**Written evidence submitted by the Royal College of Anaesthetists (EPW0017)**

**1. Commitment: Ensure that the NHS and social care systems have the nurses, midwives, doctors, carers and other health professionals that it needs.**

*1.Was the commitment met overall? or (in the case of a commitment whose deadline has not yet been reached) Is the commitment on track to be met?*

Anaesthesia is the largest single medical specialty in NHS hospitals and most operations cannot take place without an anaesthetist. (1) It is, therefore, vital that the NHS has sufficient numbers of anaesthetists.

Unfortunately, the Government has not ensured the NHS has the number of anaesthetists it needs. There is currently a shortage of approximately 1,400 consultant and SAS anaesthetists across the UK, which prevents an estimated 1 million operations from taking place per year. (2)

Due to factors such as an ageing and increasingly co-morbid population, demand for surgery and hence for anaesthetists, is set to increase dramatically. Based on workforce projections from the York Health Economic Consortium (YHEC), we estimate the NHS will face a staggering shortfall of 11,000 anaesthetic staff by 2040. (2) This will prevent over 8 million operations or procedures from taking place per year. (2)

While we welcome the announcement that Health Education England (HEE) and the other statutory education bodies (SEBs) will increase the number of higher anaesthetic training places next year, this is only a first step. (3) Far more anaesthetic staff are needed to prevent the NHS's anaesthetic workforce gap from widening.

One root cause of the failure to meet this commitment is the lack of long-term NHS workforce planning, based on numerical data, with evidence-based supply and demand projections. The Government has opposed the introduction of national, independent, numbers-based NHS workforce planning – including during the passage of the Health and Care Bill, where an amendment was introduced to require such planning. (4)

*1.2 Was the commitment effectively funded (or resourced)?*

This commitment has not been effectively funded by the Government. The anaesthetic workforce requires long term, sustained investment to reverse the current shortfall.

*1.3 Did the commitment achieve a positive impact for patients and service users?*

This commitment has not provided a sufficient long-term solution to the problem of anaesthetic workforce shortages. The workforce supply will still fall short of both current and projected patient demand. Although the number of anaesthetists in the UK has increased slightly from 9,486 in 2015 to 10,057 in 2020, this is still approximately 1,400 fewer than is needed. (5)This contributes to delayed operations and procedures, which have clear negative impacts on patients.

The commitment may have had a positive impact in encouraging HEE's granting of additional higher anaesthetic training posts in England and the other SEBs in the devolved nations, however this will only partially mitigate the growing workforce gap. We need to develop different models of working to address the backlog recovery and this will require future investment in a multidisciplinary

anaesthetic workforce, which includes consultant, SAS and trainee anaesthetists, non physician anaesthetists (Anaesthesia Associates), anaesthetic assistants and other operating theatre staff may help reduce workforce shortages.

*1.4 Was it an appropriate commitment?*

While the objective of the commitment was appropriate, its ability to be effective has been undermined by the absence of appropriate funding and the Government's opposition to publish long term NHS workforce projections based on numerical data.

***2*** **Commitment: Help the million and more NHS clinicians and support staff develop the skills they need and the NHS requires in the decades ahead.**

*2.1 Was the commitment met overall? or (in the case of a commitment whose deadline has not yet been reached) Is the commitment on track to be met?*

The NHS faces several serious problems:

- 10–15% of operations have complications – which are often predictable and potentially preventable. (6)
- Within hospitals, 45% of costs can be attributed to 3% of patients – typically those experiencing complications. (7)
- Patients often spend one or two days longer than necessary in hospital after surgery due to surgical pathway inefficiencies. (6)

If the NHS wants to get its backlog down, it must address these avoidable issues.

Perioperative care refers to the process of optimising the surgical pathway. This covers interventions and processes from the moment someone contemplates surgery all the way to complete recovery. It covers preoperative care (before surgery), intraoperative care (on the day of surgery) and postoperative care (after surgery).

One example of perioperative care is prehabilitation. The healthier someone is going into an operation, the greater the chances the surgery will be a success. Prehabilitation programmes increase patients' health before surgery through interventions, such as physical exercise, nutritional support, psychological preparation, smoking cessation, and alcohol moderation advice.

