Association of Anaesthetists Trainees

April 2024

Anaesthetic training in the UK:

best practice for today and concepts for the future

anaesthetists.org

Anaesthetic training in the UK: best practice for today and concepts for the future

B. Evans[1], E. Gibney[2], CM. Agius[3], N. Ahmed[4], E. Wain[5], M. Davies[6], S. Edwardson[7]

1. Specialty Registrar, Northern School of Anaesthesia
2. Speciality Registrar, Mersey Deanery
3. Specialty Registrar, Queen Elizabeth Hospital, Gateshead
4. SAS Anaesthetist, Acute pain lead, Airedale NHS Foundation Trust
5. Associate Specialist, Robert Jones and Agnes Hunt Orthopaedic and District Hospital
6. Consultant, Department of Anaesthesia, North West Anglia NHS Trust
7. Specialty Registrar, South East Scotland School of Anaesthesia and Intensive Care Medicine

Published: April 2024

This work is licensed under a Creative Commons Attribution-NonCommercial-No Derivs 4.0 International License CC BY-NC-ND

Contents

Click arrows below to view sections

Anaesthetic training in the UK: best practice for today and concepts for the future

Anaesthetic training in the UK continues to be among the longest and most challenging in the world. This produces a workforce of highly talented, skilled, and experienced senior anaesthetists who are able to tackle the ever-evolving challenges that we face in the NHS and healthcare. However, balancing a high quality training experience which promotes longevity and wellness within our workforce alongside the growing nature of problems with our healthcare infrastructure is a very real and present challenge.

This document aims to do three things:

1. Re-affirm requirements that are mandated and essential parts of the trainee experience with regards to factors such as rotas, educational support and facilities at work.
2. Describe what we feel are examples of best practice in these areas. This would exemplify the training experience that aims to provide a 'good' experience to those who train within it.
3. Take a broader view of the current curriculum and attempt to reimagine what this could look like in the future. This includes the reshaping of training structure to improve factors such as agency, equity and burnout within our training workforce.

We know that one of the major factors in preparing our workforce for the future is to improve retention of those working now. This document aims to be a guide on ways in which we can do this today, and how we can conceptualise a better way of working in the future.

All information is accurate at time of writing. If you have any comments or suggestions relating to this guide please get in touch.

Association of Anaesthetists Trainees

This work is licensed under a Creative Commons Attribution-NonCommercial-No Derivs 4.0 International License CC BY-NC-ND

Anaesthetic training in the UK:
best practice for today and concepts for the future

Section 1

The essentials

Association of Anaesthetists

The essentials

Teaching

Exams can cause significant distress and fatigue for anaesthetists in training and, as such, suitable support and teaching should be available both at departmental and deanery level. Local teaching, aimed at exams and post-fellowship, should be both stage-specific and relevant to the anaesthetists in training in that placement. Best practice would suggest this teaching should be protected (bleep-free) time and ideally delivered as a half or full day (1).

The Royal College of Anaesthetists (RCoA) mandates that Critical Incident Training and Simulation Training are delivered during Stage 1 – this often forms part of a 'New Starters Course' (2).

Portfolio and ARCP requirements

The RCoA derogates a number of Annual Review of Competence Progression (ARCP) processes to local deaneries; however, it does make a number of suggestions that should be followed. Anaesthetists in training need only create one multisource feedback (MSF) per year, except when doing an Intensive Care Medicine placement when another is required. Multiple trainer reports (MTRs) should be created once per year minimum. Anaesthetists in training already have a large burden of paperwork and forms, and local deaneries should, where possible, follow this minimum recommendation. There is no stipulation for a minimum number of reflections per year by the RCoA (1).

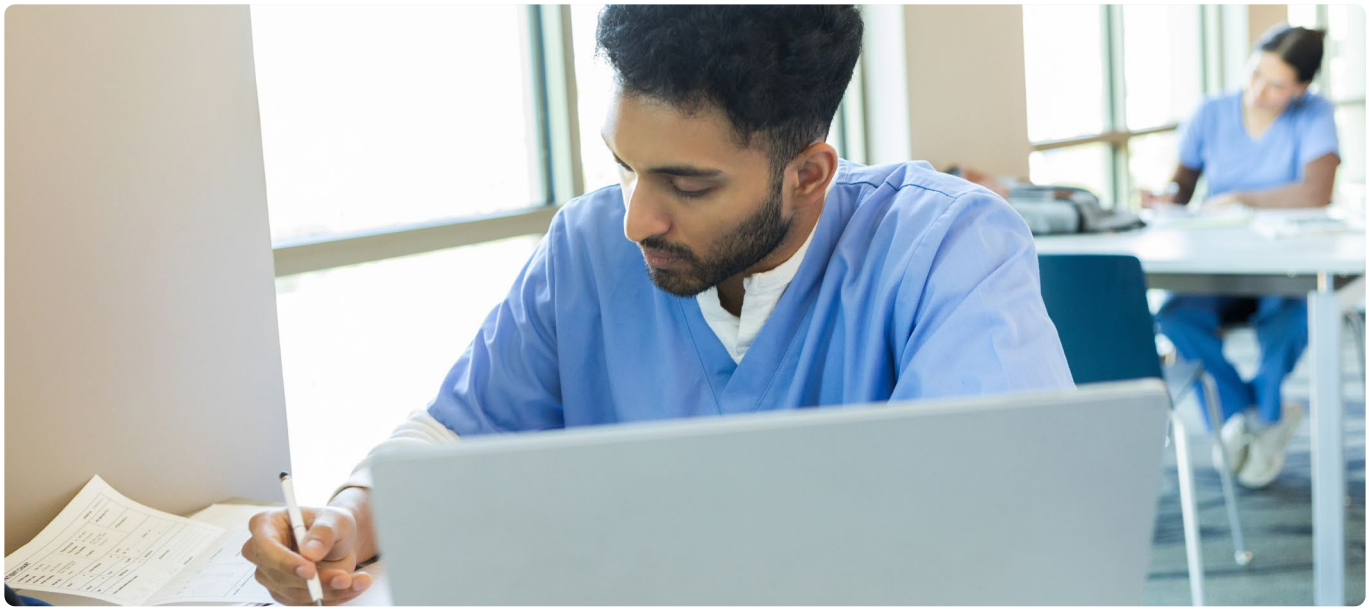
Mandatory training, which may be required by the local Trust, is not a requirement for success at ARCP (2). The RCoA stipulates that trainees should have the Primary FRCA complete by the end of Stage 1 and the Final FRCA complete by the end of Stage 2 (1).

