Membership of the working party

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Dr David Wilkinson Previous Vice President, AAGBI.
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Dr Anthea Mowat Conference Chair, BMA SAS UK.

The Working Party wish to thank all the contributors to the Handbook and the GAT Committee for their permission for the SAS Handbook to follow the format of the GAT Handbook.
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Welcome to the first edition of the Staff Grade and Associate Specialists (SAS) doctors Handbook. The idea for a handbook arose during the preparation of the latest edition of the Association’s glossy for SAS doctors. It was felt that it would be useful to have all the necessary information related to SAS doctors in a comprehensive manner in one document to which the Managers, Clinical Directors and SAS doctors can refer.

Whilst most of the issues covered in this handbook are very topical, and therefore are more likely to change over the course of time, every effort has been made to keep it up to date at the time of going to press.

I would like to thank all contributors to the handbook especially Dr Les Gemmell, member of the AAGBI Council and the Chairman of the Working Party, for the publication of the glossy and all the members of the working party. I would particularly like to thank Professor Mike Harmer, the President of the Association and the members of Council for all the assistance and encouragement.

I would also like to thank Claire Elliott and the staff at Portland Place for all their help with the design and printing. I do hope that this is going to be an on-going process. If there is anything you would like to see included in the next edition, please contact the SAS Committee at the Association.

Dr Ramana Alladi  
Chairman, SAS Committee, AAGBI
The Association of Anaesthetists of Great Britain and Ireland [AAGBI] was founded in 1932 with the following objectives: To promote the development of anaesthesia; to co-ordinate the activities of anaesthesia; to represent anaesthetists and their interests; and to encourage friendship amongst anaesthetists. Current membership of the Association stands at over 9000. This accounts for 90% of anaesthetists in the country. The Royal College of Anaesthetists [RCoA] census in 2004 identified 1243 doctors in Staff and Associate Specialist [SAS] Grade posts in anaesthetic departments in the UK. The number of SAS doctors with Association membership has increased to 400.

The activities of the AAGBI are co-ordinated by its Council. This consists of officers, elected members and several co-opted members including the SAS committee chairman. The AAGBI also has representation on the Council and subcommittees of the RCoA and the anaesthetic subcommittee of the specialists, committee of the BMA.

A large amount of the AAGBI's work is in education and development within the specialty. Two scientific meetings are organised each year. The Annual Congress is the largest and takes place at a different venue around Great Britain and Ireland each September. The Winter Scientific Meeting is held in London each January and includes a core topics day. The educational and professional development needs of SAS anaesthetists can be addressed through the Seminar programme. There is an annual joint AAGBI and RCoA meeting exclusively for SAS anaesthetists.

The AAGBI also organises an Annual Continuing Medical Education Day jointly with the RCoA as well as numerous seminars throughout the year, held at 21 Portland Place. All events are open to every anaesthetist, but discounted rates apply to members of the Association. The Association also has several working parties in progress at any one time to set standards and address concerns within the specialty. These then produce a ‘glossy’ of their findings and recommendations. A complete list can be found in the Directory of this Handbook. The glossies are available on the AAGBI website or as hard copies from Portland Place. The Association provides numerous grants and awards to its members for research and travel and, through the International Relations Committee, administers significant monies for projects in developing countries and sponsors a number of overseas lectures. A research grant up to £5000 is offered to SAS members of the Association. The grant may be used for any project of their choice, clinical or non-clinical. The project must have the support of the anaesthetic department and at least one consultant anaesthetist who should act as the project supervisor and share responsibility.

Anaesthesia, Europe’s leading anaesthetic journal, is the Association’s monthly scientific journal and is circulated to all members. With Anaesthesia, comes Anaesthesia News, the newsletter of the Association. This aims to keep members up to date with specialty news. There is a dedicated section for the SAS anaesthetist in Anaesthesia News. Both publications are also available to members online.

The AAGBI Staff and Associate Specialist Committee
The AAGBI committee was established in 2002.

The function of the committee is to:
- Represent the interests of SASG members in the AAGBI
- Advise Council on matters relating to SASG doctors
- Promote the aims and benefits of the AAGBI to SASG doctors
- Encourage professional development of SASG doctors
- Ensure effective collaboration with the SAS committee of the RCoA, other Royal Colleges and professional bodies.

The committee is structured as follows:
- An elected or co-opted member of Council who holds SAS status [The chairman]
- An Executive Officer of Council
- An elected member [non SAS] of Council
- Four SAS doctor representatives
- A representative from the Royal College of Anaesthetists [RCoA] SAS Committee.
The SAS committee, since its inception, has tried to raise the profile of SAS doctors and improve the membership recruitment. During the last two years, SAS membership in the Association increased by three-fold and now stands at 400. It has established a database of SAS doctors working in anaesthetics by writing to the secretaries of all the anaesthetic departments. In May 2005, a major survey of SAS doctors was carried out to obtain information about SAS doctors, their jobs, concerns and views on various aspects of their lives and work in hospitals. The questionnaire had a good response rate and this provided the Association with some very useful information that will assist the SAS committee in representing its members effectively.

The SAS committee organises a session for SAS doctors at the Annual Congress and this session includes topics relevant to SAS doctors. It conducts an SAS Review Day annually in association with the Royal College of Anaesthetists. The SAS committee has a separate section on the AAGBI website and provides useful and relevant information relating to SAS doctors in anaesthetics. The Anaesthesia News magazine has an ‘SAS Page’ which includes contributions from SAS doctors and articles relevant to SAS doctors.

A working party was formed to re-edit the Association’s glossy for SAS doctors. Due to the comprehensive nature of the information collected, the Council has decided to publish the information in the form of a handbook as well as a glossy in an abbreviated version.

The SAS committee meets twice annually. The chairman made presentations to the Advisory Committee and Linkman conference last year highlighting the issues faced by the SAS doctors in anaesthetics. It is the intention of the SAS committee to provide all the possible guidance regarding their careers, jobs and continuous professional development and raise the profile of SAS doctors working in anaesthetics.

Dr Ramana Alladi
Chairman, SAS Committee, AAGBI

Why join the Association?

The membership fee is extremely good value; some of the benefits of membership are:
- Up to £1 million of free personal accident insurance to cover you during any off-site work such as ambulance transfers
- Monthly copy of the international journal Anaesthesia
- Monthly copy of the newsletter Anaesthesia News
- Reduced conference fees for the WSM, Annual Congress and other Association-run conferences
- Free copies of all the Association’s ‘glossy’ guidelines, numbering 35 at the last count
- Professional advice
- AAGBI research grant.

To join please complete and return the application form in the centre of the handbook. For further information, contact the Association Membership Office on 020 7631 8801 or email members@aagbi.org.

BMA SAS Committee (UK)

The BMA
- Is a voluntary professional association of doctors
- Speaks for doctors at home and abroad
- Provides services for its members
- Is an independent trade union
- Is a scientific and educational body
- Is a publisher
- Is a limited company, funded largely by its members.

Its policies are decided by elected members, mainly practising doctors.

The BMA established the Staff and Associate Specialists Committee (SASC) at its annual representative meeting in July 2002 specifically to represent the unique needs of this group of senior hospital and community doctors. The committee has voting and non-voting members and has representatives from 12 English regions as well as the devolved nations. The full membership can be seen on the BMA web site.

The terms of reference

To consider and act in matters affecting those doctors working in NHS trusts who are not general practitioners, nor in the training grades and whose posts do not require their names to be on the Specialist Register, including matters arising under the National Health Service Act.
or Acts save in so far as the above matters fall within the duties and powers of the Central Consultants and Specialists Committee or the Committee for Public Health Medicine and Community Health’.

Aims

- Improve access to training
- Promote the enormous contribution made by the SAS group of doctors to the NHS
- Address poor pay for this group and the growing pay differential between them and medical colleagues
- Negotiate a new contract based on the proposals for a single spine
- Improve opportunities for career progression
- Develop clinical independence within recognised areas of competency for doctors in the SAS group
- Develop links with the Academy of Medical Royal Colleges and the PMETB
- Refine its policies on the role of competency-based assessment for SAS doctors
- Work with the Departments of Health, employers organisations and the medical royal colleges for improved career progression for the SAS group through the implementation of many of the proposals set out in Choice and Opportunity.

To join the BMA, or contact SASC
email: info.sasc@bma.org.uk or write to Secretary SASC, BMA House, Tavistock Square, London WC1H

The Royal College of Anaesthetists and SAS Grades

The College recognises and understands that the SAS Grade doctor have needs and concerns that are unique. We have our own committee in the College and there are two SAS members of Council who are there to represent all your views and concerns to the college. They are not just “the SAS members”, but full members of Council who take part in all the activities of the College including meetings with the DoH, especially where matters pertaining to SAS doctors are concerned.

The College is concerned with standards of anaesthesia. This means that the overall level of competence and education of all anaesthetists is under the remit of the College. To this end, the College looks at Professional Standards, Continuing Medical Education, Appraisal and Revalidation (with the GMC). These are, in the light of recent events, things that need to concern us as SAS doctors as well.

