

# The SAS Handbook

4th edition | 2020



Association  
of Anaesthetists

[www.anaesthetists.org](http://www.anaesthetists.org)



# Foreword

I am very pleased to introduce the 4th edition of the Association of Anaesthetists SAS Handbook. I hope it will continue to be an invaluable resource for our SAS members, but also other members, clinical directors and managers. It is also supported by the SAS section of the Association of Anaesthetists website [www.anaesthetists.org](http://www.anaesthetists.org).

I hope that you will find it a helpful reference to support you in your career and professional life, and to answer some of the commonly occurring questions and queries. SAS doctors make up over 20% of the anaesthetic workforce, and have been described as the hidden heroes of the NHS. They are a diverse group, often working in isolation or frequent out of hours work, and in the past have sometimes had difficulties getting the information or answers they need about their role. Some SAS anaesthetists still struggle to get the recognition and support they deserve. Hopefully this handbook can be a small step in our efforts to help correct this.

Since the handbook was first launched there have been huge changes in the NHS and for SAS anaesthetists specifically, and we have updated our handbook to reflect this, particularly regarding job planning, appraisal and revalidation. Other sections are aimed at supporting those who are returning to work, or who have suffered illness or other difficulties in their careers. Again these are great resources for all our members, SAS anaesthetists and clinical leads.

I would like to take this opportunity to thank all those who have given support to the SAS Committee and to the preparation of this handbook. Particularly to my fellow members of the SAS Committee, the President, Officers and Board of the Association of Anaesthetists and the staff at 21 Portland Place for their help and support. Especially I would like to thank Dr Kathleen Ferguson (President), Dr Paul Clyburn (Past President) and Dr Olivera Potparic (previous Chair of the SAS Committee) for their help, support and advice. Finally, as a membership organisation, if there is anything else you would like the SAS Committee to consider or to include in future editions of the handbook then we would love to hear from you, email [sas@anaesthetists.org](mailto:sas@anaesthetists.org).

**Dr Thomas James**

*Chair of SAS Committee, Association of Anaesthetists*

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Every effort was made to ensure that the information in this book was accurate at the time of going to press, but articles (particularly those to do with the organisation of training) have a tendency to go out of date, so you are advised to check with the appropriate organisation for the most up-to-date information. This has been designed as an interactive document and accessible links are highlighted in blue. Weblinks were correct as of October 2019.

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# 1. Why Join the Association of Anaesthetists?

There are many reasons why SAS anaesthetists should join the Association of Anaesthetists.

The obvious reasons are the benefits you can get from being a member. For all of us, study leave budgets and leave are under increasing pressure. Being a member of the Association allows you discounted rates for booking conferences, seminars and webinars. Some of these are tailored specifically to issues facing SAS anaesthetists. You can access Learn@, the online learning zone for members where you can find a wealth of educational, learning and CPD resources including free access to videos and lectures from recent meetings. You can learn in your own time and keep a record of your completed CPD for use in appraisals and revalidation. As a member you will receive a subscription to the journal *Anaesthesia* and *Anaesthesia News*, the official magazine of the Association. Both are invaluable resources to keep you up to date with what is happening in the Association and the world of anaesthesia, with many articles written by and about SAS anaesthetists.

Other benefits include eligibility for the SAS professional development grant of up to £2,000 to help further your career, and the exclusive SAS audit poster prize with cash prizes available. Those sitting College exams or planning to apply for consultant posts are able to attend the final day of the annual trainee conference, with sessions dedicated to providing excellent resources, support and advice. Finally, as a member you will have access to an extensive detailed library of anaesthetic guidelines through a guidelines app and useful information for your day to day practice.

The less obvious reasons why you should consider joining the Association are, however, just as important. As a membership organisation, it is dedicated to being a voice for the specialty and in order to effectively represent SAS anaesthetists, the more members we have, the stronger our community. As a member of the Association, you will be joining over 10,000 anaesthetists, working together for the benefit of our specialty. The Association is involved with several areas, such as wellbeing, fatigue, bullying and harassment and ageing that are of particular relevance to SAS anaesthetists. As a member, you have the chance to shape such work. Being a member gives you access to the Association's mentoring scheme, with trained mentors available to help and support with decisions and transitions. There is no doubt that being an anaesthetist in the modern NHS has its challenges, and that there are many challenges specifically facing SAS doctors. However, being part of the Association brings you together with your colleagues as part of the wider anaesthetic community, to help support you through your career, as well as helping to face some of these challenges working alongside over 10,000 anaesthetists.

Finally, if any more reasons are required, the subscription fees may well be tax deductible, saving you money!!

## List of benefits:

- Personal injury and life insurance of up to £1m for transfers
- Subscription to *Anaesthesia* and *Anaesthesia News*
- Access to Learn@
- Access to guidelines app
- Discounted rate for Association meetings and conferences
- Regional seminars and core topics meetings
- Guidance and information for SAS doctors
- Access to The SAS Handbook
- SAS audit poster prize and professional development grant
- Representation at Westminster and the Department of Health
- 20% discount on textbooks from OUP and Wiley
- 30% discount on books from Cambridge University Press
- Basic TTE Education
- Mentoring
- SAS Links network

## The SAS Committee

The SAS Committee has been established for just over 15 years and continues to go from strength to strength. The Committee was established by Dr Kate Bullen, the first SAS doctor to be elected to the Association's Council. SAS doctors have been described as the hidden, unsung heroes of the NHS. Despite making up approximately 20% of the anaesthetic workforce, historically, SAS doctors have sometimes felt overlooked and under-valued, with some colleagues unaware of who we are and what we do. The Association recognised this, and so the Committee was set up to address these concerns and to represent the specific needs of SAS anaesthetists.

The Committee includes the SAS Chair, Association Officers ex officio, elected Association Board members and co-opted SAS members. These include representatives from the British Medical Association (BMA), the Royal College of Anaesthetists (RCOA), the devolved nations and Ireland.

As a membership organisation, the Association exists to represent the views of its members, and as such, the role of the SAS Committee is to represent the interests of those SAS members, and to advise the Association Board on matters affecting SAS doctors, as well as encouraging the professional development of SAS doctors. Members of the Committee also sit on many of the Association's other committees, e.g. education and safety, and working parties, to represent our members.

### **Continuing Professional Development**

A key priority of the SAS Committee is encouraging the professional development of our SAS members. We recognise that SAS doctors are a distinct group of anaesthetists, with their own specific development needs, and so organise seminars and webinars aimed specifically at SAS issues.

### **Publications and prizes**

The SAS Committee has established two awards exclusively for SAS members; the audit poster prize and the SAS professional development grant. These are to fulfil our aim to encourage our members to participate in academic anaesthesia and to develop their career interests. The Committee first published this SAS Handbook in 2007 and has continued to revise and update it. This has proved an extremely useful resource for SAS doctors and their colleagues. The Committee have continued to write articles relevant to SAS anaesthetists for *Anaesthesia News* and the Association's website.

### **The future**

The Committee owes its success to all the presidents and members of the Association Board who have supported us and all the previous chairs and members of the SAS Committee who have given so much dedication and support. There is still much we would like to achieve to further represent as many SAS anaesthetists as possible, and to raise the profile of the grade within the Association and wider medical world. We hope to continue working on issues relevant to SAS doctors, such as leadership, wellbeing, fatigue and ageing as well as promoting education and career development. In 2019 a place in the Association election to Board was reserved for an SAS anaesthetist who will sit on the Board and Council for a four year term and drive these initiatives forward.

### **SAS Link Scheme**

The Association is in the process of developing a specific SAS Links scheme. The Association's focus is to increase SAS membership, and with the help of its SAS Committee, has developed a SAS member engagement strategy to achieve this. One of the objectives is to develop an SAS Link scheme with two-way communication between the Association and the SAS Link person enabling the Association to tailor its core activities and services, including wellbeing and support for individuals, education and advocacy to help deliver what is most relevant and beneficial to SAS doctors.

The aim is to have a SAS representative in each region or hospital. This is an excellent opportunity for SAS members to become involved in developing and transforming the Association's offering to SAS doctors. It will also contribute to personal and professional development in areas such as leadership and management.

### **Dr Thomas James**

*Chair of SAS Committee, Association of Anaesthetists*

## **2. Other support mechanisms and organisations**

### **Association Link Scheme**

In addition to the SAS Link Scheme, the Association's Link Scheme aims to maintain links and facilitate communication between members and the Association. This is a two-way process and not only allows the dissemination of important information to the members, but also allows us to hear your views. Your Link is one of your representatives to the Association. You can find the details of your Link by logging into your Association online member account.

## Local Negotiating Committee (LNC)

The LNC represents medical and dental staff of all grades employed within an organisation in local negotiations and employment issues. The LNC is made up of local, elected representatives from different grades. Although it is supported by the BMA and its Industrial Relations Officer, one does not necessarily need to be a member of the BMA to become involved in the LNC. It is an ideal local platform for SAS doctors to obtain management and committee experience. Further guidance on LNCs can be found on the [BMA website](#).

## Medical Staff Committee (MSC) / Medical Advisory Committee (MAC)

This is another body that comprises all the career grade medical staff in a hospital including SAS doctors. The MSC/MAC meets regularly to discuss matters of mutual concern between colleagues and enable regular communication between senior medical staff and management. These committees provide yet another platform for SAS doctors to get involved and develop their leadership skills.

## SAS Tutor

Also known as an SAS Educational Adviser, this is an educational role usually filled by a senior SAS doctor who oversees educational placements, arranges tutorials, lectures, etc. SAS Tutors manage the local SAS development budget and can be approached for any help regarding education and career development. The Association has written to all SAS Tutors advising of the support it can provide to them.

## Role of mentors

Many departments have dedicated SAS mentors (consultants or senior SAS doctors) whose role is to support and guide SAS doctors in their professional practice, personal wellbeing, and personal and professional development. The Department of Health, the BMA, several deaneries and many independent organisations offer mentoring schemes and training. It has been proven in several studies that mentoring helps to improve confidence and reduce stress.

## Deanery support

Most deaneries have dedicated Associate Deans for SAS doctors. They oversee the development of CPD opportunities, thereby enabling these doctors to have wider options for career development. They also ensure a close working relationship between deaneries, local educational providers, Royal Colleges and faculties. Some deaneries have mentoring schemes that help and support doctors. Please visit your deanery's website for further information.

## SAS Charter

A new charter for SAS doctors, agreed by the BMA, NHS Employers, Health Education England and the Academy of Medical Royal Colleges, sets out the objectives and support mechanisms that Health Education England promotes and provides through individual Local Education Training Boards and Local Education Providers. The English and Scottish Charters can be found [here](#).

## Other

Many doctors come directly from overseas to take up SAS or other middle grade posts. There are many international medical graduate organisations that offer support and guidance for doctors coming from outside the UK to take up posts in the NHS. The support includes mentoring schemes, induction programmes and web forums.

## Useful websites

- [British Association of Physicians of Indian Origin](#)
- [British Interners' Association](#)
- [Medical Association of Nigerians Across Great Britain](#)
- [Association of Pakistani Physicians & Surgeons of the UK](#)
- [Egyptian Medical Society](#)
- [Sri Lankan Medical and Dental Association in the UK](#)

## Dr Achuthan Sajayan

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# Employment issues

### 3. Model Charter for SAS grades

NHS Employers, the Academy of Medical Royal Colleges, Health Education England and the BMA have jointly agreed a charter for SAS grade staff in England to recognise both the diversity of SAS doctors and the major contribution they make to patient care. This is available for [download](#). Similar guidance is being developed in the devolved nations. NHS employers should be committed to ensuring the role of the SAS doctor is fully acknowledged and respected by management, colleagues and patients. The Association has previously suggested the following recommendations, and the points remain valid.

Each employer should work towards every SAS doctor having the following:

- An appropriate contract of employment incorporating national terms and conditions and ideally following the [BMA recommended model contract](#) format
- An appropriate agreed job plan. This may only be changed by mutual agreement between the SAS doctor and the Clinical Director (in accordance with the procedure for the agreement for the review of job plans), and from recommendations following appraisal
- An adequate daytime sessional allocation with separate and identifiable time allocated for administration, education, audit and teaching commitments, etc.
- Access to office accommodation and a computer in each directorate where SAS doctors are employed. This should include email and suitable storage facilities for confidential work, related papers, books, etc.
- Adequate support and time allocation to allow SAS doctors to fully participate in the employer's appraisal process (including access to appraisal training) and the necessary CPD and study leave requirements, which are a natural consequence of appraisal
- Adequate and fully funded study leave
- All SAS doctors (permanent staff) should be members of the MSC/MAC/Hospital Medical Board and should be invited to attend meetings
- SAS representation on the Local Negotiating Committee
- Access to a fair and appropriate mechanism for the award of optional points for staff grades and discretionary points to associate specialists who remain on the pre-2008 contracts. A minimum number of discretionary points/ optional points should be awarded in a similar fashion as for consultants
- Equal access to the benefits of the 'Improving Working Lives Initiative'
- Membership of the directorate and be invited to attend directorate meetings

**Dr Anthea Mowat**

*Former Chair, BMA Representative Body*

## 4. SAS contract and job planning

### SAS contract background

In April 2008, a new SAS contract was introduced in the UK called the 'Specialty Doctor contract'. At the same time, the previous SAS grades contracts (comprising Staff Grade, Associate Specialist [pre-2008], Clinical Assistant, Hospital Practitioner, senior Clinical Medical Officer and Clinical Medical Officer) were closed, so that no new appointments to these grades could be made in England.

Individuals currently in those grades may remain in these posts until they leave the post, but any new appointments have to be to the Specialty Doctor grade. Details of the terms and conditions of these closed grades can be found on the [BMA](#) and [NHS Employer](#) websites. SAS grade doctors currently in the closed grade posts may transfer to the new contract at any time by requesting to do so. It should be noted that this is an irreversible decision once implemented.

At the same time the Specialty Doctor contract was introduced, a new Associate Specialist (2008) contract was introduced, with similar terms and conditions of service as the Specialty Doctor post. Entry to this grade was only possible for those SAS grade doctors and dentists who successfully underwent personal re-grading following application within the 'window of opportunity' between 1 April 2008 and 31 March 2009. No further applications can be made for personal re-grading, and the grade is also now closed. However there have been growing calls to reopen the Associate Specialist grade, or create a similar grade, and many Foundation Trusts have been doing just that. Jointly with the RCoA, the Association have given their support to this at a national level for all trusts.

### Specialty Doctor grade

It is expected that entrants to the grade will be competent doctors with experience, who will develop to be highly competent with a specialised area of expertise. The level of responsibility delegated to the Specialty Doctor will depend on experience and capability and will be agreed between the doctor and their Clinical Manager as part of the job planning process.

The minimum entry requirements are:

- Full registration with the GMC
- Minimum of four years (or equivalent) postgraduate training, of which two years must be in a relevant specialty (although the RCoA expects Specialty Doctors in anaesthesia to have three years' experience)

### Salary scale

The grade has 11 pay points. There is annual progression up to point 5. In order to progress from point 4 to point 5, the doctor will need to pass through Threshold One, and evidence for this must be provided before the move can be made. Progression from point 5 to point 8 is at two-yearly intervals. To progress from point 7 to point 8, the doctor will need to provide evidence to enable passage through Threshold Two. Progression from point 8 to point 10 is at three-yearly intervals.

### Contractual requirements

The post holder will be required to undertake annual appraisal and annual job planning. It should be noted that these are separate processes and should be carried out as such. There is no requirement that they are done at the same meeting or by the same person.

### Working week

A full-time Specialty Doctor contract is for 10 Programmed Activities (PAs). In general each PA is a 4 hour unit of activity, which may be programmed as blocks of 4 hours, or in half units of 2 hours each. The only exception to this is work done out of hours (OOH).

Additional Programmed Activities (APAs) may be allowed, subject to the Working Time Regulations of a 48 hour working week.

Programmed activities are separated into:

- **Direct Clinical Care (DCC)** including all administrative work associated with clinical care, such as: telephone calls, letters, reviewing results, travel to peripheral sites to deliver clinical care, attendance at multidisciplinary team meetings about specific patients, etc.
- **Supporting Professional Activities (SPA)** including continuing medical education, professional development, teaching and training, audit, research, and other similar activities
- **Additional NHS responsibilities** such as Rota Coordinator or Lead Clinician
- **External duties** such as trade union duties, work for Royal Colleges, Specialist Societies or for the Government

For full-time doctors, most PAs will be devoted to DCC, with a minimum of one PA per week for SPA work. It should be noted, however, that the Academy of Royal Colleges has confirmed that it is likely that SAS grade doctors will require at least 1.5 SPAs in their work pattern in order to meet the requirements of revalidation, and employers are advised to consider this in the job planning process.

All work undertaken outside normal working hours (OOH), between the hours of 7pm and 7am, and all work at weekends and on public holidays, will be paid at an enhanced rate of pay of time and a third. In most cases, this will mean that a PA of work undertaken in OOH will last for 3 hours instead of 4, but will be paid as 4 hours. Alternatively the OOH PAs could remain as 4 hour units of time, but will be paid at time and a third.

Where work is carried out as part of the basic 10 PA working week, this will be pensionable. PAs for any work over and above the basic 10 PA working week, such as APAs or OOH work, which are undertaken in excess of the basic 10 PA commitment, are not pensionable. All emergency work that takes place at regular and predictable times should be programmed into the working week, and counted towards the PAs.

For shift work, all time on-call will be counted as working time and will be paid as such. For those doctors who undertake on-call instead of shifts, only the time actually worked on a regular and predictable basis during the on-call period can be included in the PA total, but there will be an availability supplement, paid as a percentage of the basic salary, that is payable to recognise the frequency of the on-call. Shift work does not attract this supplement as all time on-call is already being recognised in the PA allocation. The implication of the Working Time Regulations is that there should not be resident on-call, as such work may be better suited to a shift pattern. Advice on resident on-call work is available for BMA members on the [BMA website](#).

## Job planning

Participation in job planning is an agreed requirement under the new national terms and conditions of service for Associate Specialist and Specialty Doctor, under Schedule 4 of the Terms and Conditions of Service. It is also applicable to the other closed SAS grades.

### *Purpose*

A job plan is a prospective agreement that sets out a doctor's duties, responsibilities and objectives for the coming year. It will build upon existing NHS activities in the main. The job plan meeting should be undertaken in a spirit of partnership, and ensure clarity of expectation for the doctor and the employer about the use of time and resources to meet the prospective objectives, which will be both individual (informed by the personal development plan generated in the appraisal process) and any agreed service objectives.

### *Process*

Current activities need to be reviewed and considered alongside future service needs. This should be supported by use of activity data and work diaries. The work diary should be kept for a minimum of one rota cycle, or for six weeks, but a longer period will ensure more accurate information. It should include all work undertaken from each of the four categories listed above. Some departments agree generic specialty team job plans, which can then be personalised and adapted as necessary during the individual job plan meeting.

There is no one model for a job plan, but it will contain:

- Main duties and responsibilities
- Schedule of commitments (timetable)
- Agreed personal objectives and service objectives
- Support and resources required to fulfil the agreed activities

Within the job planning meeting, consideration should be given to the balance of activities within the job plan, so that there is not an excess of OOH activity. The balance of activities should also include some elective work and not consist of only emergency cover. Consideration should be given to the health effects on older SAS grade post holders of undertaking such OOH activity. If a job plan cannot be agreed, local mechanisms should be used to try and reach resolution. Failing that, there is an appeal mechanism in the terms and conditions of service. The Association and RCoA are currently working together to produce guidance on what a good job plan for an SAS doctor should look like.

Job plans should be undertaken annually. Should the workload or service needs change in the meantime, either the individual or the employer may call for an interim job plan meeting to discuss these issues. Guidance on job planning is available on the [NHS Employers' website](#).

### **Dr Anthea Mowat**

*Former Chair, BMA Representative Body*

## **5. Revalidation and appraisal**

### **Revalidation**

The GMC introduced a system of revalidation for all doctors, to provide assurance that doctors are fit to practise. Revalidation is the process by which licensed doctors demonstrate to the GMC, normally every 5 years, that they remain up-to-date and fit to practise. It is a formative process that provides a focus for professionals to plan continuing improvement on personal practice.

### **Relicensure**

All doctors wishing to work in the UK require a licence to practise, which is issued by the GMC, and is renewed every 5 years using the revalidation process. All doctors who are registered with the GMC, with a licence to practise, will have to participate in revalidation.

Revalidation is based on a local evaluation of the doctor's performance against national standards approved by the GMC. A portfolio should be collected on an ongoing basis, containing information drawn from their practice to provide evidence that the required standards are being met. To revalidate, the GMC needs to receive assurance that the doctor is meeting the required standards. In most cases, this recommendation will be made to the GMC by the Responsible Officer for the employing organisation. This recommendation will be made, normally every 5 years, based on the doctors appraisals over this period, together with information derived from local clinical governance systems. The Responsible Officer makes a recommendation to the GMC, but does not approve revalidation/relicensing. The final decision for this is taken by the GMC.

For the majority of doctors, the evidence to be gathered within a portfolio is that which is already required for a robust appraisal, with a structured and planned approach to CPD, which should be based on what one does, or should be capable of doing, as an anaesthetist.

CPD is a process of 'lifelong learning' applicable to all individuals and teams aiming to meet the needs of patients and deliver the health outcomes and healthcare priorities of the NHS. Although many colleges and faculties have provided guidance on CPD, the quantity, quality and content of CPD is a matter for agreement between an appraiser and appraisee, subject to approval by the doctor's Responsible Officer and the GMC.

Membership of a college or faculty is not a requirement for revalidation, nor is membership of a CPD scheme organised by a college or faculty, although some doctors find them helpful. Learn@ is available free to Association members to help plan and record CPD activity. In addition, the CPD Matrix has been developed by the RCoA to assist in planning CPD to ensure that all the necessary areas have been covered over the 5-year cycle.

