improve their mental wellbeing. When asked what would influence them to stay in the profession longer, 80% of our members said they would stay longer if they were offered reduced or no on-call work – this is a particular issue for anaesthetists in older age groups.

The 10 Year Health Plan should acknowledge the challenges posed by the ageing anaesthetic workforce. Hence it should include commitments to better working patterns, facilitating where possible efforts to come off the on-call rota, in order to retain senior, experienced anaesthetists.

The 10 Year Health Plan, and the Government more widely, must also avoid any return to the damaging pension taxation policies of the recent past. Our census data in 2020 revealed that 1,133 anaesthetic consultants (14.4% of the workforce) were reducing their hours because of pension taxation. In fact, some went further and chose to retire entirely. The RCoA welcomed the changes made to alleviate pension taxation problems for the majority of doctors in the March 2023 budget and we are keen to ensure that these issues do not re-emerge. We note that the new Government in Westminster has expressed a preference for a solution aimed exclusively at doctors. In theory, we are comfortable with a doctors-only solution, so long as it genuinely alleviates the problems that doctors face.

<u>Perioperative care</u>

The case for boosting the anaesthetic workforce is furthered by the involvement of anaesthetists in delivering perioperative care. We recommend the proposals developed by the Centre for Perioperative Care (CPOC), an organisation which we host. Perioperative care aims to optimise the surgical pathway for patients, from the moment surgery is contemplated all the way until full recovery.

Currently, NHS productivity is hindered by avoidable inefficiencies in the surgical pathway, including:

- Each year, around 80,000 on the day surgical cancellations take place, estimated to cost the NHS £400 million annually in lost operating theatre time
- Complications occur in 12% of operations, resulting in extended stays in hospital
- Patients often spend one or two days longer than necessary in hospital after surgery

By introducing simple but effective perioperative interventions into the surgical pathway, we can improve NHS efficiency, improve quality of care, empower patients and reduce the elective backlog.

Comprehensive details of the proposals developed by the CPOC are set out in their own submission, but we will highlight two here:

Turning waiting lists into preparation lists

- Evidence shows that preparation for surgery reduces complications by up to 50% and length of hospital stay by 1-2 days, as well as lowering the risk of last minute cancellations
- This aligns with the shift to preventative care
- First, patients are assessed to uncover any addressable health issues or behaviours.
- They should then be offered help to tackle these, via medical optimisation of conditions such as anaemia and diabetes, and 'prehabilitation' programmes to address any identified behaviours that could impact on health, such as smoking, excess drinking, or physical inactivity.

Discharge planning

- This involves collaboration between healthcare staff and patients to plan the patient's discharge process, identifying a patient's needs and ensuring they are properly supported and managed. Ideally, this should happen before the patient is even admitted to hospital.
- Better discharge planning has been shown to reduce re-admissions by 11.5%

The NHS is already trying to introduce measures like these, but widespread implementation remains inconsistent due to funding barriers. We have heard that some NHS trusts are unable to establish services due to financial constraints, despite acknowledging the long-term cost savings they would bring. To overcome this, the NHS 10 Year Health Plan should pledge funding for initial set up costs.

2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

While we support the ambition to shift as many services as possible from secondary care to the community, the fact remains that most operations and procedures will continue to take place in hospitals, and it is important to achieve the right balance of investment between the two.

Investment in hospital facilities is essential to addressing the retention issues mentioned earlier. Improvements are needed particularly as a means to boost levels of wellbeing and good mental health within the medical workforce, which is currently a concern for 1 in 4 anaesthetists. Funding must be allocated to improving rest, refreshment and parking facilities in hospitals for healthcare staff, including anaesthetists, who will continue to be based in hospitals, to ensure they feel valued and supported in their work.

That all said, we do believe that some care can be shifted from hospitals to communities. One way to do that is by addressing poor discharge planning.

Poor discharge planning comes from lack of sufficient coordination between hospital staff and patients, carers, GPs and other health and care services in the community. For example, according to Carers UK's 'State of Caring 2023' report, 60% of carers reported being excluded from discharge planning, signaling a breakdown in communications.

Well planned discharge can help a patient recover and prevent the need for them to return to hospital. Research shows that effective discharge planning reduces re-admissions by 11.5%.

To address this, the NHS 10 Year Health Plan should implement a mandatory discharge planning process that begins as early as possible in the patient pathway, ideally before admission to hospital, therefore facilitating better communication between hospitals, patients, carers, GPs and other community health and care services. We are keen to work with NHS England and DHSC to help roll out perioperative care programmes across the country.