Rotas

Rotation details, including hospital and placement, should be provided a minimum of 12 weeks in advance (3). Details regarding study leave, travel arrangements, parking, induction details and local policies where appropriate should be provided a minimum of 8 weeks in advance (3). A complete rota should be provided a minimum of 6 weeks in advance (3).

Travel to work

Travel expenses are claimable when individuals are travelling to a hospital site that is further away than their base site. Further details and information regarding relocation expenses are available from the BMA (4).



Study leave, expenses and educational development time

Study leave is essential for the continued development of anaesthetists in training. Study leave costs in themselves should not be capped per individual trainee, and courses should be assessed on individual merit. Study leave should be granted for all FRCA examination days, as well as approval and funding for exam preparation courses (5).

Where study leave is required by the school of anaesthesia or the local employer (e.g. Advanced Life Support courses), this should be funded directly by the requesting organisation (5).

All anaesthetists in training receive 30 days of study leave per year, pro-rata for those working less than full-time (LTFT) (5).

Educational development time is recognised by the RCoA as an important aspect for developing areas of the curriculum not covered by clinical practice. Time commitment stipulations are:

- Two hours per week in Stage 1 and 2
- Four hours per week in Stage 3

When and how educational development time is taken should be agreed in advance and there should be the ability to be flexible in its use. If it clashes with on-call or annual leave it should be moved and the time not 'lost' (6,7).

Training and service provision

The RCoA *Guide to Anaesthetists in Training* (The Handbook) provides specific guidance for the appropriate allocation of time in training and the demands required of trainees of service provision. Anaesthetists in training should do no more than 21 nights in a 6-month block. A minimum of three supervised clinical sessions per week (averaged over 3–6 months) is required to ensure sufficient workplace learning to allow anaesthetists in training to progress to a Certificate of Completion of Training (CCT) within the indicative 7 years of the programme (7).

Obstetric out-of-hours cover can be a significant burden for anaesthetists in training. It is recommended that no more than a third of time in Stage 2 (indicative ST4 and ST5) should be spent covering obstetric anaesthesia out-of-hours (7)

The Faculty of Intensive Care Medicine continues to advocate for a greater utilisation of Intensive Care Medicine trainees, and lower utilisation of anaesthetists in training to cover intensive care units. A CCT in Anaesthesia requires only 9 months of Intensive Care Medicine; 6 months in Stage 1 and 3 months in Stage 2 (1).

Anaesthetists in training should not cover Intensive Care Medicine outside of these blocks, either out of hours or in-hours, unless providing advanced airway support in a supervisory role (7). This is due to recognition by the RCoA of the importance of being on-call for general theatres. The RCoA allows for an additional 3 months out-of-hours cover for Intensive Care Medicine, outwith a recognised Intensive Care Medicine block in Stage 2.

Clinical supervision

When undertaking a 'solo list', anaesthetists in training should have an allocated, immediately available consultant, who should be aware of the different trainees, their supervisors and the case-mix. This named, responsible consultant should be documented on the anaesthetic chart. It is prudent to either have this consultant free of any other clinical work or be in a nearby operating theatre with a trainee who can be left alone at any time. At all times, the requirements of the Cappuccini test should be met. This is an auditable standard from the RCoA (8,9).

Rest facilities

It is a national standard that all hospitals have a provision for hot food, 24 hours a day, 7 days a week (10).

Where anaesthetists in training provide out-of-hours cover and work overnight shifts, there should be sleep facilities available for every anaesthetist working overnight. These anaesthetists should be encouraged to rest, and it should be expected that rest facilities are utilised. Adequate local provision should be in place for those anaesthetists in training who are too tired to drive, if good quality rest has not been possible throughout their shift (11,12).

The BMA Fatigue and Facilities Charter stipulates that rest facilities include an individual room with a bed with good quality linen that is changed regularly, a telephone with access to the hospital switchboard, electrical power points and adequate sound and light proofing to allow for good quality sleep (13).

Less than full-time working

Anaesthesia as a specialty is now covered by Category 3 LTFT rules; as such with 12 weeks' notice anaesthetists in training can go LTFT for any reason. The RCoA recommends that anaesthetists in training should not go LTFT before completion of the Initial Assessment of Competence (14).

Those who work LTFT should have an equivalent reduction in their out-of-hours commitment in line with their %LTFT (14).

Anaesthetics is competency-based and while there are indicative time periods for the completion of Stages 1, 2, and 3, these are not mandatory. Competencies should be assessed and progression recommended if suitable at ARCP (1).

Parental leave and pregnancy

When an anaesthetist in training becomes pregnant, there should be a risk assessment completed to establish whether current working conditions would put them or their pregnancy at risk. If it is deemed that their working conditions would put them at risk; for example, the high-pressure nature of out-of-hours anaesthesia during the third trimester, the anaesthetist in training should come off the on-call rota and continue to receive their normal rate of pay. When this occurs, there is no expectation that anaesthetists in training will 'repay' this out-of-hours commitment or arrange swaps or prospective cover. If, for health reasons, an anaesthetist in training is unable to continue to work in any capacity, they will be removed from work on full pay (15).

Any appointment required by a medical practitioner for the purposes of antenatal care is essential and time off is mandated by law (15).

Anaesthetists in training who are expected to have parental responsibility, but are not pregnant, are entitled to take either one week, or two consecutive weeks of parental leave. They should inform their employer of their intention to take this leave by the end of the 15th week before the expected birth date of the child BMA (16).

Anaesthetists in training who are adopting a child are entitled to the same parental leave, they must inform their employer within seven days of notification of adoption placement (16).

Annual leave and sick leave

Anaesthetists in training are entitled to 27 days of annual leave on appointment. This increases to 32 days upon 5 years of NHS service. When anaesthetists in training are LTFT this is reduced pro-rata. Requests by anaesthetists in training that are filed with more than 6 weeks' notice should be granted wherever possible. Under the 2016 terms and conditions, leave for life-changing events (as defined by a doctor) must be granted where 6 weeks' notice has been given (17).