### **Appraisal**

The generic principles of appraisal are that a portfolio of evidence will be required to demonstrate standards of practice as set down in the GMC [Good Medical Practice](#) guide, which sets out training and development requirements.

## **Principles**

These fall into four domains:

1. Knowledge, skills and performance
2. Safety and quality
3. Communication, partnership and teamwork
4. Maintaining trust

## **Domains**

Each domain has areas of attributes with generic standards that map to these attributes. The RCoA has produced specialty specific guidance to match these generic standards:

### *Knowledge, skills and performance*

- Develop and maintain your professional performance
- Apply knowledge and experience to practice
- Keep clear, accurate and legible records

### *Safety and quality*

- Put into effect systems to protect patients and improve care
- Respond to risks to safety
- Protect patients and colleagues from any risk posed by your health

### *Communication, partnership and teamwork*

- Communicate effectively
- Work collaboratively with colleagues to maintain or improve patient care
- Establish and maintain partnerships with patients
- Continuity and co-ordination of care
- Teaching, training, supporting and assessing

### *Maintaining trust*

- Show respect for patients
- Treat patients and colleagues fairly and without discrimination
- Act with honesty and integrity

## **Portfolio**

The portfolio of evidence that will be required to demonstrate compliance with the standards should include, among other things:

- Confirmation of participation in, and reflection on, CPD
- Results of appropriately tailored multisource feedback, both peer and patient
- Outcomes-based assessment of performance
- Robust audit data
- Peer review of departments (not individuals)

Some forms of evidence will cover more than one standard, such as multisource feedback.

## **Examples of evidence required**

Confirmation of participation in annual CPD:

- Log of CPD and training activity
- Evidence of courses attended, including attendance certificates and reflections on how it may change practice
- Log of any teaching or research activity, including any feedback
- Any work for the wider NHS
- Link evidence to job plan

Multisource feedback:

- Available material from patient surveys, and relevant colleague correspondence and feedback
- Formal feedback is required prior to revalidation date, but not annually
- Details of complaints with relevant explanations and resolution
- Letters of accolade or appreciation

Outcome-based assessment of performance:

- Review previous personal development plan (PDP), and identify achievements over the year
- Identify and record reasons for any areas that are incomplete in the PDP

Clinical governance:

- Collect clinical audit data relevant to you and your department (could include national audits)
- Ensure data being collected on your behalf are valid, reflect your clinical responsibility, and are evidence-based
- Evidence of annual participation in clinical governance systems
- Evidence of quality improvement activity

Departmental peer review, if available:

- Case discussions
- Audit meetings
- RCoA assessments

## **Process**

The appraiser will evaluate all the evidence in the portfolio against the specialty standards and will record, for each domain, whether the evidence is sufficient to show that there are no serious concerns for patient safety or quality of care. If evidence shows no areas for concern, but that further development is needed, this will be highlighted. In addition, if the evidence is insufficient to make any comment for an attribute, this will be noted.

A PDP will be generated during the discussion, with personal objectives. These personal objectives are reviewed at future appraisals, but may also feed into the job planning process. The appraiser will complete a summary of the appraisal discussion, to which the appraiser may also add comments. This appraisal summary, together with the forms for each domain and the PDP, are sent to the Responsible Officer and are used over a 5-year period to enable a recommendation on revalidation to be made to the GMC.

## **Dr Anthea Mowat**

*Former Chair, BMA Representative Body*

## 6. Working less than full-time

Anaesthesia is a specialty that easily lends itself to working less than full-time (LTFT), and many SAS anaesthetists do exactly that. Let us first of all define clearly what we mean by part-time or LTFT. This depends on what contract you are on. In essence, you are full-time if you work the same as, or more than, the number of hours needed to be paid the basic salary for your terms and conditions of service. For example:

- 2008 Specialty Doctor and Associate Specialist (AS) contract: full-time = 40 hours per week
- pre-2008 Staff Grade contract: full-time = 40 hours
- pre-2008 AS: full-time = 38.5 hours

This means if you are working for 38.5 hours per week on the old AS contract, you are deemed to be full-time; but if you work 38.5 hours per week on the new AS contract, doing the same work, you are technically part-time.

### Why work part-time?

Just as there are many reasons to be working in the SAS grades, there are also many reasons to seek LTFT work, with each person having their own individual story. Obviously, part-time work is particularly popular with parents of young children, but other reasons include working in another specialty or for a different employer for part of the week; undertaking further education or academic work; health issues or disability; caring for elderly or sick relatives; or even wanting to do a completely non-medical activity such as write a novel!

### Contractual arrangements

When agreeing a part-time contract, it is important to read carefully the terms and conditions of service for your grade and ensure you are given your rights under part-time workers regulations. Your contract should clearly state your hours, location of work and salary. The BMA offers a contract-checking service for members. You should, like your full-time colleagues, have an agreed job plan setting out your weekly timetable and on-call duties. You are entitled to have the same access to job planning and appraisal. You are also entitled to a minimum of one Supporting Professional Activity (SPA) session if you are on the new contract, although you need to provide evidence of what Supporting Professional Activity work you do. You should also make sure you have a sensible ratio of daytime sessions to out of hours work.

### Problems and obstacles

#### *Attitudes*

Sometimes full-time colleagues will believe that working part-time indicates a lack of commitment or enthusiasm, and as a result you could be 'passed over' when non-direct clinical care (DCC) work becomes available. This attitude is hopefully changing but it may still be the case that your Clinical Lead would find it easier to let a full-timer drop a theatre list than someone who has only a few lists in the week. You can end up having a much higher ratio of DCC to other work than your full-time colleagues. The knock-on effect of this is that if you are still on the pre-2008 contract, you are less likely to be successful in applying for optional and discretionary points, and on the new contracts you may find it more difficult to pass through the thresholds. If you are in a large department there will already be many part-time anaesthetists so this should be less of a problem, but it is up to you to ensure your commitment is never in doubt.

#### *Additional Programmed Activities*

The new 2008 contracts specify 'full-time' as 10 PAs or 40 hours. Any more than that requires a separate contract for Additional Programmed Activities (APA). Part-time doctors may also be offered such additional duties, for example, you may have a core job plan for 20 hours per week, but you can agree to APAs to undertake extra work on a temporary basis, with 3 months notice built in on either side.

#### *Waiting list initiatives*

The new contracts have no specific guidance on this, or on payment, but if your department is offering waiting list initiatives work to full-timers, they should offer it to part-timers as well. You may come up against attempts to pay you only 'plain rates', a matter for robust negotiation with assistance from your Local Negotiating Committee or local SAS committee.

## Rotas

If you are on an on-call rota, or have resident out of hours or weekend work, one thing you need is a calculator. The precise arrangements for your working week are in your job plan. It is particularly important to have agreement on whether or not you will be providing prospective cover for absent colleagues in order to calculate your PA allowance and salary correctly.

## Leave arrangements

You are entitled to a pro-rata share of annual leave and public/statutory days. The precise arrangements for this will vary from one department to another, but you should not be treated less favourably than your full-time colleagues. For example, you may be told that if you work half-time, you can only have three weeks annual leave instead of six: this is incorrect, and some examples later will illustrate this. National terms and conditions of service specify your leave as five weeks per year, going up to six after you have completed two years' service, and your contract should do the same, but many departments calculate leave in days rather than weeks. Some places are calculating leave in sessions, and where micromanagement is the norm it could even be in hours.

## Continuing Professional Development and Study Leave

The RCoA currently recommends that anaesthetists complete 50 hours of CPD on average per year and does not reduce this for part-time anaesthetists. A minimum of 20 hours each should be allotted to internal and external activities. The [College website](#) provides detailed advice about how to use the CPD Matrix and keep a logbook of your CPD activity. Some of this will require you to apply for study leave; this is paid leave, so you should either claim additional salary if you go on study leave on a day when you are not normally at work or get time off in lieu. Study leave is not pro-rata. It is advisable to plan ahead with your appraiser, consultant supervisor, or SAS educational lead, what your CPD needs are for the forthcoming year. You should also include this in your annual job-planning meetings: as a generality, 'external' CPD is achieved by taking study leave; whereas 'internal' CPD could be included in your SPA time, although this varies.

## Tax, insurance, pensions

You are advised to seek expert advice on what effect working part-time is likely to have on tax, national insurance and pensions. For example, it is often not realised that NHS pension contributions are based on your full-time equivalent salary and therefore takes a higher proportion from it.

## Increments and thresholds

It is incorrect that part-time doctors cannot progress through annual pay increments or thresholds on their incremental date alongside their full-time colleagues. Your basic salary on the new contract should progress each year, or two, or three, depending on which part of the scale you are, on the anniversary of your incremental date. Passing to a higher threshold may be more problematic if you have not had the opportunity to meet the criteria, so it is more important than ever to ensure that this is raised at appraisal and at job planning well in advance of the expected threshold date. Your employer is obliged to make this possible for you and must not put barriers in the way of your progression. For example, if your full-time colleague has been given a session to undertake an audit, research, or special project for the department, you should be given a similar opportunity.

## Changing from one to the other

It sometimes happens that a doctor who is working full-time wishes to change to part-time, and vice versa. For example: this author worked full-time as a junior doctor for nine years; then was unemployed for three years while her children were little; returned to work as an SAS anaesthetist part-time for 18 years; became full-time for seven years; then back to part-time in the lead up to retirement. Such flexibility is an important means of managing your personal and family life according to circumstances. Your employer has no obligation to allow this, but in practice if you have a good reason to reduce your hours, a good employer would try to enable that. Increasing hours from part-time to full-time is also not a 'right', but if a vacancy arises in your department, they may find it a good solution to offer the vacant sessions to you instead of incurring recruitment costs. In either case, you will need an amended contract and a new job plan.

Working LTFT is an excellent way to continue to practise anaesthesia and have a satisfying career when full-time work is not possible. Part-time workers' legislation has removed some of the problems that once existed with regard to annual, statutory and study leave, and good employers recognise and encourage this contribution to the workforce.

## Appendix: Example job plans and leave calculations

### Example 1

Dr A works as a Specialty Anaesthetist. She has been full-time, but now wants to work for 20 hours per week and does not want to do any out of hours; her Clinical Director is agreeable to that. She is not required to do prospective cover. They agree a job plan as follows:

Monday	08:00 to 13:00 theatre list
Tuesday	Off
Wednesday	13:00 to 18:00 SPA (including attending the M&M meeting and taking care of the department library)
Thursday	08:00 to 18:00 theatre list
Friday	Off
Saturday	Off

This is a job plan for 20 hours, or 5 PAs.

#### *Leave arrangements*

Dr A has a leave entitlement of 6 weeks per year. If the department uses a weekly system: she can take 6 full weeks off.

If the department uses a daily system: she can take 6 Mondays, 6 Wednesdays, and 6 Thursdays off each year (but she shouldn't take 12 Mondays plus 6 Thursdays).

If the department calculates leave in sessions, then she can take  $5 \times 6 = 30$  sessions off per year, but, they should be evenly balanced and include the SPA sessions as well as the DCC sessions.

#### *Public holidays*

Dr A is entitled to 10 days per year, pro-rata, making 5 days in total. In the year in question, there were 5 days that fell on a Monday, 2 on a Tuesday, and 3 on a Friday. If Dr A took the time off as they happened to fall, then she would be absent on 5 Mondays. However, she normally only works in the mornings on a Monday, so to achieve her full entitlement of 5 days, she will need to take some time off on other days as well. Her Clinical Lead agrees that she should have 2 Thursdays off and 1 Wednesday.

## Example 2

Dr B is an Associate Specialist on the new contract. He is resident in the labour ward one night per fortnight. He also does one Saturday morning trauma list every fortnight. He is not required to do prospective cover. His agreed job plan is:

### Week 1

Monday	Off
Tuesday	22:00 to 07:00 labour ward
Wednesday	Off
Thursday	08:00 to 18:00 theatre list
Friday	08:00 to 13:00 theatre list
SPA	13:00 to 18:00
Saturday	Off

### Week 2

Monday	Off
Tuesday	08:00 to 18:00 theatre list
Wednesday	Off
Thursday	08:00 to 18:00 theatre list
Friday	08:00 to 13:00 theatre list 13:00 to 18:00 SPA
Saturday	08:00 to 14:00 trauma list
Sunday	Off

Dr B is working 29 hours in week 1, and 36 hours in week 2, average 32.5 hours per week. This job plan is rated at 8 PAs for week 1, 9.5 PAs for week 2, and should be rounded up to a job plan paid as 9 PAs.

### Annual leave

Dr B is entitled to 6 weeks annual leave per year. If the department uses a weekly system: he can take 6 weeks off, 3 being week 1, and 3 week 2. If the department uses a daily system: he can be off for 6 Mondays, 3 Tuesday nights, 6 Thursdays, 6 Fridays, and 3 Saturday mornings.

Dr B is entitled to 10 days per year, pro-rata, making 9 days in total. In the year in question, there were 5 days that fell on a Monday, 2 on a Tuesday, and 3 on a Friday. If Dr B simply took them as they happened to fall, it turns out that he would be off for 1 Tuesday night and 3 Fridays. He needs to discuss with his Clinical Lead how to achieve his full entitlement ensuring an even spread of day and night duty.

### Prospective cover

SAS doctors, whether full or part-time, have no contractual obligation to provide prospective cover for colleagues' leave. However, it is considered sound professional practice to do so, with the PA allowance being adjusted. Further information on how to calculate this can be found on the [BMA website](#).

### Dr Christine Robison

Retired Associate Specialist, Anaesthetics

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## 7. Addiction, sickness and returning to work

### Addiction

Out of each cohort at medical school, approximately 10% will develop an addiction. Figures are unreliable as no large study has ever been conducted in the UK and most rely on postal surveys. The majority of us (even most of the heavy drinkers or drug users) in Medical School were able to 'settle down' and never developed a serious problem. A minority, however, will go on to develop full-blown addictive states. This transition from heavy use to addiction is consequent on several factors. Evidence from DNA and biochemical testing shows that addiction is multifactorial and can be regarded as having genetic, psychological, social and environmental components. There is frequently an alcoholic parent or history of child abuse. Addiction becomes an active and serious problem when those individuals with predisposing factors discover which drug or drink (or behaviour such as gambling) fixes the way they feel. Access then often dictates which substances someone will try until they find 'the one'. Since the early 1990s, it has been recognised as an actual disease, and is classified accordingly with other chronic illnesses. It therefore often involves cycles of relapse and remission. Unfortunately, society's attitude has not changed significantly and addiction is still a rather taboo subject.

### Definitions [1]

The simplest definition of alcoholism is from the American Society of Addiction Medicine (ASAM): *'(Alcoholism) is characterised by continuous or periodic impaired control over drinking, preoccupation with alcohol, use of alcohol despite adverse consequences, and distortions in thinking; most notably denial.'*

They also describe addiction as characterised by:

- a. Inability to consistently **A**bstain
- b. Impairment in **B**ehavioural control
- c. **C**raving or increased 'hunger' for drugs or rewarding experiences
- d. **D**iminished recognition of significant problems with one's behaviours and interpersonal relationships
- e. A dysfunctional **E**motional response

Substance use disorder (SUD) is now used instead of substance dependence and substance abuse since the recent reclassification. Addiction used in this chapter relates to an end-stage SUD.

The inability to abstain and impaired control refer to the loss of control in addiction, the broken promises of 'I'll just have one', etc. Characteristically, there is a history of multiple failed attempts at controlled drinking or stopping for a month, but after the first drink has been taken again, control over not drinking any more is lost and the seemingly irrational compulsion to continue is overwhelming. This feeling wins even though there is an important meeting, interview or difficult theatre case the next morning. Differences in GABA, 5HT and dopamine DA3 receptors have been demonstrated as, in part, an explanation for these traits. In active addiction, large amounts of time are spent trying to avoid being caught out, trying to sneak a 'top up' while no one is watching, concocting excuses for being late or missing deadlines, leaving early, hiding bottles or ampoules, etc. Adverse consequences include marital problems, car accidents, drink-driving offences, childcare issues and financial problems. These all take a back-stage position and obtaining and using the substance to remove the craving becomes the user's prime objective.

Denial refers to a subconscious 'protective mechanism' that prevents the individual seeing objectively exactly how bad things have become, and the resulting reassurance this gives of not being seriously addicted. It can be quite profound, even with our medical knowledge. Similarly, one's colleagues may also be in denial of the situation, as it can be embarrassing, time-consuming and a generally uncomfortable situation to deal with.

Some signs of addiction at work:

- Personality changes (most common)
- Loss of efficiency and reliability
- Increased sick time and other time away from work
- Poorly prepared presentations, failure to fulfil departmental responsibilities
- Patient and staff complaints about a doctor's changing attitude/behaviour
- Late for appointments, etc., with increasingly elaborate excuses
- Moodiness, anxiety, depression
- Memory loss, indecision
- Increasing personal and professional isolation
- Physical changes: weight loss, less effort made with clothing and general appearance
- Inappropriate prescription of large narcotic doses
- Heavy 'wastage' of drugs
- Dropping/breaking an already empty ampoule to get a full replacement
- Insistence on personal administration of parenteral opioids to patients in pain despite high doses of opioids charted as given
- Preference for working alone
- Long sleeves when inappropriate
- Frequent toilet breaks
- Nasal rubbing/itching or drowsiness after 'top-up' breaks
- Nasal discharge, yawning, tears, pallor, sweating, piloerection and feeling cold if withdrawing
- Alcohol on the breath
- Poor anaesthetic charts, particularly altered or (deliberately) illegible entries. Similarly, uncharacteristically poor handwriting (alcohol withdrawal tremor)
- Using techniques without narcotics, falsifying charts and diverting drugs for own use
- Offering to prepare drugs for day lists before going home after a night shift
- Difficulty finding the person when on-call
- Frequent appearances in the hospital when not on-call or on leave (if drug abused is obtained from workplace)
- Frequent vague, unexplained or complex illnesses
- Frequent minor accidents and car crashes (if a case of propofol abuse)
- Messy CV: many locums or those working below qualification level will leave and change jobs when questions are asked

Outside work:

- Deterioration of marriage/relationships
- Decreased involvement in family activities and commitments
- Children developing problems
- Frequent arguments: life revolves around the partner's addiction; family walk round 'on eggshells' due to unpredictable moods
- Social isolation and loss of friends
- Cessation of hobbies and interests
- Financial difficulties
- Drink-driving convictions

Widely believed misconceptions are that to be diagnosed as alcoholic requires drinking every day and starting first thing in the morning. This is not the case. Binge drinkers may exhibit just as much loss of control as daily drinkers in that once they have one or two drinks, they are unable to stop and will continue for a whole binge. This usually happens on a daily basis until the end of the binge, which may last a few days or a few weeks. The same craving and compulsion to continue despite negative consequences occurs, but there may be a few weeks or more between bouts.

## Anaesthetists and opioids

Our specialty is over-represented in treatment centres and we have the highest incidence of intravenous opioid dependence. Fentanyl is most commonly used and severe dependence can occur after only a few weeks of use. Usage occurs most often in the under 40s age group, and is therefore more common in trainees. It is because of the rapid decline that occurs with opioid abuse that inpatient treatment is usually required. Access to potent opioids is often cited as a cause for this addiction; this is true, but it usually only occurs in those who are genetically 'primed' to become an addict, and the availability of opioids decides the drug of choice. Frequently, there is a history of codeine or dihydrocodeine exposure. Management and monitoring have recently improved, and recently some opioid-addicted anaesthetists have been able to return to work.

With alcohol, however, it usually takes many years for end-stage dependence to develop, and so problems are more common in the over 40s age group.

## Families

Most of the advice here is specific to the addicted doctor, but family members suffer too. Helpful contacts can be found in the contacts section.

## What to do if you suspect a colleague has a problem with substance abuse

The Association's guideline on drug and alcohol abuse [2] describes this in detail, the major concern being patient safety. It should be discussed with the Clinical Director (CD) or equivalent, with dates and times and what you have noticed. An intervention will then be arranged with evidence to hand, attended by the doctor in question, the CD, college tutor (in the case of a trainee) and perhaps a psychiatrist. It is not something that you should confront the doctor with on a one-to-one basis, unless the situation arises out of hours and is a safety concern, in which case the consultant on-call should be notified immediately. An intervention should never be a 'corridor consultation'.

## The GMC

If there is a perceived risk either to patients or the doctor him/herself, then the GMC should be contacted. Self-reporting to the GMC has often been requested recently by management. This is not necessarily a threat, as if a doctor can demonstrate that they have insight, are open and honest about a problem, and are seen to be taking remedial steps, then the GMC will often be happy for this to be managed at local level by Occupational Health, the department, and usually also the Medical Director.

If the GMC ask for the doctor to attend a hearing, they will then usually place conditions or undertakings on the doctor's registration. These usually require attendance at peer-support groups, plus Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). The most helpful peer-support group is the British Doctors and Dentists Group (BDDG; see helpful contacts). If these groups are being attended and a doctor has been into a treatment centre, again sometimes the GMC will suggest management continue at a local level and they will occasionally not take on the case. This is more likely with alcohol problems than opiates. With a straightforward alcohol problem and no patient care issues, doctors are often not suspended by the GMC, and just given conditions on their registration.

If the doctor has a subscription to a defence organisation (MPS, MDU, etc.) at the time of the discovery of addiction at work, the organisation will provide legal representation for GMC hearings. They should be notified as soon as the doctor is reported to the GMC.

It is not helpful to report the opiate-abusing doctor to the police for theft. This causes more stress and complicates proceedings unnecessarily. These doctors are basically honest people who only remove these drugs as a consequence of their addiction. Often, however, opioid addictions will result in GMC Fitness to Practise hearings and possible suspension – every case is different. Return to work involves continued regular psychiatric appointments and hair or urine testing, all organised and paid for by the GMC.

