



# Clinical Management in Anaesthesia

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The Association of Anaesthetists of Great Britain and Ireland  
21 Portland Place, London, W1B 1PY  
Telephone 020 7631 1650 Fax 020 7631 4352  
[info@aagbi.org](mailto:info@aagbi.org)  
[www.aagbi.org](http://www.aagbi.org)

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# Membership of the working party

Dr I H Wilson	Chair and AAGBI President Elect
Dr V R Alladi	AAGBI Council Advisory Member
Dr P Bell	AIM Council Member
Dr L W Gemmell	AAGBI Honorary Secretary
Dr A Hartle	Secretary and AAGBI Honorary Secretary Elect
Dr I G Johnston	AAGBI Honorary Treasurer
Col P F Mahoney	Defence Professor in Anaesthesia & Critical Care
Dr C Meadows	GAT Immediate Past Chair
Dr W Rawlinson	AIM Council Member
Dr E Tierney	AAGBI Irish Standing Committee Member
Dr C Williams	GAT Representative

**This guideline has been seen and approved by the Council of the AAGBI.**

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# 1. Recommendations

Clinical management is a core responsibility within the consultant role that requires training and development.

Effective clinical management is key to running a safe and efficient hospital including anaesthetic services.

Clinical managers must have the time, resources and administrative support to perform the role.

Clinical managers should have clear lines of accountability and a formal job description.

There should be an open and transparent process for the appointment of clinical managers.

All doctors take legal responsibility for their actions involving colleagues, trainees and patients.

Clinical managers take legal responsibility for the safety of their service; chief executives are legally accountable for the quality of care within their hospitals.

All doctors need to understand local and national management of their health service.

All doctors and managers have a responsibility to work together for safe patient care.

## 2. Introduction

The National Health Service (NHS) is the fourth largest employer in the world and spent more than £100 billion in 2009. The system is hugely complex and needs expert management from political level to the patient interface to ensure that healthcare is prioritised appropriately, the funds are used well and that care is delivered safely.

Clinicians have many responsibilities in management and anaesthetists are involved at all levels of healthcare management. The term NHS is used throughout this publication to indicate government provided health services. This small guide about management will describe:

- Information about how the separate national health services in the UK, Eire and the Armed Services are organised.
- How NHS hospitals and departments are organised.
- Management roles within the NHS for clinicians including training opportunities.
- Routine management tasks.
- A glossary of organisations contributing to healthcare management.

We anticipate this information will prove useful to trainees grappling with the complexities of the NHS, particularly as they prepare for a consultant interview. Anaesthetists who are interested in taking up a management role will find the information helpful, and the accompanying website resource will continue to develop both as a library of articles and as a source of extensive links to relevant external organisations and publications.

### **Every doctor is a leader/manager**

All doctors are managers of some description, in organisational, supporting or training roles, as well as running their clinical service. Anaesthetists make up 15% of the consultant workforce, work with a wide range of services and are ideally placed to contribute to running services. Sub-specialties of anaesthesia, such as pain management and critical care, involve a great deal of organisation. Most medical leaders start learning their skills in a small way such as rota management, representing their peers or chairing a committee. Many anaesthetists find the challenge of management in medicine absorbing and progress to medical director posts.

## Why should I be interested?

Those working in publically funded health services would always aspire to improve services, but in reality are part of a political system that grants money to health, education, social care and defence, amongst others. The decisions as to how money is apportioned, and how effectiveness is judged, are complex issues. Doctors need to be involved at the highest level where decisions are made. All of us should ensure that our own part of the service runs effectively and safely, but also develop a view that takes the whole of the NHS forward.

For many years consultants in departments have traditionally taken it in turn to fulfil the management/leadership role, instead of recognising that the task involves expertise different from anaesthesia. More recently Trusts have appointed medical managers with a job description and paid sessions to carry out the work.

Unfortunately the role of clinicians being involved with management is seen negatively by some colleagues as having 'moved to the dark side!' Fortunately this culture is improving, and it is the view of AAGBI and Anaesthetists in Management (AIM) that clinicians should be managing clinical services with the support of their colleagues if the NHS and anaesthetic services are to advance. The importance of management as part of a doctor's role has been emphasised by specific guidance from the General Medical Council (GMC). Management is also one of the five areas assessed in the NHS Clinical Excellence Award scheme.

# 3. NHS structures

## United Kingdom

In 1948 the Health Minister, Aneurin Bevan, established the NHS as a free, comprehensive health care service, available to the entire population. When the NHS was launched in 1948 it had a budget of £437 million (roughly £9 billion at today's value). In 2008/9 it received 10 times that amount - more than £100 billion. Nearly 80% of the total budget is distributed for patient care. The money to pay for the NHS comes directly from taxation. In the view of independent bodies such as the King's Fund, this remains the "cheapest and fairest" way of funding health care when compared with other systems.

The NHS has three main components: family practitioner services, community based services, and hospital services. The general principles governing the NHS have been the same throughout the UK, although the ways in which health services have been organised have varied. Devolution led to the first elections to the Northern Irish Assembly in 1998 and the Scottish Parliament and the Welsh Assembly in 1999. All of these bodies have responsibility for the organisation and delivery of health services which has resulted in a system of four different national health services across the UK, and patients in England, Scotland, Wales and Northern Ireland receiving different standards of care.