On completion of 5 years of service, doctors are entitled to 6 months' full pay and 6 months' half pay for long-term sick leave. Sickness will be reviewed at ARCP and should not automatically cause an extension to training times. However, a period of more than 14 days in 12 months will trigger a review (18).

Anaesthetic training in the UK:
best practice for today and concepts for the future

Section 2

Best practice

Association of Anaesthetists

Best practice

Teaching and exams

Exam-specific teaching should be easily available to those sitting the primary and final exam and there should be an expectation that anaesthetists in training are freed from clinical duties to attend. This teaching should include exam practice such as structured oral exam practice and coverage of specialty work the anaesthetist in training may not yet have experienced. Post-exams, this teaching could be in-placement aimed at subspecialty work or at a deanery level delivered by consultants and relevant specialists with outside speakers invited. There should be provision within post-Fellowship teaching to cover non-clinical topics such as consultant interviews, CV building and consultant contracts to aid in preparation for the step up to consultant.

Departments should be proactive in discussing with anaesthetists in training whether they will be sitting exams during that placement and exam leave should be guaranteed. Study leave for relevant exam courses should be made available wherever possible. This may be challenging in placements where a large portion of anaesthetists in training are sitting exams but the department should ensure provisions are fair and utilise locum cover and swaps where necessary to make it possible.

In Stage 3 there should be a straightforward application process for specialist interest area modules with a brochure of available units. The timeline for applications should be clear well in advance.

Portfolio and ARCP requirements

These generate a substantial workload for anaesthetists in training, even following the curriculum changes in 2021. ARCP guidance documents should be available at the beginning of each academic year with a clear outline of expectations for ARCP. In specialty placements, there should be a clear plan of requirements for signoff guided by the RCoA and department and these should be easily achievable by full-time and LTFT anaesthetists in training.

With regards to educational supervision, where anaesthetists in training are in unavoidable short placements then there should be provision for an overarching education supervisor for the year as a single point of contact regarding progression. There could be separate clinical supervisors within short placements to ensure placement specific requirements are met.

Within the department the consultant body should be proactive in signing off workplace-based assessments and highlighting to anaesthetists in training when there are suitable opportunities for assessment. There should be regular refresher training for consultants to ensure good understanding of the new curriculum and aspects such as supervision levels (3).

There should be provision within placements for anaesthetists in training to request specific lists to meet their learning needs, particularly with regards to the Initial Assessment of Competence, regional procedures and specialist interest areas. Where there are particular training needs they should be recognised, assigned to appropriate levels of anaesthetist in training, and with a consultant who is happy to teach and sign off appropriate workplace-based assessments.

Human resources, induction and support

There has been a move over the past few years towards a lead employer for rotational doctors. While this process is not universally successful, it has generally been accepted to have improved the process for rotational trainees by reducing the paperwork burden. However, there remains a certain amount of paperwork required by each individual department including contact details, information for car parking and ID badges as well as IT access. An induction passport held by the deanery (with relevant permission from the rotating doctor) has the potential to further reduce the administrative burden for doctors and streamline the rotation process. This would allow departments to prepare a significant amount of the induction process before the arrival of the rotational doctor. There should be adequate administrative support for this and, if done by the consultant body, adequate time away from clinical duties provided. Best practice should ensure car parking, ID badges and IT access are available on day one of the rotation and if not, no on-call commitments should be expected before this is provided.

Within a department there should be access to an anaesthetist in training specific office or space that is separate from the consultant or SAS office. This space should have access to computers and telephones to allow doctors an area for work or revision as well as a space where they are likely to see a friendly face for support and decompression. It is well recognised through the Coffee and a Gas initiative that anaesthetic doctors appreciate the ability to talk to colleagues of an equivalent level away from a clinical setting due to its multiple wellbeing benefits. Having a separate doctors in training office allows a space for this to happen in an ad hoc fashion in addition to anything more structured.

There should be a clear process for support for anaesthetists in training who are in difficulty, both at a deanery and departmental level. There should be the option for doctors to access this support within the department they are currently working or from an outside source within the area without prejudice or judgement of their decision. The process and points of contact should be made clear annually and at each rotation. There should also be an accessible method for debriefing and support for anaesthetists in training who are involved with traumatic cases or difficult clinical situations. Again, this support should be available either within the department or a separate process within the deanery.

Travel to work

According to the BMA Fatigue and Facilities charter there should be sufficient parking which is safe to access irrespective of time of day (13). The process for claiming mileage should be straightforward and the use of a Lead Employer allows mileage claims to be tax-free. The use of a Lead Employer also allows anaesthetists in training to access salary sacrifice schemes for purchase of both cars and bicycles.

Study leave and expenses

It is widely known that the study leave budget should not be capped and assessed on merits but experiences of this nationally show wide variation. As a standard, the study leave budget should not be top sliced regionally for mandatory or expected courses. The process of application for study leave expenses should be clear and easy to achieve with rapid payment of expenses. This should not require the course to have occurred if the anaesthetist in training has evidence of payment. The process for requesting study leave itself should also be clear and unambiguous and any study leave refusal should have a clear explanation as to why. There should be a process for appealing this and 'service demands' should not be used as a blanket reason.

Training and service provision

It is well recognised that an aspect of anaesthetic training is service provision to cover both elective and on-call work. However, this should not be at the detriment of the training of the anaesthetist. There should be minimum expectations of training lists in each rotation and these lists should be identified in advance.

There should also be acknowledgement of the out-of-hours workload in rota writing. Where nights and weekends are known to be particularly busy, the run of on-calls should be shorter if possible, though a balance should be sought to avoid excessive zero days interrupting access to training lists.

NHS England's Long Term Workforce includes a commitment to significantly expand the number of Anaesthesia Associates (AAs). It is imperative that this does not affect the training of anaesthetists. Recent literature has described that some anaesthetists feel there is a negative impact on their training when AAs are present in the department (19). When a consultant anaesthetist is supervising an anaesthetist in training and an AA, this list does not count as a training list due to a lack of direct supervision, and the anaesthetist in training not being supernumerary (20). As such, a good department will ensure that anaesthetists in training are appropriately allocated and supervised in lists that can contribute to their ongoing development.

