The Royal College of Anaesthetists
Educating, Training and Setting Standards in Anaesthesia, Critical Care and Pain Medicine

Chief Executive
Kevin Storey

Churchill House
35 Red Lion Square
London WC1R 4SG

tel: 020 7092 1500
fax: 020 7092 1730
email: info@rcoa.ac.uk
web: www.rcoa.ac.uk

Dr Noel Gavin and Dr Simon Gardiner
The Association of Cardiothoracic Anaesthetists
By email

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Dear Drs Gavin and Gardiner

Thank you for your letter on behalf of the ACTA committee addressed to the President and Council of the Royal College of Anaesthetists regarding potential changes to the training of anaesthetists in the light of the 'Shape of Training' proposals. As Chair of the Training Committee I have been invited to reply.

As yet there have been no decisions made regarding restructuring in response to the Greenaway report. In addition, the Centre for Workforce Intelligence report into Anaesthesia and Intensive Care has just been released, as has a statement from the Shape of Training Steering Group (STSG). http://www.cfwi.org.uk/our-work/medical-and-dental-workforce-reviews/medical-specialties/anaesthetics-and-intensive-care-medicine-in-depth-review

The CfWI report quantifies a significant increased demand for anaesthetic services, which will outstrip supply. This comes at a time of a reduction in training numbers at ST3+ level (although a slight increase at core level) with the obvious consequences across all branches of anaesthesia including cardiothoracic anaesthesia. This is further compounded by recent recruitment rounds showing an under fill at ST3 recruitment across the UK to the order of 89%. The RCoA has made significant comment to HEE regarding these worrying workforce issues.

Your information regarding consultant recruitment challenges in cardiothoracic anaesthesia and potential retirements is useful and I will pass this onto our workforce co-ordinator. This comes at a time when we also face increasing retirements from the SAS grades and a push from the DoH and HEE to consider alternative ways of meeting service demands. Add into this the push for 7-day services, and I think all will agree we have real workforce issues brewing in anaesthesia and intensive care. The RCoA is conducting a census of all our Fellows and Members later this year so at least we will have current accurate data to inform debate.

The STSG confirms that the UK Health ministers have now approved the development activity to explore how medical training might be adapted to meet future patient and service needs under the umbrella of the Shape of Training initiative. It is reassuring that the STSG recent statement states that those aspects of the current training system that have been shown to work well and are fit for purpose should remain and that patients' interests remain at the heart of the proposals.

To answer your specific questions:

1 Does Council envisage that trainees will undergo a dedicated block of sub-specialty training within the revised Anaesthesia National Training Program? If so, how long would this block be and would it incorporate dedicated on-call commitments?

Given that such detail regarding SoT has not been agreed, neither Council nor the Training Committee have debated the constitution of a revised curriculum, specifically if training time is shortened. Although Greenaway's report suggests broad-based training followed by 4-6 years of specialty specific training, there has been published opposition to a reduction in time for training if we are to produce CST holders equivalent to current CCT ones. This has been from Trainee Groups and the Royal Colleges of Physicians. Other Colleges have not made further pronouncements principally because there have been no specific proposals until recently from the STSG. However of interest to ACTA is our findings during our on-going curriculum review of a significant variation of how schools of anaesthesia deliver intermediate and higher cardiothoracic training, with similar issues applying to neuroanaesthesia. (Advanced training is essentially consistent with usually one year Fellowship type training). The time allocated to cardiothoracic varies between 12 and 26 weeks and the proportion of time spent in theatre as compared to cardiothoracic intensive care also varies considerably. In addition schools differ as to whether this is delivered in one or two blocks of training. However examination results and ARCP outcomes are consistent which implies that the competencies required at intermediate and higher can be delivered in a single 3 month block.

I cannot envisage a CST programme existing without cardiothoracic training and the curriculum not requiring out of hours activity and training.

2. *When is it envisaged that these changes will come into effect?*

The STSG states that patients, service users and healthcare professionals should be assured that any proposed changes to training will be properly considered, modelled and costed and consulted upon before any changes are made. A major problem with the SoT proposals is the lack of any financial and service delivery considerations.

We cannot currently predict if and when any changes might occur but be reassured that all stakeholders including the specialist societies would be consulted.

3, Will there be an option for an in-programme or out-of-programme sub-specialty training module?
Again difficult to answer without knowing the duration of anaesthetic training agreed on, however I cannot envisage intermediate and higher cardiothoracic training being removed from any reconfigured training programme. The question of advanced training is more difficult and it is conceivable that this could move to a credentialed programme. Whether this could be completed pre or post CST would again be for future consideration in the round. There are a variety of aspects to discuss regarding credentialing, but the College would see the specialist societies including ACTA as being key stakeholders in any future discussions in this area.

4. Will the content/syllabus of the primary and Final FRCA exam be revised in light of any changes to trainees' exposure to Cardiothoracic Anaesthesia?

I cannot envisage any linked changes to the Primary examination since the basic/ core curriculum has no cardiothoracic component. The Final examination tests intermediate competencies at ST3/4 which will I predict will still be present in any potential revised curriculum, however short its delivery timescale.

I hope that I have provided some appropriate answers to your questions. The implementation of any changes to anaesthetic training will be discussed and communicated with the Heads of Schools and Regional Advisers and we will continue to keep you and other colleagues in leadership roles of the larger specialist associations informed of developments.

Yours sincerely

Dr Nigel Penfold
Chairman, Training Committee
Electronically signed to minimise delay