There have been several re-organisations of healthcare provision over the years and the following represents the situation in 2010.

### England

The Government allocates funds to the NHS in England via UK taxation. The Secretary of State for Health decides how these funds will be spent and is accountable to Parliament for the overall performance of the NHS in England.

#### Department of Health (DoH)

The DoH is responsible for running and improving the NHS, public health and social care in England. This organisation provides strategic direction, secures resources, sets national standards and invests in the service.

#### Strategic Health Authorities (SHAs)

There are 10 SHAs which manage the NHS at local level and act as a link back to the DoH. Responsibilities include:

- Developing plans for improving health services in their local area,
- Ensuring quality of local health services,
- Increasing the capacity of local health services,
- Making sure national priorities - for example, programmes for improving cancer services - are integrated into local health service plans.

### Primary Care Trusts (PCTs)

There are 152 PCTs in England, each charged with planning, securing and improving primary and community health services in their local area. They work collaboratively with patients, the public, GP practices, and partners to deliver these healthcare services. PCTs are allocated 75% of the NHS budget to fund services and are accountable to their local SHA. PCTs commission secondary care from hospitals, independent hospitals and treatment centres via service level agreements.

### Hospital Trusts

NHS Trusts employ the majority of the health service workforce. They obtain most of their income via service level agreements negotiated annually with their local PCT on a 'payment by results' basis. Trusts that exceed contractual expectations receive more funding. Trusts that fail to deliver their contract have their funding reduced.

Foundation Trusts have more financial and managerial independence than Hospital Trusts and are appointed and regulated by Monitor. Monitor has statutory powers to authorise NHS Trusts as NHS Foundation Trusts, oversee compliance by NHS Foundation Trusts with their terms of authorisation (like a 'licence' to operate) and intervene in the event of significant non-compliance with the terms of authorisation and other statutory obligations.

### Other Trusts

Ambulance Services and Mental Health Care are also delivered by NHS Trusts.

### Arm's Length Bodies (ALBs)

The DoH works with three kinds of ALBs:

- Executive agencies that have responsibility for particular business areas - the agencies are still part of and accountable to the DoH. The Executive agencies are the Medical and Healthcare Products Regulatory Agency (MHRA) and NHS Purchasing and Supply Agency (PASA),
- Special health authorities are independent bodies, but can be subject to ministerial direction like other NHS bodies. There are 13 special



health authorities that include the National Patient Safety Agency (NPSA) and the NHS Litigation Authority,

- Non-departmental public bodies have a role in the process of national government, but are not part of government departments. There are nine non-departmental public bodies. The Council of Healthcare Regulatory Excellence is an example.

## **Scotland**

In 1999 direct responsibility for health and education was devolved in Scotland to the newly established Scottish Parliament led by the Scottish Executive. In 2008 the Scottish Executive was rebranded as the Scottish Government and the post of Minister of Health replaced by the Cabinet Secretary at the Department of Health and Wellbeing. The Scottish Government Health Directorate is now responsible for both NHS Scotland and for the development and implementation of health and community care policies.

The Chief Executive of NHS Scotland leads the central management of the NHS, is accountable to the Government for the efficiency and performance of the service, and heads the Health Department which oversees the 14 NHS Boards responsible for planning health services and 8 additional 'Special Boards.'

### Regional Health Boards

Health services are delivered through 14 regional NHS Boards which are responsible for the provision and management of the whole range of health services in their areas, including hospitals and general practice. Hospital Trusts (introduced by the UK Government in the early 1990s) were abolished in Scotland in 2004 and amalgamated into the Regional Boards.

Each Board has its own individual structure but generally includes a Corporate Services Division (management and planning), Specialist Services Unit (hospitals), Community Health Partnerships which include community health services and form a link between primary care and specialist services and sub-divisions such as Managed Clinical Networks, mental, sexual and dental health, and pharmacy.

### Special Boards

In addition to the 14 regional Boards Scotland also has 8 Special Boards which are funded directly by the Scottish Government Health Directorate. These comprise of:

- The Scottish Ambulance Service,
- The NHS National Services Scotland. Formerly known as the Common Services Agency, this provides a variety of specialist services including health statistics, blood transfusion services, communicable disease surveillance, national screening programmes and remuneration of primary care practitioners,
- NHS 24 – a 24-hour telephone health advisory service for patients,
- The State Hospital (Carstairs) – the sole high security hospital in Scotland,
- NHS Health Scotland – a national focus for improving health in Scotland by encouraging healthy lifestyles,
- NHS Quality Improvement Scotland (QIS) – has the remit of improving the quality of healthcare in Scotland by implementing and monitoring national standards of care. The Scottish Patient Safety Programme (similar to the NPSA in England) harbours under the umbrella of QIS,
- NHS Education for Scotland – the training organisation of NHS Scotland,
- National Waiting Times Centre Board.