Anaesthetists in training must be prioritised for access to regional anaesthesia opportunities, a requirement at all stages of training in the 2021 curriculum. Where departments utilise AAs to run regional lists with consultant supervision, they must have agreed supervisory protocols for the training of anaesthetists.

Clinical supervision

Within a department there should be a clear process for accessing supervision when working solo or on-call. There should be a clear escalation process when the immediate supervisor is unavailable for any reason. There should also be information in induction as to which cases in that unit require on-site or in-theatre supervision by an autonomously practicing anaesthetist (for example, patients aged < 1 year, ASA physical status ≥ 3, etc.) The RCoA suggests there should be the opportunity for senior anaesthetists in training to supervise more junior trainees in appropriate lists in order to gain skills and practice in this (9). As per RCoA guidelines, anaesthetists in training should never be expected to supervise AAs (9) . When an anaesthetist in training is working with distant supervision with a consultant directly supervising an AA, then it is essential the anaesthetist in training has a clear escalation protocol for concerns and has a named supervisor.

There should be regular monitoring of supervision levels and any concerns acted upon.

Rest facilities

The provision of good rest facilities is an essential component of long term out-of-hours working for the anaesthetist in training. In addition to the essentials described earlier, there should also be suitable catering facilities, open 365 days a year with varied and freshly prepared meals including options for a range of cultural and dietary requirements. Where possible there should be extended meal-times and late opening, with overnight opening where possible.

The availability and quality of rest facilities should be regularly audited with a clear process for escalating issues within the department or Trust.

Rotations

Following the Extraordinary General Meeting of the RCoA in 2023, there is likely to be a move towards the avoidance of short rotations and deaneries should assess their training programmes to minimise this wherever possible (21). If absolutely unavoidable, short subspecialty placements should be grouped, with an overarching educational supervisor for the anaesthetist in training. The burden of short rotations should be recognised at a departmental and deanery level and work done to mitigate the impact. There should be discussion early in the programme about timing of these short rotations to allow for planning to avoid those major life events that can be predicted. There should be recognition of flexibility to blend a placement with both Stage 2 and Stage 3 requirements if this results in the anaesthetist in training having to rotate less frequently.

Anaesthetists in training should be aware of their rotations a minimum of 6 months in advance and any changes after this done only with the agreement of the doctor in question.

Less than full-time working

Any anaesthetist in training who wishes to work LTFT should have the ability to choose their LTFT working days and this should be respected by the departments. Ideally there should be a deanery held list of non-working days and agreements about working shifts around this (for example working nights into non-working days, split vs. full weekends). This should then be passed to the departments when informed of the doctors rotating to reduce the administrative burden on both the doctors and the departmental administration staff or rota writers.

Any rotation or module in subspecialty training should offer an equivalent period of training (for example 6 months full-time would be 8 months at 80%) (22). Placements should not be excessively lengthened beyond this where avoidable.

Within a department or deanery there should be a consultant LTFT lead who can act as a point of contact for advice and information. Within Lead Employer practice there should be a LTFT administrative lead to reduce the burden on doctors to contact multiple people for information, and to minimise the risk of pay issues or rota concerns.

Parental leave and pregnancy

As per the Association of Anaesthetists guidance *Parenting in Anaesthetic Training*, there should be ample and easily accessible support for anaesthetists in training going through pregnancy and maternity leave (23). There should be a clear process in each department for managing workplace risks while pregnant, including the ability to avoid exposure to ionising radiation and infectious diseases, in keeping with national guidance. Managing shift work in the third trimester should be proactively approached and led by the doctor's needs and preferences. There should be no blanket or standardised approach.

Anaesthetists in training may experience pregnancy loss themselves or in their partner during training. While there are statutory requirements, there should also be an understanding approach from the department and deanery and support for return as and when the doctor feels ready. There should be an understanding that there may be a need to avoid particular placements such as obstetrics or paediatrics and the doctor may need a phased return. There should be easy access to additional support as required.

While on maternity leave, there should be the ability to take the full entitlement of keeping in touch days. These should be made easy and not arduous to organise. Return to work courses should be advertised and open to any doctor returning to work after a period extended leave for any reason. They should be funded separately from study leave. The return to work period should be planned in advance and an appropriate number of supervised sessions complete before an expectation of solo or out-of-hours work (23). This, again, should be done in accordance with the doctor's needs, and a return to solo or out-of-hours work when they feel ready.

There should also be clear signposting to Supported Return to Training (SupporTT) and how to access this as well as a good understanding within the department and funding for supernumerary periods (24).

Section 3

Concepts for the future of anaesthetic training

Association of Anaesthetists

Concepts for the future of anaesthetic training

The *State of the Nation Report* predicts we will have a shortage of 11,000 anaesthetists by 2040 (25). This will prevent around 8.25 million operations each year. In addition, the *Respected, Valued, Retained* report tells us that in 2021, 1 in 5 anaesthetic consultants was planning to leave the NHS within the next 5 years, and an even higher 1 in 3 anaesthetists in training were also planning to leave the NHS in the same timeframe (26).