Continuing Medical Education

This is part and parcel of our commitment to furthering ourselves. The College is aware of this and is actively participating by providing educational days that are specifically for the SAS. The College is also cooperating with the Association of Anaesthetists of Great Britain and Ireland to provide more opportunities for Continuing Medical Education. AAGBI is more concerned with “Terms and Conditions” and working conditions. By getting together, both organisations will be able to strengthen and complement each other in their commitments to the SAS community in Anaesthesia.

Progression of the Grade

There is a lot of movement from the DoH and the BMA on this subject. The College is very much concerned and is working hard to be at the forefront of whatever happens here. We will need to wait, however to see what the legislation is going to be from the Department of Health.

The College also undertakes the assessment of doctors who apply under article 14 of the PMETB order 2003, for eligibility to enter the specialist register. It is, however, not a route for gaining a CCT. Further information on how to apply can be found on the PMETB website and also on the RCoA website.

Dr Andy Lim
Chairman SAS Committee, RCoA
Model Charter for SAS Grades

The NHS employer should aim to provide a working environment which recognises both the diversity of the SASG doctors and the major contribution that they make to patient care. The NHS employer should realise that the SASG doctors need both support and resource to develop both personally and professionally. The NHS employer should be committed to ensuring that the role of the SASG doctor is fully acknowledged and respected by management, colleagues and patients. In order to deliver these aspirations, the following recommendations are suggested.

Each Trust should work towards every SASG doctor having the following:

- An appropriate contract of employment incorporating national terms and conditions
- An appropriate agreed job plan. This may only be changed by mutual agreement between the SASG doctor and the Clinical Director (in accordance with the procedure for the agreement for the Review of Job Plans), and from any 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 SASG 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 SASG 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 SASG doctors (permanent staff) should be members of the Medical Staff Committee/Hospital Medical Board and should be invited to attend meetings
- There should be SASG representation on the LNC
- The employer should agree a mechanism or adopt BMA recommendations for regrading from Staff Grade to Associate Specialist
- Access to a fair and appropriate mechanism for the award of Optional points for Staff Grades and discretionary points to Associate Specialists. A minimum number of discretionary pointsoptional points should be awarded in a similar fashion as arrangements for consultants
- SASG doctors shall have equal access to the benefits of the Improving Working Lives initiative
- All SASG doctors should be members of the directorate and should be invited to attend directorate meetings.

How do I change my job plan?

Each SAS doctor’s job plan (including the work programme) should be subject to review each year. This annual review should provide an opportunity for the SASG doctor and the named consultant to discuss any problems which may have arisen and to settle any changes which need to be made to meet new circumstances or service priorities. It is likely that in many cases job plans will need to be amended only occasionally and even then will be subject to minimal alteration.

If it is a matter of change in sessions etc then the SASG doctor should talk to the Clinical Director or the Lead Clinician and arrange changes informally. If it is a change in number of sessions or time/allocation etc or on call day, then it is a change in job plan. Again the Clinical Director has to approve the change. This will require a job plan review.

If the change is significant e.g., wanting to come off ‘on-call’ duties, the SASG doctor can use guidance from the Fatigue and Anaesthetists glossy to help in the job plan review. If the request is based on some health grounds it is best to get the opinion of the Occupational Health physician as to the appropriateness of the request. When the changes reflect a significant change in job plan, the job description has to be revised and Human Resources informed to make necessary changes in salaries etc.
If there are any contentious issues you can write to Chairman of SAS Committee for further advice in the matter. Always remember to put everything in writing so that you can produce this for future reference.

Dr Ramana Alladi
Chairman, SAS Committee, AAGBI

How to apply to PMETB under Article 14

The Postgraduate Medical Education and Training Board (PMETB) was established by the General and Specialist Medical Practice (Education and Qualifications) Order 2003 to develop a single and unifying framework for postgraduate medical education and training across the UK. It assumed full statutory responsibilities in September 2005, taking over the function of the Specialist Training Authority STA (and the Joint Committee of Postgraduate Training for General Practice, JCPTGP) and became the competent authority for approving specialist training and certifying that doctors have reached the level of competence required to be included in the Specialist Register.

The Specialist Register is maintained by the GMC under Article 13(2) and contains the names of:
- Persons who hold a Certificate of Completion of Training in a specialty listed in Schedule 3; and
- Other eligible specialists as specified under Article 14

Under Article 14(4), applicants may have their training, qualifications AND experience considered against the requirements for one of the recognised specialities in Schedule 3. (SASG doctors are most likely to apply under this section).

Under Article 14(5), specialist training or qualifications from outside the UK in a medical speciality not listed in Schedule 3 OR knowledge/experience gained in academic or research work PLUS experience will be considered.

The tests to be applied to the applicant must demonstrate that training + qualifications + experience result in a level of knowledge and skill consistent with practice as a newly appointed consultant in the NHS. The generic criteria used to determine this are those covered by the GMC’s “Good Medical Practice” headings:
- Good clinical care
- Relationships with patients
- Maintaining good medical practice
- Teaching, training, appraising and assessment
- Working with colleagues
- Probity and health.

Evidence must be provided under all these categories and this must be original or authenticated documentary evidence of specialist qualifications and training. In this context, PMETB has defined ‘specialist qualification’ to be:

‘A diploma, certificate, accreditation, or other written evidence of success in a programme or programmes of postgraduate education or training in any speciality, including general practice, which may or may not be listed in Schedule 3 of the 2003 Order and shall have been awarded by an approved University, College, training body or institute as a result of success in an examination or formal assessment against defined standards’.

Such programmes will normally have been of at least 6 months duration.

Authenticated evidence must bear the official stamp or seal, signed and dated, of the employer or supervisor or notarised copies.

The application form requires:
- Proof of identity
- Copies of primary and specialist qualifications plus other relevant certificates
- Registration details
- Confirmation of training and other posts held
- Evidence of range and depth of experience/case mix
- Fee.

Examples of evidence might include:
- Curricula of training programmes
- Logbooks of training
- Portfolios for recent experience
- Evidence of performance review/appraisal
- Evidence of:
  - examinations
  - CPD
  - workplace assessment
  - research
  - teaching/management activity
- 360-degree feedback from colleagues or patients.

Weight will be given to recent or current evidence (5 years) but earlier experience may be considered.

Structured references will be required from 5 referees (plus one reserve). These should normally cover the last 5 years but there may be reasons why names from earlier periods will be used.
The process PMETB will follow when assessing applications will include:

- Receiving and checking applications, obtaining structured reports from referees and determining that the information is complete
- Passing the application to the College for evaluation against PMETB criteria, making a report with a recommendation
- Considering that recommendation and deciding whether to award a statement of eligibility.

Assessment will be made within 3 months of receipt of complete applications.

If the application is incomplete, the candidate will be informed and no fee charged. If the application is unsuccessful because further training or a workplace assessment is required, PMETB will inform the doctor.

Unsuccessful applicants may request a review of the process if the decision is thought to be unfair or the process defective. They also have a statutory right to an Appeals process. Further applications may be made after additional training or assessment within 3 years of the initial rejection.

Dr Kate Bullen  
Training Committee, PMETB

How can I re-enter training?

The College wishes to encourage SAS anaesthetists who want to return to training to gain entry to the Specialist Register. Re-entry might be into the formal Certificate of Completion of Training (CCT) programme or it may be individually tailored training to gain entry by the ‘equivalence’ route. Each case will be different and the advice given has to be pragmatic depending on the point at which formal training ceased, the individual’s experience, level of capability and confidence, and the length of absence from formal training. SASG doctors who are contemplating a return to training should first discuss the matter with their local Regional Advisor.

- **Point of re-entry to a formal CCT training programme**
  The point at which an individual re-enters the CCT training programme will be decided by the College’s Training Committee on the advice of the Regional Advisor. Training undertaken more than five years, previously should not normally be counted; exceptions to this are made on an individual basis.

- **Re-entering training in SpR year 1**
  Since February 2004 Senior House Officers applying for Specialist Registrar year 1 (SpR1) posts have been required to produce an SHO Training Certificate. However:
  1. Anaesthetists who completed their SHO training before 1 February 2004 and who are competently filling an SAS post will normally be assumed to satisfy the requirements of the SHO Training Certificate.
  2. Any other doctors without an SHO Training Certificate will be assessed individually by the local Regional Advisor prior to applying for a SpR post. If appropriate the Regional Advisor will issue a letter in lieu of the Certificate.

- **‘Top-up’ training and experience to fulfil equivalence criteria**
  Unsuccessful applicants for entry to the Specialist Register via the ‘equivalence’ route will be advised by the Postgraduate Medical Education and Training Board (PMETB) to gain further specified training or experience before re-applying. This can be undertaken anywhere in the world, but most SASG doctors will obviously want to do this in the UK. As yet no arrangements have been made to accommodate the needs of such doctors in the national postgraduate training programme.

- **‘Run-through training’**
  In August 2007 the first trainees will enter the new run-through training programme at the end of their second Foundation Year. Plans to allow SASG doctors to enter training at appropriate points are currently being discussed by the Modernising Medical Careers team. The Association strongly supports these principles.

Dr Andy Lim  
Chairman, SAS Committee, RCoA
How do I get involved in teaching?

The College, supported by the Association, recognises that SASG doctors have a valuable role to play in teaching. To be a teacher possession of the FRCA is not a prerequisite but, like consultants, SASG doctors must fulfil the RCoA’s CPD requirements; this is essential for those areas where they have clinical and on-call responsibilities.