We know perioperative care interventions provide a variety of benefits to patients and clinicians, including fewer cancelled or unnecessary operations, fewer complications and reduced patient stays in hospital. An international evidence review commissioned by the Centre for Perioperative Care (CPOC) in 2020 revealed that specific prehabilitative interventions could reduce postoperative complications by 30–80% and reduce the length of stay after surgery by one to two days. (8) Ensuring that appropriate postoperative support and separate discharge planning is available has also been shown to reduce patient readmissions by 11.5%. (9)

Perioperative interventions offer important, cost-efficient solutions to tackling the NHS backlog. But the full benefits of perioperative care interventions cannot be achieved without Government investment in the NHS workforce who work in the surgical pathway.

The NHS has proposed innovative perioperative interventions, such as the inclusion of the perioperative care teams in the elective recovery plan, (10) however more investment is needed to achieve the full benefits for patients, clinicians, and the NHS. Efforts towards embedding perioperative care in the NHS are being made with the forthcoming development of a perioperative care curriculum, which will be led by the Centre for Perioperative Care (hosted by the Royal College of Anaesthetists).

We believe the Government needs to continue to support this development of perioperative training and prioritise its roll out across the NHS.

**3. Commitment: Introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services.**

*3.1 Was the commitment met overall? or (in the case of a commitment whose deadline has not yet been reached) Is the commitment on track to be met?*

NHS employees' mental health and wellbeing has not been fully supported. While we acknowledge that, since March 2020 NHS employees have benefited from free access to health and wellbeing apps such as Head Space and Unmind, this access will stop at the end of December 2022. (11) (12) Unfortunately, many NHS health professionals - including anaesthetists - are still struggling with maintaining good mental health and wellbeing.

We know poor mental health and wellbeing remains a problem amongst the anaesthetic workforce and is a key factor hindering retention. 25% of consultants and 20% of SAS Anaesthetists told us they planned to leave the NHS within five years. (13) The pandemic has exacerbated this problem, as 3 in 10 anaesthetists told us that COVID-19 had made them less inclined to stay in the NHS- with a main reason being feeling 'emotionally or physically burnt out'. (13) Anaesthetists who had retired, or recently returned after retiring, reported that one of the main reasons they stopped working was to improve their mental wellbeing, reduce stress and alleviate the effects of burnout. (13)

This was echoed by the General Medical Council's (GMC) Barometer Survey in 2021, which found 42% of doctors felt that working during the pandemic has had a negative impact on their mental health and wellbeing – a 10% increase from 2020. (14) Concerningly, the GMC suggested the anaesthetic workforce's level of health and wellbeing support is linked to their continued struggle with high workload and burnout. (14) 12% of anaesthetics/intensive care doctors disclosed 'struggling' with workload, and anaesthetists in training who reported being at 'high risk of burnout' increased from 8% to13% between 2019-2021. (14)

We asked our members what would encourage them to stay or return to the NHS; 46% of SAS anaesthetists and 26% consultant anaesthetists cited increased availability of wellbeing services and support networks as a key factor. (13)

*3.2 Was the commitment effectively funded (or resourced)?*

The commitment lacked adequate investment in targeted support designed to address the daily professional challenges and stresses that clinicians face. We know that key factors affecting career decisions to leave or retire early include chronic high workloads and lack of flexibility in working hours. Anaesthetists told us the combination of these factors can contribute to the workforce's propensity to experience stress or burnout. (13) To address this, Government and NHS leaders must

commit significant, sustained investment in the expansion of the anaesthetic workforce to fill the existing shortfall.

*3.3 Did the commitment achieve a positive impact for patients and service users?*

While the commitment may have had some positive impact, we do not believe it has been sufficient to protect patients and service users. In fact, GMC survey data from 2021 revealed that there are strong concerns about patient safety held by clinicians – particularly amongst anaesthetists. (14) 40% of 'Anaesthetic/ Intensive Care' doctors reported having experienced a situation in which they believed a patient's safety or care was compromised –this is the highest proportion identified amongst all medical specialities in the NHS. (14)

*3.4 Was it an appropriate commitment?*

This commitment did not focus on addressing the fundamental daily stresses and workload issues that clinicians face. While provision of mental health apps may be helpful in some cases, it is better to address the root causes of mental health problems rather than try to mitigate them once they emerge.

To truly address mental health and wellbeing issues, effort needs to be taken to address high workload and burnout. At its heart, this means increased numbers of staff must be in place to deal with the volume of work that needs to be done. It also involves setting realistic targets for reducing the waiting lists, which allow burnt out staff to recuperate from the effects of the pandemic and enable them to access the support resources and time off they need. (13) Additionally, NHS employers and managers should consider and support requests for flexible working and Less Than Full Time (LTFT) working to improve the work-life balance of all staff. (13)

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