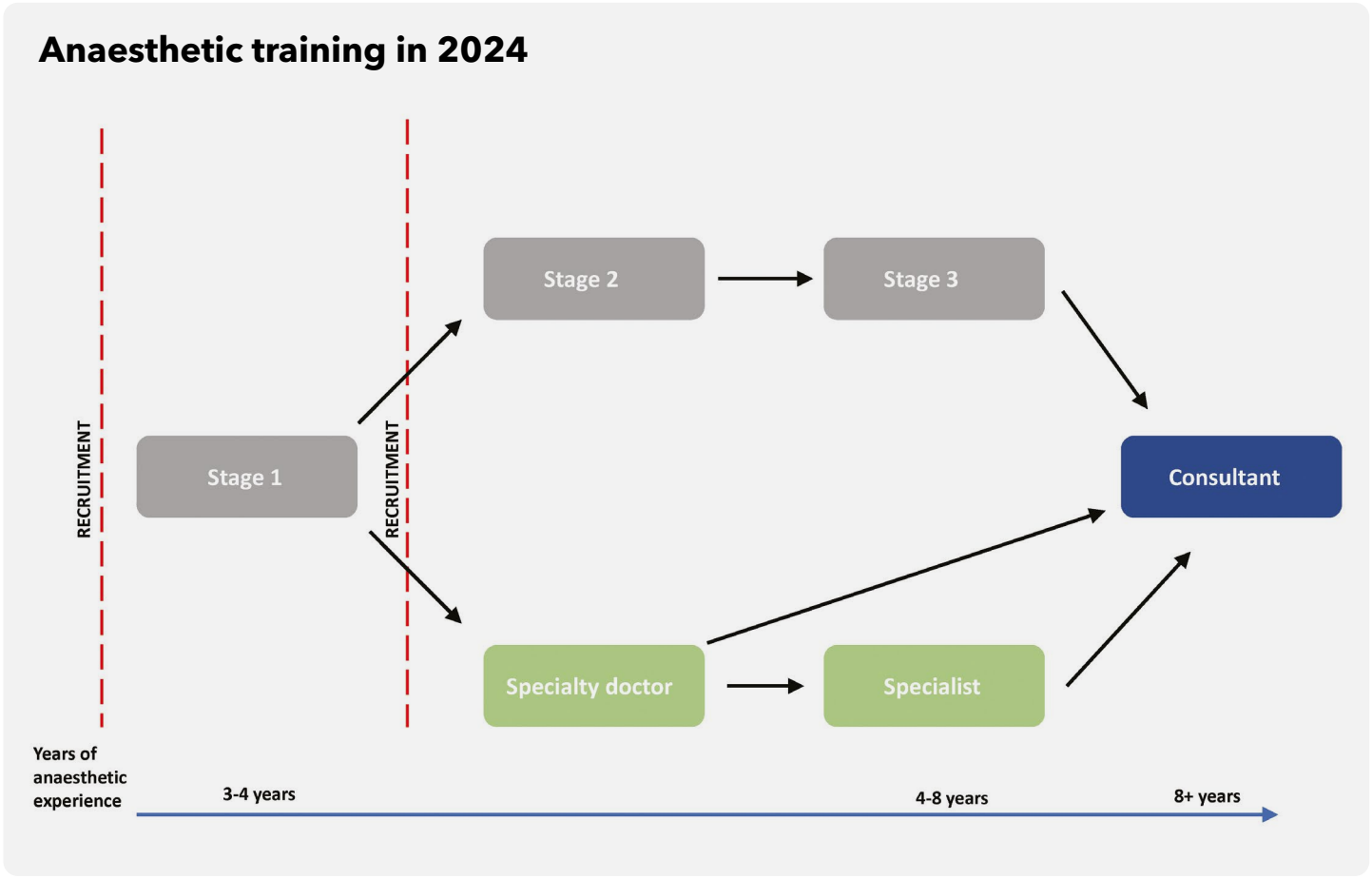
These predictions, combined with our current surgical backlog, create a sobering discussion for our profession. The key part of this conversation is hinged upon retention of our workforce.

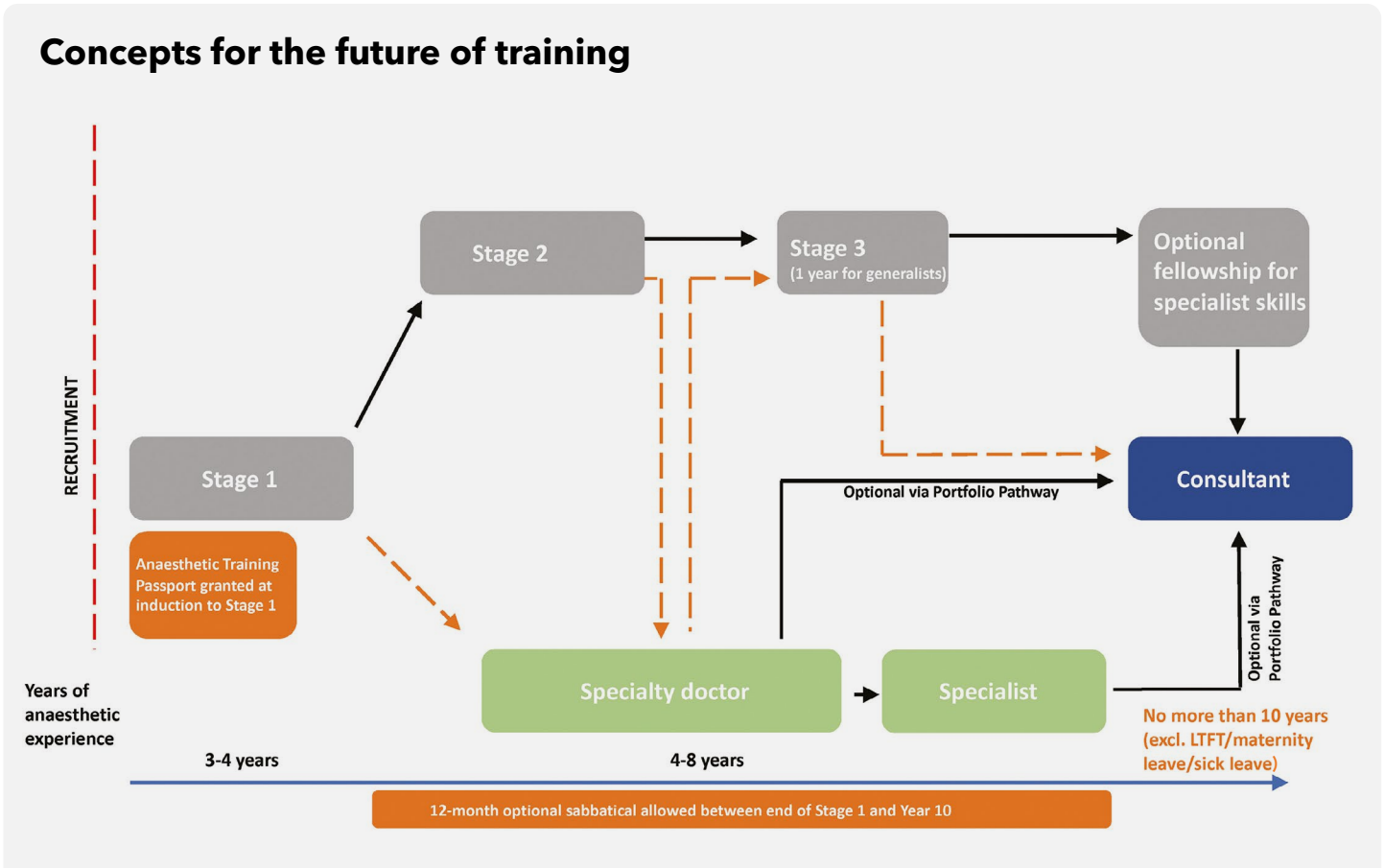
It is clear that an increase in numbers of anaesthetists in training, alongside improved equity of access and experience for SAS doctors is vital. Pay restoration for the entire medical workforce and improved working conditions also play a significant role. However, there are many factors included in the framework of training and its environment which also play an impactful role in poor retention or poor training experience. Much of this results in lack of equity of access to good quality training while being incompatible with the continued wellbeing of the doctor.