### Funding

The National Health Service in Scotland is funded by UK taxation and the predicted budget for 2010 exceeds £11 billion of which approximately £8.6 billion will be allocated to the Health Boards. Since 2000, 70% of the available funds have been allocated to Health Boards in line with the 'Arbuthnott Formula' which was based on patient population and the additional costs of supplying healthcare to specific areas and patients with greater needs. It is planned, in view of the subsequent changes to the service and patient demography, to replace 'Arbuthnott' in 2009-10 with a new formula derived by the NHS Scotland Resource Allocation Committee. This will also be based on patient population and area specific costs, but will take better account of the effects of increasing life expectancies on available resources and the under-utilisation of services in deprived areas.

### **Wales**

Following devolution in 1999, the National Assembly Wales (NAW) has full legislative power for health in Wales. It contains the Office of the Chief Medical Officer [CMO] (who advises the government on health matters) and the Health and Social Services Committee (who contribute towards NAW's health policy development). As a result of the Government of Wales Act 1998, the NAW has adopted the powers of the old Health Authorities, which ceased to exist on 1st April 2003. The Welsh Assembly Government (WAG) is the executive body of the NAW, comprising of the First Minister and the

Cabinet, including the Minister for Health and Social Services. In 2006 the WAG gained the ability to make its own legislation on devolved matters such as health, education, social service and local government. These are now a new category of Welsh laws called Assembly Measures.

All NHS statutory organisations in Wales are accountable to the Minister for their performance and the Minister is ultimately accountable to the Welsh Government for the overall running of the Welsh NHS. The Welsh Government is responsible for policy direction and dissemination of funds to the health service.

### Arm's Length Bodies

Some of the ALBs in England also have responsibilities in Wales, such as the NPSA and MHRA. The Healthcare Inspectorate Wales (HIW) was established in 2004 to promote improvement in the quality and safety of patient care within NHS Wales. In April 2006 the remit was expanded and HIW became the independent watchdog of healthcare. HIW inspects NHS bodies and services.

### Regional offices

There are three regional offices, located in North, Mid and West, and South East Wales. The regional offices of the Department for Health and Social Services act as agents of the Head of Department on a day-to-day basis, in holding to account the Chief Executives of the statutory NHS bodies, and managing their performance in line with the Framework for Continuous Improvement.

### Revised health structures

The NHS in Wales was reorganised in 2009 and a National Advisory Board was established and is chaired by the Health Minister. A separate National Delivery Group is to be established, chaired by the NHS Wales Chief Executive, with responsibility for the day-to-day operational performance of three NHS Trusts and seven Health Boards. The Health Boards will combine mental health, community services, acute trusts and primary care into one integrated service.

### **Northern Ireland**

Devolved powers were returned to the Northern Ireland Assembly in 2007. The Assembly can pass both primary and secondary legislation. The Health and Social Services Committee advises the Minister for Health, Social Services and Public Safety (Fire, Rescue and Ambulance Services). The Public Accounts Committee considers and reports on accounts laid before the Assembly.

### Department of Health, Social Services and Public Safety

In Northern Ireland Health and Social Care is equivalent to the NHS in England. Health and social care functions are integrated and the commissioner-provider split has been retained through the establishment of a commissioning board and 7 GP-led Local Health and Social Care Groups. In 2007 the Review of Public Administration formed 6 Health and Social Care Trusts from the former 19 Health and Social Services Trusts, and in April 2009 the single Regional Health and Social Care Board replaced the 4 Health and Social Services Boards. It is responsible for commissioning, performance management, improvement and financial management. The Regional Agency for Public Health and Social Well-being is responsible for health protection, health improvement and addressing existing health inequalities. The Patient Client Council has replaced the 4 Health Councils and is responsible for providing a voice for patients, carers and clients. The Regional Business Support Organisation is responsible for supporting the health and social care sector.

The Regulation and Quality Improvement Authority was established in 2003. It is an independent body responsible for monitoring and inspecting the availability and quality of the health and social services and encouraging improvements.

The Guidelines and Audit Implementation Network has a safety and quality improvement role through commissioning of regional audits and guidelines.

## **Republic of Ireland**

The health service in the Republic is managed by the Health Services Executive (HSE), supervised by the government's Department of Health. The Department of Health is led by the Minister for Health who is responsible to the Dáil or Parliament.

The HSE was created in 2005 as the single body responsible for meeting Ireland's health and social care needs; it replaced eleven health boards which were seen to be inefficient. The HSE has an annual budget of about €16 billion, this total including some social welfare expenditure.

The HSE is divided into four administrative regions: Dublin and the North-East, Dublin and mid-Leinster, Southern, and Western.

The Primary Community and Continuing Care section of the HSE provides health and personal social services in health facilities and communities all

over Ireland. This includes primary care, mental health, disability, child, youth and family, community hospital, continuing care services and social inclusion services. Services are delivered through 32 Local Health Offices.

The National Hospitals Office of the HSE is responsible for the strategic management of acute hospital services. It is led by a national Director who reports to the Chief Executive Officer of the HSE and collaborates closely with the Directors of Population Health and Primary, Community and Continuing Care.

