

**DEPARTMENT OF ANAESTHESIA:  
SECRETARIAT AND  
ACCOMMODATION**

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9 Bedford Square

London WC1B 3RA Tel: 0171 631 1650 Fax: 0171 631  
4352

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## **PREFACE**

The primary responsibility of a health authority or National Health Service (NHS) trust is to provide a safe and effective service to patients<sup>1</sup>. To that end, and to secure improvements in efficiency and quality, management has a responsibility to ensure that consultant staff are given the necessary administrative and secretarial support to allow them to concentrate on clinically related work. Anaesthetists, like other clinicians, require appropriate levels of administrative and secretarial support and adequate accommodation to enable them to provide optimal safe patient care and resource utilisation.

The Department of Health and Social Security (DHSS) first published guidance on the accommodation required for the administration of anaesthetic services in a district general hospital in 1971.<sup>2</sup> This document reviewed the functions of the anaesthetic service, as perceived at that time, and drew attention to the responsibilities of anaesthetists for training medical, nursing and technical staff and their involvement in research. The document acknowledged that: 'To enable the anaesthetic service to discharge its growing responsibilities efficiently, it needs an operational base in the district general hospital'.

The introduction of clinical directorates and resource management in anaesthesia has spread widely. In addition, participation in clinical audit has become a contractual responsibility for all consultants. These innovations have had a substantial impact on the requirements for administrative support and departmental accommodation.

In response to requests from members, the Association of Anaesthetists convened a working party to consider these requirements and offer guidance on the levels of administrative staff and accommodation required to provide an efficient anaesthetic service. The working party makes recommendations which are practical and realistic.



# SECTION I

## SECRETARIAL ASSISTANCE

### 1. INTRODUCTION

The vital role of the departmental secretary in the provision of an efficient anaesthetic service has been recognised by anaesthetists for many years. The departmental secretary has acted as the central reference point for all communications, the 'lynch pin' of the system, providing prompt action to ensure continuity of medical staff cover for clinical services. The tasks undertaken by the departmental secretary are diverse, ranging from those of a routine secretarial nature to administrative and managerial related work well outside the range of simple clerical duties.

'Medical secretary' is a job title, not a grade. The term is probably no longer applicable in most anaesthetic departments since the duties carried out by this individual are more appropriately described by the title office manager or administrative assistant.

### 2. CRITERIA FOR MANAGERIAL/SECRETARIAL STAFFING LEVELS.

The level of managerial, administrative and secretarial support required within an anaesthetic department must be determined locally. Factors which determine the level of support include:-

#### 2.1. Departmental establishment

The number of consultants within the department, assessed in whole-time equivalents (WTEs), is a basic determinant when assessing levels of support staff (*vide infra*). Other career grade staff also require secretarial support.

It is important to emphasise that trainee anaesthetic staff also need ready access to secretarial assistance when preparing manuscripts for publication, examination entries, curricula vitae, lectures, audit presentations etc.

Other members of the departmental staff, such as nursing officers, operating department assistants (ODAs) and technicians also may require access to secretarial and audit facilities.

## **2.2. Clinical services**

The extent and type of work undertaken by the secretariat will depend largely on the number and range of clinical services provided by the department and the activities of the consultant anaesthetists throughout the hospital and beyond.

Consultant anaesthetists provide a whole range of clinical services throughout the health district. These include anaesthesia in operating theatres, obstetric analgesia and anaesthesia, Intensive Therapy Unit (ITU) and High Dependency Unit (HDU), acute and non-acute pain management, emergency anaesthesia and resuscitation. Anaesthesia is the largest single specialty within the NHS and the demand for the services of anaesthetists is constantly expanding. If this is to be met, adequate and additional non-medical help must be provided.

## **2.3. Teaching**

A major component of the workload of consultant anaesthetists is the education of trainee anaesthetists informally in the operating theatre, wards and other clinical areas and formally at departmental, regional and national meetings. In addition, anaesthetists play an important role in teaching and training medical students, nurses, ODAs, paramedics and other health care workers.

## **2.4. Other activities**

A number of consultants and trainees have additional responsibilities at local, regional and national levels. These include activities on behalf of the hospital, health authority and national bodies such as the Association of Anaesthetists of Great Britain & Ireland, the Royal College of Anaesthetists, the British Medical Association and specialist bodies.