While some of these factors are modifiable by improving adherence to current standards of training (as detailed earlier in this document), some are not. The ideas put forward here are in no way intended to be the solution, as much of this will come with logistic refinement, but it is important that the structure of training is guided by those using it. The concepts discussed serve as a platform to begin this conversation. Naturally, the 2021 Curriculum for a CCT in Anaesthetics will not change any time soon (1). However, this is an opportunity for us to think radically about how we imagine the training of an anaesthetist may look in (for example) 10 years' time. Instead of asking "Can we do that?", simply ask "Can we afford not to?".

This is particularly topical as, at the time of writing, some changes to training are being discussed by the RCoA (duration of rotations, recruitment processes) and so there is value to be had in having this discussion now. The following changes are designed to attenuate some of the commonly heard issues with the current training structure, including equity, agency, burnout, and inflexibility. Figure 1 serves as a summary of this. The major take home points from this include the introduction of run-through training, reduction of mandatory training duration by one year, introduction of optional sabbatical year, and flexibility to enter and leave formal training at the end of each formal stage.

Figure 1. A comparison of some of the current pathways to careers in anaesthesia and some ideas of how this could be changed.





Back to contents

Recruitment and training numbers

The national recruitment process continues be a significant problem for our profession. Multiple logistical issues have resulted in unjust and needlessly stressful experiences for anaesthetists of the future, and reform of our national recruitment office is required to ensure this does not continue. This, coupled with the significant bottleneck in training numbers at ST4, provides a significant source of stress and uncertainty for the anaesthetist in training. One proposal would be to make anaesthetic training a run-through programme. This would result in a single recruitment process at CT1 (for both pure Anaesthetics and ACCS Anaesthetics programmes). Once successful, the anaesthetist in training would be given a 'training passport' with their training number. This allows logging of all experience and placements both in and out of formal training and will serve as part of the evidence towards the award of a CCT. This passport will be valid for a maximum of 10 years full-time equivalent (excluding sick leave, maternity leave, military time, academic time etc.). There are, of course, concerns regarding run-through training. The emphasis, however, should be placed on examining whether this will not only improve the working lives of anaesthetists in training, but also result in more anaesthetists able to gain a CCT.

The issue of increased training numbers continues to be worked on by the Association of Anaesthetists and RCoA. One strategy could include the use of 'slot sharing' of training numbers. Some deaneries are currently able to do this, and some not. This involves employing a number of trainees based on whole working-time equivalents, and not on the individual number of doctors. For example, in deaneries that do not do this 2x50% LTFT doctors = 200% work time (logged as 2 full-time doctors). In deaneries that are able to do this, 2x50% LTFT doctors = 100% work time (logged as total one full-time doctor). Doing this would free up a number of training places, as we see more of our training cohort electing to pursue LTFT working patterns. This would be appear to be a solution achievable in the short term which could increase the number of anaesthetists in training in the UK.

Exams

The RCoA has already undertaken both an internal and independent review of the current FRCA exam structure (27). It has committed to increase anaesthetist in training roles within the assessment process, review their purpose in today's changing nature of our clinical practice and undertake new research to investigate the impact of differential attainment in these assessments. This work is welcomed.

In our proposed changes to training structure, it is felt that the Primary FRCA remains a summative assessment which needs to be obtained for completion of Stage 1 training, and the Final FRCA the same for completion of Stage 2.

Clinical training

Increasing the flexibility of the training experience could involve the use of a 'training passport', as mentioned earlier. This would allow its user to enter into and exit the formal training pathway at agreed junctions in order that they take a job elsewhere (e.g. Specialty doctor). The time and experience gained within this job would be logged within the passport, having it count towards a potential CCT and helping dictate further training needs should the doctor re-enter formal training again (see Fig. 1).

Within formal training, we would advocate for a stop to any rotations that are less than 3 months long, alongside a strong recommendation for 6 month or longer rotations outside of specialty blocks. We do, however, recognise the value of a breadth of experience working between different hospitals, particularly between teaching and district general hospitals. A minimum number of different hospitals recorded in the passport would help ensure that some of the benefits of this variety are retained. We would recommend that there is flexibility in the timing of the delivery of some of the domains in Stage 2 and Stage 3 learning. As such, this would support schools of anaesthesia to reduce frequency of rotations in the formal training programme and alleviate some 'bottlenecks' to get many people through subspecialty training blocks.

The current natural 'pause' points in training (end of foundation, core and specialty training) do offer some opportunity for doctors to step out for a multitude of other experiences. This naturally leads to some difficulties in prediction of incoming and outgoing workforce at these stages. Keeping this benefit, while maintaining some more predictability may be improved by the automatic offer of a sabbatical year to anyone who holds a national training number. This could be up to 12 months of time offered at a prior agreed point between the end of Stage 1 training and CCT where a doctor is released to have a year unpaid by the NHS with an agreed return date to come back to work. This year could be spent doing anything of that individual's choosing.