The RCoA encourages College Tutors to identify those SASG doctors with aptitude and to nominate them to the local School of Anaesthesia, specifying the areas in which they have appropriate expertise.

SASG doctors who are Fellows or Members of the RCoA and who have been accepted by their School of Anaesthesia as teachers may, if they so wish, ask for their name to be recorded with the College as ‘Approved to Teach’. This list will soon be available on-line on the College Website.

The specific areas in which SASG doctors teach are best identified at local level, but may include specialist operating lists where an individual has expertise. SAS anaesthetists who undertake teaching must have the opportunity to acquire the skills of a competent teacher. There are courses available from the RCoA to teach anaesthetists “how to teach”.

When being taught by a SASG doctor, trainees must at all times have unimpeded access to consultants for advice.

Dr Andy Lim
Chairman, SAS Committee, RCoA

Help for Doctors with Difficulties

Almost all doctors will experience some difficulties either personal, professional or both during their careers. Although in many cases they will be able to cope with these satisfactorily without help, there will be times when the burden of the particular problem is too much.

In such circumstances the Association, in conjunction with other bodies such as the BMA, is working to provide guidance towards the most appropriate help. Some problems, both personal and professional can be anticipated, and to a considerable extent avoided by training in relevant interpersonal and life skills.

The Association has established a standing committee with the specific remit of caring for members’ welfare. This committee will plan, co-ordinate and oversee the services for doctors with difficulties. This will include providing educational seminars and other meetings to help members cope better with problems. We are also raising the profile of the whole issue by commissioning regular articles to educate and inform members.

We are concerned that a doctor with difficulties is able to contact help at any hour of the night or day. In order to do this we have agreed to link with the BMA Doctors for Doctors service, which provides a 24 hour service. Callers will immediately speak to a trained counsellor with additional access to a trained doctor advisor. Callers do not need to be members of the BMA or the AAGBI. The number to call is BMA- 08459 200 169 and ask to speak to a doctor-adviser.

For less urgent problems members should contact the secretariat at the AAGBI, 020 7 631 1650, who will put them in contact with the most appropriate person to advise them.

Dr Diana Dickson
Honorary Membership Secretary, AAGBI

Appraisal

The Department of Health has issued guidance for the appraisal of doctors belonging to the SASG. The guidance has been agreed with the SASC and issued as AL (MD) 05/02.
Appraisal is a positive two-way process, based on the seven headings of the General Medical Practice ‘Good Practice Guidelines’; namely, good medical care, maintaining good practice, teaching and training, relationships with patients, working with colleagues, probity and health. It uses information gathered on day-to-day activities, work and workload, self-reflection on practice, audit and multi-disciplinary working. The appraisal itself involves a discussion and review of the information gathered and identifies development needs.

Who is the appraiser?
Appraisal must be undertaken by a senior doctor on the medical register. The chief executive/medical director nominates an appropriate doctor who is properly trained in appraisal. Normally this will be the clinical director, lead clinician or named consultant, who would be the most appropriate person to carry out the appraisal. An important principle is that the appraisee should trust and have respect for the appraiser. There is a provision for the situation where there is an existing problem between the SASG doctor and the nominated appraiser; when the process is unlikely to be open and constructive. If this is the case the appraisee should notify the chief executive/medical director who will nominate suitable alternatives, which must include an appropriate SASG doctor, who is trained in the appraisal process and carries the confidence of the Trust management.

Content of appraisal
The process is largely based on the consultant model. It involves the development and maintenance of an appraisal folder for collection of supporting data and information using standard forms:

Form 1: Background details.

Form 2: Current medical activities (includes current job plan).

Form 3: Record of reference documentation and development action in past year (includes the 7 core headings from the GMC’s Good Medical Practice: good clinical care, maintaining good medical practice, relationships with patients, working with colleagues, teaching and training, probity and health.

Form 4: Summary of appraisal discussion and personal development plan.

Form 5: Personal and organisational effectiveness.

Form 6: Confidential account of appraisal interview.

SASG doctors will need to prepare their folder containing documentation which informs their appraiser of their professional details, their current medical activities (including a copy of their job plan), details of CPD undertaken in the past year, plus further information deemed relevant or useful for a structured discussion with their appraiser. Although doctors compile their own folders, Trusts are responsible for collecting and providing the data needed, such as audit data, and an early discussion needs to take place on what data is relevant and will be required. Appraisal includes relevant non-NHS work and the doctor is responsible for providing information and data on this work.

Preparation and training
The Department of Health stipulates that an appropriate level of support should be given to appraisers and appraisees and that adequate time should be allocated for preparation. In its guidance, it makes clear that time for the appraisal and any preparation should be instead of, and not in addition to, the SASG doctor’s existing workload and should take place within normal working hours. The guidance states that SASG doctors should be explicitly released from duties for a specified period of time in order to allow for proper preparation and for the appraisal itself.

Maintaining Good Practice
This is to show that your competencies and knowledge have been updated. It is also called Continuing Professional Development (CPD).

Teaching/Training.
This is about your contribution to teaching other health professionals, such as students, training grades, nurses or paramedics.

Relationship with Patients.
This is about how well you communicate with patients and their relatives. It is to clarify whether you are approachable, and give polite full answers.

Working with Colleagues.
This concerns working in teams with other health professionals and support staff such as secretaries/clerks, managers and ambulance personnel.

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Probity.
This is about honesty and integrity.

Health.
Make a statement about your health.

Management.
Note any management activity such as:
• Attending Directorate meetings
• Rota co-ordination
• Local Negotiating Committee work, and indicate the duration of these.

Research and Audit.
• Document any research activity, noting projects or proposals for research, and any reports or publications arising from research. If your service commitment, or a lack of resources, prevents research being carried out, then write a statement to that effect.
• Note any audit activity both local and national.

This will not be applicable on first appraisal.
• Review your personal development plan from the previous appraisal and state whether your goals were achieved
• If they were not achieved note why e.g. course cancelled, or training arranged but not yet undertaken. Decide whether further action is needed
• A recognised training need remains a need until fulfilled.

Next steps
It is the responsibility of the appraisee to forward the necessary documentation to their Chief Executive. Form 4 is essential and for the majority of doctors forms 1-3 should also be sent. Do not send all the reference documentation, or the detailed confidential account (if used), but retain them all, as they may be needed for revalidation through the managed route. Try to achieve your goals from the Personal Development Plan, and start to collect documentation for the next appraisal.

SASG doctors need a minimum of six half days over the course of the first year of the appraisal scheme and four half days in subsequent years. This is in addition to one whole morning or afternoon session which needs to be allocated for the appraisal meeting itself. Appropriate support and resources need to be provided by the Trust to assist SASG doctors in extracting the documentation and data necessary to inform the appraisal process.

Outcomes of appraisal
The appraisal generates a personal development plan for the SASG doctor and informs the job plan review.

The personal development plan (PDP) should also provide the basis for a review with specialty teams of their working practices, resource needs and clinical governance issues. The chief executive is responsible for ensuring any necessary action arising out of the appraisal is undertaken. The chief executive must also submit an annual report on the process and operation of the appraisal scheme to the Trust board.

Where there is disagreement
Where there is disagreement which cannot be resolved in the meeting, this is recorded and a meeting between the appraiser and appraisee will take place with the medical director or clinical director to discuss the specific points of disagreement.

Dr Anthea Mowat
Member, SAS Working Party, AAGBI

What is the EWTD?

European Working Time Directive (EWTD) is a directive from the Council of the European Union (93/104/EC) to protect the health and safety of workers in the European Union. It lays down minimum requirements in relation to working hours, rest periods, annual leave and working arrangements for night workers. The Directive was enacted in UK law as the Working Time Regulations, which took effect from 1 October 1998. This initially applied to consultants and career grade doctors only but was extended to the training grades in 2004.

What are the key features of the EWTD?
The main features are: No more than 48 hours work per week (averaged over a reference period) - 11 hours continuous rest in 24 hours - 24 hours continuous rest in seven days (or 48 hrs in 14 days) - 20 minute break in work periods of over 6 hours - four weeks annual leave - For night workers an average of no more than eight hours work in 24 over the reference period.

Can’t we ignore it?
No. The Working Time Regulations are UK health and safety legislation. Contracts requiring doctors to work outside the regulations will be illegal. It is also about the national commitment to improve working lives for all NHS employees.

Dr Les Gemmell
Chairman, SAS Working Party, AAGBI
Dignity and Respect in the Workplace

A survey in 2001 indicated that 37% of doctors reported being bullied at least once in the previous year and that this was more likely to affect black and Asian doctors.

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 difficulties in defending himself 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.

Employers should have mechanisms to help employees deal with concerns, as this issue is now being widely discussed. Previous beliefs that a career would be affected if concerns were raised are diminishing as the medical profession and society recognises that certain behaviours are no longer acceptable.

All employees should be able to work in a safe environment and there is legislation both UK (sex, gender, race and disability discrimination, protection from harassment, health and safety) and European (equal treatment directive, protection of dignity at work) which confer certain rights to all. It should also be remembered that if the bully is a doctor they are not complying with the requirements of Good Medical Practice and could be reported to the GMC.