Addiction should be managed primarily as a health problem (as is done by the GMC), and not a disciplinary issue. Obviously, there may be exceptions to this if it is not a straightforward case. The GMC is aware that some doctors may seek help before the abuse becomes obvious at work, and go into treatment and return to work without it ever becoming known to them. In this case, the CD should be made aware, as time to attend peer-support groups and appointments with occupational health (OH) and psychiatrists, etc., will have to be built into a return to work programme.

It is becoming more common for questions to be asked at job interviews about a history of substance abuse. These should be answered honestly, as failure to do so could result in a probity issue and possible GMC involvement. However, it is important to appreciate that an addict is not a bad person, but a sick one who deserves to get well and be treated as any patient of their own with a chronic illness would be treated. Sources of information and support are listed in the new drug and alcohol abuse guidelines and on the Association's website.

GMC hearings can be very stressful. The BMA now offers a confidential Doctor Support Service, which provides support at hearings by another doctor who is experienced in providing peer support, and is completely independent from the GMC. It is free and BMA membership is not required to use the service. This can be organised via email at [doctorsupportservice@bma.org.uk](mailto:doctorsupportservice@bma.org.uk) with your name and phone number or 020 7383 6707 (<https://www.gmc-uk.org/concerns/information-for-doctors-under-investigation/support-for-doctors/doctor-support-service>).

If the GMC has been involved in your case, it is very helpful, prior to any hearings, to gather evidence of attendance at peer-support groups, online learning modules and other CPD activities you may have pursued while on sick leave. This is evidence of you being keen to keep up-to-date and strengthens your case for wanting to get back to work.

### **Sick leave and return to work**

Sick leave can be for many reasons: physical, mental, planned or unplanned. For the purpose of this document, sick leave of over 3 months is discussed.

Some dos and don'ts:

- DO ensure you are registered with a general practitioner
- DO keep in touch on a regular basis with your CD or equivalent. Many OH departments will only accept referrals from the CD and not self-referrals, and the OH department may give details to the CD. This is something you may wish to discuss with OH and to make sure you know how yours operates. If the CD is a personal friend, this may become a little awkward, and necessitate primary liaison with another manager. OH require your consent, usually renewed at each appointment, for details of the consultation to be sent to your GP
- DO keep a copy of your sick notes when submitted
- DO ensure managers are notified if you are going to be away from home or uncontactable for more than a few days, to avoid missed emails or appointments
- DON'T self-medicate

Bereavement leave is usually 1 week, but most human resources departments' absence policies will allow a further period under the heading of 'carer' or 'special leave'. More than this can be taken as short notice annual leave sometimes.

If an injury is sustained at work, or as a consequence of your daily work, e.g. back trouble, it is possible to obtain some degree of financial compensation from your employer. If you should end up on half pay as a consequence of such an injury, this Temporary Injury Allowance will make pay up to 80% of what you normally receive rather than 50%.

If you are attending hospital for a review with your CD or other managers, try to make the appointment soon after rather than just before an OH visit, allowing time for any correspondence to be seen. Most OH reports do not go into clinical details, but are restricted to fitness to work and a time frame where possible. You are not under obligation to discuss details of your illness with all your colleagues. You can take someone with you e.g. a mentor to any meetings where you feel need support.

It is perhaps worth mentioning here, that if the situation arises, instead of allowing a Trust to terminate your contract, voluntary resignation may be the better option financially. The BMA would be able to advise on this.

Regular contact is vital and provides several things:

- General progress reports: it is not necessary for everyone else in the department to know all the details. Do not rely solely on email as the method of contact – phone calls are important. Ask your CD when a good time to ring is, as such conversations should not be conducted in the middle of a busy list
- Regular review: correspondence from OH and any other specialists, e.g. surgeons and psychiatrists, consulted during the absence can be integrated and discussed with the CD and any other line manager involved
- Plans for return can be discussed: this frequently involves working alongside another senior anaesthetist for a week or so, and so a plan is needed at least 2 weeks in advance. Any interpersonal difficulties can be avoided by not being rostered to do lists with certain colleagues. You can ask for a mentor or trusted colleague to support you through this process
- A link with colleagues and the workplace is maintained, which helps avoid the feeling of isolation and being totally estranged from work
- Any GMC restrictions or conditions on employment can be accommodated and integrated into the return to work plan
- Importantly, any possible changes in pattern of work on return can be planned well ahead

- If the workplace and its stresses are a significant factor in your illness, this can be discussed in order to minimise recurrent illness
- Continuing reviews after return should allow for any new difficulties to be discussed; feeling that another week is needed before returning to solo practice, or perhaps feeling more tired than expected are issues that should be raised at the time. It is difficult to take more time off once back in the workplace.

Things to do before return:

- Ask for your home email address to be included in departmental communications and practise getting up early for at least a week before
- If you have a local simulation centre, investigate the possibility of attending a course as an observer, by way of an introduction to the theatre atmosphere again or consider a simulation course such as those run by GASagain via the RCoA (see contact section)
- Annual leave: a prolonged period away from work may result in accumulation of annual leave. Sick leave of more than 6 months will result in half pay, but taking annual leave after being signed off sick leave and before return to work is at full pay rates. This may be regarded in a negative way by some colleagues, but 2 weeks holiday and rest are very different to being on sick leave
- Each employer will have rules about carrying over annual leave not taken in the previous year, frequently 5 days. This should be confirmed by agreement with the appropriate manager and documented. More than this can sometimes be negotiated
- It is important that your CD and the rota master know of any conditions or voluntary undertakings from the GMC, as these should be built into and considered in the return plan, e.g. any supervision, no on-call, etc.
- Following depressive illnesses, night-time medication may initially cause some morning drowsiness and it is important you are stable on these treatments. It may, for instance, require postponing commencement of on-call duties. Similarly, if you cannot drive following a drink-driving offence, allowances may have to be made.

### Return to work

A date for return to work should be reached after discussion with OH, your CD and rota master. A sick note specifying light duties, for instance, with a commencement date is needed, i.e. a 'fit note'. Don't rush back or try to bring the return date forward; the specialists looking after you know what time frames are reasonable far more than we ourselves may perceive. Nothing is to be gained from doing what you think would go down well with the department; you may be quite emotionally vulnerable for a while. Often there is a feeling of being 'tested' and under criticism from colleagues sharing their list with you. It is important to bring up any problems during your phased return and maybe accept that your previous sessions require some alterations. The Association is currently producing a guideline on 'returning to work'.

Those first few weeks back at work:

- Go to bed early
- Don't be surprised if it is a bit of a culture shock - it is!
- Don't worry if, for a while, all you do is get up, go to work and get a good night's sleep
- Don't feel obliged to organise or take on new ventures. It is easy to feel a bit guilty after a while away and tempting to make up for it by volunteering for new things. Your personal welfare must come first at this stage
- Try to be positive and appropriately enthusiastic, but don't do things because you feel you ought to
- Discuss the possibility of doing certain lists to learn things you've wanted to learn before; you may not get another chance to be free to do it
- Make sure any outpatient and other follow-up appointments are allowed for in your initial work plan

### References

1. American Society of Addiction Medicine. Public policy statement on the definition of alcoholism. <https://www.asam.org/resources/definition-of-addiction>.
2. Association of Anaesthetists. Drug and Alcohol Abuse amongst Anaesthetists: Guidance on Identification and Management. London: AAGBI, 2011. <https://anaesthetists.org/Home/Resources-publications/Guidelines/Drug-and-alcohol-abuse-amongst-anaesthetists>

## General articles on addiction that are well worth reading

- Warner DO, Berge K. Substance use disorder among anesthesiology residents, 1975-2009. *JAMA* 2013; **310**: 2289-96
- Bryson EO. The opioid epidemic and the current prevalence of substance use disorder in anesthesiologists. *Current Opinion in Anaesthesiology* 2018; **31**: 388-92
- Mayall RM. Substance abuse in anaesthetists. *BJA Education* 2016; **16**: 236-41
- Berge K, Seppala MD, Schipper AM. Chemical dependency and the physician. *Mayo Clinic Proceedings* 2009; **84**: 625-31.
- Bryson EO, Silverstein JH. Addiction and substance abuse in anesthesiology. *Anesthesiology* 2008; **109**: 905-17.
- Domino KB, Horbein TF, Polissar NL, et al. Risk factors for relapse in health care professionals with substance use disorders. *JAMA* 2005; **293**: 1453-60.
- Baldisseri M. Impaired healthcare professional. *Critical Care Medicine* 2007; **35** (Suppl. 2): S106-16.
- Earley PH, Berry AJ. Reentry after addiction treatment: research or retrain? *Anesthesiology* 2009; **110**: 1423-4.

## Some useful numbers for addiction problems

### NHS Practitioner Health - Tel.: 0203 049 4505, <http://www.php.nhs.uk>

This is an NHS funded, but entirely confidential, service open to all doctors and dentists (living or working in the London area only). Care is multidisciplinary in nature and provides appropriate specialist care and support for any doctor with addiction, mental or physical health concerns. Where inpatient therapy is thought necessary, this will be organised and funded by NHS Practitioner Health. Follow-up, monitoring and help with returning to work are also part of the services offered. This is currently only available to London-based doctors, but plans for expansion to cover other areas of the country are underway. Useful advice can be obtained by phone, even if outside the London area.

### Sick Doctors Trust (SDT) - Tel.: 0370 444 5163, <http://www.sick-doctors-trust.co.uk>

The SDT is an independent charity established over 20 years ago, which provides a 24-hour helpline manned exclusively by experienced doctors who are in recovery from addiction themselves. It provides help and support to doctors who think they may have a problem with their use of alcohol or other drugs, whether prescribed or not. Calls are treated with strict confidentiality, and callers may remain anonymous if they wish. Help offered includes advice, help finding a suitable treatment centre when appropriate and introduction to long-term befriending and support. Helpline responders do not act as diagnostic doctors, but chatting to callers helps them realise the extent of any problem and where to go thereafter. The helpline also accepts calls from family members or friends, concerned colleagues or medical managers.

### British Doctors and Dentists Group (BDDG) - the National Secretary: 07904 570729, Ruth Mayall on 07976 717211, or via the Sick Doctors Trust helpline: 0370 444 5163, <http://www.bddg.org>

This is a countrywide network of doctors and dentists at various stages in their recovery from addiction, who are well again and who meet on a monthly basis at one of 18 groups covering the UK. Following initial contact, callers may be put in touch with another doctor (in some cases from the same speciality) nearer to their home who may then introduce a new doctor to the group at the local meetings.

Problems can be discussed at these meetings, which are not appropriate to discuss at meetings of AA or NA, for example, GMC proceedings and issues surrounding return to work etc. Doctors under the GMC for substance abuse problems will be required to attend these meetings as conditions on their practice, or as part of their stipulated undertakings. Certificates and proof of attendance can be obtained from the group secretary and given to the GMC.

### BDDG Families Group - Rory on 07725 872866; 0207 485 5231 (London Area), or 0114 230 4100 and 07714 331725 (outside London); website: <http://www.bddg.org/families-group-of-bddg/>

Many of the BDDG meetings have a separate family group, where direct relatives of addicted doctors and dentists can obtain help and support. These usually run at the same time and venue as the main BDDG meeting, monthly.

Many have also found Al-Anon, the family branch of AA helpful. There are regular meetings, which can be found on the website <https://www.al-anonuk.org.uk/> or helpline on 0800 0086 811.

## Ireland

A Practitioner Health Programme has recently been set up – 01 297 0356 or email [confidential@practitionerhealth.ie](mailto:confidential@practitionerhealth.ie). This 'Practitioner Health Matters' programme has replaced the Irish Sick Doctor Scheme and is a multidisciplinary service for all doctors in Ireland with addiction or mental health issues.

BDDG contact for Dublin area: [jamesoneill@fastmail.fm](mailto:jamesoneill@fastmail.fm) or 00-353 87 1992488

## Northern Ireland

**NIDDG (Northern Ireland Doctors & Dentists) – John B Belfast: 07710 741169, email: [drjburton@btinternet.com](mailto:drjburton@btinternet.com).**

He can also give (limited) legal advice. Dublin contact: 00 353 87 1992488

**Narcotics Anonymous (NA) – national helpline: 0300 999 1212, <http://www.ukna.org>**

NA is for recovering addicts who meet regularly to help each other stay clean. It is not restricted to those with opiate/narcotic abuse problems as the name may suggest, but any drug including tranquillisers, recreational drugs and alcohol. The website contains some questions and information for those who think they may have a problem.

**Alcoholics Anonymous (AA) – helpline: 0800 9177 650; email: [help@aamail.org](mailto:help@aamail.org); [www.alcoholics-anonymous.org.uk](http://www.alcoholics-anonymous.org.uk)**

**Cocaine Anonymous (CA) – helpline 0800 612 0225**

The majority of AA, CA or NA meetings are ‘closed’ and are only for recovering addicts/alcoholics and those who think they may have a drug problem. A meeting described as ‘open’ may be attended by anyone, e.g. professionals working with addicts or family members, friends, etc. Meetings lists are on the AA or NA websites with details of open meetings at each venue.

**SMART Recovery – <http://www.smartrecovery.org.uk>**

The 12-step approach of AA and NA may not appeal to everyone. SMART Recovery uses psychotherapeutic techniques that are similar to those used in many treatment services in the UK, being more along the lines of cognitive behavioural therapy. The concept started years ago, with online meetings with a facilitator, which many found helpful, and now there are many meetings ‘on land’ also, extending from Banff right down to Brighton. Details can be found on the website, <http://www.smartrecovery.org.uk/>

**Simulation practice – Tel.: 020 7092 1673; <https://www.rcoa.ac.uk/GASAgain>**

Simulation practice is available if not absent from work for more than 2 years. Courses run every 3 months or so, provide updates in resuscitation and patient safety checks, for example, and help to build confidence again.

## Financial help

**Royal Medical Benevolent Fund (RMBF) – Tel.: 0208 540 9194; <https://rmbf.org/contact/>**

The RMBF will send an assessor to a doctor’s home. If hardship continues after a doctor has died, long-term support is often available to the doctor’s family. The Association has forged a good relationship with the RMBF and they have been most helpful to some of our members.

**The Royal Medical Foundation – Tel.: 01372 821010; email: [rmf-caseworker@epsoncollege.org.uk](mailto:rmf-caseworker@epsoncollege.org.uk)**

This exists to support medical practitioners and/or their dependents who find themselves in financial difficulty.

**BMA Charities Trust Fund – Tel.: 020 7383 6142; email: [info.bmacharities@bma.org.uk](mailto:info.bmacharities@bma.org.uk)**

This provides help to doctors with financial difficulties who are not working during life crises.

## Non-addiction illnesses:

Doctors are not immune to mental illness; in fact, doctors have quite high rates of depression and anxiety, and female doctors have significantly higher suicide rates than the general population.

**The Practitioner Health Programme** (which hopefully will be available to all doctors soon, and not just those in London) sees patients with all types of mental health issues.

Other support is available from:

**The Doctors Support Network (DSN) – <https://www.dsn.org.uk>**

Primary contact is via email accessed via the website contact page. It is a peer-support group run by volunteers and therefore does not offer individual counselling.

**The BMA website** has a list of support agencies for many conditions and situations such as mental health, bereavement, <https://www.bma.org.uk/advice/work-life-support/your-wellbeing/sources-of-support>

**BMA Counselling – Tel.: 0330 123 1245**

This is a helpful option for mental health concerns (but is not addiction specific), and BMA membership is not necessary. A fixed number of counselling sessions are available, including video consultations, **24 hours a day, 7 days a week**. The BMA can also help with some of the employment laws and issues surrounding return to work after a period of suspension or ill-health.

**Doctor Advisor Service – Tel.: 0330 123 1245**

This runs alongside the BMA Counselling Service and enables contact with another doctor. It is confidential, but not a diagnostic or emergency service.

**Doctors' Support Network (DSN) – email: [secretary@dsn.org.uk](mailto:secretary@dsn.org.uk) or Tel.: 0871 245 8376 for general enquiries**

This is a group with regular meetings throughout the country for help with stress, burnout, anxiety, depression, psychoses and eating disorders. This may be helpful for addicted doctors with dual diagnosis.

**DocHealth - <http://www.dochealth.org.uk>; Tel.: 020 7383 6533; email: [enquiries@dochealth.org.uk](mailto:enquiries@dochealth.org.uk)**

**Efficacy - <http://www.efficacy.org.uk> (used by NHS Practitioner Health), are both paid services offering CBT and stress management.**

### **Physical disabilities**

In the USA, although nearly 20% of the population has some kind of disability, less than 3% of medical school entrants do, making it a very under-represented group. Help for non-mental health conditions tends to be sparse in this country. The Equality Act 2010 states that employers have a duty to make adjustments in the workplace for people with disabilities. This includes the local HEE offices, deaneries and other employers who recruit doctors. Medical schools must also make similar adjustments. They also have a legal duty to avoid unlawful discrimination, whether direct or indirect.

It is important to negotiate flexible working patterns and have regular revisions of task allocation. Positive leadership in your department helps, as does a willingness to discuss difficulties. The Disability Discrimination Act may help with sources of funding and general resources.

The GMC is currently updating its guidance. Its website has a very comprehensive list of links to all the helpful agencies. <https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/health-and-disability-review/links-to-disability-organisations>

A PDF is available concerning the discussion: [https://www.gmc-uk.org/-/media/documents/identifying-unmet-needs-from-the-gateways-to-the-professions-guidance-final-report\\_pdf-73587370.pdf](https://www.gmc-uk.org/-/media/documents/identifying-unmet-needs-from-the-gateways-to-the-professions-guidance-final-report_pdf-73587370.pdf)

**Other resources can be found here:**

<https://www.healthcareers.nhs.uk/explore-roles/doctors/career-opportunities-doctors/doctors-disabilities>

**Hope for Disabled Doctors <http://www.hope4medics.co.uk/homepage.php>**

**The Association of Disabled Professionals <https://www.adp.org.uk>**

**Disabled Doctors Network <https://www.disableddoctorsnetwork.com>**

The University of Michigan has a society for disabled doctors with helpful general information

<https://www.physicianswithdisabilities.org>

**Dr Ruth Mayall**

*Membership Services Committee member, Association of Anaesthetists*

## 8. Clinical governance and professional development

Clinical governance may be the two most overused words in the NHS, either as an excuse not to do something, or a justification for change (usually spending money), but rarely, with an understanding of its provenance. Once described as 'corporate responsibility for clinical performance', its incorporation into the fabric of daily work followed inquiries into several scandals, exemplified by the public inquiry into paediatric cardiac surgery in Bristol. Clinical governance is the overarching framework that ensures patients receive the highest possible quality of care. It covers how healthcare professionals treat patients; the level of information provided to patients; their involvement in decision-making; the provision of up-to-date and well-supervised services and the reporting, learning and thus prevention of errors and accidents.

It is a framework through which NHS organisations are statutorily accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Every doctor working in the UK is required to comply with clinical governance, both as part of their contract of employment (in the NHS) and as part of their licence to practise from the GMC. Evidence of participation in clinical governance is an essential part of revalidation (GMC domains 2.1 and 2.2) and so should be evidenced at ARCP by trainees and at appraisal for all other doctors. Regrettably, more recent scandals, such as that at Mid Staffordshire, have still occurred; clinical governance is only effective when the whole organisation, up to and including Board level, is actively involved. Clinical governance is never 'someone else's problem'. The Francis Report into Mid Staffordshire made 290 recommendations, many to do with clinical governance. The effectiveness of clinical governance is a key area assessed during regulatory inspections, such as those conducted by the Care Quality Commission.

Clinical governance exists for the benefit of everyone: staff, patients and the organisation. It aims to deliver the highest quality of patient care that is possible by identifying and redressing failures in the system whatever their cause. Clinical governance may be broken down into separate, overlapping elements:

### **Clinical effectiveness**

These include clinical guidelines for specific conditions and national service frameworks, published by NICE, Quality Improvement Scotland, Royal Colleges, or organisations such as the Association.

### **Clinical audit/quality improvement**

The NHS Executive defines clinical audit as 'the systematic critical analysis of the quality of healthcare, including the procedures used in diagnosis, treatment and care, the use of resources and the resulting outcome and quality of life for patients. It embraces the work of all healthcare professionals'.

Although complaints can identify failures, they are essentially a negative way of trying to improve matters. Clinical audit, on the other hand, encourages individuals to look critically at one's own practice and identify areas where improvements can be made. It is a cyclical process in which standards are agreed and data collected. Analysis of the data shows if the standards are not being met. If not, changes are planned and implemented and data are collected for a second time and analysed to see if any improvements have resulted from the changes. This process can be repeated several times as necessary. Audit projects are now an essential part of appraisal for non-trainees, and of training requirements for trainees. All too often audits fail at the last hurdle - a recommendation and implementation of change, and a reassessment of the effectiveness of that change. Clinical audit is being incorporated in quality improvement programmes. This is an area where the details, priorities and processes are different for National Health Services in England, Scotland, Wales and Northern Ireland.

### **Research**

Research and audit are quite different, although they are frequently confused (particularly in abstracts submitted ahead of poster presentations). Audit compares performance with an established standard ('Is what I am doing as good as everyone else?'), while research resolves an unanswered question ('What should everyone be doing?'). Research increases overall knowledge and seeks to discover best practice. Audit reviews current practice and compares it with best practice, stimulating change to achieve best practice.

### **Education and training**

Competency-based training is delivered subject to the curricula and training rules of the various Royal Colleges, and approved by the GMC. The curriculum changes often and any doctor contemplating a change of career status should consult the most recent rules, and a colleague (usually the College Tutor) who has up-to-date knowledge of them.