3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

Currently, the NHS operates on outdated digital systems that are inefficient and undermine productivity. Issues with connectivity, electronic patient records, and systems that don't effectively

communicate with each other, slow down the delivery of care. Taking advantage of modern data systems could be of substantial benefit to the NHS.

The NHS needs to make use of data sharing technologies, such as the 'patient passports' recently announced by Wes Streeting, to strengthen the links between primary and secondary care. Currently, GPs and clinical staff record patient data on separate platforms that can't communicate with each other. Systems within secondary care are also sometimes fragmented, hindering data sharing. This hampers productivity and has a significant impact on patient care.

Data sharing technologies could also be a vehicle to implement practices that will improve overall NHS efficiency. For example, an integrated patient record would help transform waiting lists into preparation lists and assist with discharge planning, as mentioned previously. Clinicians in secondary care could access patient data recorded by GPs to identify health issues which need interventions. And on the reverse, GPs could access discharge notes for patients coming out of secondary care. Potentially these could be integrated into user-friendly digital apps which provide easily accessible data to both clinicians and patients. These could be produced either via working with industry or in-house within the NHS.

It must also be supported by more modern computers. Lengthy loading times are a frequent problem for clinicians and turn tasks that could take seconds into ones that take several minutes. The impact of this is cumulative and can severely undermine productivity in certain cases.

More comprehensive data should also be collected on the surgical pathway. This could include patient-level data such as:

- Co-morbidities
- Health behaviours
- Pre-screening
- Prehabilitation

It could also include systems-level data, such as:

- Cancellations
- Complications
- Hospital bed days
- Readmissions
- Anaesthetic outcomes after surgery

Combined, this could help improve patient experiences and outcomes, and also highlight areas for systemic improvement, allowing the NHS to address problems more effectively. Examples of this could include improving the allocation of resources, increasing theatre efficiency, and supporting smart rostering. This could also be supported by new apps that allow easy data input, produced in collaboration with the clinicians who would use them.

4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

As has been suggested by the Centre for Perioperative Care, a huge opportunity to spot illness early and tackle the causes of ill health occurs when patients are referred for surgery. This is when groups that are sometimes hard to reach are a) in contact with health professionals and b) highly motivated to make behavioural changes.

The waiting period leading up to surgery could be used as a 'teachable moment' for healthcare professionals to deliver individualised health messages. This has been shown to embed long-term behavioural change, with 46-75% of patients in prehabilitation programmes reporting positive lifestyle changes, including 48-75% increasing physical activity, 43% stopping smoking, and 40% reducing alcohol consumption after surgery.

An example of this is University Hospital Southampton NHS Trust's preoperative 'Fit 4 Surgery' school which provides a 2-hour classroom-based session covering the benefits of exercise, nutrition, the enhanced recovery approach, and lifestyle modification advice regarding smoking and alcohol intake. Currently however, only around half of NHS trusts and health boards have implemented some kind of prehabilitation programme, with the main obstacle being available funding.

To support the rollout of better perioperative care, online resources should be collated and disseminated, providing easy templates for NHS Trusts to implement. CPOC has already produced examples of guidance, which could be better promoted and supported by NHS England.

The RCoA has also joined several healthcare alliances in pushing for further action to be taken to tackle the causes of ill health, including measures to tackle the misuse of alcohol, tobacco and vaping, and the onset of obesity. As part of the Alcohol Health Alliance, we want to see greater funding for early interventions and alcohol treatment, as well as mental health services, which can support those who might turn to alcohol. As part of the Obesity Health Alliance, we'd like to see greater investment in the Public Health Grant and the creation of a sustainable strategy for weight management services. Alongside Action on Smoking and Health, we'd like to see the 10 Year Health Plan include a roadmap to a smokefree future.

5. **Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivering in.**

- Provide funding for more anaesthetic training places in both core and higher training.
- Invest in hospital facilities for NHS staff, providing resources for rest, refreshment, and support
- Support better workforce planning and flexibility in working patterns to retain senior anaesthetic staff
- NHS England to mandate, encourage, and facilitate the adoption of surgical pathway efficiencies
- Provide new funding for interventions to optimise the surgical pathway, such as prehabilitation schemes and better discharge planning

We believe these policies should be implemented as soon as possible, with particular emphasis placed on the urgent need for more anaesthetic training posts. Timelines for implementing each of these interventions varies by type. Our survey of college tutors and heads of school in 2023 revealed, at a conservative estimate, that there is already space for at least 59 extra core training places per year, and 81 extra higher training places, meaning this could be in place within the next year.

Prehabilitation programmes, as recommended by CPOC, could also start within the next year or so but the speed of adoption may be dependent on resources made available to implement them.