Duration of training

Anaesthetic training in the UK is among some of the longest specialty anaesthesia training in the world, requiring a minimum of 7 years. More often, this is combined with a multitude of other 'add-on' years for ACCS training, dual training, research fellowships, teaching fellowships or post-CCT fellowships. While some of this is down to personal choice and shaping of one's career, there is certainly an impact of increasing competition meaning that many feel they need these extra years to become a competitive job applicant. This means that many of those that do finish formal training actually do so in excess of the necessary 7 years. This is in contrast to the ANZCA curriculum (5 years), Canadian (5 years) and USA (4 years) curricula. That being said, it is clear that time spent is a poor single metric for the level of experience and leadership required of a senior anaesthetist. However, it is difficult to rationalise the time spent in training in the UK when examining that of other comparable nations.

The resulting increase in consultant anaesthetists would seem an achievable goal in the medium to long term as part of a solution to the workforce crisis. A possible solution could be the reduction of training from 7 years to 6 years, with the change in Stage 3 to being a single year (instead of two). For anaesthetists who wish to gain subspecialist skills, this could be done as a post-CCT fellowship and not in formal training. This Stage 3 year would be best spent in one single hospital (unless asked for by the anaesthetist in training).

We would also advocate that those in a training programme be able to adjust their work pattern to LTFT anywhere down to 60%. This could be decided yearly and agreed at ARCP with agreement for continual annual review. This should be done with no questions asked, and an option to increase working time again should the doctor wish to do so.

Balancing training with other challenges

Many of those who leave formal postgraduate training cite difficulties with combining training with life outside of medicine. While many of these challenges are not intrinsic to the training curriculum per se, they are part of the training environment.

The NHS as an employer could choose to make a significant change to help those who work within it. Specific to the anaesthetist in training, some suggestions include:

- The implementation of shift systems that are more conducive to hours of childcare;
- Automatically, and easily, allowing those on rotation to gain parking permits such that they can arrive at work after a commute without stress;
- Potentially staggering or fully altering changeover dates away from August such that summer holidays are not impacted.

These are a few small suggestions which represent a larger issue at the heart of the NHS workforce and its wellbeing.

Reflecting on those who leave

We would recommend an established process whereby those who exit the training programme (either before or after a CCT) are exit interviewed. This could be done on a case-by-case, annual or bi-annual basis. We recognise that many talented doctors leave training for a number of reasons, and take with them a significant knowledge of the system they worked within and how it could have been improved for them. This process would seek to reflect on these experiences and allow continual modification of the training experience and how it balances with the challenges of life outwith it. A selection of exit interview videos with individuals who have chosen to leave the traditional training structure to pursue another path are available on the Association website. https://anaesthetists.org/Home/Wellbeing-support/Career-support/The-Exit-Interviews-Reflections-of-the-anaesthetic-training-pathway.

Conclusion

The workforce crisis within anaesthesia is set only to worsen in future years. Alongside increasing training numbers and pay restoration negotiations there are a number of other ways in which we can improve the working life of the anaesthetist in training. For today, we re-affirm and emphasise what we feel are the core pillars of the training environment. Our description of best practice illustrates what a good school of anaesthesia offers – something which each hospital should be aiming for. For tomorrow, we attempt to re-imagine how training could be structured in order that we can enhance the balance, humanity, equity and flexibility of a long training journey while maintaining the high-quality output of the anaesthetic training programme.

References

1. RCoA. 2021 Curriculum for a CCT in Anaesthetics [Internet]. 2021 Aug p. 190. Available from: https://www.rcoa.ac.uk/media/22396

2. RCoA. National Anaesthetic ARCP Checklist: 2021 Curriculum [Internet]. Available from: https://www.rcoa.ac.uk/sites/default/files/documents/2023-11/National%20Anaesthetic%20ARCP%20Checklist%202021%20curriculum%20v1.0.pdf

3. NHS Employers, BMA, HEE. Code of Practice: Provision of Information for Postgraduate Medical Training [Internet]. 2017 [cited 2024 Jan 12]. Available from: https://www.bma.org.uk/media/1985/code-of-practice-2017.pdf

4. BMA. bma.org.uk. 2022 [cited 2024 Jan 12]. Expenses for junior doctors relocating for work. Available from: https://www.bma.org.uk/pay-and-contracts/pay/expenses/expenses-for-junior-doctors-relocating-for-work#:~:text=Paragraph%20315%20of%20the%20terms,eligible%20to%20claim%20excess%20mileage.pdf

5. HEE. Health Education England (HEE) Study Leave: An Overview of the HEE-wide approach [Internet]. [cited 2024 Dec 1]. Available from: https://www.hee.nhs.uk/sites/default/files/documents/Health%20Education%20England%20%28HEE%29%20Study%20Leave%20-%20An%20overview%20of%20the%20HEE-wide%20approach.pdf

6. RCoA. Rcoa.ac.uk. 2023 [cited 2024 Dec 1]. Guidance for Educational Development Time. Available from: https://www.rcoa.ac.uk/training-careers/training-hub/2021-curriculum/guidance-educational-development-time

7. RCoA. Guide to Anaesthetics Training (The Handbook) [Internet]. 2023 Jan [cited 2024 Jan 12]. Available from: https://rcoa.ac.uk/documents/guide-anaesthetics-training-handbook/introduction

8. RCoA. rcoa.ac.uk. [cited 2024 Jan 17]. Capuccini Test. Available from: https://www.rcoa.ac.uk/safety-standards-quality/patient-safety/cappuccini-test

9. RCoA. Guidance on supervision arrangements for anaesthetists [Internet]. [cited 2024 Jan 12]. Available from: https://www.rcoa.ac.uk/sites/default/files/documents/2021-07/Sessional%20Supervision%20Guidance%20FINAL.pdf

10. NHS England. National standards for healthcare food and drink [Internet]. 2022 Nov [cited 2024 Jan 12]. Available from: https://www.england.nhs.uk/wp-content/uploads/2022/11/B0508-i-National-standards-for-healthcare-food-and-drink-Nove-2022.pdf

11. Association of Anaesthetists. Fatigue and Anaesthetists [Internet]. 2014 Oct. Available from: https://anaesthetists.org/Portals/0/PDFs/Guidelines%20PDFs/Guideline_fatigue_anaesthetists_2014_final.pdf?ver=2018-07-11-163753-897&ver=2018-07-11-163753-897

12. RCoA. Guidelines for the Provision of Anaesthesia Services: The Good Department 2023 [Internet]. 2023 Mar [cited 2024 Jan 12]. Available from: https://www.rcoa.ac.uk/gpas/chapter-1