## **Incident reporting**

Organisations and individuals learn from their own experience and that of others. Any healthcare organisation must have processes in place to learn from crucial incidents, where actual or potential harm has ensued. Local incident reporting systems vary in their effectiveness. Since 2009, there has been a national, specialty specific reporting system for anaesthesia in England and Wales, originally through the NPSA, which was incorporated into NHS England in 2012. This does not include Scotland, Northern Ireland or the Republic of Ireland. In Scotland, the Scottish Audit of Surgical Mortality collected data that included anaesthetic considerations from 1994. This audit has now closed, although it is intended that it will eventually evolve into a structured morbidity and mortality review process for all hospital deaths.

Patient safety incident reporting is a crucial part of this process and incident reporting is an excellent way of learning about risks. Complaints procedures must be accessible to patients and their families and be fair to staff. Useful lessons are learnt from complaints and can reduce occurrence of similar problems. Many complaints, which can be extremely costly to the NHS, arise from poor communication.

## **Duty of candour**

All the clinical governance activities have involved healthcare staff and organisations; they have been about, but not involved, patients. Healthcare is a highly complex process, and it is inevitable that things may not go well, or will even go wrong. It has long been good practice to explain and apologise to patients and/or relatives when this happens. There have, unfortunately, been many examples when this has not happened, and this was certainly a feature of the Francis Report, which recommended the introduction of a statutory duty of candour. This statutory duty was introduced for NHS secondary care organisations in England in November 2014; failure to communicate with patients or commissioners may result in criminal sanctions. The GMC and the Nursing and Midwifery Council published joint guidance to all doctors, nurses and midwives on the professional duty of candour (to patients and employers) in 2015. Failure to follow this guidance may result in Fitness to Practise proceedings.

## **Risk management**

This process brings together several strands of clinical governance (audit, incident investigation) to identify existing and new risks, evaluate them, and take immediate steps to mitigate the actual risk whilst implementing action plans to abolish the risk in the long term. Risks may be clinical or non-clinical (e.g., financial or reputational). Risks and their mitigation are monitored with Risk Registers, which should be reviewed regularly.

## **Professional regulation**

This includes pre-employment checks of registration details, qualifications and the Criminal Records Bureau, as well as newer regulations related to children and vulnerable adults. Any registered medical practitioner is also responsible to the GMC for ongoing fitness to practise. Details of personal responsibility go beyond a single article and more information can be found on the [GMC's website](#).

### **Dr Andrew Hartle**

*Past President, Association of Anaesthetists*

### **Dr Ranjit Verma**

*Former Council Member, RCoA*

## 9. Medico-legal pitfalls in anaesthesia and how to avoid them

In practical terms anaesthetists may become embroiled with the law in several ways:

- They may be subject to civil law or more rarely criminal law proceedings
- They may be required to attend Coroner's Courts, Fatal Accident Inquiries or GMC hearings
- Since the previous version of this chapter anaesthetists with management responsibilities have for the first time been required to give evidence in cases of corporate manslaughter against a Trust

While the vast majority of claims are either abandoned by the claimant or settled out of court: less than 1% of claims go to formal trial, the cost – financial and emotional – is such that it is far better to avoid such situations altogether.

**Table 1:** Outcome of clinical claims received by the NHS Resolution 2016-17

Outcome	Damages paid	Damages not paid	Total
No proceedings	5226	6533	67.8%
Proceedings (Settled in court)	4400	1058	31.5%
Formal trial	49	72	0.7%
<b>Total</b>	<b>9675</b>	<b>7663</b>	<b>100% (17,338)</b>

*NHS Resolution 2017*

### Legal background

In the UK, although the numbers are still very small, over the past few years increasing numbers of doctors have been charged with criminal offences, including gross negligence or manslaughter, as a consequence of fatal medical errors. The level of proof required to succeed with a criminal charge is 'beyond reasonable doubt' (> 95% likelihood). Most litigation against doctors, however, involves civil as opposed to criminal charges, where the level of proof required is 'on the balance of probabilities' (> 50% chance). The subsection of civil law most commonly invoked is the law of tort (civil wrongdoing) and specifically the claim of clinical negligence.

The legal criteria for clinical negligence are:

1. The existence of a duty of care. This is rarely documented but inferred from the doctor-patient relationship. If the patient consents to treatment the clinician owes that patient a duty of care.
2. There must be a breach of that duty of care. In order to establish this, the standard of care expected must be defined. In legal terms the practitioner must 'act in accordance with the opinion of a responsible body of medical practitioners' (known as the Bolam test). More recently, the courts have demanded that the opinion must be 'reasonable', i.e. capable of withstanding logical analysis. The standard of care will also partly depend on the experience and qualifications of the practitioner. If an anaesthetist is a qualified advanced life support provider, then they will be expected to undertake adult advanced life support competently. However, inexperience is no defence if the doctor fails to manage a situation without reasonable competence.
3. A recent case has emphasised the importance of 'the reasonable patient' test when it comes to gaining consent. What you discuss with a patient should be guided by what a reasonable patient would consider important (rather than what a responsible group of practitioners would be likely to discuss). This brings the law in line with GMC guidance on consent.
4. Guidelines and protocols are useful indicators of currently accepted practice. As such, knowledge, particularly of local guidelines, is essential. Ignorance is not a legal defence. If the anaesthetist plans to deviate from such guidelines he/she must document and have a reason for this.
5. There must be foreseeable injury arising from the breach of duty of care. Most cases fail on the issue of causation. Negligent practice may have occurred but frequently there is insufficient evidence to link the injury claimed to that negligence.

## Common themes in litigation against anaesthetists

This has recently been reviewed in an analysis of claims against the NHS in England taken from the NHS Litigation Authority databases. Anaesthesia as a specialty made up only 2.5% of claims, of which nearly half involved regional anaesthesia and close to a third in obstetric patients. Table 2 lists the specific events involved.

**Table 2:** Common clinical events associated with medical negligence claims\*

Category	Main clinical event
Regional anaesthesia	Nerve injury/inadequate blockade/epidural-related problems
Obstetric anaesthesia	Inadequate regional anaesthesia during caesarean section/ inadequate general anaesthesia during caesarean section
Inadequate anaesthesia	Inadequate general anaesthesia/inadequate central neuraxial block/brief paralysis due to drug order errors/obstetrics
Airway	Tracheal tube/soft tissue injury/aspiration/hypoxia
Other respiratory	Hypoxia/pneumothorax/equipment problems
Central venous cannulation	Vascular injury/carotid puncture/wire
Drug related, excluding allergy	Drug switches/overdose/muscle relaxant
Drug allergy related	Administration of known allergen
Positioning	Nerve injury while insensate during general and regional anaesthesia

\*Cook TM, Bland L, Mihai R, Scott S. Litigation related to anaesthesia: an analysis of claims against the NHS in England 1995-2007. *Anaesthesia* 2009; **64**: 706-18.

The preponderance of obstetric cases and those involving regional techniques reflect a growing area of litigation - which involves the issue of consent and specifically of informed consent. Even in expert hands, complications occur, and it is vital that the patient is made aware of these and if alternative techniques are available.

Until recently, the patient had to persuade the court that if they had known of the complication that occurred they would not have undergone the procedure. However, in a more recent ruling (*Chester vs Afshar*), the successful claimant admitted that she would have undergone the procedure, even if she had been informed of the complication that arose. The 'injury' that arose from the surgeon negligently failing to warn her of this was that she was denied her right to make an informed decision on the matter. Not just common complications but rare and/or serious ones should be mentioned. For example, the parturient requiring a caesarean section should not only be warned of common side-effects such as nausea/vomiting, pruritis, and motor block, but also of inadequate anaesthesia, the risk of postdural puncture headache and of neurological damage and infection. Whether an estimation of the risk is attempted is still debated. Where robust and especially local data are available, they should be referred to. However, it should be remembered that the patient is only interested in the risk of that complication occurring in your hands to that patient. Specific to obstetrics, it would always be wise to mention general anaesthesia as an option from the outset (rather than just as 'plan B' if things go wrong with regional anaesthesia). It is perfectly acceptable to then discuss why the preferred option is regional anaesthesia.

The use of faulty equipment and faulty use of equipment are common themes. Meticulous checking of equipment (using guidelines where they exist) and familiarising yourself with equipment you are unfamiliar with are mandatory. Injury to teeth and eyes, due to positioning or due to invasive procedures, are also common causes of claims. Thorough attention to detail and ensuring competency in procedures undertaken should be self-evident. Poor communication with the patient and between professionals is a recurring theme. In cases where pain during surgery is claimed, the anaesthetist may have decided the patient was experiencing anxiety instead. This is hard to defend especially if there are witnesses (e.g. other healthcare professionals or the partner in obstetric cases) stating the opposite. If a patient complains of pain, it is wise to believe them and offer treatment including general anaesthesia. Poor communication between professionals can give rise to injury, especially in an emergency situation. Again obstetrics provides an example: the section for fetal compromise where the anaesthetist has not been informed

of the degree of urgency. In one series, anaesthetists were either given no information (11%); or incorrect information (20%) about cases requiring the most urgent delivery and this resulted in the 'incorrect' anaesthetic technique on several occasions. [1]

Avoiding medico-legal outcomes:

- Practise within your limits of competence and expertise
- Adhere to guidelines and protocols unless there are good clinical reasons not to (and preferably after consultation with a colleague)
- Listen carefully to the patient and communicate clearly with other healthcare professionals
- Be a team player (you are more likely to get support if things go wrong)
- Ensure your knowledge and practice are up-to-date
- Be meticulous checking equipment, drugs and the patient

It is unfortunately not enough to be a good, conscientious and caring clinician. It is essential there is documentary evidence of this. In the medico-legal context, if it is not written down it did not happen. Time and again clinicians let themselves down through poor note keeping. This is particularly so with documentation of discussions of options and risks. Patients remember very little of what they are told. Doctors to date are not very good at recording discussions with patients. In the words of an eminent legal expert 'For some reason they [doctors] do not realise...that although their skills are for the patients, their notes are for themselves'. Although 'defensive' medicine is to be deplored, defensive documentation is just good sense.

### Dr Felicity Platt

*Past Honorary Membership Secretary, Association of Anaesthetists*

### Reference

1. Roberts ND, May AE. Prospective audit of non-elective caesarean section referrals to anaesthetists July-Sept 2001. *International Journal of Obstetric Anaesthesia* 2002; **11** (suppl): 3.

### Recommended reading

- NHS Resolution Annual report and accounts 2016-17 <http://www.resolution.nhs.uk>
- Cook TM, Bland L, Mihai R, Scott S. Litigation related to anaesthesia: an analysis of claims against the NHS in England 1995-2007. *Anaesthesia* 2009; **64**: 706-18.
- Merry AF. How does the law recognise and deal with medical errors? *Journal of the Royal Society of Medicine* 2009; **102**: 265-71.
- Leigh B. Consent in anaesthesia. In: Hardman JG, Moppett IK, Aitkenhead AR, eds. *Consent, Benefit and Risk in Anaesthetic Practice*. Oxford: Oxford University Press, 2009: 345-54.
- Association of Anaesthetists. *Consent for Anaesthesia* 2017 <https://anaesthetists.org/Home/Resources-publications/Guidelines/Consent-for-Anaesthesia>
- GMC. *Consent: Patients and Doctors Making Decisions Together*. London: GMC, 2008. [http://www.gmc-uk.org/guidance/ethical\\_guidance/consent\\_guidance\\_index.asp](http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp)

## 10. Handling patient complaints and staying out of trouble

### Handling complaints

In Section 4 (Maintaining Trust) of Good Medical Practice, the GMC states 'You must respond promptly, fully and honestly to complaints and apologise when appropriate. You must not allow a patient's complaint to adversely affect the care or treatment you provide or arrange' (Paragraph 61).

The NHS Constitution spells out a patient's right to complain, specifically that patients are entitled to:

- Have a complaint dealt with efficiently and be properly investigated
- Know the outcome of any investigation into the complaint
- Take the complaint to the independent Parliamentary and Health Service Ombudsman if they are not satisfied with the way the NHS has dealt with the complaint
- Make a claim for judicial review if they think they have been directly affected by an unlawful act or decision by an NHS body
- Receive compensation if they have been harmed

NHS England introduced the NHS and Social Care Complaints Procedure in 2009. There are similar procedures in place in Wales, Northern Ireland and Scotland.

Six principles of good complaint handling are set out, and all healthcare organisations in England are expected to adhere to them, (See Box 1).

#### Box 1 Principles of good complaint handling

1. Getting it right.
2. Being customer focused.
3. Being open and accountable.
4. Acting fairly and proportionately.
5. Putting things right.
6. Seeking continuous improvement.

The number of complaints made by patients is increasing year on year. In 2013, > 100,000 written complaints were received. In 2016-17, there were 208,400 - on average, 571 per day. Indeed, having a complaint made against you is now probably an unavoidable aspect of clinical work. The majority of written complaints are about doctors. Managing complaints properly is vital. It reduces the likelihood of the complainant resorting to legal action and can provide opportunities to improve practice. The Francis report into 1200 unnecessary deaths in Mid-Staffordshire NHS Foundation Hospital, found that the issues causing such poor outcomes had, over the years, been identified in written complaints, but these data had been ignored. Analysis of complaints can reveal systemic errors.

The vast majority of complaints are successfully handled at a local level. Every Trust has a complaints handling policy that any anaesthetist should be familiar with.

Frequently in practice, the first you know about a complaint is that you will be asked for a comment or report by someone from risk management with often a ridiculously short deadline. The reason for this is that most policies demand that written complaints submitted to the Chief Executive Officer are acknowledged within 48 hours and responded to properly within 25 days. No leeway is given for leave, whether annual, sick or professional. You must not ignore such requests. You may find it useful to enlist the help of a colleague with experience in responding to complaints. You may want to contact your medical defence organisation. Your department should have a named consultant responsible for handling complaints from whom you can get advice.

Your report must be factual and accurate: state facts not feelings, impressions or beliefs. Set out what happened and what you base your account on. This will preferably be your comprehensive, legible contemporaneous notes. Once again your best protection is documentation. A common complaint in the delivery suite is that a woman has had to wait for her pain relief. Anaesthetists are expected to respond within half an hour to the request for an epidural. So what about Mr X who is furious that his partner didn't even get to see an anaesthetist for four hours after arriving on delivery suite? The wise anaesthetist will have recorded the time they were bleeped. If they couldn't respond because of being busy with another patient, this should also be recorded. This level of documentation is not just to protect you; it may also allow underlying system flaws to be identified. Perhaps the level of cover was inadequate for that particular unit or the midwives were not aware that they could access a second pair of hands.

If you receive a written complaint directly, you should inform your line manager and/or the Complaint's Department. I would not advise an anaesthetist to handle any but the most informal complaints by themselves. Complainants are not infrequently upset: they may be angry and distressed and a meeting involving a third party is more likely to be successful and less upsetting for everyone.

When addressing a complaint, it is really important to listen to the complainant. Let them tell their version of events first. Although it may not chime with yours, it will show you why they are upset or angry and are thus making the complaint. Saying sorry is not automatically an admission of guilt. You are sorry that the patient is upset; you are sorry their treatment was poor – even if it is not your fault. If you are a woman in labour who has decided to have an epidural, every minute you have to wait is agony and you are entitled to a response within 30 minutes; as the anaesthetist, you are sorry that standard was not met if more than 30 minutes elapsed. If whatever happened was your fault, admit it and apologise. I once arranged to meet a patient to discuss their forthcoming anaesthetic, but on the day, got embroiled in an emergency and completely forgot. After 4 hours wait, the whole family were furious – as I would have been. Sometimes, a grovelling apology is the right thing to do!

I must emphasize that although complaints may be common, even trivial ones can be incredibly upsetting. We do not get up in the morning intending to give poor care or upset people. Anaesthetists are perfectionists. We tend to dwell on the smallest issues. Sometimes, we even get obsessed. I once spent months reading about anaesthetic techniques for a particular procedure following a complaint by a patient. Being aware of one's own emotional reaction is important. Avoid being defensive with the complainant, but equally, look after yourself. Find a colleague to tell – they will almost certainly have had a similar experience. As a senior member of the department and responsible for risk management, I try to read letters of complaint before they land in my trainees' pigeonholes, so I can support them and offer them practical advice.

Try to think positively about complaints as hard as that may be. They can be an opportunity for thoughtful reflection and provide opportunities for quality improvement projects (both good for the next appraisal!). In the case I mentioned above, I ended up writing a review article about alternative techniques.

### **Staying out of trouble**

The following can really be summarised by the advice to read and adhere to the GMC's *Good Medical Practice*. A lot is common sense. Most is very straightforward.

### **Look after your patient by looking after yourself**

It is incumbent on each of us to ensure that we are fit to practice. You should not treat patients if you are sick, under the influence of alcohol or other substances or exhausted. If, for whatever reason, you find yourself required to work, but feel impaired for whatever reason, tell someone and see if you can find a way of avoiding treating patients until you feel well enough to do so. The GMC requires that we are all registered with a GP. If you suspect you have a condition that could impair your performance, you should 'consult a suitably qualified colleague' (paragraph 28) and not diagnose nor treat yourself. The GMC now comes down hard on doctors who self-prescribe or prescribe for friends and family, and pharmacists are instructed to report doctors if they think this is occurring. Be aware that doctors are very poor at admitting fallibility and asking for help before things become critical.

Maintaining a lifestyle that does not impair your general fitness is something we should all strive for. This includes not just a healthy diet, avoiding smoking or excessive alcohol and enough sleep. It also involves getting the right work/life balance. These may seem like trite recommendations, but studying the judgements of the Fitness to Practise Panel on the GMC website reveals that many doctors who land up in trouble ignore these simple recommendations.

### **Don't get out of your depth**

No anaesthetist can do everything and no anaesthetist should be expected to be able to do everything. There will be times when an anaesthetist, whether consultant, specialty doctor or trainee, will not have the skills, knowledge or experience to provide a patient with the best care available. When this happens seek help from others. Practise within the boundaries of your abilities and be honest with yourself about what these are. I have not done a thoracic list for over 20 years so when my endocrine surgeon decided on a thoracic approach, I went to find a colleague who regularly inserts double lumen tubes.

## **Admit it if you make a mistake**

This is now a legal requirement of the organisation – the duty of candour introduced following the Francis inquiry into the Mid-Staffordshire inquiry. This is also a requirement at a personal level. If you harm or annoy a patient, go and see them and their relatives and explain the situation honestly. Then apologise for what happened. This is not an admission of negligence, but by being open and straightforward may persuade them not to take any further action.

## **No one's perfect**

'To err is human'. The person who says they have never made a mistake is not telling the truth. Make every effort to avoid mistakes, and stick to guidelines and operating procedures designed to minimise the chance of making a mistake and/or mitigate the harm if a mistake occurs. Do not be hard on either yourself or others for unintentional mistakes.

## **Don't get proud**

Even the best anaesthetists have bad days. When none of the lines will go in, get someone else to help you. The person you ask to help you does not always have to be more experienced than you. I have often had difficulty putting a line in and have asked a trainee to help, only to watch the trainee put it in at their first attempt.

## **Keep good records**

I cannot emphasise how vital this is to keeping you out of trouble. Contemporaneous notes are convincing proof of what happened. Years (or sometimes only weeks) down the line, all memories of a particular case may have completely disappeared. In contrast, the patient will provide a vivid account of what happened or what you failed to do. Basing your defence on an account of 'my usual practice at the time' will be much less convincing than 'based on my contemporaneous notes ...'. Consent is a case in point. It is no longer sufficient to record informed consents as 'risks and procedures discussed'. You should document what those risks are. Good record keeping is another GMC requirement. It enables the next doctor who sees your patient to know what is going on and will be able to provide continuity, which is especially important in shift work.

## **Treat consent seriously**

From both the ethical and legal viewpoint, the process of consent is becoming increasingly important. The GMC is very clear about what is required, although not specific. You must explain what you are going to do to your patient, tell them what you hope to achieve by it, what might go wrong, and what the alternatives are. The information discussed must be tailored to the patient in front of you. Be guided by the question: 'if I were this patient, in their position and with their concerns, what would I want to know in order to make a decision about this treatment?' To repeat: keep a record of what has been discussed; patients have notoriously terrible memories about what they've been told and, if a recognised complication occurs, you'll want to be able to demonstrate that you warned them about it in advance. In the absence of a contemporaneous note from you, the courts will tend to believe the patient and not you.

## **Follow guidelines**

Guidelines are written by experts, whose support you will need if things go wrong, so follow them. Saying you were not aware, especially of a local guideline, is no defence. However, guidelines cannot deal with every situation. If you do decide to deviate, make sure that it's for a good reason and you document clearly (and legibly) why you did it.

## **Keep up-to-date**

Doctors tend to fall foul of the GMC at two times in their career: when they are starting out and when they are not far off from retirement. This latter group may have failed to keep up-to-date with changes in medical practice. If you practise anaesthesia that is 20 years out of date, you may not be providing the best care for your patients. Go to meetings, watch others give anaesthetics, read journals and keep up-to-date.

## **Communicate**

We do not work in isolation. Ensure that lines of communication between you, your surgeon, the theatre staff, the wards, the labs and other essential members of the team do not break down. The anaesthetist is arguably best placed to act as the hub for sharing and disseminating information and this important role should be taken seriously.

## Be nice

Doctors who get on well with their colleagues are less likely to end up in front of the GMC. Most anaesthetists who do find themselves there have been reported by colleagues/managers rather than by patients. Patient safety must always remain your first concern. Whistle-blower protection is getting better, although there is still a way to go. Follow GMC guidance on this and consult a trusted, preferably senior, colleague.

### Dr Felicity Plaat

*Past Honorary Membership Secretary, Association of Anaesthetists*

## 11. Dignity and respect in the workplace

If a doctor is being bullied at work, it is your duty to speak up, whether you are that doctor or whether you are witnessing a bullying or harassment event. Bullying and harassment affects all individuals involved, whether participants or witnesses, and has a negative effect on staff wellbeing, patient outcomes and organisational culture. It is important to NHS finances: it is estimated that there is a loss of £13.75 billion per year to the UK economy due to bullying and harassment [1].