Hospital care in the Republic is currently being reconfigured, with planned closure of acute services in smaller hospitals. Smaller hospitals will in future provide elective day-care and five-day surgery, outpatient clinics and other investigations, with larger hospitals providing the acute service and major surgery.

The Health Information and Quality Authority was established in May 2007. It is an independent Authority, separate from the HSE, with broad ranging functions and powers reporting to the Minister for Health. It was set up to improve quality, safety, accountability and the use of resources in health and social care services, whether delivered by public, voluntary or private bodies.

Expert Advisory Groups advise the HSE on the organisation and development of health and personal social services. They enable health professionals and clinical experts, patients, clients and service user groups to play an active role in health care reform and operational policy development, and monitoring of policy implementation within the HSE.

Overall, the service is broadly similar to the UK NHS with a number of key financial differences at the point of use. In primary care, because of means-testing, only about 30% of the population is eligible for free GP and pharmacy services. The remaining 70% pay their GP a fee per visit and pay the first €100 of their monthly pharmacy bill, the HSE paying the remainder.

Private practice has traditionally been a strong feature of the Irish hospital system, with government hospitals having up to 30% of patients attending privately. These patients pay the hospital a daily care rate, as well as paying fees to consultants. The network of private hospitals has expanded greatly over the last few years. About half the population has private health insurance.

## 4. Hospital structures

Hospital structures differ considerably, ranging from Foundation Trusts to units based around Health Boards. Every hospital has an internal management structure with differing degrees of autonomy from external influence.

The hospital Board has overall responsibility and comprises Executive and Non-Executive Directors (including a Chairman). Strategy and governance are key responsibilities.

Non-Executive Directors (NEDs) are part-time appointments who bring relevant experience (often financial, legal, business, government) to the Board. They have an important role in independent oversight of how the hospital runs. They are involved in senior executive appointments, remuneration committees and may chair internal investigations or disciplinary appeals. Apart from Foundation Trusts, their appointments are made by the Appointments Commission or a similar body.

Executive Directors are full-time NHS employees and have specific areas of responsibility within the hospital. Examples include the Chief Executive and Medical Director, and the directors of nursing, finance and operations. The precise number, role and title of members vary.

Below Board level the hospital is managed in divisions or directorates. The exact configuration depends on the size of the hospital. Clinical groupings such as medicine, surgery, and diagnostics work alongside others such as human resources or estates. Most will have a clinician leader and a business manager. However, many Trusts are now dividing clinical activities in patient-based groupings such as emergency, elective, and support services.

In addition to the directorate structure of a hospital there is professional responsibility for medicine through clinical leaders to the Medical Director(s). A similar system works in nursing.

Hospitals are complex organisations but the following posts and departments will be found in most hospitals.

**Chairman** – the senior NED, accountable for giving leadership to the Board to ensure the Trust meets its legal obligations.

**Chief Executive** – the Senior Accountable Officer of the Trust with personal

legal responsibility for the delivery of high quality, safe patient care in compliance with statutory, regulatory and financial duties: a wide-ranging role both inside and outside, linking and negotiating with other healthcare organisations.

**Medical Director** – the senior medical professional within the hospital with Board level responsibilities for the medical care. Responsibilities include overall medical strategy, investigations of incidents and complaints, ensuring consultant appraisal (and soon revalidation) and supporting other clinical leaders. Normally acts as the Caldicott Guardian.

**Nursing Director** – the senior nursing professional within the hospital. Similar level of responsibilities as the Medical Director. Will often lead in other areas such as patient experience, safety or clinical governance.

**Finance Director** – responsible for all aspect of finance: expenditure, budgets, negotiation of contracts for services with suppliers, commissioners (such as Primary Care Trusts).

**Human Resources Director** – responsible for all matters relating to the employment of staff.

**Director of Estates & Facilities** – responsible for the infrastructure of the hospital, which may be a largely contracted process in a hospital with a Private Finance Initiative building, or the Director may manage large numbers of maintenance staff, as well as specialists in hospital design and development.

**Department of Information, Communication and Technology** – responsible for security and integrity of information, computer systems providing everything from email to performance reports and telecommunications.

**Governance Committee** – encompassing clinical governance through the governance or safety committee chaired by a NED. Patient safety responsibilities include incident reporting and investigation, infection control, compliance with external guidance and standards (e.g. NPSA, NICE, Care Quality Commission). Financial and business governance (the responsibilities of the NEDs) may sit here or as a separate committee.

**Therapies** – occupational and rehabilitation, speech and language therapies, pharmacy and physiotherapy services may be integrated within other organisational structures, or exist separately.

**Support Services** – cleaning, portering, catering, laundry, sterile supplies, purchasing, receipt and despatch, security and transport may be provided by directly employed staff or by sub-contractors.

**Occupational Health** – responsible for the fitness of staff to perform their roles.

**Research and Development** – an integral part of all NHS organisations to support funding, organisation and governance of research.

**Education and Training** – the Clinical Tutor/Director of Medical Education has overall responsibility for the standard of training within a hospital. Externally they have a complex relationship with the Deanery, GMC, Foundation Schools and Colleges. Within the organisation they liaise with College Tutors, Educational Supervisors, etc.