Trusts should have a policy which defines how the issue of bullying is dealt with in your workplace and this will be available from the Trust HR department and website.

An important first step in dealing with this situation is to recognise that it is happening and being 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 (the clinical director) should be informed whenever possible. The College Tutor is also an impartial source of help and support.

The HR department can provide advice if you are being bullied and can refer you to occupational health and counselling services. Some Trusts have established a confidential service to advise staff who feel bullied and harassed.

If there is no-one locally you feel able to talk to then the post-graduate deanery or the BMA will be able to help.

Talking about what happened is never easy but is the first step in taking control of the situation.

It is advisable to write down what happened, where and when, who was present, what was said and how you felt. Try to get witnesses to incidents by avoiding situations where you are alone with the bully. If you feel bullied and harassed it has usually happened more than once, is there a pattern?

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 the legal system. Informal resolution should be attempted whenever possible but the situation may be so serious that 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 and there is the possibility of resolving the problem. 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. The person concerned may feel they are acting quite reasonably and be completely unaware of the effect of their behaviour and actions on you and others.

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 which you can use. If this seems like the correct way to resolve the situation 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. Whatever the outcome, it is important for those who feel bullied to realise that they are not powerless and have choices in dealing with the situation.

Dr Melanie Jones
Chairman, AIM

Staying out of Trouble

“Old man trouble, I don’t mind him, you won’t find him round my door.” George Gershwin

Very few of us will get through our careers without encountering some serious problems.

So the purpose of this section is not to turn you into an error-free practitioner - it can't be done. Instead, take note of the ten top tips that follow and you will hopefully make fewer errors, suffer fewer adverse consequences and, most importantly, learn from your mistakes.

1. Keep good records
When you make clinical decisions, you are going through a problem-solving process and reaching logical conclusions that dictate your management. Years down the line, however, if something goes wrong and you have to defend your practice, memory will have faded. If you are a good practitioner, then good, contemporaneous record-keeping is your best protection (if you are a lousy practitioner, of course, then it can damn you for all eternity, but you’re not, are you?). Good records will also mean that the next doctor who sees your patient will know what’s going on and be able to provide continuity.

2. Treat consent seriously
From both the ethical and legal viewpoint, the process of consent is becoming increasingly important. You are responsible for explaining what you are going to do to your patient, telling them what you hope to achieve by it, what might go wrong, and what the alternatives are. Be guided by this simple question: “If I were this patient, in his/her position and with his/her concerns, what would I want to know in order to make a decision about this treatment?” The debate between written and verbal consent is too complex to consider here (read the Association booklet on the subject), but the most important precaution is to 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.

3. Follow guidelines
Of course you are a professional, and of course guidelines can’t deal with every situation. But if you are going to deviate, make sure that (a) it’s for a good reason and (b) you make a good note of why you did it.

4. Don’t get out of your depth
Always maintain insight into what is going to be beyond your expertise.

5. Don’t get excessively focussed
We are a speciality that is very target-driven, and we pride ourselves on our skill at practical procedures. It is all too easy to become obsessed with getting that epidural/central line in to the detriment of the overall care of the patient. Stop, stand back, and consider. Is this necessary? Do I need help?

6. Communicate
No anaesthetist is an island. We can only work well if we work with others, so ensure that lines of communication between you, the surgeon, the theatre staff, the wards, the labs and the myriad of 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.

7. Be honest
Making a mistake is rarely, if ever, a disciplinary offence. Covering it up most definitely is. If something
goes wrong, come clean. Inform your supervising consultant and the other members of the team as soon as possible. Make a full note in the patient records explaining what happened and what you’ve done about it. Fill in an incident form. If you try to hide what you’ve done, you will almost certainly be found out, and your career will be at stake.

8. Apologise
It is an entirely natural tendency to avoid contact with a patient who you have harmed as a result of an error. Don’t. Patients and relatives will understandably see this as you being evasive and self-protective. When the furore dies down, go and see the patient/relatives and explain the situation honestly. Then apologise for what happened. This is not an admission of negligence and your honesty and openness will often persuade the patient not to take any further action.

9. Be nice
It is a fact of life that the nice doctor who makes an error is far more likely to come out of it smelling of roses than the nasty doctor. You are bound to need the help and support of your colleagues at times, and they won’t rush to help you if you’ve alienated them. The same applies to patients, who seem to be far more forgiving if they like you.

And, as a wise man once said, “be careful out there!”

Dr David Bogod
Editor-in-Chief Anaesthesia, AAGBI

Handling Complaints

It is an unpleasant fact of life that complaints occur in the NHS. A complaint can be defined as an expression of dissatisfaction requiring a response. Complaints can be informal or formal, verbal or written. They can come from patients, relatives, visitors or other members of staff, directly or via PALS (Patient Advice and Liaison Service) or ICAS (Independent Complaints Advocacy Service).

Most Trusts will have a Complaints Policy and it is important to follow it carefully. However, if dealt with promptly and sympathetically, it is often possible to resolve a complaint at an early stage and avoid a formal complaints procedure.

An informal complaint is where an issue is raised and it is possible to resolve it at the time, to the complainant’s satisfaction, without going through the formal process.

If it is impossible to resolve a complaint at this early stage, it becomes a formal complaint. Written formal complaints must be acknowledged in writing by the Complaints Department of the Trust within two working days of receipt. Any complaint should normally be made within six months of the incident, or within six months of discovering the problem, in order to allow a full investigation. A written response will be provided following an investigation into the issues raised by the complainant and the response letter signed by the Chief Executive or deputy. This will be sent to the complainant within 20 working days, as required under the 1996 NHS Complaints Procedure.

In this final response letter the Chief Executive must ensure that the facts are correct, include an apology (not necessarily accepting blame or fault), address and explain each of the issues in turn, and give details of the investigation and any action taken. The complainant will also be given the name and contact details of the investigating officer and offered an opportunity to meet the key staff involved.

Rarely, if the matter is not resolved to the complainant’s satisfaction, they have the right to ask for an Independent Review. Where a complainant indicates or implies that legal action may be taken or compensation sought, the matter is passed on to the Legal Services Department.

As clinicians, we may be involved at an early stage in an informal complaint or asked to be part of a formal investigation. Nothing but experience will prepare you for a face to face encounter with a dissatisfied patient or relative. As a SASG doctor, even if the complaint is directed at you, it is entirely inappropriate for you to deal with it by yourself and you must seek help from an experienced consultant. Do, however, ask to be involved closely at every stage of the procedure, in order that you might learn from it.

In the case of an informal, verbal complaint, it is important to respond without delay. An interview should be arranged in a quiet, undisturbed and non-confrontational setting. For instance, do not sit behind a desk or dress as if you have been called suddenly from theatre (even if you have). Turn off your bleep, pager or mobile telephone. If the patient is still in bed recovering from surgery or in pain, offer to meet at a later date. Have a witness with you, perhaps a ward nurse, and ask the complainant if they would like someone else in to give them support.

The first thing to do is to establish the exact nature of the complaint. To do this you need to listen carefully to the patient without interruption until they have stated their case. It is quite possible that they will
APPLICATION FOR MEMBERSHIP

to

The Association of Anaesthetists of Great Britain and Ireland

21 Portland Place, London W1B 1PY
Title: ........................  Forenames: ..........................................................  Surname:  ..........................................................

I offer my name as a candidate for membership (please tick the appropriate category)

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<th>Category</th>
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<td>NEW Ordinary and Associate</td>
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<td>Trainee Fourth Year of Training</td>
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<td>Trainee 6th plus Year of Training</td>
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<td>Trainee Overseas</td>
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<td>Retired (not receiving the journal or Anaesthesia News)</td>
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Date of Birth: ....................................................................................................................... Gender: Male/ Female

Qualifications/Honours: ......................................................................................................................

RCA Membership number: .............................................................. Job Title: ............................................................... 

Correspondence address: ......................................................................................................................

Postcode: ................................................................. Email address: .................................................................

Home phone (inc code): ............................................................ Mobile: .................................................................

Hospital name: ............................................................ Hospital Phone: .................................................................

Signed: ................................................................. Date: .................................................................

On occasion, the Association may make available its list of members to other societies and companies wishing to circulate information which it considers may be of interest to anaesthetists. If you do not wish to receive such information please tick the box.

We, being Members* of the Association, nominate the above named as a candidate for membership.

*Both sponsors must be Ordinary Members of the Association.

PLEASE USE BLOCK CAPITALS THROUGHOUT

1. Surname .............................................. Initials ............... Membership No ..............................................

   Signed ................................................................................................. Date .................................................................

2. Surname .............................................. Initials ............... Membership No ..............................................

   Signed ................................................................................................. Date .................................................................