Bullying and harassment may occur between peers, by a person in a position of authority, or 'bullying-up' by those in subordinate positions. Bullying can occur within specialty or across healthcare professions. The 2017 BMA survey indicated that one-fifth of all doctors reported being bullied at work. Up to one-third of SAS doctors have reported bullying or harassment, more likely affecting black and Asian doctors and those doctors who raise concerns. The annual GMC trainee survey also reports doctors' experience of bullying in the workplace.

Bullying emerges when one or several persons persistently, over a period of time, perceive themselves to be on the receiving end of negative actions from one or several persons, in a situation where the one at the receiving end has difficulty in defending themselves against these actions. Examples of bullying behaviour include derogatory remarks, insensitive jokes or pranks, insulting or aggressive behaviour, ignoring or excluding an individual, setting unrealistic deadlines, public criticism or constantly undervaluing effort.

Bullying and harassment at work are not acceptable legally, morally or ethically. Harassment is held to be discriminatory under the 2010 Equality Act. Harassment is also prohibited under the Criminal Justice and Public Order Act 1994, which means that intentional harassment is a criminal offence. Employers should have mechanisms to help employees deal with concerns as this issue is now being discussed widely. Previous beliefs that a career would be affected if concerns were raised are diminishing as the medical profession and society recognise that certain behaviours are no longer acceptable.

All employees should be able to work in a safe environment, and there is both UK (sex, gender, race and disability discrimination, protection from harassment, health and safety) and European (equal treatment directive, protection of dignity at work) legislation that confers certain rights to all. It should also be remembered that if the bully is a doctor they are not complying with the requirements of the GMC's *Good Medical Practice* and could therefore be reported to the GMC. Employers should have policies that define how the issue of bullying is dealt with in the workplace, such as Grievance Procedures, Dignity at Work Policy and Freedom to Speak Up (Whistleblowing) Policy. These will be available from the Human Resources (HR) department and website.

An important first step in dealing with this situation is to recognise that it is happening and to be willing to share your thoughts and feelings with another person, either a trusted colleague or your partner. The Clinical Tutor in the postgraduate centre is also a useful impartial listener. Your line manager should be informed whenever possible. The College Tutor or Educational Supervisors can also be an impartial source of help and support. The HR department can provide you with advice in line with Trust policies. If the situation is making you unwell, you may wish to access your employers Occupational Health and counselling services (these are confidential) or your GP. Some employers have also established a confidential service to advise staff who feel bullied and harassed, for example 'Bullying Champions'. You will also have nominated Freedom to Speak Up Support Officers and a Guardian in your Trust. Their role is to listen where you are unable to raise concerns with a line manager or where your concern has not been addressed (your conversation is confidential). The National Guardian's Office is an independent, non-statutory body leading culture change in the NHS. If there is no one locally you feel able to talk to, the BMA will be able to help. Other organisations that may be able to help are signposted from the Association website. Talking about what happened is never easy, but is the first step in taking control of the situation. You may wish to contact one of the Association's Mentors to talk through your ways forward.

If you feel bullied and harassed, it has usually happened more than once. Is there a pattern? Keep a diary as evidence of repeated episodes of bullying and harassment. It is advisable to write down what happened, where and when, who was present, what was said and how you felt, contemporaneously if possible. Try to get witnesses to incidents by avoiding situations where you are alone with the bully. It may also be helpful to reflect on your own behaviour and feelings. Those who are feeling low and depressed or who are dealing with loss or personal stress will have more negative thoughts and feel less assertive. If you are seen as passive by others, the development of assertiveness skills can help you feel more comfortable when dealing with this situation and courses are widely available, as are self-help books and websites.

Most recipients just want the bullying to stop and do not wish to formalise their complaints or resort to internal procedures or the legal system. Informal resolution should be attempted whenever possible, but the situation may be so serious that the employer has to take action. Do not take action alone and seek support from your employer's HR department. Informal resolution is possible if you feel able to discuss your feelings with the other person. This will bring long-term benefits for other potential victims and help you regain your self-respect; however, this may be a difficult decision to make. Your Trust may use mediation for this process. The person(s) concerned may feel they are acting quite reasonably and be completely unaware of the effect of their behaviour and actions on you and others. Raising concerns about the negative impact those behaviours are having on individuals, patients and the organisation may be enough to change those behaviours.

Those who do not feel able to confront the bully should discuss how they wish to proceed with an impartial supporter. It is always helpful to have an impartial supporter with you so that you feel in control of what happens next. You may wish to take a more formal route to resolving the situation and all employers will have a reporting system that you can use. If this seems like the correct way to resolve the situation, then you should use it.

There is good and structured advice available from numerous sources on how to deal with bullying and harassment and most employers will operate a zero tolerance policy. The Association of Anaesthetists and the Royal College of Anaesthetists have started the #KnockItOut campaign, which aims to foster a positive workplace culture that is free from bullying, harassment and undermining behaviours in anaesthesia.

Whatever the outcome, it is important for those who feel bullied to realise they are not powerless and have choices in dealing with the situation.

## Reference

1. Giga S, Hoel H, Lewis D. *The Costs of Workplace Bullying*. London: Unite the Union/Department for Business, 2008.

## Resources

- Association of Anaesthetists: Wellbeing & support. <https://anaesthetists.org/Home/Wellbeing-support>
- [British Medical Association](#)
- ACAS. Bullying and harassment at work. A guide for managers and employees. <http://www.acas.org.uk/media/pdf/c/j/Bullying-and-harassment-in-the-workplace-a-guide-for-managers-and-employers.pdf>
- BMA. How to address bullying and harassment at work. <https://www.bma.org.uk/advice/work-life-support/your-wellbeing/bullying-and-harassment>
- Oxtoby K. I'm being bullied by a colleague: what should I do? *BMJ* 2017; **358**: j4300
- Woodrow C, Guest DE. Leadership and approaches to the management of workplace bullying. *European Journal of Work and Organisational Psychology* 2017; **26**: 221-33
- BMA. Bullying and Harassment: How to address it and create a supportive and inclusive culture. <https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/tackling-bullying-and-harassment-in-the-nhs/bullying-and-harassment-policy-recommendations>

## Dr Melanie Jones

Director, Medical Career Support, Past Chair of Anaesthetists in Management

## Reviewed and updated by Dr Ann Harvey

Consultant anaesthetist and Elected Board Member, Association of Anaesthetists

## 12. Good practice guidance for SAS anaesthetists

In 2010, a survey of SAS doctors working as anaesthetists highlighted some concerns about aspects of their job plans and terms and conditions.

The survey suggested that the main problems concerning those who responded are:

- Out of hours work
- Ageing doctors and residency on-call
- Minimum elective or daytime work (anaesthetic sessions)
- CPD activity ([see Chapter 8](#))
- Career progression opportunities and criteria for pay thresholds
- Clinical governance and supervision ([see Chapter 8](#))
- Health and welfare ([see Chapter 7](#))

### Out of hours work

Working outside 'normal' hours is an accepted part of the role of doctors. In addition to providing the service required by the hospital, it offers doctors ongoing clinical exposure to emergency cases, thereby maintaining key anaesthetic skills. Several SAS doctors have been offered job plans that place more than 50% - and up to 75% - of their scheduled clinical work in what would be termed premium time in the 2003 consultant contract, i.e. out of hours (OOH). Very often this work involves busy and clinically demanding duties such as covering ICUs, obstetric units and general on-call activity. This is more likely to be the case in smaller hospitals. Such working patterns may cause problems in terms of fatigue and thereby clinical governance, might give anaesthetists less opportunity to observe the practice of colleagues, and are not conducive to a good work-life balance. The balance between work scheduled in weekday hours and that scheduled OOH should be similar for SAS doctors and consultants in the same department, and the proportion of OOH work for any SAS anaesthetist should not, as a rule, exceed 50%.

### On-call

At some point during their careers, many anaesthetists seek to relinquish their on-call duties for a variety of reasons that include illness, increasing age, and family or other domestic and professional commitments; although if 'on-call' is part of the contract, there is no right to drop it. If an SAS doctor wishes to drop their on-call duties, they should discuss this with their clinical director. If the reason relates to stress or illness, assessment by the Occupational Health (OH) department is appropriate. If OH recommends the SAS doctor be removed from the on-call rota for health reasons, employers must make every effort to make this possible. The Association has recommended that 'there should be a review of on-call responsibilities for anaesthetists over 55 years of age' [1]. Special consideration should be given to SAS doctors who participate in resident on-call rotas or whose duties include attending acute emergencies and cardiac arrests - the physical demands made by these duties may become difficult for the ageing doctor.

### Regular anaesthetic sessions

The job plans of many SAS doctors include a large proportion of flexible working. Although this flexibility may benefit the department in terms of service delivery, a lack of regular anaesthetic sessions does not allow anaesthetists to develop subspecialty interests and denies them the satisfaction of working as part of a regular theatre team. The balance between fixed and flexible sessions in the job plans of SAS doctors and consultants in the same department should be similar, and there should be a minimum of three fixed sessions in the average full-time job plan.

### Criteria for pay thresholds

There is such a variety of work and roles that anaesthetists are involved in that it is difficult to determine criteria for thresholds. The basic principle is the ability to take independent decisions and cover for some of a consultants' work without supervision. The [NHS Employers website](#) deals with this issue.

The Clinical/Medical Director is responsible for ensuring processes are in place to sign off the incremental progression assessment. Where one or more of the criteria are not achieved in any year, the Clinical/Medical Director, or designated person, has discretion to decide, where appropriate (for instance, because of personal illness), that the doctor should be regarded as having met the criteria for that year.

## Progression through Threshold One

All doctors will pass through this Threshold unless they have demonstrably failed to comply with any of the following criteria:

- Participated in job planning
- Made every reasonable effort to meet the time and service commitments in their job plan
- Participated in the annual job plan review
- Met the personal objectives in the job plan, or where this is not achieved for reasons beyond the doctor's control, made every reasonable effort to do so
- Worked towards any changes identified in the last job plan review as being necessary to support achievement of joint objectives
- Participated satisfactorily in the appraisal process in accordance with the GMC's requirements set out in [Good Medical Practice](#)
- Undertaken 360° appraisal/feedback (in the year preceding Threshold one) and for those doctors undertaking private practice, taken up any offer to undertake Additional Programmed Activities in accordance with Schedule 7 of the Terms and Conditions of Service and met the standards governing the relationship between private practice and NHS commitments set out in Schedule 10 of the Terms and Conditions of Service

## Progression through Threshold Two

The criteria for passing through Threshold Two recognise the higher level of skills, experience and responsibility of those doctors working at that level. Doctors will pass through Threshold Two if they have met the criteria at a), b) and c) as set out below:

- a) Doctors should meet the Threshold One criteria set out above
- b) Doctors should be able to demonstrate an increasing ability to take decisions and carry responsibility without direct supervision
- c) Doctors should also provide evidence to demonstrate their contributions to a wider role, for example, meaningful participation in or contribution to relevant:
  - Management or leadership
  - Service development and modernisation
  - Teaching and training (of others)
  - Committee work
  - Representative work
  - Innovation
  - Audit

The list referred to above is not exhaustive but is intended to give an indication of the types of evidence of contributing to a wider role that a doctor could provide.

In making a judgement about whether a doctor has met the requirements for Threshold Two, there will not be an expectation that the doctor will be able to provide evidence in all wider areas of contribution listed in addition to those required for Threshold One. An overall picture will be considered.

## Threshold One and Two - process

When a doctor has successfully demonstrated they have complied with the criteria to pass through a Threshold, this should be signed off by a Clinical Manager. The Clinical/Medical Director will have the responsibility of ensuring processes are in place to sign off the threshold assessment. It is expected that payments will be made automatically unless payroll are informed otherwise [2,3].

## Career progress and development

The RCoA Council recommendations on [Career Development for Specialty/SAS Doctors in Anaesthesia, Critical Care and Pain Medicine](#) deals with this issue adequately.

The SAS survey clearly indicated that SAS doctors felt there are limited or no opportunities to obtain career progress. The RCoA recommends that all the departments employing SAS doctors identify a named consultant as Educational Supervisor responsible for overseeing the career development. As it is recommended that such career development be based on attainment of competencies identified in the curriculum document, the Educational Supervisor should link with the College Tutor. There is a move towards appointing SAS Tutors in hospitals and appointment of Associate Deans in deaneries who will oversee the career development needs of the SAS doctors.

An individual's clinical skills and competencies will be expected to develop over time and this is essential to ensure a satisfying career. Several SAS doctors have very strong subspecialty interests such as obstetric anaesthesia, chronic pain and critical care. There are very limited opportunities to develop and nurture these skills. Annual appraisal should be the means by which career development needs are identified and these needs should be addressed by an appropriate personal development plan. The personal development plan can and should be a powerful way of ensuring that development needs are resourced.

Opportunities for top-up training must be available for SAS doctors to develop these specialty skills.

Employers and postgraduate Deans will have to support such career development opportunities actively if they are to be realistic goals, the reason being a need to commit periods of time for top-up training, not service delivery. Employers should see this as an opportunity to develop the careers of some of their permanent 'non-training' staff to ensure long-term retention of its workforce. The Association of Anaesthetists has a responsibility to support and advise its SAS members, but it is not a trade union. However, it is able to respond to most enquiries about terms and conditions of jobs and job plans. SAS doctors who fail to reach agreement with their Clinical Managers on the details of contracts, job plans, working arrangements and terms and conditions should follow mediation and appeals processes within their hospitals and should consider seeking the support of their Local Negotiating Committee. The Association recommends that all anaesthetists should be members of a trade union that can offer formal support in resolving disagreements about contractual matters.

The Association recommends that SAS doctors only take up jobs that conform to national terms and conditions. This will make it easier to negotiate in case of any issues that may arise. Otherwise it will be entirely up to the individual doctor to resolve any issues concerning their contracts.

The overall principle is that of accountability and mutual respect for both parties. The profession accepted a time-sensitive contract, in which there is a simple and direct relationship between time spent working and the payment for this work. All the allocations of time spent working should be discussed in job-plan meetings.

#### **Dr Anthea Mowat**

*Former Chair, BMA Representative Body*

#### **Dr Ramana Alladi**

*Past SAS Committee Chair, Association of Anaesthetists*

#### **Dr Paul Clyburn**

*Past President, Association of Anaesthetists*

#### **References**

1. Association of Anaesthetists. *Fatigue and Anaesthetists*. 2004. <https://anaesthetists.org/Home/Resources-publications/Guidelines/Fatigue-and-Anaesthetists>
2. NHS Employers. Terms and Conditions of Service - Specialty Doctor (England). April 2008. Version 3 (1 March 2014). [http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/Terms\\_and\\_Conditions\\_Specialty\\_Doctor\\_2014%20Final.pdf](http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/Terms_and_Conditions_Specialty_Doctor_2014%20Final.pdf)
3. NHS Employers. *Specialty, Associate Specialist and Staff Grade Doctors*. Key documents. <http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/specialty-and-associate-specialist-doctors/key-documents>



# Career progression and development

## 13. Certificate of eligibility for specialist registration

### Introduction

To be a substantive consultant in the NHS in the UK, a doctor must be on the GMC's Specialist Register. This is the only legal requirement as defined in the respective devolved nation statutory instruments. This legislation does not stipulate how an individual enters the Specialist Register. For the majority, entry will be through the award of the Certificate of Completion of Training (CCT) in anaesthetics (including the former versions issued on the completion of UK training). Entry is also possible following award of the Certificate of Eligibility of Specialist Registration (Combined Programmes) [CESR(CP)], to holders of a recognised European specialist qualification or by the award of the Certificate of Eligibility for Specialist Registration (CESR).

The CESR route is open to applicants who have not completed the UK training programme, completed a European programme that is not recognised by the European Union or have completed specialist training outside of the European Union. There is actually no requirement to have 'completed' any training programme. Many applicants will be working in the UK at SAS grade, or in similar posts, and will have undertaken some training before moving into a substantive post. The experience gained in these posts may be submitted for consideration (along with evidence from formal training) but must fulfil the equivalence requirements (discussed below) in totality if the application is to succeed. Those who apply under the CESR route must demonstrate equivalence to a newly graduated CCT holder. How is this done? Quite simply, by providing the GMC with evidence that demonstrates the individual's training and experience when considered together are equivalent to a new CCT holder.

A few words of caution. Evidence of training in the distant past (for practical terms, more than 10 years ago) will be difficult to obtain and unlikely to remotely satisfy current training requirements. If no evidence is provided in a specific domain or against a mandatory training requirement, the application will fail whatever the seniority or position of the applicant.

It is important to understand that obtaining a CESR enables doctors to be eligible to apply for a substantive consultant post in the UK. The consultant appointment process is a competitive process, which may not result in a successful outcome.

### The spiral of learning

The spiral of learning is reflected in the curriculum by dividing it into core, intermediate, higher and advanced training. To assess the breadth and depth of training and experience, it is critical that the evidence submitted demonstrates competence in the subspecialties listed in the curriculum to the mandated level, e.g. ICU to intermediate level, cardiothoracic to higher level. It is therefore important that the application in all its component parts delivers evidence at the appropriate level. It would be expected that an application demonstrates a continuum of learning with increasing competence and responsibility, leading to readiness for independent practice.

### Demonstrating equivalence

This process is a paper exercise, conducted by the GMC. The RCoA, acting as the agent of the GMC, cannot visit you in the workplace and conduct a clinical assessment nor can your application be discussed with your colleagues. Good applications provide an abundance of good evidence for the assessors to review and usually amount to approximately 800-1000 pages. Good evidence can be characterised by its ability to provide a positive answer to the questions posed by the Good Medical Practice (GMP) sub-domains when considered against the requirements of the 2010 CCT in anaesthetics curriculum.

The GMC requires the application to be assessed against the four domains of GMP. The four domains have sub-domains. These are:

#### GMP 1 Knowledge, skills and performance

- a) Has the applicant demonstrated that they have the full range, depth and breadth of experience and skill to the level required?
- b) Has the applicant demonstrated application of knowledge and experience to practise (e.g. recognising and working within the limits of their competence). In particular, keeping up-to-date with CPD, audit, clinical governance, applying the skills and attitudes of a competent teacher/trainer, and making appropriate referrals to colleagues and keeping clear and legible records?

## GMP 2 Safety and quality

- Has the applicant demonstrated putting into effect systems to protect patients and improve care, e.g. taking part in and responding to the outcome of audit, appraisals, performance reviews, risk management and clinical governance procedures, and reporting adverse drug reactions or concerns about risks to patients?
- Has the applicant demonstrated that they monitor and respond to risks to safety and that they safeguard and protect the health and wellbeing of vulnerable people (e.g. responding to risks posed by patients and following infection control procedures)?
- Has the applicant demonstrated that they protect patients and colleagues from any risk posed by their health?

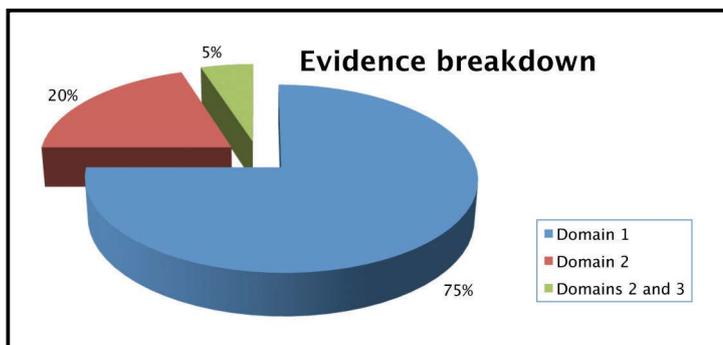
## GMP 3 Communication, partnership and teamwork

- Has the applicant demonstrated that they communicate effectively with: (i) patients (e.g. keeping them informed about progress of their care) and (ii) colleagues (e.g. physician colleagues, nursing staff, allied health professionals, GPs and other appropriate agencies) in both clinical and management situations within and outside the team (e.g. passing on information when patients transfer, encouraging colleagues to contribute to discussions)?
- Has the applicant demonstrated that they work constructively with colleagues by supporting them, delegating effectively, acting as a positive role model and providing effective leadership?
- Has the applicant demonstrated that they establish and maintain partnerships with patients and encourage them to take an interest in their health and obtain appropriate consent to treatment?

## GMP 4 Maintaining trust

- Has the applicant demonstrated that they show respect for patients, e.g. is polite, considerate and honest with patients and has implemented systems to protect patient confidentiality?
- Has the applicant demonstrated treating patients and colleagues fairly and without discrimination (e.g. being honest and objective when appraising or assessing colleagues and writing references, giving constructive feedback, raising issues of colleagues performance and responding promptly to complaints)?
- Has the applicant demonstrated acting with honesty and integrity (e.g. is honest and accurate in any financial dealings, practice reports, obtaining appropriate ethical approval for research projects, etc.)?

When compiling evidence for an application, the GMC recommends applicants apportion the evidence provided for the domains according to the pie chart below.



### Types of evidence

The GMC defines evidence as either primary or secondary. The important thing to consider with primary evidence is that it can stand on its own. Examples of primary evidence are a logbook, case diary, logbook summary, appraisal, qualification certificates (e.g. a degree), curriculum (validated by the institution) and CPD certificates. In all cases, evidence must be formally validated, preferably by the institution where the evidence originated from. Secondary evidence covers structured references, rotas, teaching contributions, thank you cards, testimonials and other validated evidence.

When collating your evidence, you should aim to have more than one piece of evidence demonstrating equivalence for each domain. The evidence is triangulated to decide whether the applicant has satisfied the requirements for each sub-domain. For example, if the applicant did their specialist training in India, the applicant should provide a copy of the logbook, a copy of their training programme, supporting evidence from the institution where they completed the training programme and, if available, copies of assessments. A breakdown of duration of actual time spent in subspecialty training is essential to demonstrate appropriate training in all essential areas.