## 2.5. Audit activities

Participation in clinical audit is now a contractual requirement for all hospital doctors. Health authorities and NHS trusts have been instructed to ensure that adequate resources are available to support an agreed audit programme. The expanding involvement in clinical audit necessitates an increase in the level of support required from audit/coding clerk, data processors and systems analysts.

## 2.6. Clinical directorates

In many hospitals the clinical director of the anaesthetic services has managerial and budgetary responsibility for a range of related clinical services including obstetric anaesthesia and analgesia, pain management, ITU, HDU, recovery, resuscitation, the operating department and day-stay surgery.

The new contracting system necessitates close monitoring of activity against targets and quality requirements. A fundamental determinant in assessing managerial/secretarial staffing requirements is the extent to which the department has embraced resource management and the requirement for contracting in the new environment of the purchaser and provider.

Administrative, managerial and secretarial staffing levels have resource implications which should be documented in the anaesthetic services directorate business plan.<sup>3</sup>

To ensure the effectiveness of a system of devolved management, and to permit the clinical director to fulfil clinical commitments satisfactorily, it is essential that there is sufficient senior administrative support to facilitate day-to-day operational management of the department of anaesthesia.

## 3. REQUIREMENTS

**The recommendations for a departmental secretariat are based on a department with a consultant establishment of 10 WTEs.**

The range of models required extends from a small department with basic requirements for administrative and secretarial support, the **'core requirements'**, to a fully developed clinical directorate with managerial and budgetary responsibility for a range of clinical service, the **'extended requirements'**.

### 3.1. Core Requirements

#### 3.1.1. Office manager

The office manager will have overall responsibility for administration and co-ordination of the day-to-day departmental activities and be responsible to the director/chairman.

#### 3.1.2. Departmental secretary

The occupant of this post will provide secretarial support to all consultants, other career grade and trainee staff. Depending on the workload the departmental secretary could also provide secretarial support for a small ITU and/or a limited pain management service (*vide infra*).

In small departments the requirements **may** be met by an office manager with secretarial skills.

### 3.2. Extended requirements

When a clinical directorate or a department of anaesthesia has responsibility for provision of specialist and other services an extended secretariat will be required. Appropriate staffing levels should be determined locally and agreed between the clinical director and the chief executive officer.

#### 3.2.1. Intensive therapy unit

Most ITUs are administered by anaesthetists and should have a director or designated consultant in administrative charge, a minimum complement of 4 beds with an annual admission rate of at least 200 patients who could not normally be monitored or managed in a general ward or HDU.<sup>4,5</sup> The Working Party recommends that the minimum secretarial support for this level of clinical activity and related audit should be one WTE medical secretary. The ITU medical secretary should normally be responsible to the ITU director or consultant in administrative charge and receive support from the department of anaesthesia business manager.

#### 3.2.2. Non-acute pain management service

The criteria used to assess the need for secretarial assistance within a pain management service should be the same as those applied in the employment of personal secretaries to physicians or surgeons. Efficient appointments, data storage and retrieval systems must be maintained, letters typed and telephone enquiries answered.

Dealing with this group of patients may require additional skills to those required for other posts in the department of anaesthesia.

A non-acute pain management service, running out-patient clinics for 3-4 NHDs per week with associated in-patient work, procedures and a consultant service will require one WTE medical secretary.

**3.2.3.** The fully-developed clinical directorate

The following represents an example of the staffing level which may be required in a fully-developed clinical directorate which, in addition to the anaesthetic and resuscitation services, incorporates the ITU, non-acute pain management service, the operating department and a day-stay surgery unit.

- (a) Business manager
- (b) Office manager
- (c) Anaesthetic department secretary(s)
- (d) ITU secretary
- (e) Pain management service secretary

- (f) Operating department: secretary  
information input officer  
stores procurement officer
- (g) Day-stay surgery unit: admissions officer  
clerical officer

#### **4. GRADING**

In the future Whitley Council agreements on terms and conditions of service for administrative and clerical staff<sup>6</sup> may not apply. It is essential that local negotiations ensure that the remuneration of the secretariat is at an adequate level to attract and retain high quality staff.

As changes in managerial arrangements, clinical budgeting and information technology evolve it is likely that requirements for administrative staff within the department of anaesthesia will increase. The duties and responsibilities of the departmental secretariat should be the subject of regular review. This should be carried out annually or more frequently if there are changes in the consultant staff or in the duties and responsibilities of the existing staff.