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The Staff and Associate Specialist Grades Handbook 19
## ANNUAL SUBSCRIPTION RATES

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### HOW TO APPLY FOR MEMBERSHIP

1. Complete the application form overleaf.
2. Ask two members of the Association to countersign the application, both of whom must be Ordinary Members.
3. Send this form to the Membership Department, Association of Anaesthetists, 21 Portland Place, London W1B 1PY. (Telephone 020 7631 8801; Fax 020 7631 4352)
4. Your application will be taken to Council for approval and acceptance, following which we will write to you again.
5. **PLEASE DO NOT SEND ANY PAYMENT WITH THIS FORM**
be distressed or angry. It is crucial, however, that you remain completely unemotional, even if you are feeling particularly aggrieved, as an aggressive response will only result in an escalation of the problem. If you are unclear about the details, using open questions, gently probe for more information or ask for clarification. When you think you have got the gist, repeat the problem as you see it to the complainant and ask if that is right. Ask if there are any more points that need airing. Above all, be unhurried, calm and sympathetic.

It is perfectly fine to say you are sorry, particularly if you are! Saying sorry does not mean an admission of liability. You might be sorry because the service has been less than optimal, or you might simply be sorry that the complainant is upset, however misguided. Say so. Most people can understand that systems occasionally break down. A simple apology and evidence that lessons have been learned may be all that is needed. A very angry (and rightly so) patient once burst out laughing after I had apologised profusely by saying “I’m really sorry Mr X, we have been completely rubbish this afternoon and you are quite entitled to be furious at the inconvenience.” It is, however, not always possible to resolve matters quite so easily.

Complaints are often multi-factorial and it may be necessary to work through, step by step, teasing out all the issues and addressing each one in turn. Try and pick out those that you can agree on and deal with them first. For example, “Yes, hospital food is not as good as it might be”; “It was unlucky that you were last on the list and had to wait so long”; “I’m sorry if I seemed brusque but today has been a particularly hectic one and it was really necessary that I concentrate on giving you the best and safest anaesthetic I could.” This helps the complainant to feel you are on their side.

Stop and recap frequently to make sure you are both talking about the same issues. Ask the patient what they feel could have been done differently and what they would like to see happen in future. If there are still unresolved points towards the end of the interview and/or the issue looks serious or complex, the complaints manager can intervene - either to investigate the problem or co-ordinate, in conjunction with appropriate staff, the resolution of the issue.

You should date and document a précis of the main points of your conversation and record who was present. Show this to the complainant and, if possible, ask them to sign it as a true record. Before you leave, offer further opportunities to discuss the matter, at a time and place that are convenient to you both.

Occasionally, complaints that seem vexatious and unfair are made, often by persistent complainants. It is important to remember, however, that if someone makes a complaint, it is real to them, whatever you think. If you label a complaint as vexatious from the start, it will never be anything else. This may get in the way of your ability to understand, and may prolong the resolution of the issue. Most Trusts will have a procedure for dealing with difficult complainants and this should be invoked.

The basic principles that apply to a verbal response also hold true when composing a written response. First, make every effort to understand and define the complaint, treat the matter seriously and empathetically, analyse the issues and be honest about failings and mistakes, ask for further investigation of unresolved points, and finally, suggest future policy that will prevent recurrence.

Further information, case studies and links can be accessed on the DOH Complaints Procedure website.

www.publications.doh.gov.uk/complaints/toolkit/

Dr Stephanie Greenwell
Vice President and previous Editor Anaesthesia News, AAGBI

Pensions

Those working within the NHS are lucky enough to qualify for the NHS Superannuation pension scheme. As a final salary scheme based on an individual’s length of service, it is one of the most generous perks that can be provided by an employer.

The government constantly worry about the running costs of such a scheme and have suggested that, in
the future, the level of benefit may be reduced. This is likely to be in one of two ways. The first is by increasing the normal retirement age from 60 to 65. The second is to calculate pension income on career average earnings as opposed to final salary. If you are still working within the NHS after 2013 you may be affected by the changes; however the biggest impact will be for employees starting after 2013.

Unlike the private sector with its funded schemes, the NHS does not rely on the performance of the stock market to generate sufficient monies to enable payments to its members. You are therefore allowed to read this article with relative smugness; you are a member of an index-linked, government-backed final salary scheme. There are only a handful of schemes that are more generous!

However, as with all plans including retirement strategy, it is important that you understand the tactics available to you and that you maximise certain opportunities. Over the following pages I will outline key actions that should be acted upon as a matter of course, and those that be considered when planning for retirement.

Request a statement of membership from the NHS Pensions Agency
A statement of membership will summarise all of your NHS pensionable service to date. In my experience approximately 25% of statements are inaccurate. Although it is normally simple to amend, it can be time consuming and should therefore be done well in advance of retirement. When requesting the statement it may be useful to also request a statement of benefits through to age 60.

A request for this information can be requested from the following address, for ease always have your National Insurance Number to hand.

NHS Pension Agency
www.nhsa.gov.uk
Hesket House
200-220 Broadway
Fleetwood
Lancashire
FY7
Tel: 01253 774774

Consider the purchase of Added Years
Within an article it is impossible to offer advice that is applicable to everyone; however I am able to give generic ideas. At present, as members of the NHS scheme you pay 6% of your pensionable earnings to fund the pension. The NHS pays 14% on your behalf. The main portion of your pension is heavily subsidised.

Although inflexible, added years generally represent excellent value for money. They are a method of enhancing the level of the pension that you will receive from the NHS. The cost for each year depends on your age and will be paid from the date the contract commences until the age of 60 or 65. I would strongly encourage the earlier retirement date of 60 (please see next point for further explanation).

The amount of added years you are eligible to purchase is limited to 9% of your NHS pensionable salary. For younger doctors, this allowance is large enough to purchase all years missed. For older doctors, this may cap the shortfall that can be made up.

Added years offer a defined level of benefit, which makes it easy for you to calculate the length of time you must live in retirement in order to justify the cost of their purchase. Typically, this may be as little as 6 years.

Retire at 60 and not 65
To decide the appropriate retirement age many factors must be taken into account. From a purely financial standpoint, however, it is rare that the above rule is invalidated.

Individuals who retire prior to 60 (the normal retirement age) are penalised due to actuarially calculated costs of paying an individual for a longer period of time. The same principle should be applied for those that retire after aged 60, with actuarial enhancements. Sadly this is not the case.

If at age 60 an individual is eligible for a pension of £40,000 per annum, but chooses not to draw the...
pension, the ‘surrendered’ amount totals £200,000 over a five year period.

From an income perspective, it is rare for the further accrual of service and potentially higher salaries to generate sufficient pension income to justify the continued work. A typical break-even point for the additional years of service is beyond 105.

Due to the above principle it is becoming more common for hospital doctors to ‘retire’ and then to return to work either on a part- or full-time basis.

**Review your Personal Pensions and Additional Voluntary Contribution schemes**

Many doctors, particularly those with private practice, run personal pensions alongside their superannuation scheme. Others have opted for free-standing additional voluntary contributions (FSAVCs) as an alternative to buying added years.

If you set these up some time back (and certainly if it was prior to 2001) you might find that the charges are higher than you would expect today. You should take independent advice on whether it would be in your interest to transfer to a pension with a more modern, flexible and ‘clean’ charging structure. Although charges aren’t everything, higher charges will inevitably impose drag on your investment growth.

The new pension regime that arrived on April 6th allows you to transfer FSAVCs to other forms of pension arrangement – in particular personal pensions-something that wasn’t previously possible. Once again, this might enable you to invest in a lower-charged contract, possibly with more extensive fund choices.

If you want the fullest possible investment choice and have a decent sized fund already (probably around £150K or more) then a Self Invested Personal Pension (SIPP) might be the right thing for you. Rather than a number of funds selected by a life company, a SIPP gives you the option to invest in the market range of unit trusts and OEICs, individual shares and bonds, commercial property – the list is almost endless. SIPPs, though, are generally more expensive than personal pensions, and best suit those with larger funds and perhaps slightly more adventurous investment appetites.

**Optimise your non-pension assets**

Many doctors have built up collections of unit trusts, shares, ISAs and PEPS over the years. Quite often this has been a little bit of an ad hoc process, lacking in any over-arching strategy. The problem is that investments that were doing well at the time might have slumped – the manager might have left, the sector in which the fund is invested might be going through the doldrums or it might just have been a poor fund from the start.

You need to take advice on your current portfolio, first to work out what percentage you want in shares, bonds and property (the three major ‘asset classes’). This determines to an extent the level of volatility that your investment portfolio will generally exhibit. Then you need to think about how much you want invested in the UK, and how much in the world at large. Finally it’s important to decide whether you are going to use ‘active’ fund managers (who try, generally unsuccessfully, to beat the market) or a passive strategy that aims to capture the market rate of return. The latter is usually a good deal cheaper than the former.

By using an internet-based ‘wrap’ platform you can consolidate your funds and shares in one place, with up to date online valuations and far less paperwork. It can also lead to some quite significant cost efficiencies as the ‘wrap’ provider will negotiate hard with fund managers to obtain quantity discounts on charges.

**Dr Mark Martin**

*Cavendish Medical*

**How to get published**

Before launching on the long, arduous and often fruitless task of seeing your name in print, it is really worth asking yourself “Why do I want to do this?” There may be other ways to achieve your ultimate goals. Thus:

“I want to improve the way we deliver our service” – do a well-directed audit project (see below). It doesn’t need to be published to be successful and may well change practice far more than the most widely cited controlled double-blind trial.

“I want to be in a good position when the discretionary awards come round” – nothing wrong with this! But perhaps better achieved by taking on local tasks such as clinical governance, morbidity meetings, equipment purchase etc.