## Logbooks

In order to demonstrate a breadth and depth of clinical experience it is important that logbook evidence supports exposure to subspecialties in the curriculum. The logbook must be validated by the institution at which the experience was gained and include a number of important pieces of information, e.g. patient age, ASA grade, operation, complexity, level of supervision and involvement in the cases. Also important are the dates when this experience was obtained. The age of the patient is crucial when looking for evidence of paediatric training and experience.

Logbook collation of subspecialty experience is essential to support competence equivalence and populate the evidence template for all mandated curricular requirements. However an extensive logbook with large numbers of cases but limited to a few specialist areas will not demonstrate the breadth of experience equivalent to a UK trainee holding the CCT.

Logbooks or theatre records do not always provide evidence of caseload in intensive care and pain medicine. Caseload evidence in these subspecialties should be specifically addressed by applicants.

## Letters of support/testimonials

Letters of support from anaesthetists practising within that specialist field strengthen an application but are not sufficient alone. The letters of support should indicate the level of competencies attained, i.e. core, intermediate, higher and advanced.

More information on types of evidence is available on the [RCoA](#) and [GMC](#) websites.

## Triangulation of evidence

The triangulation of evidence is important in the assessment of equivalence. Evidence should indicate the breadth and depth of experience obtained in each unit of the curriculum. Each piece of evidence submitted is strengthened by cross-reference to other evidence, which supports that curricular requirement. As an example, if one was looking for higher competences in paediatric anaesthesia then evidence should include:

- a) Evidence of a post or rotation within that subspecialty indicating duration of training and experience and the level of training reached
- b) Logbook/electronic record and summaries of the cases undertaken indicating the age spectrum, surgical procedure, complexity and level of supervision
- c) Testimonial letters from supervising consultants indicating the level of competencies reached and, in this example, relating to the higher competencies in the subspecialty of paediatrics

## Test of knowledge

All applicants have to demonstrate they have passed an acceptable test of knowledge. The test of knowledge should cover the same areas to the same level as the RCoA's final Fellowship examination. There is a list of examinations on the [RCoA website](#) in the CESR and Equivalence section, which has been assessed as acceptable tests of knowledge for a CESR application. It is theoretically possible to demonstrate equivalence to the knowledge demonstrated by passing an approved examination. This has not happened to date.

## The RCoA process

When the GMC considers sufficient evidence for an assessment has been provided by the applicant, it will send the application pack to the RCoA for formal assessment. The RCoA has an Equivalence Committee, which meets once a month to consider applications. Each application is reviewed independently by at least three medical members of the Committee prior to the meeting and then each application is discussed at the Committee meeting. The Committee reviews the evidence for each GMP domain and agrees an outcome. A draft assessment is written by the Committee Secretary and it is reviewed by the RCoA Training Manager and the Chairman before submission to the GMC. More information on the process is available on the [RCoA website](#).

## Not recommended for specialist registration

Recommendations not to be added to the Specialist Register are usually the result of a lack of and/or poor evidence. Remember, this is a paper exercise and a lack of evidence makes it difficult to demonstrate equivalence. In such cases, the assessors will err on the side of patient safety.

When an applicant is not recommended for specialist registration, the applicant will be specifically advised where there was inadequate evidence and what they would need to do to demonstrate equivalence. For example, if the applicant had failed to demonstrate higher level cardiothoracic competence, the RCoA will advise the applicant to provide more evidence demonstrating they have the training and/or experience or suggest a period of clinical attachment where the applicant can demonstrate the required level of clinical practice defined by the 2010 CCT in anaesthetics curriculum through workplace-based assessments or equivalent. The RCoA equivalence administrator is available to provide advice if needed.

### **Key tasks before deciding to apply for CESR**

1. Read the 2010 CCT in anaesthetics curriculum carefully to understand the mandatory training requirement
2. Read the guidance on the types of evidence you should provide
3. If you cannot demonstrate equivalence with the evidence that is available, discuss the possibility of obtaining top-up training with the College Tutor/Training Programme Director/Regional Adviser
4. Arrange the top-up training and ensure you are assessed to the correct level using the approved workplace-based assessment tools
5. Contact the RCoA if you have any questions
6. Choose your structured referees carefully. The Clinical Director and/or Departmental Head should be selected if possible. Structured references from medically qualified individuals from the last five years have a higher evidential weighting as they can comment on current practice and cover the other GMP domains

Aspects of the equivalence process are currently under review. The GMC is considering a number of fundamental changes including mandating a period of UK practice. In parallel with this, the GMC and RCoA are revising the application paperwork. Training evidence, particularly in Domain 1, will be mapped to the 2010 curricular requirements, with explicit advice on how these may be satisfied. A checklist for CESR application can be found in Appendix 1.

#### **Dr Simon Fletcher**

*Council member, RCoA*

*(Updated by the Equivalence Committee September 2018)*

## 14. The RCoA Fellowship Examination

The SAS Committee at the RCoA has continued to ensure that SAS anaesthetists are able to sit the FRCA examinations with the proviso that they meet certain criteria. Indeed the RCoA wishes to encourage anaesthetists who have not become members or fellows of the RCoA to sit the examination. It consists of two parts, Primary and Final, taken at different stages of an anaesthetic trainees' career. Although not a membership exam, success in the Primary examination is one of the key criteria to [become a member](#) of the RCoA.

The eligibility criteria for all FRCA exam components are published within the [examination regulations](#).

**The Primary FRCA examination** which is blueprinted to the [Core Level Training Curriculum](#) consists of three sections:

**Multiple Choice Question (MCQ) examination;** 90 questions in three hours, 60 x Multiple True/False (MTF) plus 30 x Single Best Answer (SBA) questions.

**Objective Structured Clinical Examination (OSCE)** Up to 18 stations in approximately one hour 45 minutes

**Structured Oral Examination (SOE)** consists of two subsections:

- SOE1 - Pharmacology and Physiology, covered in 30 minutes
- SOE2 - Clinical and Physics, covered in 30 minutes
- The MCQ exam must be passed before sitting the OSCE/SOE.

A pass in any of the Primary components is valid for three years as part eligibility to other components. The maximum number of attempts allowed for each of the Primary components is six.

A pass in the whole Primary FRCA examination is valid for seven years as part eligibility to the Final FRCA examination.

The Final FRCA examination which is blueprinted to the [Intermediate Level Training curriculum](#) consists of two sections:

Written examination which consists of two subsections:

- Short Answer Question (SAQ) examination: 12 compulsory questions in three hours
- Multiple Choice Question (MCQ) examination; 90 questions in three hours, 60 x Multiple True/False (MTF) plus 30 x Single Best Answer (SBA) questions.

Structured Oral Examination (SOE) consisting of two subsections:

- SOE1 - Clinical anaesthesia with linked applied clinical science (normally am); consisting of four clinical short cases each with linked applied clinical science, split in two parts taken at the same time. Each part is 26 minutes.
- SOE2 - Clinical anaesthesia (normally pm); consisting of a two section clinical long case followed by two stand-alone clinical short cases taken in one sitting. This SOE is 36 minutes in duration.

Candidates must pass the written examination before they can apply to sit the SOE.

A pass in the written exam is valid for three years.

The maximum number of attempts allowed for each of the Final components is six.

The FRCA is a comprehensive, prestigious and well-recognised examination that requires significant preparation and studying in order to succeed. The [resource for candidates](#) section of the RCoA website provides a consolidation of example questions, videos, courses and exam guides made available by the Royal College of Anaesthetists, any of which may guide a candidate in their preparation for the various FRCA examination components. There are over 25 exam videos which are available on the [RCoA YouTube](#) channel and are invaluable in providing an insight into all the examination components of the FRCA. However, it cannot be stressed enough that those preparing for any FRCA exams must create a focussed training package, based on the relevant training curriculum/exam syllabus and the utilisation of e-LA modules. Additionally, doctors should ensure they have experienced adequate clinical exposure across the range of the relevant curriculum.

The RCoA is committed to maintaining the highest possible standards for the fellowship examinations and rigorously quality assures its examiners and its exam processes to ensure the examinations meet the GMC standards and remain fit for purpose. The RCoA is continually in the process of conducting reviews of current methods to ensure they are as robust and up to date as possible. Notice of exam changes are published on the [RCoA website](#) and those intending to sit examinations should familiarise themselves with any changes to the exams that may be introduced in the near future.

#### **Reasons for obtaining the fellowship diploma might include:**

- Personal satisfaction
- Career progression
- To facilitate becoming a Member of the RCoA after successfully passing the full Primary examination
- Entitlement to use post nominals, MRCA for members and FRCA for fellows of the RCoA
- Opportunity to stand for College Council. There are two nationally elected full council seats for SAS members and fellows
- Enhanced ability to teach and train others
- Facilitate re-entry into training
- Application for CESR and hence facilitate entry onto the Specialist Register

#### **Ability to apply to be an FRCA examiner:**

SAS doctors who have passed the FRCA examination are eligible to become an FRCA examiner, providing they meet the essential criteria set out in the [examiner person specification](#). Becoming accepted for such a prestigious role would be tremendously rewarding. Vacancies to the Board of FRCA Examiners are advertised annually. Examiners are recruited to the Primary examination in the first instance. The number of Examiners required will reflect the number of retirements from the current Board of Examiners.

A recognised test of knowledge is an essential component when applying for a CESR and possession of the FRCA fully meets this criterion. Entry onto the GMC Specialist Register is an essential requirement in order to apply for a consultant post.

While not a pre-requisite when teaching anaesthetic trainees, the process of studying and passing the Fellowship exam confers a good scientific and clinical basis on which to train others. Indeed, it is especially desirable when teaching post-Fellowship trainees.

#### **In summary**

The RCoA fellowship examinations continue to involve comprehensive and rigorous assessment that requires determination and intense study as well as broad clinical training across the breadth of the core and intermediate anaesthetic curriculums in order to succeed. As an SAS doctor, opportunities for training can be difficult and in part this may reflect lower pass rates for non-training grades compared to those in a deanery-approved training post. It is highly recommended you make the most of support and guidance from an educational supervisor and make full use of the resources available. The award of the Fellowship of the RCoA is a justly proud achievement and has the potential to facilitate career progression.

#### **Dr Mark Forrest**

*Chair of Examinations Committee, RCoA*

## 15. Personal development planning for SAS anaesthetists

It is the responsibility of each individual anaesthetist to engage and complete their appraisal and revalidation. An essential component of this is the personal development plan (PDP). This is an opportunity for the individual anaesthetist to highlight areas they want to develop within their specialty and job plan, for the mutual benefit of themselves, their departments and their patients. If done well, it allows the anaesthetist to develop their interests and gain support from their Trust. For example, if paediatric training needs updating in order to safely provide a service, the Trust should facilitate this with supported CPD.

The RCoA PDP guidelines for SAS doctors state 'All career grade doctors have CEPD and PDP requirements and should have equal access to protected time, funding and study leave for these activities' (Peter Hutton, RCoA President, March 2003). This is still proving a challenge, but it is up to the individual SAS anaesthetist to at least ask for this as a basic requirement.

All anaesthetists should maintain a personal portfolio containing evidence in support of their CPD within their appraisal folder. Ideally, this is done electronically, so as to allow ease of access for their appraiser, Responsible Medical Officer and the GMC. The CPD Matrix allows you to quantify the level of CPD training. For example, CPD Matrix 1 covers the core skills required by all anaesthetists, and CPD Matrix 3 covers more specialised advanced areas such as regional blocks, etc.

Therefore, when embarking on personal development planning at the appraisal meeting, particular areas for future training can be discussed. These should be mutually agreed. The CPD Matrix framework can be used to plan this proposed training and the level of training that is required. Specific training areas that need to be developed are set out clearly for completion within an agreed timescale.

The PDP should be used proactively, within the appraisal process, to develop special interests and requirements for your job plan. It is essential to be realistic when planning, and it is better to develop slowly and have achievable goals, so that you can demonstrate progress at your annual appraisal. If done well, a PDP should empower the individual anaesthetist to develop within their specialty and team to meet their needs, as well as the needs of their department and their patients. In addition, the PDP allows the appraiser to feedback progress achieved and, if required, areas to develop. The annual cycle of personal development planning is completed at the appraisal meeting with feedback and the next year's PDP is discussed and agreed (Fig. 1).

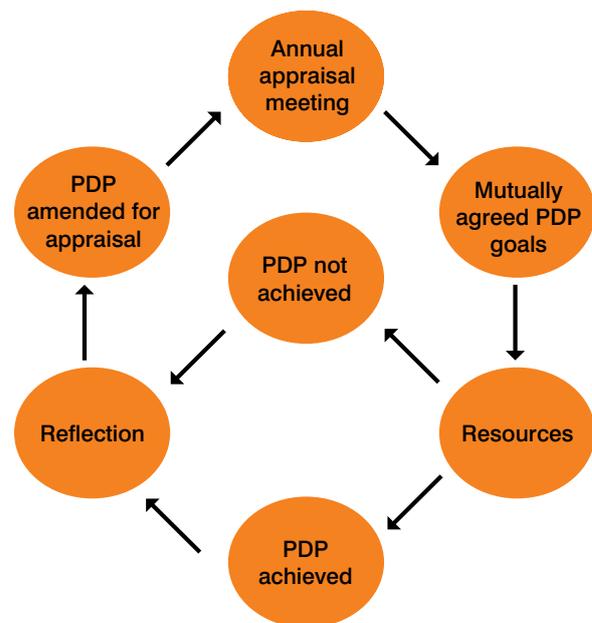


Figure 1 Annual cycle of personal development planning.

In a good PDP, there is an opportunity to explore self-improvement and allow possible changes in direction if desired, providing it still meets the needs of the department and patients and, importantly, is mutually agreed.

To conclude, a PDP begins with reflection and is mutually agreed within the appraisal process to allow the anaesthetist to develop perspectives in their career pathway and allow growth or changes as required. This must be done in order to complete appraisal and revalidation. A PDP has to be supported and adequately resourced. Any areas of weakness need to be highlighted sensitively and supported positively and confidentially.

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*Associate Specialist in Anaesthesia*

**Dr Olivera Potparic**

*Past SAS Committee Chair, Association of Anaesthetists*

## 16. Successful Clinical Audit and quality improvement - Tips

Clinical audit is a crucial part of every healthcare professional's career. It allows organisations to continually work toward improving quality of patient care. There are several definitions of clinical audit. One way to define clinical audit [1] is 'a quality improvement (QI) cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes'.

This chapter aims to clear the mist around clinical audits and quality improvement (QI) projects, in order to provide practical and useful tips on how to undertake a successful audit. We have avoided giving specific examples, which are best left to your own practice, circumstances and preferences.

QI aims to improve the patient experience. Audit and QI projects are essentially the same thing, they both look at the adequacy of healthcare standards and aim to improve them. Audits have a more formal standard to measure against and also tend to have a longer time period, for example, they can be done once every few months. QI projects can be done weekly or even daily using the Plan-Do-Study-Act (PDSA) framework.

Getting involved in these projects not only helps to improve patient care, but also contributes to learning transferable skills, such as teamwork and time management. They are an integral part of annual assessments and appraisals (and revalidation) for all practising doctors in UK. It is a mandatory requirement for UK Junior Doctors to get involved in these projects to ensure the progression of their training. Your clinical audit participation is usually one of the topics discussed at various job interviews.

The components of clinical audit should meet the SMART criteria:

- **Specific**
- **M** measurable - there should be an issue you can audit against a local or a national standard
- **A**chievable - limit yourself to one or two outcomes
- **R**ealistic
- **T**imely - choosing something that can be done quickly will keep you motivated and give you more opportunity to re-audit

They should include:

- Identifying standards
- Measuring current practice (data collection)
- Comparing results with standards (analysis)
- There are two likely outcomes at this stage:
  - If the practice meets or exceeds the standards, then only periodic re-audit is required to ensure that the standards are consistently maintained. Efforts can and should be made to exceed the standards. If this happens in every cycle, then the standards may have to be changed - the bar must be raised.
  - If the practice falls short of standards, then deficiencies have to be identified, specific time-bound recommendations made and changes have to be implemented.
- Re-auditing to make sure the outcomes have improved
- Continued re-audit to ensure the standards are continually exceeded or met
- This process of implementing change and re-audit is also known as completing the *audit loop/cycle*
- Presentation at local/regional/national meetings
- Depending on the strength, importance and uniqueness of the project you can hope to get a poster or even a publication out of it

In August 2014, the RCoA recommended demonstrating active engagement in completing at least one audit cycle once in 5 years. If an audit is not possible, other methods of demonstrating QI activity should be undertaken [2]. All doctors are expected to produce such evidence of clinical audits and review of clinical outcomes. Audit and other QI activity should reflect the breadth of one's own professional work. Depending on the size of the department, one or two audits should be undertaken per year, based on the topics selected from the RCoA [Audit Recipe Book](#) [3]. This RCoA guidance is based on the GMC document, which originates from the work of the Academy of Medical Royal Colleges.

Identifying an area for improvement:

The first step is identifying what you want to evaluate and hope to change. Almost everything we do in our daily practice (procedures, care pathways, drug administration, availability of equipment etc.) has certain set standards. These are described by the Royal Colleges, Department of Health or in peer-reviewed literature. You can also refer to previous audits done in your department.

The next step is an audit of current practice. Without this step, it would be hard to motivate people to change their practice. Any QI project requires evidence that compliance will improve outcomes. Occasionally, there may not be set standards, but there are certain expectations or guidelines. Sometimes, the standard can be derived from overseas work or can even be set by your work. In its most simplified form, clinical audit is comparing current practice against certain standards.

It must be emphasised that audit is not research. Research answers the question: 'What is a good practice?' whereas an audit answers: 'Is our practice good or not?' A research project requires ethics committee approval and an audit project does not. However, an audit needs to be registered with the local clinical governance committee. This ensures a centralised record of all the projects and helps avoid duplication. It also provides ideas for re-audit where previously a change was introduced, thus completing the audit cycle. There is generally an audit lead in every department who is the link person to liaise within the directorate and the Trust regarding issues raised with audits and effectiveness. The following are the possible steps of an audit project. They may appear somewhat comprehensive but are borne out of experience.

1. Decide a topic/project: a good audit is one that is relevant to your own practice and one that can be completed and presented. Topics requiring access to clinical notes often get delayed. Do not take up a new project if you already have other incomplete projects!

Topics for audit can be found:

- In the RCoA [Audit Recipe Book](#) [3]
- In local audit committee records
- As ideas from literature/meetings
- By talking to colleagues/seniors

Topics for clinical audit can also be the result of problems faced in daily practice, e.g. monitoring standards in the recovery room (end tidal CO<sub>2</sub>), hypothermia in theatres, etc.

2. Identify the team: the lead author must be agreed at this stage. Should the project lead to a poster or a paper, there can be confusion or even (sometimes major) arguments about who should be the first author/co-author. People often want to join a project that is moving towards success and get on as a co-author! A supervisor (sometimes more than one) should also be identified at this stage. This could be you. Some projects can be done single-handedly and you can get credit for all the work, but usually clinical audit is a good example of teamwork.
3. Distribute the workload: each member's role must be clearly defined. This is even more relevant if you are doing a multicentre or multispecialty audit.
4. Define standards of practice against which your results will be compared. Make sure some form of reference is available.
5. You must register the project at this stage with the local clinical governance unit. Usually, the forms are available on the Trust intranet. It is also good practice to send a copy of the same to the departmental audit lead. In some departments, approval of your project by the audit lead is a prerequisite.
6. Data collection. Is your audit going to be *retrospective* (looking back at what has happened in the past) or are you going to collect data *prospectively* (at the time care is delivered)? In reality, this does not matter much to the eventual outcome. These two phrases are more relevant in research than audit.
  - Prepare a data collection form
  - This can be in paper format where a form is completed and then, for each data set, the findings are transferred to a spreadsheet
  - Alternatively, data can be directly entered in a spreadsheet that can be on a handheld device (e.g. a smartphone) or a laptop. Sometimes a web-based shared spreadsheet can be very convenient
  - Always keep multiple backup copies of the data
  - Make sure there is no patient identifiable information on your devices and that you are complying strictly with the local data protection regulations/information governance guidelines

## Surveys

An increasing number of audits are questionnaire-based surveys. This is not necessarily a bad idea as long as you are aiming to compare specific outcomes against set standards. Occasionally, you may undertake a novel survey and may come out with revised or even new standards.

Surveys can be local, regional or national. Once again, these can be in paper format. Try and limit it to about 10-12 questions and one side of A4 paper. Remember, we all hate completing surveys. In some cases, you will be expected to keep anonymity of the responses. You may need to post it, if it is a regional or national survey. Here, you will have to include a covering letter explaining the project and possibly a self-addressed, stamped envelope. This means two-way postage costs. There is increasing awareness to set up online surveys by using websites such as SurveyMonkey or Google Forms. You may prepare a simple email and request the recipients to click reply, enter answers and send it back to you. In any case, be prepared for poor response rates. A 30-40% response rate for a national survey should be considered as good.

## Final Steps

- You may need a statistician's help if data are complex and need multivariate analysis. This is often a stumbling block. Most NHS Trusts have decommissioned their statisticians to save costs. Private statisticians are known to charge around £1500-£2000
- If your Trust still has a statistician, they may expect to be included as an author on the poster/paper. If you anticipate the need for such help, talk to one at a very early stage. They can give you an idea about how many cases are required to make the project statistically robust
- At this stage, do not forget the very basic audit concept: compare your results with the agreed standards
- Start preparing a presentation. Talk to the audit lead to book a slot for presentation at the next departmental meeting
- Consider what else can be done at this stage. Possibilities include:
  - Introduce change and re-audit
  - Presenting at another forum
  - Can you get a poster out of this?
  - Can this be submitted for an audit poster competition? (The Association runs the SAS audit poster prize annually)
  - Can you make a paper out of this for a peer-reviewed journal?
  - Can you do the same exercise at another institute to make this a multicentre project?
  - If this has not been previously undertaken, can you publish this as an audit recipe with the Royal College of Anaesthetists? This will be a good addition to your portfolio
- If this project is finished, get on with the next one

Not every audit is complex. Topic selection is crucial. If you think you have got it wrong for some reason, do not hesitate to drop the project. You would still save time, effort and embarrassment. A good audit is one that is relevant to your practice, and one that can be completed and presented. As a rough guide, do not aim for more than one to two projects per year, but this will vary depending on the complexity of the topic, level of your involvement and most importantly, your ability in terms of time commitment.