## 5. Leadership roles in anaesthesia, intensive care and pain services

With changes to the size and structure of hospitals, the traditional, specialty-based clinical directorate is becoming less common. Many anaesthetic departments now find that they are part of a larger directorate or division. Each directorate will have a medical leader but this person will not necessarily be an anaesthetist. Nevertheless, leadership roles still exist within anaesthetic departments - for the purpose of this publication called 'lead clinician' roles. The job descriptions for these roles include a supporting role to the clinical director and so will include appraisal, job planning, and performance management for medical staff, clinical governance and business planning. Depending on local arrangements for devolving budgets, financial management may or may not play a large part of the role.

### Job planning

There is a great deal of information about job planning for consultants and SAS grades available from the British Medical Association (BMA) and NHS Employers. The 2003 contract for consultants in the NHS was instituted with minor variations in the different nations. All split the contract into Direct Clinical Care (DCC) and Supporting Professional Activities (SPA). A further division in DCCs is into elective and emergency care. A prospective job plan reflecting weekly activity should be agreed and reviewed by the consultant and the lead clinician annually. In some cases, for example where a doctor has significant external duties, it may be appropriate to annualise the job plan. In anaesthesia services, it is not uncommon to have an agreed tariff for different lists negating the need for individual diaries, but the approach varies in different hospitals.

As with any NHS specialty, anaesthetists have responsibilities requiring paid SPA time, and these activities should be recorded within appraisal and job planning to demonstrate that NHS money is being spent appropriately.

The annual job plan review should set objectives that are allied to the Trust strategy and some flexibility between doctors and management usually ensures issues are agreed. The Trust is the employer and is able to require employees to work on particular days and sessions, but this is usually worked out to ensure that all doctors in a department have a fair working week. Dealing with colleagues who are inflexible is a particular challenge requiring good negotiating skills. Where agreement cannot be reached, the case should be referred to the medical director for mediation.

## Appraisal

Appraisal is an annual task for the lead clinician, although they may not undertake all appraisals personally. It is linked to job planning and will be a significant part of the GMC's revalidation programme. The framework for appraisal has been agreed nationally using standardised documentation and processes. Large departments will have several appraisers for consultant and SAS doctors. Appraisal for anaesthetists-in-training is the remit of the Post-graduate Dean.

The appraisee should ensure that the completed appraisal documentation is with the appraiser in advance of the meeting (ideally two weeks). The appraiser should ensure that the interview takes place in the agreed timeframe and is conducted fairly and thoroughly. If the lead clinician is not to carry out the appraisal he/she should ensure that the appraiser is informed of all issues relating to the department and the individual prior to the meeting. The appraisee should present details of activity, outcomes and Continuous Education and Professional Development (CEPD) and there should be departmental support to facilitate this. The appraiser is responsible for completing Form 4, the summary of the appraisal discussion and agreed action, and personal development plan. The appraiser and appraisee are responsible for ensuring that any necessary action arising from the appraisal is acted upon.

For appraisal to work well both appraiser and appraisee must act with integrity, honesty and trust in a culture of openness. The discussion should be structured, focussed and recorded accurately. It is imperative that it is confidential and conducted in an environment where interruptions are minimised.

Consultants must have undertaken an annual appraisal to apply for a salary threshold advance or Clinical Excellence Awards.

## Clinical governance

Clinical governance is the process by which health services are held accountable for the safety, quality and effectiveness of clinical care. It is a statutory requirement of NHS Boards and is achieved by coordinating three interlinking strands of work:

- Identifying, implementing and reporting on national and local quality improvement measures.

- Ensuring appropriate and safe care is delivered by health care staff to patients.
- Establishing a supportive, inclusive learning culture for improving care.

Within an anaesthetic department this is achieved through clinical audit, critical incident reporting, clinical risk management, complaints monitoring, research and development and CEPD.

The lead clinician should ensure that the department has in place a system of clinical audit that reflects not only the priorities of the department but also national (Royal College of Anaesthetists [RCoA] and the NPSA) priorities. The results of audits should form the basis of reviews of staff performance and service delivery so that the quality of patient care improves. Critical incident reporting should be encouraged as should the development of a risk register.

The lead clinician will normally be involved in formulating the chief executive's response to patients' complaints about their care in the department. Trends in complaints should be monitored so that an action plan can be formulated to minimise patient dissatisfaction and improve the quality of the service.

Responsibility for research and development governance will lie with the director of research and development. The lead clinician should assess the feasibility of conducting the research within the resources of the department.

The lead clinician should ensure that all members of the department have equitable access to study leave and funding. A culture of facilitation of CEPD should be engendered with timings of educational meetings permitting attendance by the greatest numbers possible.

## **Performance targets**

Since 1997 a system of targets for healthcare has been developed as quality markers with strong sanctions for those failing to meet them. Targets have continuously been refined.

Current access targets vary between the four regions of the UK but include the 18-week patient pathway and waiting times for both outpatient consultation and inpatient treatment. These targets are shorter for cancer treatments. Waiting time targets for out-patient consultation may put pressure on chronic pain clinic services, many of which are under-resourced. Similarly, the pressure to ensure elective and cancer surgery is timely can stretch theatre, recovery and critical care services. The lead clinician and

clinical service managers must plan for this.