## SECTION II

### DEPARTMENTAL ACCOMMODATION

#### 1. INTRODUCTION

In 1990 the West Midland Regional Health Authority (WMRHA) published guidelines entitled 'Planning Guide No. 104: Department of Anaesthesia'.<sup>7</sup> This guidance was intended to be used within the Region and to supersede the DHSS design guide issued in 1971.<sup>2</sup> It was formulated by the WMRHA Health Systems Design and Evaluation Group after seeking the views and experience of a wide range of departments within the Region. The Association of Anaesthetists was invited to comment, its suggestions being incorporated in the final version.

The WMRHA document provides guidance to those involved in the briefing and design stages of schemes aimed at providing new buildings or adapting existing premises. It established standards of accommodation that are consistent with functional requirements and forms a basis for cost allowances. Functions, activities, equipment, environmental conditions, engineering services and dimensions are identified and discussed.

The Association of Anaesthetists strongly commends the WMRHA document as providing realistic, detailed guidance to anaesthetists and health authorities when planning appropriate accommodation for anaesthetic services. However, in the majority of departments of anaesthesia the introduction of clinical directorates, resource management and clinical audit has substantially increased accommodation requirements. The Association of Anaesthetists now offers updated guidance on departmental accommodation based on that published by the WMRHA, incorporating additional features to meet the requirements of a clinical directorate providing a comprehensive anaesthetic service.

## **2. LOCATION**

The services provided by the department of anaesthesia cover a wide range of activities throughout the district hospital(s). To ensure maximum efficiency, this service should be organised from one site. For most anaesthetists the major commitments will be in the operating department, recovery, ITU, HDU, obstetric department or Accident and Emergency department. The department of anaesthesia should be provided as a suite of rooms in close proximity to the main areas of activity. Fragmented accommodation, as currently exists in many hospitals, both old and new, is inefficient and unacceptable. In addition, basic office accommodation for anaesthetists may be provided in specialist areas such as ITU and obstetrics.

The department of anaesthesia is an operational, not a clinical base. Patients will therefore not normally visit the department and clinics should be held in appropriate accommodation elsewhere.

## **3. ACADEMIC DEPARTMENT**

Where an academic department is to be provided the NHS and university departments should normally be contiguous, to ensure close integration of clinical services, teaching and research facilities.

## **4. PLANNING AND DESIGN**

The working party strongly advocates that anaesthetists should be involved at the earliest possible stage in the planning of a new or adapted department of anaesthesia.<sup>8</sup>

Wherever possible the departmental accommodation should be designed to permit flexibility of use, in line with future developments within the specialty. When calculating the total floor area an allowance of 33% for 'circulation space' (walls, partitions, movement of people and fire regulations) should be added to the proposed activity space.<sup>7</sup> Doors and corridors must be wide enough to allow passage of equipment.

Anaesthetists spend a significant proportion of their time working in artificial light. The secretariat may spend their entire day in the department. The provision of natural lighting and ventilation in the department of anaesthesia is therefore of particular importance. Failure to address this important point could have serious consequences for staff morale.

Security measures should be considered carefully. Specific problems include the requirements of 24-hour access by anaesthetic staff and the presence of expensive equipment, such as anaesthetic machines, ventilators, monitoring equipment, blood gas and other biochemical analysers and computers. Fire and security officers should be consulted since a conflict of interests may exist.

#### **5. COMMUNICATIONS**

It should be recognised that the department of anaesthesia must maintain efficient telephone communications on a 24-hour basis throughout the hospital and with all hospitals covered by the anaesthetic service. Many calls are about the day-to-day provision of elective anaesthesia services, while others will require urgent action on life threatening situations. An appropriate high quality modern telephone system with direct access to outside lines must be provided. An 'intercom system' between the department and related clinical areas such as the operating theatres, ITU, labour room, accident and emergency department should be considered. The hospital staff location system should give adequate cover to the department of anaesthesia.

#### **6. PROVISION OF COMPUTING**

Information technology plays a vital role in health management, audit and medical education. When designing a department of anaesthesia, adequate space and power supplies must be allocated for computer equipment including modems, visual display units, printers and associated stationery. In addition, provision should be made for ducting transmission cables. All offices (*vide infra*) should be equipped with a VDU terminal.

#### **7. UPGRADING OR ADAPTATION OF EXISTING BUILDINGS**

The guidance offered in this report applies essentially to the provision of accommodation within a new building. However, the principles may be applied when existing accommodation is being upgraded or new accommodation is to be constructed within an existing building previously used for other purposes.