Completing an audit is only the beginning. Although it can be relatively simple to perform an initial audit, taking the next step and improving care quality is much harder [3]. Audits and QI are a great way to learn more about a certain topic, show interest, and acquire new skills. Good planning is essential and always try to re-audit!

## Dr Smita Oswal

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*(with contributions from Dilip Oswal, Consultant Radiologist, Mid Yorkshire NHS Trust. He was previously a member of the Audit Committee of the Royal College of Radiologists)*

## References

1. The Royal College of Radiologists. Audit and quality improvement <https://www.rcr.ac.uk/clinical-radiology/audit-and-quality-improvement>
2. The Royal College of Anaesthetists. Supporting information for appraisal and revalidation: guidance for doctors in anaesthesia, intensive care and pain medicine. August 2014. <http://www.rcoa.ac.uk/system/files/REV-SUPPORTING-INFO-2014.pdf>
3. The Royal College of Anaesthetists. Raising the standard: a compendium of audit recipes for continuous quality improvement in anaesthesia. [https://www.rcoa.ac.uk/system/files/CSQ-ARB-2012\\_1.pdf](https://www.rcoa.ac.uk/system/files/CSQ-ARB-2012_1.pdf)

## 17. How to conduct a quality improvement project

*'Every system is perfectly designed to get the results it gets, the only way to get real change is to change the system; to do this you need will, ideas and execution.'*

- You must have the **will** to make the system better - this may be because you have identified poor performance or outcome through audit or patient experience
- You must have **ideas** about how you could change things for the better
- You must have skills to make it happen - **execution**

*Paul Batalden, Institute for Healthcare Improvement [1]*

### What is quality?

There is no universally accepted definition of healthcare quality [2]. However, the Institute of Medicine recognises the following six domains of healthcare quality; safe, effective, patient-centred, timely, efficient and equitable [2]. When setting priorities for improvement these domains should be actively considered [2].

In the 2008 High Quality Care For All - NHS Next Stage Review Final Report, Lord Ara Darzi defined three core areas for quality in the NHS: patient safety, clinical effectiveness and patient experience [3-5]. The [Care Quality Commission](#) currently uses these quality indicators amongst its key lines of enquiry for healthcare regulation in England [3,6].

### What is quality improvement?

Quality improvement is an umbrella term describing the continuous, systematic and formal approach to the analysis and subsequent efforts to improve healthcare performance, processes and patient care using a range of tools and techniques [1,3].

Quality improvement is by no means a new concept. Continuous quality improvement methodologies focus on making improvements in outcomes [7]. This is in contrast to audit, where making a change is one of the key cornerstones in the audit cycle, regardless of whether there has been any real improvement in outcome [7]. Although, within quality improvement changes are often made, these are less important than the improvement itself [7].

The RCoA recognises this shift away from audit towards quality improvement, such that the concept of improvement was introduced in the latest edition of its [Audit Recipe Book](#).

### Why get involved with quality improvement?

The NHS has problems, yet "it is not always clear who should be responsible for fixing the system...managers see a clinical system that they don't understand...doctors see a 'system problem' and hope that managers will sort it out [8]" [3]. "For the quality of care to improve, it is imperative that clinicians understand and engage with quality improvement as part of their daily work [3]".

### Models for improvement

Several models and tools exist for continuous quality improvement; however, one method is yet to prove superior [3]. The most commonly quoted model is the Model for Improvement which was developed by Associates in Process Improvement [1]. Part of the model uses a simple 'Plan-Do-Study-Act' (PDSA) cycle [1]. This cycle is analogous to a rapid-cycle audit [7]. You begin with a short cycle of data collection, then analyse the data looking specifically for immediate flaws and obstacles [7]. Changes which may involve structures or processes can then be made [7]. Before repeating the cycle, learning from the previous cycle is used to refine the next test of change thus allowing for small tests of change in a controlled fashion [3,7]. These small, frequent samples allow more proactive changes to be made regularly until improvement in outcome is attained [7].

A comprehensive description of improvement science and models for improvement are beyond the scope of this chapter. However, the [Institute for Healthcare Improvement website](#) and the RCoA's [Quality Improvement in Anaesthesia](#) provide valuable resources for those interested.

## How to get involved in a quality improvement project?

Most trainees are expected to complete at least one audit or quality improvement project per year. Similar to a clinical audit you may decide to get involved in an ongoing quality improvement project within your department or start a new project.

When thinking of a new topic try to choose an area that has been identified as being a problem within the department, poses a risk to patient safety, or where processes are inefficient and waste resources. Also, choose a topic area where you as an anaesthetist can have the most influence. Discuss your project with a senior colleague who may be able to help drive the needed change.

Unlike an audit, the key to a quality improvement project is an understanding that each project is unique to the hospital it takes place within, and that what works well in one hospital may not in another.

The most important factors in success of your quality improvement project are your perseverance, motivation, commitment and ownership of the project. Although the PDSA cycle requires organisation and resources, the improvement in outcome should lead to the sustained success and ultimate longevity of the project.

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Former Trainee Committee Member, Association of Anaesthetists

## References

1. Royal College of Anaesthetists. Colvin JR, Peden CJ. Raising the Standard: *A Compendium of Audit Recipes for Continuous Quality Improvement in Anaesthesia*, 3rd Edn, 2012. [https://www.rcoa.ac.uk/system/files/CSQ-ARB-2012\\_1.pdf](https://www.rcoa.ac.uk/system/files/CSQ-ARB-2012_1.pdf) (accessed 22/07/2018).
2. The Health Foundation. Quality improvement made simple; What everyone should know about health care quality improvement; Quick guide, August 2013. <https://www.health.org.uk/sites/health/files/QualityImprovementMadeSimple.pdf> (accessed 22/07/2018).
3. Adams D. Quality improvement; part 1: introduction and overview. *BJA Education* 2018; **18**: 89-94.
4. Department of Health. High Quality Care For All - NHS Next Stage Review Final Report, June 2008. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/228836/7432.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf) (accessed 22/07/2018).
5. The King's Fund. Improving the quality of care in general practice, 2011. <https://www.kingsfund.org.uk/sites/default/files/Independent-inquiry-GP-3-defining-and-measuring-quality-general-practice-March-2011.pdf> (accessed 22/07/2018).
6. Care Quality Commission. The five key questions we ask, 2018. <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/five-key-questions-we-ask> (accessed 22/07/2018).
7. Farrell C, Hill D. Time for change: traditional audit or continuous improvement? *Anaesthesia* 2012; **67**: 699-702.
8. Roueche A, Hewitt J. 'Wading through treacle': quality improvement lessons from the frontline. *BMJ Quality & Safety* 2012; **21**: 179-183.

## Recommended Reading

- Weekes L, Lawson T, Hill M. How to start a quality improvement project. *BJA Education* 2018; **18**: 122-7.
- Lawson T, Weekes L, Hill M. Ensuring success and sustainability of a quality improvement project. *BJA Education* 2018; **18**: 147-52.

## 18. How to design a study

The strength of a study depends on its design. Rather than classify the different types of study and get bogged down in statistics, I'm going to approach it from a practical point of view.

### The idea

Some ideas arise from clinical cases (e.g. 'Is my anaesthetic technique better than yours?'), while others come from reading or discussing published papers, conferences, or just out of the blue. Sometimes a small scale project like a local audit becomes much more interesting than expected, and can be expanded into a full paper. Many ideas fall by the wayside because of the practicalities (see below), and it's always worth testing the idea to see whether it has a good chance of running, before investing too much time and energy. Sometimes an idea stands up to all the challenges, only to fall at the 'PubMed hurdle' - someone has done it before (not that this is a fatal flaw; most studies are worth repeating. In fact, an easy way to think of a project is to repeat someone else's).

### The question

It may be surprisingly difficult to narrow down a general idea to a specific question or questions that might be answerable by a study. For example, 'Is my anaesthetic technique better than yours?' could raise questions about individual drugs, combinations of drugs, practical procedures and even individual anaesthetists. Even if one were to decide upon 'Is drug A better than drug B?' the matter of what 'better' means must also be defined, (e.g. less pain, faster recovery, shorter hospital stay, lower cost, etc.). For most outcomes there are also different measurements from which to choose - e.g. 'less pain' might be measured as lower pain scores, less morphine requested, or a longer time before requests. Defining the question is crucial since it determines the type of data collected and sets the scene for the entire project.

### The design

By 'design' I mean what is actually done during the study. For example, is any intervention happening, (e.g. giving a drug) or is it simply observational, with measurements being recorded but nothing 'done' to the participants? Is data collection prospective or retrospective? The latter is weaker as the data were collected without the study in mind, so one can be less certain about their accuracy or completeness. An important consideration is the choice of appropriate controls, for example drug A versus drug B, where drug B is the standard treatment (thus control) and drug A the newer (experimental) one. But even here, unless there is good evidence that drug B is effective, a finding that drugs A and B have similar effects could mean either that they're equally effective or that they are equally ineffective.

### The practicalities

Many a good idea has to be abandoned because the study is just impractical in that setting. For example, anything involving extensive data collection by other parties (e.g. ward nurses, midwives) is likely to fail because such people are busy and furthermore have no interest (in the 'ownership' sense) in the study. Studies of rare outcomes require huge sample sizes and are probably not worth the effort on a local level. Some measurements are just too difficult to obtain. Every study has easy bits but at least one 'painful' bit will drive you mad - this may be collecting the data, taking the samples, doing the follow-ups, etc. You have to be realistic about being able to complete the study before starting, since giving up halfway through is a waste of everyone's time.

### The numbers

This isn't the place for an account of statistical methods but it's worth considering a few basic questions. The first is 'How many participants?', and for a comparison study, in order to answer it you need to decide: (i) what you're expecting to see in your control group; and (ii) what difference is worth looking for in the experimental group. This and subsequent questions, such as how to present or compare the data, really do require the input of someone who has done it before - and not necessarily a statistician. So time spent discussing the statistics is not only useful - it's vital. Sometimes the complexity of the statistics or the sample size required is such that a study has to be abandoned at this stage because the practicalities don't stack up.

## The regulations

These are increasingly seen (by investigators) as barriers put in the way of honest folk whose only wish is to improve the world, but history is littered with dreadful abuses of research and publication ethics, as well as plenty of bad science. The most useful advice, as before, is to seek guidance from someone who has done it before. In general, studies require ethical approval, hospital R&D approval, directorate/department approval, and possibly MHRA approval, depending on the type of study. Funding requirements add another layer of paperwork.

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## 19. How to write a paper

You've done the easy and interesting part and completed your study, but now you have to sit down, put fingers to the keyboard and write the paper! Perhaps you see this as a daunting task, but it shouldn't be because you've actually already written most of the paper. A well-written protocol should have the introduction, methodology and a lot of the discussion ready for a bit of cutting, pasting and editing. Your literature search should contain most of the references you'll need and hopefully they have been entered into a reference management system ready to merge with your manuscript.

Where to begin? Before sitting at your computer, you should first give careful consideration as to which journal you intend to submit to; take advice from experienced colleagues on this question. In addition, ask yourself who is the intended audience for your paper? Is it for a broad church of anaesthetists (think *Anaesthesia*, *British Journal of Anaesthesia* or *European Journal of Anaesthesiology*), or only of interest to a small sub-specialty group (either an anaesthetic sub-specialty journal or a relevant surgical journal)? Is it basic science or animal work (consider a basic science journal such as *Nature*)? Is it of interest to non-anaesthetists (perhaps suitable for the *BMJ* or *Lancet*)?

Once you've chosen the journal, read it, get an idea of its style and layout and, most important of all, carefully read the journal's guidance for authors. Then read the guidance for authors again and keep a copy handy to consult frequently during writing; it should become worn and dog-eared by the end.

Although acceptance of your paper will depend on its scientific value, it is helpful to make a good impression with reviewers. A poorly written paper with careless typos, misspellings and a disregard of the guidance for authors will leave a bad impression on reviewers. A sloppily written paper will suggest the study has been carelessly conducted, lowering its scientific value.

A common misconception of budding authors is that a long paper is more impressive than a short one. Like many things in life, size isn't everything! Keep your writing succinct, use plain English, avoid over use of the passive voice, (e.g. 'we administered fentanyl to the patients...' is better than 'fentanyl was administered to the patients...'), take care with punctuation and avoid excessive abbreviations; all of which will help to make the paper easier to read.

Now it's down to the writing. Start with the introduction, which should have three clear messages: what is already known about the subject, what is not yet known, i.e. the questions needing answering, and what does your study intend to answer? Keep it simple: three short paragraphs answering these questions.

The methods section should already have been written and can be lifted directly from the protocol and edited, keeping it simple so that it contains enough detail for anyone else to repeat your study. If someone has described part of the methodology before, you do not need to repeat the description but clearly reference it. Include at the end a succinct but accurate description of the statistical methods you used for your analysis. Where relevant, you should include enough detail of your power analysis to allow the reader to confirm how you arrived at your sample size.

Clarity is essential in the results section. Use clear group names (e.g. group morphine and group fentanyl rather than groups A and B or groups M and F). Make sure you retain a consistent order of reporting, particularly when there are more than two groups. Avoid unnecessary duplication of results: perhaps use a table to provide details of numbers and simply give a brief summary of main or important findings in the text. It is important to ensure that tables are laid out as per guidance for authors. If there are figures or photographs, make sure they are of sufficient resolution for printing (again refer to the guidance). Most journals reproduce images in black and white, and it is important to check that the image remains clear with important detail retained when it is converted from colour.

Keep the discussion simple; don't be tempted to draw it out believing that a long discussion is more impressive. You should consider what your results mean, how they fit in with existing knowledge, and if they don't fit then explain why. It is important to be up front and point out the flaws in your study as no study is perfect and it is better to acknowledge these flaws and try to convince the reader why they do not distract from the validity of your findings. Finish your discussion with a concluding paragraph, reinforcing the main findings and suggesting areas for future research.

Inserting references should be straightforward, especially if you've been entering the results of your literature search into Reference Manager or Endnote, which should allow you to format the references correctly for any journal with the click of a mouse. Don't feel you have to use every reference in your search; keep to those that are directly relevant to your paper and discussion.

Finally, think of a simple, accurate title (avoid newspaper headline style titles) and write the abstract using a structured or unstructured format as prescribed by the journal. Your abstract is the gateway to your paper; it may in fact be the only thing read by many, but can also draw the reader into exploring further. It therefore needs to summarise why you did the study, your methods, main results and conclusions, keeping the order of groups as described in the paper and ensuring that the results are the same. It's surprising how often there are discrepancies because of transcription errors.

There, it's all done and ready to be sent off to your chosen journal. No...not yet; re-read your paper, get all co-authors to read and edit in turn and, lastly, get a lay person to read it (partner or friend); they may not be able to understand the technical aspect of the paper, but they will be able to tell you whether it is clearly written.

After submission, you can heave a big sigh of relief and await the verdict. If it is not accepted, do not despair or take it as a personal rejection. It does not necessarily mean it is worthless; there are many reasons for rejection. Despite your careful selection, it may be felt inappropriate for that particular journal, or you may have just been unlucky with the choice of reviewers; the difference between acceptance and rejection is sometimes a fine one and quite subjective. Hopefully, the Editor has given you constructive comments and an explanation of why it was rejected. If not, it is worth writing back and politely requesting feedback. Use these comments to revise your paper and prepare for submission elsewhere, but only after you've carefully read the new journal's guidance for authors!

#### **Dr Paul Clyburn**

*Past President, Association of Anaesthetists*

## **20. Pensions and financial planning**

This chapter covers a number of topics that are often at the top of the FAQ list. However, it is recommended that when considering your individual situation you should take financial advice as this section only gives a flavour of the issues.

### **Financial advice - the good, the bad and the downright ugly**

There are various types of financial advice currently available. There are two types of financial adviser; those representing one organisation (thus acting on behalf of their company/bank), and an independent financial adviser, able to draw on the entire market (thus acting on behalf of their client). The distinction between the two and benefits of the latter has increased even further as part of regulatory changes imposed by the Financial Services Authority that took effect in 2013.

It is said that doctors tend to favour an independent adviser who works on a fee basis rather than those advisers being remunerated by commission. The fee basis ensures you are paying to receive independent, professional and impartial advice, not the sale of an independently chosen financial product. After all, which patient would willingly consult a doctor paid by the pharmaceutical companies on the basis of the number and value of prescriptions written? Professional independent financial advisers are able to create bespoke financial planning solutions that are right for your individual circumstances.

### **Pensions - your exit strategy**

A new NHS pension scheme was introduced on 1 April 2015. Approximately 75% of existing NHS employees and all new employees will have joined this scheme (2015 NHSPS). This provides career average related earnings (CARE) benefits for all doctors, and is no longer a final salary scheme.

## Will you have to join the new scheme?

- Some members will not have to join the 2015 NHSPS because they have full protection. This means that they were within 10 years of their normal pension age on 1 April 2012
- Others, who were between 10 and 13.5 years of their normal pension age on 1 April 2012, will get tapering protection. This means that they will still have to join the 2015 NHSPS but their joining date will be delayed, depending on how close to their normal pension age they were on 1 April 2012
- Members who were more than 13.5 years away from their normal pension age on 1 April 2012 will join the 2015 scheme

The 2015 NHSPS differs in many ways to the previous sections of the NHSPS. The previous NHSPS had two sections: the 1995 and 2008 sections, which provided final salary benefits for doctors working in secondary care. The new Scheme was introduced on 1 April 2015 and is called the NHS Pension Scheme 2015. The 1995 section has a normal pension age (NPA) of 60. This means that at age 60 doctors can draw their pension and lump sum benefits at an unreduced rate. In the 2008 section the NPA is 65. However the 2015 Scheme NPA will be linked to an individual's state pension age (SPA). Benefits drawn prior to NPA are usually subject to an actuarial reduction because they are being paid earlier than anticipated and for longer.

## Career average revalued earnings

CARE pension schemes differ from final salary in that they take account of pensionable earnings in every year of scheme membership rather than just prior to retirement. The accrual rate in the 2015 NHSPS will be 1/54 (equivalent to 1.85%), this means that every year a member will accrue 1/54 of their pensionable earnings. The total of all the annual pension accrual amounts is added together at retirement to calculate the final pension.

When basing pension accrual on lifetime earnings, it is necessary to have in place a mechanism for revaluing previous years' earnings so that they do not lose value. In the 2015 NHSPS the revaluation rate will be the Consumer Prices Index (CPI) plus 1.5%.

### An example:

- Let's say you earn £75,000 in pensionable income this year and the CPI rate is 3%
- Your pension would be  $1/54 \times £75,000 = £1,389$  and it would be increased by the revaluation rate (CPI 3% + 1.5%) to £1,452
- Every year the total of the previous years' pension accrual would be increased by the relevant rate for that year

The NHS pension still remains an enormously valuable asset.

Those who wish to make contributions over and above the NHS pension have typically invested additional funds into personal pensions, benefiting from tax relief and building a larger fund at the same time. This remains a highly efficient way of uplifting your pension benefits but you should be aware that the Government introduced a pension 'ceiling' in 2006 called the Lifetime Allowance (LTA).

The LTA is the amount an individual may have in tax allowable pension savings in his or her lifetime. Limited to £1.03 million for tax year 2018-19, the rules state that benefits in excess of this LTA amount can be taxed up to 55%, which is a punitive rate. For many SAS doctors this will not represent a threat until later in their career, but whatever your circumstances you should take professional advice in respect to your retirement/pension planning as using the correct strategy in the beginning makes a big difference in the end. Expert advice is needed regarding this.

## Financial protection - what do I need?

Thankfully the NHS offers some good in-house benefits. If you die while you are an employee, your nominated beneficiary will receive a death-in-service lump sum equal to twice your pensionable salary as well as a dependant's pension. If you are not well enough to work you will be paid for up to six months on full pay and then up to a further six months on half pay (depending on length of service). If you are over 50 and are unwell and unlikely to be able to return to work, you may be eligible for early retirement on the grounds of ill health, which might include an enhanced pension.

However, many doctors find that while these are valuable benefits they are insufficient for their own personal and family circumstances. Therefore you can choose to make private arrangements over and above these benefits to ensure that neither you nor your family is financially prejudiced should the unforeseen happen.

The first choice is often income protection, tailored around your NHS sick pay scheme. This ensures that if you were still unwell enough to work once the NHS sick pay runs out, you would receive an ongoing income until you return to work or reach your normal retirement age. There are many permutations of this benefit available which can be tailored to your circumstances but one aspect is uniform; it is paid tax-free.

While income protection pays an ongoing income based on your inability to perform your normal duties due to ill health, critical illness cover pays a one-off tax-free lump sum on the diagnosis of one or more 'critical illnesses'. However, the range (and sometimes the definitions) of listed conditions varies quite widely from provider to provider and so careful selection is again required.

If you have debts and/or mortgage liabilities greater than the death-in-service lump sum mentioned above, you should take out life cover to ensure these are repaid if you die. You will need more still if you have a family, and there are a number of specialist types of life cover that are suitable for this function.

Finally, make a will - especially if you have a family. While you might think that when you die your spouse or partner would automatically inherit everything, the Laws of Intestacy are not quite so generously disposed. Take even more care if you are in an unmarried (or non-civil partnership) relationship, and/or if one of you is not domiciled in the UK. You should consult a solicitor for advice regarding the content and construction of your will.