Not all targets relate to waiting times: efficiency targets have direct relevance to anaesthesia. These include financial efficiencies and also efficiencies such as reduction in the non-attendance rate for first outpatient visit (relevant to the chronic pain service), length of stay targets (good post-operative pain management), and reduction in staff sick leave. Treatment targets relevant to anaesthesia include improvement in the quality of the healthcare experience, reduction in the number of readmissions (critical care units) and reduction in hospital acquired infection.

## **Business planning**

The business plan is the document in which a department sets out its objectives for the next 1-5 years. Priorities will be determined by the Trust to meet priorities set by the Department of Health with reference to the government policy.

To develop the business plan, the lead clinician must consider the objectives and the priorities of the trust, and the quantity and quality of the services it must deliver. As much of the workload of an anaesthetic department is determined by other specialties, it is important to work collaboratively. Performance targets should be considered and a strategy developed by clinical colleagues and business/general manager and clinical service managers (CSMs) to deliver these. They will have to be delivered within the constraints of the overall budget and allowance must be made for any efficiency savings. Business planning is also a tool to ensure departments are developed along strategic lines and should be embraced with this crucial long-term objective in mind.

Before signing off the department's section of a business plan it is useful to check with the lead clinicians of other services that there is no obvious mismatch between the plans of other services/departments.

## **College Tutor – roles and responsibilities**

The College Tutor is responsible for ensuring that anaesthetists-in-training have access to appropriate training and education within the department and that the resources required for this are available. This includes access to suitable training lists with an appropriate level of supervision. Under the clinical governance agenda, the lead clinician is responsible for the clinical performance of the trainee.

Tutors must arrange for trainees to have an adequate departmental induction and an educational supervisor and personal mentor. They are responsible for ensuring that trainees have protected education time including appropriate study and examination leave and are able to carry out audit, research or management activities. Support should be available for the completion of logbooks and in-training assessments.

The college tutor should work with the lead clinician to ensure that the demands of service and training are met fairly. This includes managing both daytime and out-of-hours rotas ensuring compliance with the European Working Time Directive and that adequate rest periods are achieved.

The college tutor is also responsible for ensuring that trainees have completed their competencies and for co-ordinating feedback on individual trainees to be forwarded to the deanery to support annual assessments. If issues regarding a trainee's performance appear to have potential to cause harm to patients, where their conduct is unacceptable, or their health is impaired so that patients might be at risk, the college tutor should bring this to the attention of the lead clinician. The lead clinician must then ensure that appropriate action is taken in collaboration with the deanery.

## **Clinical service manager – roles and responsibilities**

The CSM plays an important part in the day-to-day management of the department. They are usually managerially responsible to the overall directorate business manager for the smooth running of the department and for ensuring that the department achieves its activity and quality goals as set out in the business plan. Depending on the organisational structure they may be responsible for all the work carried out by a department of anaesthesia or for just part, (e.g. theatres). In some hospitals only a part of the work of the department may fall within their remit, (e.g. chronic pain clinics may be the responsibility of the outpatient CSM). Most CSMs will have a background in the healthcare professions and have undertaken management training. They will have some delegated responsibility for clinical governance and the performance of other managers (such as theatre, intensive care unit or outpatient department).

The lead clinician, as part of the directorate management team, should meet with the CSMs on a regular basis to discuss the performance of the department. The CSMs should bring data to this meeting to support the discussion, (e.g. waiting times, staff sick leave, activity patterns, recruitment, critical incident trends, budget issues etc.). The lead clinician should ensure

that decisions taken at these meetings are aligned with the business plan and with the objectives of the department and do not impair the safe delivery of anaesthetic services.

## **Finance**

A working knowledge of how money flows in the Trust and how your department generates income and manages its costs is vital. The complexities of budget management within a department are such that the lead clinician should work closely with an identified individual in the finance department with responsibility for overseeing the financial management of the department. The directorate business manager and the CSMs also have key roles to play in this complex area.

Income generation for the department will depend to some extent on local arrangements – the presence or absence of a tariff, the extent of local and national commissioning, the presence or absence of internal cross-charging between specialty, e.g. surgery/anaesthesia, which in turn depends on whether or not they are in the same cost centre. Some income may be generated for the department from waiting list initiatives and from private practice.

As far as capital expenditure is concerned, the lead clinician should be aware of any rolling programme for replacement of equipment and ensure that money is available to implement this. If the capital budget will not permit replacement, then a risk assessment should be performed and the Trust board advised. The medical devices co-ordinator has a supporting role here. Purchase of new equipment needs to be supported by a business case. It is useful for the lead clinician to agree with members of the department a priority list of equipment.

## 6. Managing people

The role of a clinical manager varies enormously from strategic planning to resolving issues in a dysfunctional team. Although many of the skills in dealing with patients as a doctor are useful, a range of additional skills is needed to perform all aspects of the role. Some of these non-clinical skills may be learned on courses, but in reality most are learnt through experience.