“I want to raise the standing of SASG doctors” – then get involved in politics. The SASG doctors need good regional and national representation. Very few readers of a journal will recognise that the chief author of a paper is a Staff Grade anaesthetist, rather than a consultant.
Still determined? Then consider the various routes onto the journal pages.

**Correspondence**

Still the easiest route to get published. A letter is more likely to succeed if (a) it is a comment on a published paper, (b) it arrives on the editor’s desk within a week or two of the original article, (c) it makes a clear, unambiguous point which the authors have failed to address, and (d) it is 400 words or fewer. Don’t resort to personal abuse (even if you don’t like the author) and do reference your points if you can.

Many journals nowadays – including Anaesthesia – have a web-based system for responding to published articles. Read the instructions carefully to make sure you’re heading down the route (electronic or paper) that you intend to follow.

**Case reports**

If there is one area where the SASG doctor has an advantage over the consultant, it is with the case report. You are more likely to have regular lists (and more of them), of a specific speciality and a good relationship with your surgeon. This is the fertile ground in which case reports grow.

Case reports do not need ethics committee approval (see below), but the journal editor may well insist that you obtain the patient’s consent to publish. It is best to have this eventuality covered while the patient is still under your care.

The problem with case reports is that they have a lousy acceptance rate. Anaesthesia accepts about 1 in 3 original papers, but only about 1 in 4 or even fewer case reports. One of the reasons is that the editor always has one eye on his ‘impact factor’ and this is closely related to how often papers get cited by other authors; case reports don’t get cited very often. Here are the main excuses for rejection:

(a) It’s been described before.
(b) The patient may well have a novel condition, but it doesn’t impact much on how you anaesthetise them.
(c) Nobody in their right mind would have anaesthetised this patient this way. Editors don’t like to promulgate poor practice in their pages.
(d) It’s a brief enough communication to be relegated to a letter.

If you want to increase your chances, make sure that there’s a lesson in the report that is new and important, accompany the report with a well-researched and referenced discussion, and ensure that it’s exciting to read (the word ‘sexy’ has been used).

**Review articles**

This is another area where you can remain a stranger to the ethics committee, but it is far from an easy option. A review article is doomed from the outset if the topic is not chosen very carefully. Ensure that it is not something that has been done before (or at least in the last five years) and that there is enough material already published to make a review worthwhile. Thus “coagulation and regional blocks” has been done to death, and “Anaesthesia and sick sinus syndrome” is likely to be rather too short and unsupported.

Review articles live and die on two things: the quality of the literature review, and the quality of the writing. The literature review is a lot easier than it was in pre-computer days, but it still needs someone who really knows what they are doing to avoid missing a lot of relevant work. Your librarians are there to help you and have resources that you don’t even know about yet: use them. Ensure you haven’t missed anything by manually searching the reference lists of the first tranche of papers that you identify. And get help. A well-motivated trainee will be able to assist with gathering the literature. A respected consultant in the field of study will add some weight to the author list – regrettably still a factor that influences editors when considering reviews.

A review needs to be readable. The English should flow naturally and easily, and you should work hard to distinguish evidence from opinion and to express both – both are needed for a good review.

**Audit projects**

There is a view ‘out there’ that editors don’t like audit projects. This is not true, at least with respect to Anaesthesia. A good audit project has the potential to improve practice across the health service, something that can rarely be said for a clinical trial. But the emphasis here is on the words ‘good’ and ‘audit’. A research project aims to determine what is best practice. An audit project is designed to find out whether the best practice – as defined by the previous research – is being achieved and, if not, how to achieve it.

Therefore, make sure that there is an existing standard, preferably national, which you can use. Set up the audit carefully to assess that standard and how well it is being achieved. You may well not want the staff to know you’re auditing them, or the results will magically improve and not reflect the usual situation. When the standard is not met, devise a method to improve compliance, introduce it, and then re-audit.
Most audit submissions are rejected by editors because the cycle has not been completed.

Finally, even when data is anonymised and collected as part of normal practice, you may need approval from your Local Research Ethics Committee (LREC) in order to pass the editor’s scrutiny. It’s not as difficult as it seems from the amount of paperwork required, and it’s best to be on the safe side.

Clinical studies
The holy grail of the researcher, the controlled, double-blinded clinical trial, is a target to aim for, but realism must be maintained at all times. A lot of studies fail because researchers run out of time, money, energy, or goodwill. The answer to all of these problems is: keep it simple.

A good research study needs a primary question that can be addressed by testing. The ideal question should be clinically relevant, easy to understand, and able to be tested by simple and cheap means. The question “do patients get a larger bruise after venepuncture if they keep their arm straight and press on a swab or if they bend their arm to keep the swab in place?” fits these criteria, and was the subject of a study which, in all modesty on the author’s part, is worth examining.(1) There were only two groups of subjects (quick to perform and easy to analyse); subjects were able to act as their own controls (one arm straight, the other bent, minimising the number required and allowing powerful statistical tests to be used); volunteers could be used instead of patients (easier recruitment); there was minimal invasion (few ethical problems and easy to persuade people to take part); analysis of the final outcome could take place only 48 hours after the initial venepuncture (study quickly wrapped up).

However simple the study, time spent planning is never wasted. Getting the hypothesis right, establishing exclusion criteria, choosing the sample size, and selecting appropriate statistical tests can only really be done at this stage. LREC approval, Research and Development approval (often needed separately), and funding need to be sorted. Your Trust may well have facilities to help with these tasks; if so, use them. When planning, be pragmatic. Your recruitment rate will probably be a lot slower than you think it will be, and the time needed for the study a lot longer.

How NOT to get published
Sadly, it is difficult to get published and much easier not to. If you want to achieve the first and avoid the second, here’s some pitfalls to watch out for:

**The woolly hypothesis** – difficult to test clearly

**Inadequate sample size** – insufficiently powerful to sufficiently minimise the risk of the dreaded type 2 error.

**Historic controls** – taken from a time when other practices as well as those under study were different

**Lack of best blinding** – introducing the risk of unconscious bias.

**Inappropriate comparison with placebo** – raising ethical questions (e.g. comparing a new anti-emetic against placebo in a young female sample undergoing laparoscopy and therefore at high risk of PONV).

**Inappropriate statistics** – get expert help before you start.

**Not reading the instructions to authors for your chosen journal** – there is little that annoys editors more than failure to follow guidelines. If in doubt, e-mail the journal and ask.

**References**

**Dr David Bogod**
Editor-in-Chief Anaesthesia, AAGBI

Snow’s Chloroform Vaporizer in use, 1847
Since the inception of the NHS, it has been a requirement that every patient’s care is undertaken either by a Consultant or in their name by a trainee or non-consultant career grade. Although this is more apparent in “bed owning” specialities it applies to all. The RCoA’s Guidelines for the Provision of Anaesthetic Services (1999) paragraph 2.1 states that “all services provided in the NHS are under the supervision of a consultant. This applies to all anaesthetic services. Where trainee or non-consultant career grade anaesthetists are providing clinical services this principle must be applied”. More recently NCEPOD advice and recommendations from Quality Improvement Scotland require that each anaesthetic form records the name of a responsible consultant if the case has not been undertaken directly by a consultant. Similar requirements exist in the Republic of Ireland. The AAGBI believes that all Departments of Anaesthesia should now ensure that every patient undergoing anaesthesia has a designated consultant anaesthetist whose name is recorded on the anaesthetic chart.

All departments should have an agreed and recognised system whereby a ‘named’ consultant is identified and recorded for every patient. This will be the person to whom trainees and SASG doctors should turn to for advice and/or help about a case. It should be clear to all grades of staff how the local system operates and the named individuals should be able to provide or arrange for immediate advice and/or direct assistance as required.

Each department should have a protocol for trainees and non-consultants clearly stating the criteria which make seeking advice or instructions mandatory and the degree of judgment which individuals can exercise on their own responsibility. This will obviously vary considerably depending on the training and experience of the individual. For trainees the degree of supervision and support provided should adhere to Royal College of Anaesthetists’ requirements.

The maximum number of lists which can be supervised by any one consultant will depend on the geography of theatre suites, the experience of those requiring supervision, together with the complexity of the patients and procedures proposed.

The local interpretation of the above for individual SASG doctors will depend on a number of factors – not the least of which will be the knowledge, skills and experience of the individual. Clearly when a senior Associate Specialist is working in an area with which he or she is very familiar, the requirement for contact and discussion about individual cases may be rare. Indeed what discussion takes place may well be in the context of overall strategy and management policies in the unit. In contrast, it may be appropriate for a recently appointed staff grade doctor to be more formally supervised.

Dr Alastair Chambers  
Honorary Secretary, AAGBI
Clinical Governance

Clinical Governance is the system of steps and procedures adopted by the NHS to ensure that patients receive the highest possible quality of care. It covers how the healthcare professional treats 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 prevention of errors and accidents.

It is a framework through which NHS organisations are 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 United Kingdom is required to comply with clinical governance. It is there 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 failures in the system, particularly failures in standards of care be they due to organisational, financial, failures of management or failures in medical care.

The various elements that form part of Clinical Governance include:

Clinical Effectiveness
These include Clinical guidelines for specific conditions and National Service Frameworks.