### **Dr Anthea Mowat**

*Former Chair, BMA Representative Body*

## **21. Leadership and management**

GMC guidance [1] reminds us that 'Being a good doctor means more than simply being a good clinician.' We must 'be competent in all aspects of your work, including management' [2] working with others to ensure that patients receive safe, effective and efficient care. To do this well, all doctors need to develop leadership and management skills.

The Medical Leadership Competence Framework (MLCF) [3] describes five competencies:

- Demonstrating personal qualities
- Working with others
- Managing services
- Improving services
- Setting direction

This chapter concentrates on the first three areas. For a service to be effective there must be a shared sense of responsibility for the success of the organisation and its services. Leadership is everyone's business; it is not restricted to people who hold designated leadership roles.

### **Demonstrating personal qualities - managing oneself**

#### *Self-awareness*

To be effective, we must understand our own core values, what motivates us [4], our strengths and weaknesses and what is likely to 'derail' us.

We can develop our own self-awareness through feedback from colleagues, attendance at leadership development courses and use of self-assessment tools. A number of suitable questionnaires are available, e.g. Belbin's Team Inventory and the Myers-Briggs Type Indicator [5].

#### *Self-management*

We should demonstrate our core values in everything we do, always behaving in an open, empathic and ethical manner as a positive role model [4]. Whatever our level of seniority, we should show humility, encourage and respect

the contribution of others and have the courage to do what is right, challenging the system when it does not work to the benefit of patients and colleagues. Doing this is not always easy. Paying attention to how we behave comes more naturally to some than others, but these skills can be learned and developed.

### *Resilience*

Resilience is the ability to recover from setbacks, adapt well to change and keep going in the face of adversity [6]. Training helps people to focus on the practicalities of addressing problems and to manage their emotional response to events. Self-confidence, optimism, a strong sense of purpose and being good at judging when to seek support from managers and colleagues [7], all contribute to resilience. However, an individual's ability to be resilient also depends on their work environment and the organisational culture [8].

Resilience training encompasses recognising and controlling feelings, ways of tolerating ambiguity, being good at defining boundaries and problem-solving strategies. Problem-focused coping refers to dealing with practicalities while emotion-focused coping involves dealing with the feelings provoked by the situation. Sometimes it is not possible to control events; all that can be done is to manage your emotional response. Positive psychology helps to identify positive ways of thinking and challenge negative thought patterns, and 'mindfulness' focuses attention and awareness on the present moment.

### *Time management*

It is important to balance work commitments with responsibilities outside work, including family and time for ourselves. Learning to work 'smarter' rather than longer, involves getting the right balance between planning, doing and interacting with others. Jobs can be divided into:

- Urgent (your priority/others priority)
- Important (important to you/to others)
- Active (not done unless you do them)
- Reactive (done with others)

There is a temptation to do reactive tasks, but postpone active jobs. Good time managers put time aside to get important tasks done and spend time appropriate to the job's importance. They allow enough time for everyday jobs (e-mails) and leave time to think and for the unexpected. Some important tasks are very big, and may be easier to achieve by splitting them into smaller parts.

### **Working with others**

To be effective, leaders and managers need to work with others. It is important to build and maintain good relationships both in our usual teams and in the wider hospital. People who work collaboratively with networks of colleagues achieve significant change in a more relaxed way than happens in a formal management hierarchy. Leadership is exercised when the leader is in authority, but also by leading 'across' to other teams using 'expert power', and by leading 'up', getting more senior people to do tasks. How we do this, our 'leadership style', will influence how effective we are. Whatever our position in the hierarchy it is important to be able to use a number of different leadership styles.

### *Leadership styles*

Daniel Goleman [9], who studied many public and private sector leaders, noticed that the really successful ones all have something he describes as emotional intelligence, more important for success than intellectual intelligence. There are three self-management skills, **self-awareness**, **self-regulation** and **motivation**, and two that others notice, **empathy** and **social skill**. Goleman defined several different styles of leadership:

**AFFILIATIVE** leaders emphasise good personal relationships and strive to achieve harmony. People who are happy and feel their contribution is respected, are more productive. This style is useful when tasks are routine and in managing conflict.

**PARTICIPATIVE** (democratic) leaders build commitment and consensus. They listen to everyone and encourage everybody to have an input, so decisions result from a group consensus. Because of this, staff are more realistic

about what is possible. This style fosters responsibility, flexibility and high morale. Once trust has been established, close supervision becomes unnecessary. The team's effort is rewarded and negative feedback is offered sparingly. Participative leadership works well in a stable working environment where staff have experience and credibility.

Leaders who use a COACHING style are interested in long-term team development, and identify opportunities for this to happen. The leader needs to be a credible expert who empowers others to take on new roles and hence enhances their confidence and self-esteem.

A VISIONARY leader gives employees clear direction, 'sells ideas' and motivates by persuasion and feedback on task performance. This works well when clear directions are needed and standards have to be maintained.

PACESETTING leaders establish high standards and set an example by doing lots themselves; 'do it myself' managers. Reluctant to delegate, they expect others to be self-directed. This works when people are highly motivated and competent, but does not develop the team. Working in this environment is described as 'being in a permanent crisis' and demotivates staff.

DIRECTIVE leaders tell the team what to do and how to do it; 'do what I tell you'. They adhere strictly to rules and offer little flexibility in decision-making. Motivation comes from discipline and threats. With little input from experienced and skilled team members, directive leaders may not make the best decisions. When the team understand the task at hand, this leadership style dampens morale and reduces the team's creativity and productivity. As they take full responsibility for work, directive leaders are extremely busy, leading to high stress levels.

People who use four or more of the six leadership styles provide a more positive work climate and their teams achieve better results. Many NHS leaders [10] rely heavily on pacesetter leadership and hence can disempower employees. It is useful to know what styles of leadership we find easier and harder and what styles we adopt when under pressure.

### *Working in teams*

Teams always do better if they know what is expected of them, each person knows their role and they work interdependently to achieve jointly agreed objectives. Know your own skills and strengths so you know what you can offer to the team. This is easier in stable teams, where members know how others behave. There are questionnaires (e.g. Belbin Team Inventory [11]) that assess how an individual prefers to behave. It is important to have a range of behaviours in the team as well as a range of knowledge and skills. People who develop new ideas and overcome barriers, those who support and encourage others and those who ensure that the minutiae are not forgotten are all needed.

### *Working in committees*

Good preparation is key to being effective on committees. Read the previous meeting's minutes and consider the agenda carefully. Seek your colleagues' views so that you reflect their opinion accurately. Ensure that actions required of you have been completed. Put important departmental issues relevant to the committee on the agenda, so that other committee members have time to reflect on them before the meeting.

### *Delegation*

Good delegators achieve more and are appreciated by their teams. People delegate tasks to free up time, to use others' expertise, to develop others' skills, to encourage open communication, trust, creativity, initiative and to make sure a task is seen as a team success and not that of an individual.

Decide which tasks to delegate and to whom. Ask yourself 'Why do I have to do this?' Jobs can be delegated to juniors, peers and seniors. Consider 'Who is better at it than you?' and 'Who will learn from it?' Before someone else takes on a task, explain why you have selected them, describe the task, the background and answer their questions and, if needed, train them to do what is required.

When you have delegated a task, be available to support and advise the person who has taken it on, show interest, monitor their progress, and praise success. If matters are not going well, help the person to resolve difficulties or offer to take the job back.

### *Negotiating skills and conflict resolution*

All teams face challenges and manage conflicts from within and outside the team. Eighty per cent of conflict is caused by misunderstanding, in which people have different knowledge or interpretations of the 'facts', assumptions, individual perspectives, strong feelings or a difference between intent and impact. There are several perceptions of what the problem is and how to resolve the matter.

Training in negotiating skills makes us more effective at resolving both formal conflict (e.g. a formal job planning disagreement) and day-to-day negotiations with colleagues (leave, rotas, etc). Before entering a negotiation, work out what you are prepared to trade and what you might expect to receive in return, and your break point (when you will walk away leaving a situation unresolved). Some people rehearse difficult conversations with a trusted colleague to better plan for the real thing.

Skilled negotiators [12] demonstrate they appreciate others have valid perspectives that differ from their own views. They **seek information** from everyone involved, and **test their understanding** by summarising the other person's perspective. They put their strongest argument first and do not dilute it. They often offer a '**feelings commentary**', describing what they feel about a situation. A negotiator might say, 'I am worried that this approach has some serious disadvantages. It would be helpful to review why we feel so differently about...'

Skilled negotiators also use behaviour labelling, describing what they are going to do, or what they notice the other person doing, e.g. 'I notice that you have raised your voice and folded your arms.'

Less skilled negotiators might put immediate counter proposals instead of demonstrating that they have understood the other person's views. They use 'irritators' (phrases like 'when you've been here as long as me...'), argument dilution or defend/attack spirals. Argument dilution refers to giving several different reasons at once. Weak arguments dilute strong arguments. Skilled negotiators start with their strongest argument and only add others if they need to. In a negotiation, a skilled person will use about half the number of arguments than a less skilled negotiator.

### *Dealing with colleagues in difficulty*

There are many reasons why colleagues might seem 'difficult' and it is important that the appropriate person explores the underlying causes with the struggling colleague and acts appropriately. Colleagues in difficulty sometimes choose to speak in confidence to someone whom they trust, rather than to approach 'management'. If this is you, start by listening carefully to what the person says, helping them to summarise and potentially to identify an aspect that they might be able to change. It is rarely useful to give advice; helping the struggling colleague to identify where they might best go for support is of more use. If the colleague might be unwell, a confidential appointment with the consultant occupational physician can be a useful starting point. Stresses caused by life outside work, such as family or financial difficulties, and psychological and physical health problems, may present as 'difficult behaviour'. Other difficulties arise from failure to keep up to date. The remedy must address the underlying problem and assist the colleague to get back on track. The advice of senior medical managers should be sought.

## **Managing services**

Managing services so that they deliver high quality care to patients requires planning, managing resources, managing people, managing performance, and designing and delivering improvements. All of us are involved in this, sometimes as part of a theatre team and sometimes in the wider Trust.

### *Business planning and business cases*

Each year, an organisation sets out its business plan, prioritising its work and service developments, and ensuring they meet commissioners and government priorities [13]. Each directorate and department contributes, so this is one way doctors can influence service development. The effectiveness of the directorate will be judged against the business plan priorities and targets.

Business cases, which are the means by which the need for service developments/new equipment, etc., are costed and appraised, are more likely to find support if they are allied to the business plan. An organisation's business plan is usually available to all, and it is worth scanning it when the issue of a new development arises. Much can be learnt from discussing active business cases with the Clinical Director or even offering to help with the preparation of a new one.

### *Understanding the environment*

Managers often describe the environment as internal (within the organisation) or external (that part of the world that impinges on the organisation)[13]. In the health service, the internal environment is the workplace and the external includes organisations involved in the commissioning, delivery, monitoring and regulation of the health service (including professional regulatory bodies, e.g. GMC). You can find out what local priorities are by attending directorate meetings, from open meetings of the Management Board and by reading.

### *Financial management*

Although it is not necessary to understand health service finances in detail, it is useful to know how money flows to the organisation and to departments. This differs in each devolved healthcare system, so it is worthwhile asking the Clinical Director or the directorate's Finance Officer for advice.

### **Formal training in management**

Most employers and many deaneries run management courses. Outside the hospital, the [King's Fund](#), the [Association](#) and the [RCoA](#) run leadership programmes.

### **Dr Nancy Redfern**

*Vice President, Association of Anaesthetists*

### **References**

1. GMC. Leadership and management for all doctors. 2012. [http://www.gmc-uk.org/guidance/ethical\\_guidance/management\\_for\\_doctors.asp](http://www.gmc-uk.org/guidance/ethical_guidance/management_for_doctors.asp).
2. GMC. Good medical practice. 2013. [http://www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp).
3. Academy of Medical Royal Colleges. Medical leadership competency framework. Enhancing Engagement in Medical Leadership Third Edition, July 2010. NHS Institute for Innovation and Improvement. <http://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Medical-Leadership-Competency-Framework-3rd-ed.pdf>.
4. Faculty of Medical Leadership and Management. The leadership and management standards for medical professionals. 2015. <https://www.fmlm.ac.uk/professional-development/accreditation-and-standards/the-leadership-and-management-standards-for>.
5. The Myers & Briggs Foundation. MBTI® Basics. <http://www.myersbriggs.org/my-mbti-personality-type/mbti-basics/>.
6. Ovans A. What resilience means, and why it matters. Harvard Business Review, 5 January 2015. <https://hbr.org/2015/01/what-resilience-means-and-why-it-matters>.
7. Wilson S, Rickard C, Tamkin P. Understanding resilience. IES Perspectives on HR 2014. Brighton: Institute for Employment Studies, 2014. <http://www.employment-studies.co.uk/system/files/resources/files/mp94.pdf>.
8. Balme E, Gerada C, Page L. Doctors need to be supported, not trained in resilience. *BMJ Careers*, 15 September 2015. [http://careers.bmj.com/careers/advice/Doctors\\_need\\_to\\_be\\_supported,\\_not\\_trained\\_in\\_resilience](http://careers.bmj.com/careers/advice/Doctors_need_to_be_supported,_not_trained_in_resilience).
9. Goleman D. Leadership that gets results. *Harvard Business Review*, March–April 2000. [https://www.haygroup.com/downloads/fi/leadership\\_that\\_gets\\_results.pdf](https://www.haygroup.com/downloads/fi/leadership_that_gets_results.pdf).
10. Wilson K, Haq L. Making clinical leadership work. Enabling clinicians to deliver better health outcomes. London: Hay Group 2013. <https://www.haygroup.com/downloads/uk/Making%20clinical%20leadership%20work.pdf>
11. Wikipedia, the Free Encyclopedia. Team Role Inventories. [https://en.wikipedia.org/wiki/Team\\_Role\\_Inventories](https://en.wikipedia.org/wiki/Team_Role_Inventories).
12. Sherwin L. Skilled V average negotiators 2: negotiating behaviour. [http://www.lindsay-sherwin.co.uk/guide\\_consultancy\\_skills/html\\_consultancy\\_skills/06\\_negotiating\\_skilled\\_v\\_average\\_2.htm](http://www.lindsay-sherwin.co.uk/guide_consultancy_skills/html_consultancy_skills/06_negotiating_skilled_v_average_2.htm).
13. Bell PF. Leadership and management. In *The SAS Handbook*, 2nd edn. London: Association of Anaesthetists, 2011.



## Executive summary

Associate Deans in England are instrumental to the training and development of SAS doctors and, where appointed, oversee the allocation of development funding at a regional Health Education England (HEE) level, via Local Education and Training Boards (LETBs) that were established under the Health and Social Care Act. As the SAS representative to LETBs, Associate Deans (SAS) should work with local SAS doctors to identify and recommend priorities for SAS development and lead on their delivery.

## Development funding

The Department of Health made £12 million of funding available under Modernising Medical Careers and in line with Choice and Opportunity Recommendations 5 and 6 to support the development of SAS doctors working in England; this is separate and in addition to any existing study leave funding and contract implementation funding. HEE no longer provide specific funding for SAS doctors and dentists, but there is an expectation that LETBs will consider continuing SAS funding to employing bodies. This funding, commonly referred to as development funding (when provided), is allocated to Trusts, but now is often after a bid process.

Each Trust should seek agreement with its SAS doctors in regard to the priorities for the distribution of any funding: allocation of funding and the monitoring, reporting and audit thereof. Such agreement may be via the Trust's SAS representatives or Local Negotiating Committee (LNC) where there is no separate SAS representative body. There is currently some equivalent funding in Scotland and a programme of SAS development in Wales. There is no such funding in Northern Ireland and the BMA continues to lobby for devolved nations to have access to development funding.

## HEE, LETBs and Associate Deans, SAS tutors and Clinical Leads

LETBs are responsible for the management and delivery of postgraduate medical education and for the CPD of all doctors and dentists. There are 14 deaneries in England, 1 in Northern Ireland, 1 in Wales and 4 in Scotland. Further information about the UK deaneries can be [found here](#).

SAS doctors have SAS specific representation in regional HEEs through the appointment of Associate Deans. They are responsible for the development and training of SAS grade doctors in their area. The majority of regions have already appointed Associate Deans (some of whom are from the SAS grades).

To support the Associate Dean and to liaise with local SAS doctors, many areas have appointed other roles with a variety of terminology. The BMA Staff, Associate Specialists and Specialty Doctors Committee (SASC) have attempted to simplify the variety of other roles as follows:

1. **SAS Representative (otherwise known as SAS Lead):** Every organisation that employs SAS doctors should have an SAS Representative. This is a trade union role, which would normally be held by the Chair of the local SAS Committee. This representative is elected by the body of SAS doctors and dentists to represent them on the LNC/local SASC etc. This representative should ideally be a BMA member in order to draw on the local BMA support and for accreditation purposes. This role should be funded by the Trust employer (through SPAs and time off for trade union duties) rather than from SAS development funding monies.
2. **SAS Tutor (otherwise known as an SAS Educational Adviser):** This is an educational role for a SAS doctor who oversees educational placements, arranges tutorials, lectures etc. They could be known as an SAS Lead for Professional Development or Professional Development manager for SAS, etc. This person should independently manage the local SAS development budget and usually have an educational background with line management through the Director of Medical Education (DME) or Postgraduate Director. The SAS Educational Adviser should liaise closely with the SAS Representative and Associate Dean (where appropriate) but, where possible, should not be the same person. The SAS Educational Adviser should be funded (typically, one PA/week) by the employer (in job plan or additional contract), or through the SAS development funds where local employers are unwilling to fund the role. This must be an appointed role through open competition (and interview).
3. **Postgraduate Director of Medical Education (DME):** is responsible for maintaining and developing high quality medical education and training within his/her NHS workplace. They are tasked with developing a local strategy for medical education and training and will be responsible for its provision, quality control and improvement.

Some smaller organisations may of course need to make different arrangements (for example, an SAS Tutor may

not be feasible everywhere and some Educational Advisers do perform the role of SAS Representative) but the above is an indication of what the BMA would suggest for the majority of situations.

### **Person specification for an SAS Tutor (Educational Adviser)**

To aid employers in the appointment of SAS Tutors (Educational Adviser), the BMA SASC has devised a person specification and advice for a SAS Tutor. The specification is not prescriptive but is intended as a useful guide for employers.

### **Best practice guidance**

The BMA SASC has developed a number of guidance and policy documents to promote good practice and appropriate usage of the development funding monies. One key recommendation is that the funds be used to support the establishment of Associate Deans for SAS within the postgraduate deaneries, and Clinical Tutors for SAS at local level.

In addition, the BMA SASC has created the following list of suggested usage based on a BMA SASC survey of SAS doctors' professional development and training needs and career aspirations which identified local need for:

- Secondment and time limited posts
- Courses and top up training
- Diplomas and certificates
- E-learning and e-Portfolios
- Conferences and events

### **Facilitating access to training for SAS doctors**

SAS grade doctors need improved access to training in order to further develop their specialist knowledge and skills to enable them to offer their full potential to their employer and the wider NHS and to develop their careers. Many believe that it is only through formal systems for recognition of the competencies of this diverse group of doctors that this grade can be promoted as a positive career choice.

Training numbers are limited but it is a common belief that there is scope within the NHS to allow SAS doctors short-term secondments to training posts (perhaps to cover gaps in the service caused by maternity/fellowship or career breaks). Associate Deans with a remit to assist SAS doctors in their development may be able to advise on local opportunities. A key part of their function should be in spotting gaps and offering training to SAS doctors who could fill these gaps. These secondments can be invaluable for those that require top up training (either as recommended by the GMC after a CESR application or for more general development of skills).

### **Dr Anthea Mowat**

*Former Chair, BMA Representative Body*

## Appendix 1: Checklist for CESR application

**Note:** This list is not a conclusive list but an aid. Provision of the evidence below does not guarantee the success of an application.

### **GMP 1 - Knowledge, skill and performance**

- Logbooks
- Logbook summary
- Curriculum, assessment method, standard setting
- Letter from institution confirming above
- Structured referees
- Testimonials
- Letters of support
- Rotas/theatre lists
- Job description/job plan
- Training certificates/assessments
- Case diaries for ICM and/or pain medicine
- Record of procedures learnt
- Difficult airway courses - certificates
- CPD certificates
- Train the trainer course
- Feedback from trainees
- Teaching and training rotas
- Educational qualifications

### **GMP 2 - Safety and quality**

- Audit activity (defining, conducting, presenting)
- Testimonials
- Appraisal (includes 360°)
- Structured referees
- Research project (planning, conducting, presenting)
- Letters of support
- Management qualifications
- Management courses - certificates

### **GMP 3 - Communication, partnership and team work**

- Structured referees
- Appraisal (includes 360°)
- Testimonials
- Letters of support
- Feedback from trainees
- Equality and diversity training certificate

### **GMP 4 - Maintaining trust**

- Appraisal (includes 360°)
- Structured referees
- Letters of support
- Thank you letters from patients
- Equality and diversity training certificate

## Safer, for everyone

Every anaesthetist aims to keep their patients safe. We aim to safeguard every anaesthetist – by educating, supporting and inspiring them throughout their career.

**We represent** the life-changing, life-saving profession of anaesthesia – by supporting, informing and inspiring a worldwide community of over 10,000 members.

**Our work and members** span the globe, yet our voice is local and personal. We stay in close contact with our members, look after their day-to-day wellbeing, and act as their champion.

**Our world-class conferences**, journal and online resources educate and inform, and our respected guidelines continually improve standards of patient safety.

**We preserve and learn** from the history of anaesthesia. We use that to inform the present, and facilitate vital research and innovation into its future.

**As an independent organisation**, we speak up freely and openly for the interests of anaesthetists and their patients. We influence policy, raise public awareness and are at the forefront of safer anaesthesia across the world.

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