An ability to communicate and understand people is crucial, as is the patience to listen. Failure to appreciate the problem from someone else's perspective will prevent a fair solution to be formed. An understanding of one's own personality and impact on others is helpful. These insights are best achieved formally through courses using tools such as the Myers Briggs Type Indicator. Not everyone has the same personality, and negotiation should take this into account.

Much of the time of a clinical manager is spent meeting colleagues. Job planning, appraisal and service planning are the major issues, as well as investigating incidents or complaints. Dealing with doctors in difficulty or with dysfunctional teams are the most challenging parts of the role for most managers.

### Dealing with doctors in difficulty

Doctors are generally a very motivated group of employees, many of whom are reluctant to take sick leave when unwell. Physical illness is perhaps the most straightforward issue to deal with in colleagues, but particular efforts should be made to maintain confidentiality which may need to be stressed to all staff in the directorate. When X-rays and results of investigations are stored electronically this may be a particular issue.

Doctors may also present with mental illness, substance misuse or dependency. In many situations these complex illnesses present as mood or reliability issues, or performance concerns raised by peers or other employees. The clinical manager is often the first person to broach these serious issues with a colleague.

Dealing with doctors in this latter group requires expertise, and close co-operation with human resources and occupational health departments is required to ensure that correct Trust procedures are followed. The policies should normally have been agreed by the Local Negotiating Committee and Trust management, and describe a way of approaching some very difficult

issues. Acting outside of local agreements risks prolonging and complicating what may already be a lengthy process.

Clinical managers have to deal with each case on its merits, but more senior input (usually from the medical director) is often useful early in the process. Once an issue is uncovered it needs to be dealt with and not ignored. This is the responsibility of all doctors whenever patients or other staff are potentially involved. Accurate record keeping is vital.

Performance is often difficult to define accurately in anaesthesia except when a major problem has occurred. Patient safety is paramount, and concerns raised by anyone in the theatre team must be expressed to the clinical manager who must start an investigation. The National Clinical Assessment Authority and the GMC offer good advice via their websites as to when they should be involved in performance issues and are often helpful by phone. However, any decision to involve external agencies will be taken in conjunction with the medical director. Every conversation or decision should be documented and filed securely. This is of particular importance when clinical managers change.

In the NHS the clinical manager is responsible to the chief executive for the safety of the service, usually through the medical director. In the independent sector, governance responsibility lies with the hospital manager and the Medical Advisory Committee.

Trainees who develop difficulties are normally managed by the clinical manager in close consultation with a deanery representative and college tutor. Communication between the different personnel is vital so that doctors are managed properly. The exact level of responsibility will depend on the problem under consideration.

Dishonesty is an occasional issue and is viewed by the NHS as fraud or theft. It may lead to a disciplinary hearing and may result in dismissal.

## **Dysfunctional teams**

Patients rely on anaesthetists and the theatre or ICU teams to work together. The culture of the NHS too often encourages competition between consultants. Most can keep these issues in context, but small teams are very vulnerable to individuals being unable to tolerate each other. This may be very destructive for all concerned. Identification of the issues is the first step followed by team meetings and discussion as to a way forward. In serious



cases, particularly if patients are at risk, an external review, such as those organised by the RCoA and AAGBI, may be appropriate, provided all have consented to this and have agreed to endorse the recommendations.

## **Complaints and clinical incidents**

Dealing with patients' complaints is a useful way of improving the service and also of helping patients through a difficult experience. Many patients need an apology, or some further explanation of what has often been a communication failure. A few are vexatious with no factual content and clinicians need support in these situations. Most hospitals will have a complaints department which has a range of targets to meet in terms of timeliness and the clinical manager often has to help resolve these. At times patients will complain directly to the GMC who will contact the Trust Medical Director for further information.

Reporting clinical incidents in the workplace is an important safety culture in the NHS, and investigation is a part of the clinical manager role. Serious events may require an immediate review to ensure the event could not recur. A later investigation using root cause analysis with trained investigators normally follows.

## **Making space and relaxing**

The NHS has many challenges that vary on a day-to-day basis. Those in positions of responsibility, such as medical managers, face ever-changing stresses which may not be apparent to those around them. They must be given space and time and support to perform their clinical and managerial duties. They must also ensure their own work-life balance is preserved, leaving work problems at work thus preventing them from taking over their family lives.

## 7. Training in management

For many anaesthetists, exposure to aspects of management within the NHS may well be limited to organisational roles as a student or trainee before taking on tasks such as business planning, leading projects or chairing a committee as a consultant. In recent years, there has been a change in emphasis on training in management skills for clinicians. There are now many more opportunities for junior and senior doctors alike to access experience and courses designed to teach leadership, team-working and effective management for organisational change. This chapter will outline opportunities at trainee and consultant level (not an exhaustive list) supplemented by further information on the website ([www.aagbi.org](http://www.aagbi.org)).

The AAGBI specialist society, AIM, is a support group for anaesthetists with specific interest in management.

### Pre-CCT experience

Anaesthetic trainees have a vital role in running NHS departments and their input into the day to day running of the service is important. Taking responsibility for tasks such as rota organisation, or volunteering as the departmental trainee representative is a useful start. Discussion with the clinical director may allow involvement with management projects such as running audit cycles or attending patient safety group meetings and implementing their conclusions.