Clinical audit
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 collected for a second time and analysed to see if any improvements have resulted from these changes. This process can be repeated several times as necessary.

Research
There is a difference between clinical audit and research and it is important not to confuse the two. Research is a process that tries to find out what you should be doing to your patients, be they new things or established methodologies. Audit is a process that tells you whether you are actually doing what you should 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
The process to provide competency based training, leading to demonstrable evidence of skill and capability. PMETB has become the competent authority for approving specialist training and certifying that doctors have reached the level of competence required to be included in the Specialist Register.

Continuing Professional Development (CPD)
This 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. It is linked to appraisal, where training and development needs are agreed and personal development plans are implemented.

**Professional Regulation**
These include employment checks, registration details, qualification checks, Criminal Records Bureau checks etc.

**Clinical Risk Management**
This is a process that ensures that no harm comes to patients either through malice or incompetence of clinicians, and that systems exist to detect and limit any harm that may be occurring.

**Patient Safety Management**
This is both a reactive and proactive process and it requires a lively multidisciplinary approach. A Trust can learn from its own or other errors, from national safety alerts and ombudsman’s reports and from DoH directives as well. A major part of patient safety management is to ensure that lessons from all these sources are recognised and addressed.

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.

**Dr Ranjit Verma**
*Council Member, AAGBI*

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**The Healthcare Commission**

The Healthcare Commission exists to promote improvement in the quality of NHS and independent healthcare in England and Wales. For the first time Parliament has created a single organisation that can review the quality of care across both the NHS and independent healthcare sectors.

The Commission began work in April 2004 and has a range of new functions as well as responsibility for the work it took over from other organisations. It replaces the work of the Commission for Health Improvement (CHI), has taken over the private and voluntary/independent healthcare functions of the National Care Standards Commission and picks up elements of the Audit Commission’s work that relate to value for money in healthcare.

**Annual ratings and reducing the burden of inspection**
The Healthcare Commission is responsible for assessing the performance of both NHS and independent healthcare organisations and awarding annual performance ratings for the NHS.

The current annual performance rating system, also known as star ratings, has concentrated on performance against specific targets, such as how long patients wait to see a GP. From 2005 the Commission wants to use a new approach to this so that the performance rating recognises improvement and gives a richer picture of how each healthcare organisation is doing. It will assess performance in relation to the Government’s new core and developmental standards (Standards for better health), as well as the existing and new targets the NHS is expected to achieve. The Commission wants its assessments to produce relevant, useful and robust information for both patients and healthcare professionals.

Specifically assessments should help to answer two questions:
- Is the organisation getting the basics right?
- Is it making and sustaining progress?

The Government’s new standards make it clear that Trusts and their boards have to assure themselves that they are meeting the core standards and are making progress in meeting the developmental ones.

The Commission will ask for, and make better use of, the information that healthcare organisations already have available. It will only actually visit where there is cause for concern. When organisations have demonstrated good performance and effective leadership, assessments will have a ‘lighter’ touch.
The Commission recognises that going through an inspection can place a massive burden on the people providing services to patients. The Healthcare Commission is charged with being the lead health inspectorate. As such it has established a concordat with other health regulators and inspectorates, so that inspections can be coordinated, and disruption to doctors and nurses minimised as much as possible.

The Healthcare Commission runs thorough investigations to find out what’s happened when things go wrong, and when a health service has seriously failed patients.

Complaints
In July 2004 the Healthcare Commission established a second stage for complaints about NHS services that have not been resolved locally. An independent panel of lay people will hear the concern, look at the original response and make recommendations for resolution and improving services. Complaints that cannot be resolved by the Healthcare Commission may be referred to the Health Service Ombudsman.

Independent healthcare
Subject to further legislation, from 2006 the Healthcare Commission plans to assess independent healthcare by reference to the same core and developmental standards that apply to the NHS so that people can be sure standards are being met in both sectors. Every independent healthcare provider must be registered with the Healthcare Commission.

Dr Les Gemmell
Chairman, SAS Working Party, AAGBI

NICE is also responsible for three Confidential Enquiries. These are:

- The Confidential Enquiry into Maternal and Child Health (CEMACH)
- The Confidential Enquiry into Suicide and Homicide by people with Mental Illness (CISH)
- The National Confidential enquiry into Patient Outcomes and Deaths (NCEPOD).

National Service Frameworks

These nationally published documents set out best practice models of care, standards to be achieved. They set specific targets and clinical audit requirements to ensure compliance. They focus on national priority areas such as cancer, coronary heart disease, care of older people, and diabetes.

National Patient Safety Agency

The National Patient Safety Agency (NPSA) is an NHS Special Health Authority set up in July 2001 following recommendations from the Chief Medical Officer in his report on patient safety, ‘An Organisation with a Memory,’ and its follow up, ‘Building a Safer NHS for Patients.’ These reports brought attention to the estimated 900,000 incidents each year resulting in harm or near-harm in NHS hospitals. They also drew attention to the scale of the problem relating to events that might potentially result in unintentional harm to patients, and acknowledged that there has been little systematic learning from patient safety incidents in the past.

The role of the NPSA is to improve the safety of patients by promoting a culture of reporting and learning from patient safety incidents. To achieve this the NPSA has set up the National Reporting and Learning System (NRLS), and the data collected through this system will help to:

- Identify trends and patterns of avoidable incidents and underlying causes
- Develop models of good practice and solutions at a national level
- Improve working practices in NHS organisations locally through feedback and training
- Support ongoing education and training.

National Institute of Health and Clinical Excellence (NICE)

This is a special health authority for England and Wales and provides patients, health professionals and the public with authoritative, robust, and reliable guidelines on current ‘best practice.’ It produces regular publications on:

- The use of new and existing health technologies such as medicines, medical devices and procedures (technology appraisal)
- The management and care of specific conditions (clinical guidelines)
- The use of new interventional procedures
- Referral guidelines between primary and secondary care.

The Staff and Associate Specialist Grades Handbook
In order to improve patient safety, the NPSA has identified seven steps that NHS organisations should take:

1. Build a safety culture
2. Lead and support staff
3. Integrate risk management activity
4. Promote reporting
5. Involve and communicate with patients and the public
6. Learn and share safety lessons
7. Implement solutions to prevent harm.

The aviation industry is often quoted as a model for improving safety. It has been shown that as the number of critical incidents in aviation that were reported increased, the number of accidents decreased. This has been attributed to an open, blame-free culture associated with incident reporting, shared information, and training to avoid repeating the errors leading to specific critical incidents. This is the model that the NPSA hopes to emulate.

The Royal College of Anaesthetists already has an established critical incident reporting system, which is recognised by the NPSA as being invaluable for specialty specific incidents. The NRLS system is intended to have links into the College’s and other reporting systems so that anyone reporting a safety incident electronically will be directed to the appropriate additional reporting sites.

The NPSA’s activities to date include restricting availability of strong potassium chloride, standardising the crash call number to 2222, and the ‘clean your hands’ campaign. It has published a Patient Safety Alert on ‘Correct site surgery’ which is intended to prevent wrong side or site surgery (www.npsa.nhs.uk/advice).

In addition to the central agency building based in London, the NPSA has appointed a network of 32 patient safety managers across the Strategic Health Authorities in England, and the NHS Regions in Wales. A Consultant Specialty Adviser (CSA) has been appointed for most specialties. The Consultant Specialty Advisers, as the name suggests, advise the NPSA of relevant issues and promote the Agency with their specialty and vice versa. To assist in this the CSA in Anaesthesia has been co-opted onto the Safety Committee of the Association of Anaesthetists.

The NPSA is rapidly becoming the government agency overseeing all aspects of patient safety. It is likely to take on the work of NCEPOD and the function of other agencies such as the Medical Healthcare products Regulatory Agency and the National Clinical Assessment Authority.

The Medical Healthcare products Regulatory Agency (MHRA)

The MHRA was formed in April 2003 by the amalgamation of the Medical Devices Agency and the Medicines Control Agency. The Agency’s function is to ensure that medicines, healthcare products and medical equipment conform to appropriate standards of safety, quality, performance and effectiveness, and are used in an appropriate and safe manner.

On the devices side, the agency evaluates medical devices to inform purchasing and to advise on their safe use. These devices range from wheelchairs to MRI scanners, and include anaesthetic equipment (a recent report published by the MHRA being an evaluation of the performance of over 100 breathing system filters). The MHRA operates an adverse incident reporting system for medical devices, and issues safety warnings and hazard alerts. In the event of a report of an adverse incident the MHRA will investigate the report, if necessary by visiting the hospital concerned. The Agency was closely involved in the recent investigation of blocked anaesthetic connectors and issued a number of hazard notices relating to the investigation. The Safety Alert reporting system relays warnings and alerts both by hard copy and electronically. Electronic confirmation of receipt and cascade of the warnings to users is a required action of each Trust to ensure that the warnings have been disseminated appropriately.

On the pharmaceutical side, the agency is the licensing authority for medicines before marketing: it regulates clinical trials, monitors medicines and acts on safety concerns after marketing. The Agency also works closely with the Committee on Safety of Medicines that is responsible for the yellow card alert system.