## **8. BASIC ACCOMMODATION**

Recommendations for basic accommodation are based on a department with an establishment of 10 WTE consultants. The recommendations reflect the requirements of the clinical directorate, consultants, other career grades, trainees, managerial/secretariat and support staff.

When the consultant establishment exceeds 10 WTEs additional offices will be required on the basis of one office for every 2 WTE consultant posts. Similarly an additional 4.0 sq.m. should be added to the staff lounge for each additional 2 WTE consultants and the proportionate increase in trainee and support staff.

Dimensions and areas are set out in the Appendix.

It is important to emphasise that these recommendations are not intended to be prescriptive. A department of anaesthesia seeking new or upgraded accommodation should identify areas within the schedule which are appropriate to its requirements and plan accordingly.

Since the terms of a NHS Trust will normally dictate that capital and revenue charges will be ascribed to departmental accommodation, this should be considered when preparing the business plan.<sup>3</sup>

### **8.1. General office - office manager and departmental secretary.**

This area must cater for the day-to-day administration of the department. A partitioned area may be required for the office manager and the departmental secretary(s).

### **8.2. Office - director/chairman**

### **8.3. Office - business manager**

### **8.4. Consultant offices**

These will normally be provided on a basis of one office for every 2 WTE consultant anaesthetists.

### **8.5. Senior registrar(s) office**

This will normally be provided on a basis of one office for 2 senior registrars.

**8.6. Staff lounge (+/- beverage preparation area)**

This area provides facilities for the departmental staff to meet and discuss topics of mutual interest. The size of this room should be based on the number of WTE consultants on the basis of 3.5 sq.m. per consultant to take into account other staff also using the facility. A beverage preparation area should be provided, preferably as a separate small kitchen.

**8.7. Library/quiet room**

This area will house a small reference library of bench books and provide an area where trainees can study and make notes.

**8.8. Workshop/store/laboratory**

This area may provide space for technicians to service or repair anaesthetic equipment and for testing and demonstration of such equipment. It will also provide storage for items of anaesthetic equipment and sundries. An area within the room should be devoted to providing laboratory facilities. Medical gas outlets with a scavenging system may be required.

**8.9. Seminar room**

This room will provide essential facilities for training anaesthetists, undergraduates, nursing staff, paramedics and ODAs.

**8.10. Computer room/audit office**

This room provides secure space for departmental computer equipment and a base for processing information required for clinical audit. Electronic linkage to hospital information systems should be available here. A partitioned area could provide accommodation for an audit clerk.

**8.11. Office - secretary, non-acute pain management service**

**8.12. Locker bay**

The provision of a locker for each member of staff will permit secure storage of each individual's personal belongings.

### **8.13WCs**

**Note:** In departments over 16 persons additional WC facilities are required to conform to Health and Safety at Work regulations.<sup>9</sup>

## **9. SUPPLEMENTARY ACCOMMODATION**

### **9.1. Anaesthetic sister/senior operating department assistant (SODA) office**

A base will be required for the anaesthetic sister or SODA. The office may be provided within the operating department or in the department of anaesthesia.

### **9.2. On-call accommodation**

Where this is not provided elsewhere in the hospital, an on-call suite consisting of one or two bedrooms with en suite shower and WC must be included. This accommodation should be sited at a quiet end of the department and must be secure.

### **9.3. Office - secretary ITU**

Where this is not provided within the ITU suite, provision must be made within the department of anaesthesia.

### **9.4. Cleaner's room**

Local policy will determine whether this room is self-contained or is in a subsidiary of the main domestic department.

## Appendix

### Recommended Schedule of Accommodation

Departmental establishment: **10 WTE consultants**

	<b>Sq.M</b>
General Office	25.0
Office - Clinical Director/Chairman of Division	9.5
Office - Business Manager	8.0
Offices - Consultants (5 x 16.5 Sq.M)	82.5
Office - Senior Registrars	9.0
Staff Lounge and beverage bay (3.5 Sq.M/cons)	35.0
Library/Quiet Room	15.0
Workshop/Store/Laboratory	30.0
Seminar Room	40.0
Computer Room/Audit Office	12.0
Office - Secy., non-acute pain management service	8.0
WCs (2 x 4.5 Sq.M)	9.0
<b>Optional Accommodation</b>	
Office - Anaesthetic Sister/SODA	8.0
On-Call bedroom/shower/wc	15.0
Office - Secretary, ITU	8.0

**NB.** Add circulation space calculated at 33% of basic accommodation.

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