13. BMA. BMA Fatigue and Facilities charter [Internet]. [cited 2024 Jan 12]. Available from: https://www.bma.org.uk/media/1076/bma-fatigue-and-facilities-charter_july2018.pdf

14. HEE. Less Than Full Time (LTFT) Training - Category 3 [Internet]. [cited 2024 Jan 12]. Available from: https://www.hee.nhs.uk/sites/default/files/documents/LTFT%20Cat%203%20All%20Specialties%20Guidance_0.pdf

15. BMA. bma.org.uk. 2022 [cited 2024 Jan 12]. Your rights during and after pregnancy. Available from: https://www.bma.org.uk/pay-and-contracts/maternity-paternity-and-adoption/your-rights/your-rights-during-and-after-pregnancy

16. BMA. Paternity leave for doctors [Internet]. 2023 [cited 2024 Mar 14]. Available from: https://www.bma.org.uk/pay-and-contracts/maternity-paternity-and-adoption/leave/paternity-leave-for-doctors

17. NHS Employers. Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 [Internet]. 2023 Feb [cited 2024 Jan 12]. Available from: https://www.nhsemployers.org/system/files/2023-02/NHS-Doctors-and-Dentists-in-Training-England-TCS-2016-VERSION-11.pdf

18. GMC. Time Out of Training - GMC Position statement [Internet]. 2012 Nov [cited 2024 Jan 12]. Available from: https://www.gmc-uk.org/-/media/documents/20121130-time-out-of-training-gmc-position-statement-nov-2012_pdf_pdf-60998809.pdf

19. Evans B, Turkoglu LM, Brooks J, Subramaniam J, Edwardson S, Freeman N, et al. Experiences and perceptions of working with Anaesthesia Associates: a survey of UK anaesthetists in training. *British Journal of Anaesthesia* [Internet]. [cited 2024 Mar 14]; Available from: https://doi.org/10.1016/j.bja.2024.01.031

20. RCoA. 2021 Curriculum Assessment Guidance: The Role of the Trainer: Assessment Faculty [Internet]. 2021 [cited 2024 Mar 14]. Available from: https://rcoa.ac.uk/documents/2021-curriculum-assessment-guidance/role-trainer-assessment-faculty

21. RCoA. https://rcoa.ac.uk/news/outcome-rcoa-extraordinary-general-meeting-17-october-2023. Outcome of the RCoA Extraordinary General Meeting on 17 October 2023.

22. Association of Anaesthetists Rc. *Less than Full-Time Training in Anaesthesia and Intensive Care Medicine: An A to Z Guide* [Internet]. [cited 2024 Jan 12]. Available from: https://anaesthetists.org/Portals/0/PDFs/Membership/LTFT_AZ_2021.pdf?ver=2021-07-23-095655-810

23. Association of Anaesthetists. *A Guide to Parenting During Anaesthesia Training* [Internet]. 2023 Jan [cited 2024 Jan 12]. Available from: https://anaesthetists.org/Portals/0/PDFs/Membership/A%20Guide%20to%20Parenting%20During%20Anaesthesia%20Training.pdf?ver=2022-07-12-115831-177

24. HEE. SuppoRTT: Supporting doctors returing to training after time out [Internet]. [cited 2024 Jan 12]. Available from: https://www.hee.nhs.uk/our-work/supporting-doctors-returning-training-after-time-out

25. RCoA. The Anaesthetic Workforce: UK State of the Nation Report [Internet]. 2022 Feb. Available from: https://www.rcoa.ac.uk/sites/default/files/documents/2022-02/State-Nation2022.pdf

26. RCoA. Respected, Valued, Retained - Working together to improve retention in anaesthesia [Internet]. 2021 Sep. Available from: https://rcoa.ac.uk/sites/default/files/documents/2021-09/Respected_valued_retained2021_0.pdf

27. RCoA. rcoa.ac.uk. 2023 [cited 2024 Jan 12]. Response to the Independent Review of the Assessment Processes of the RCoA: https://rcoa.ac.uk/news/response-independent-review-assessment-processes-rcoa

Association of Anaesthetists

Our vision

The Association of Anaesthetists' motto is *in somno securitas* (safe in sleep). Our vision is that every patient under our care is kept safe.

Our mission

Our mission is to safeguard patients by educating, supporting, and inspiring every anaesthetist throughout their career, enabling them to provide the best care in every healthcare setting.

Our values

Committed

We are a respected and independent organisation, committed to speaking up and speaking out on behalf of our members and the anaesthesia community.

Trusted

For over 90 years, we have helped to set standards, share knowledge, and support thousands of people in a vital profession. Our expertise matters to our members and globally.

Innovative

We look forward, not back. We care about the future of anaesthesia and actively help shape its future on behalf of our members by listening, responding, and innovating.

Connected

We are a dynamic, diverse, and inclusive community. We exist because of, and on behalf of, our members.

Our strategic priorities 2024 to 2029

Patient care and safety

- Advance and improve patient care and safety in the field of anaesthesia.
- Inspire and support our members always to practice with safety in mind.
- Be the leading publisher of anaesthesia safety guidelines and expert advice.

Education and research

- Preserve, develop, and share the heritage of the specialty.
- Develop and provide world class education in anaesthesia.
- Promote global access to anaesthesia education.
- Work in partnership with others to build capacity through national and international research initiatives.

Advocacy and support

- Be the leadership voice for the anaesthesia specialty.
- Represent and advance the interests and wellbeing of our members.
- Protect and support our members throughout their careers.
- Promote anaesthesia as a specialty led by and delivered by doctors.

Innovation and growth

- Research and promote innovations in sustainable working practices for the specialty.
- Use the latest technology to enable us to deliver the best services for our members.
- Promote the diversity, wellbeing, and continuous development of our people.
- Invest wisely, protect, and optimise our assets, and always act with sustainability in mind to ensure the future of the Association.

Association of Anaesthetists
21 Portland Place, London, W1B 1PY
020 7631 1650 | www.anaesthetists.org

Association of Anaesthetists is the brand name used to refer to both the Association of Anaesthetists of Great Britain & Ireland and its related charity, AAGBI Foundation (England & Wales no. 293575 and in Scotland no. SC040697).

Association of Anaesthetists