Members of the MHRA Device Technology Evaluation and Safety department are co-opted members of the AAGBI Safety Committee and, along with representatives from the Breathing and Respiratory Equipment Manufacturing Association (BAREMA), enable informed decision making on many safety matters relevant to Anaesthetists.

Dr John Carter  
Vice President, AAGBI
Regulation of the Medical Profession

The General Medical Council (GMC) is a statutory body independent of the NHS and Government. It has the responsibility to maintain the medical register for the United Kingdom. The GMC has powers to take action when concerns are raised about the performance, conduct or health of individual doctors to such a level that the doctor’s fitness to practice is called into question.

The GMC is in the process of modernising and revalidation is crucial to this process. The commitment of the present Government to quality assurance in the health service, along with intense media and public interest in serious medical mishaps, has resulted in several other regulatory bodies being established. As a result the Government expects the profession to deliver a high quality service and reassure the public that the regulation of health professionals is open, fair and rigorous.

The GMC Fitness to Practice Procedures

Under the new procedures, complaints about doctors will no longer follow separate streams for health, performance and conduct. Instead, they will be looking at the doctor’s overall fitness.

Greater levels of investigation into complaints by the GMC will occur at the initial stages of the procedures and the current screening and Preliminary Proceedings Committee stages will be abolished. There will instead be a single investigation stage, at the end of which the decision to refer a case to adjudication will be taken by members of staff who will be known as Case Examiners. Case Examiners have been appointed by the GMC following a rigorous recruitment process, to undertake this role. All decisions will be taken by two Case Examiners, one medical and one lay. Where the Case Examiners do not agree, then the matter will be decided upon by the Investigation Committee (a statutory committee of the GMC).

The GMC inform the employer/s of the doctor undergoing the investigation at an early stage. If the GMC decision is that the complaint is not serious enough to affect a doctor’s fitness to practice, it may now issue a warning. If the complaint is regarded as serious then the Registrar has the power to order a performance or health assessment. The GMC may suspend or impose conditions on a doctor’s registration on an interim basis for the protection of patients; this action is taken by the Interim Orders Panel.

The adjudication phase is via the Fitness to Practice Panel made up of three medical and two lay panellists. The Panel’s action can be:

- to conclude the case, taking no action or issue a warning
- accept written undertakings from the doctor;
- impose a period of conditions on the doctor’s registration
- suspend the doctor for a specified period
- erase the doctor’s name from the medical register.

The National Clinical Assessment Service (NCAS) was one of the government’s special health authorities set up to ensure that patients have better protection and doctors have better support. The NCAS was established in 2001 and is an alternative to the punitive suspension system that is part of the GMC’s regulatory process. The authority deals with concerns about medical performance by investigating the problem as a whole, not just the individual doctor. During the process advice and assistance can be given and performance assessments arranged if deemed necessary.

The NCAS will advise NHS Trusts, PCTs, and Health Authorities on the course of action to take to address poor performance. The NCAS will not replace the GMC or replicate its work. The main remit will be the practice of an individual within a team or a clinical setting. The NCAS will complement the work of the GMC and other professional bodies. The emphasis is on support rather than a punitive approach. There is close collaboration between the GMC and the NCAS. There will be a team approach to educating employers, commissioners, and medical staff about disciplinary, performance and health issues. The NCAS and the National Patient Safety Agency also have links to work together to provide patient safety and public confidence.

The Council for Health Care Regulatory Excellence (CHRE) is a statutory over-arching body covering all of the UK and separate from the Government. The CHRE was established in 2003 to promote best practice and consistency in the regulation of health care professionals. It oversees the nine regulatory bodies concerned with health care, including the GMC.

The functions of the CHRE are:

- To promote the interests of the public in the field of regulation of health professionals
- To promote best practice in the regulatory bodies and to ensure a consistent approach to their methodology.
The CHRE reports annually to parliament with the discretion to report on the performance of the individual regulatory bodies. The CHRE can also refer the final decision of a regulator on a fitness to practice case to the High Court for the protection of the public.

The Clinical Negligence Scheme for Trusts (CNST) handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later). When a claim is made against a member of CNST, the NHS body remains the legal defendant. However, the National Health Service Litigation Authority takes over full responsibility for handling the claim and meeting the associated costs.

The NHSLA is a Special Health Authority (part of the NHS), responsible for handling negligence claims made against NHS bodies in England. In addition to dealing with claims when they arise, it has an active risk management programme to help raise standards of care in the NHS and hence reduce the number of incidents leading to claims. The NHSLA also monitor human rights case-law on behalf of the NHS through the Human Rights Act Information Service.

**Dr Les Gemmell**  
Chairman SAS Working Party, AAGBI
## AAGBI Secretariat

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## AAGBI Publications

The Association publishes guidelines on a wide variety of topics. Many of these are concerned with the safe practice of anaesthesia and include topics such as standards of monitoring, checking equipment and fatigue in anaesthetists. A full list of these and full text versions are available on the website [www.aagbi.org](http://www.aagbi.org).

**2006**
- Blood Transfusion and the Anaesthetist - Blood Component Therapy
- Consent for Anaesthesia
- Controlled Drugs in Perioperative Care
- Transfer of Patients of Brain Injury

**2005**
- Care of the critically ill child in Irish Hospitals
- Catastrophes in Anaesthetic Practice
- Day Surgery (revised)
- Guidelines for obstetric anaesthesia services (revised)
- The Anaesthesia Team (revised)
- Management of Anaesthesia for Jehovah’s Witnesses (revised)

**2003**
- Anaphylactic reactions associated with Anaesthesia 3 (revised)
- Theatre Efficiency

## AAGBI Grants & Awards

The Association of Anaesthetists encourages members to participate in research in order to increase knowledge, improve standards of practice and to enhance the standing of the specialty. It also wishes to enable members to travel to centres of excellence throughout the world to increase their expertise in clinical work, teaching or research so that there may be benefit to members, trainees and patients. The Association is also willing to consider applications for funds to assist with travel to developing countries to participate in teaching with the aim of improving standards of care in these nations.

The Association makes financial contributions to members only. This money comes from members’ subscriptions as well as from endowments and other gifts. The Association is pleased to make funds available for research and travel. It hopes that members will take advantage of the support available (see summary below). Further information and application forms are available on the web site or from the Association offices.

### Departmental Project Grant

This grant is up to £25,000 in value to support a programme of research in a Department. This money may be used towards salary costs for a trainee.

### Research Fellowship

The AAGBI supports the salary of a post-fellowship trainee for a period of study and research of not more than two years.
Grants of up to £15,000 are available which can be used for the purchase of apparatus or equipment for specific projects.

A grant of up to £5000, exclusively for SASG Doctors has been introduced to encourage and support research undertaken by staff grade and associate specialist doctors.

Travel grants of up to £1,000 may be requested by those undertaking visits in Great Britain and Ireland or overseas which include teaching, study or research.

Research and travel grants are also available from a number of the specialist societies and enquiries should be made directly to the relevant one.

Academy of Medical Royal Colleges
www.aomrc.org.uk

Advanced Life Support Group
www.alsg.org

Advanced human patient simulation user site
www.patientsimulation.co.uk

Anaesthesia UK
www.anesthesiauk.co.uk

Anaesthetic Research Society
www.ars.ac.uk

Association of Anaesthetist of Great Britain & Ireland
www.aagbi.org

Association of Burns and Reconstructive Anaesthetists
www.abra.org.uk

Association of Cardiothoracic Anaesthetists
www.acta.org.uk

Association of Paediatric Anaesthetists
www.apagbi.org.uk

Bandolier
www.jr2.ox.ac.uk/bandolier/

British Association of Day Surgery
www.bads.co.uk

British Association of Immediate Care
www.basics.org.uk

British Association of Medical Managers
www.bammm.co.uk

British Medical Association
www.bma.org.uk

British National Formulary
www.bnf.org

British Pain Society
www.painsociety.org

British Society of Orthopaedic Anaesthetists
www.bsoa.org.uk

Cochrane Collaboration
www.cochrane.org

College of Anaesthetists RCSI
www.coar.org

Confidential Enquiry into Maternal and Child Health
www.cemach.org.uk

Department of Health
www.doh.gov.uk

Department of Health Publications & Statistics
www.publications.doh.gov.uk

Difficult Airway Society
www.das.uk.com

Doctors.net
www.doctors.net.uk

European Association of Cardiothoracic Anaesthetists
www.eacta.org

European Computer Driving Licence
www.ecdl.nhs.uk
The Anaesthesia Heritage Centre

The Anaesthesia Heritage Centre contains the Association’s archives, museum and library and documents the history of anaesthesia. The collections are a unique research resource which is designed to complement each other.

The archives contain the Association’s records dating back to its foundation in 1932, collections of individual anaesthetists and specialist societies and photographs. The Anaesthesia Museum contains objects that illustrate the history of anaesthesia. The museum began in 1953 when A Charles King gave his historic anaesthetic apparatus to the Association. The Library contains books on anaesthesia and related subjects, pamphlets and technical literature, Anaesthesia and The British Journal of Anaesthesia. As well as the rare and technical books in the Library, there are video copies of early films relating to anaesthesia and much more.

The Anaesthesia Heritage Centre is open Monday to Friday from 9.30am - 5.00pm.