Taking part in discussions across directorates on projects common to all, for example, the hospital's response to a NPSA Alert, will give a broader sense of the hospital working as a business within the NHS. Trainees can also often attend Trust Board or other senior meetings. Some hospitals run a 'management module'; in others, trainees might offer to design a course as part of an initiative to help future trainees increase their exposure to the management arm of the organisation.

Outside the hospital, there is a range of opportunities for trainees to become involved in committee work, leadership and management such as the Group of Anaesthetists in Training (GAT) Committee, the trainee arm of the AAGBI. The GAT Committee consists of twelve elected trainee members who represent over 3500 anaesthesia trainees across the UK and Ireland at a national and international level. Once elected, there exist the opportunities to become involved in organisational and leadership projects including taking on an executive role within the Committee and gaining a

place on AAGBI Council, discussing topical policies as part of a working party and contributing to GAT publications. Trainees can also volunteer to become part of the Trainee Advisory Group at the RCoA, or the trainee representative at various specialist societies including the AIM Committee, the Association of Paediatric Anaesthetists and the Intensive Care Society. For more specific management experience, the British Association of Medical Managers (BAMM) has a trainee division called BAMMbino and the CMO has a Clinical Advisor Scheme. The latter is open to all trainees and offers placements with a range of organisations including the Department of Health and the World Health Organization, together with direct tutorials from the CMO.

In London, the new Darzi Management Fellowship Programme has been created to address the significant importance attached to the acquisition, amongst trainees, of a range of non-clinical skills such as leadership, team-working and teaching within the NHS Next Stage Review Final Report of 2008, High Quality Care for All [1]. The programme consists of live change management projects operating at individual Trusts, which ‘fellows’ work towards over the course of a year, together with a ‘bespoke’ modular leadership development programme. Completion of the coursework toward a postgraduate certificate in management is optional. It is envisaged that all Trusts across England and Wales will be given the opportunity to host a Darzi Fellow in 2010.

## **Post-CCT experience**

Consultants can gain experience in managing people, teams and working in the NHS management structure within their own places of work. Committees, such as ethics, research or governance, provide ideal first-hand knowledge of tackling the difficulties of achieving change in NHS organisations. Writing a business plan and bidding for equipment or pharmaceuticals helps to develop the practical skills of negotiation and communication. Specific roles within hospitals, such as clinical lead, college tutor, educational supervisor, clinical or medical director and, ultimately, chief executive, can form part of the career pathway for all clinicians who wish to devote more than a passing interest to NHS management.

The AAGBI, RCoA, BMA, Deanery, GMC, Department of Health and many other organisations encourage engagement by consultants and provide opportunities for a wealth of experience in leadership, financial responsibility, communication, systems thinking and working effectively in teams.

For those intending to assume a senior management role, undertaking a Master in Business Administration (MBA) should be considered. There is much variability between MBA course quality and cost, and specific advice must be sought before embarking on an application. The web version of this guide includes the experiences of a medical manager who has completed an MBA as a clinician.

## Learning & courses

There are many courses now available, organised both by NHS hospitals and through independent companies and NHS bodies. Many hospitals have an education centre that may be able to organise a programme of courses, using local expertise, along the themes of project management, running effective meetings, conflict resolution and presentation skills. Nationally, GAT runs an annual 2-day management course with speakers drawn from both NHS clinical managers and external bodies such as the NPSA and the Medical Protection Society. AIM holds an annual conference and also seminars at the AAGBI. BAMB runs a seminar series including topics such as dealing with difficult colleagues, NHS finance and revalidation. Whilst primarily education-based, many deaneries have short courses on managing poor performance and presentation skills. Other specific examples include those arranged by the King's Fund ('leadership for senior managers', 'management' and 'leadership for clinicians', etc.) and the popular management course organised by Keele University. Finally, opportunities for keeping aware of change within the NHS structure can be found online at the Department of Health website amongst others.

## 8. Clinical management and the law

The first duty of a doctor must be to ensure the wellbeing of patients and to protect them from harm. Patients expect doctors to be technically competent, open and honest, and to show them respect. By demonstrating these qualities, doctors earn the trust that makes their professional status and privileges possible. The professional status also applies to medical practitioners in a management role.

The 1999 Health Act introduced, for the first time, a statutory duty on the NHS in England and Wales to assure and improve the quality of healthcare that they deliver [2]. The Government, via the Act, has attempted to produce an acceptable definition of clinical quality, by the introduction of clinical governance. This idea builds upon the World Health Organization's description of the four elements of quality: professional management (technical quality); resource use (efficiency); risk management; and patient satisfaction with the service provided [3].

For the first time since the inception of the NHS, accountability for the quality of clinical care became an important requirement, the responsibility finally resting with the chief executive. The Bristol Royal Infirmary Enquiry highlighted significantly the interplay between managerial and clinical responsibilities. The former chief executive of Bristol Royal Infirmary was struck off the GMC register for serious professional misconduct. His appeal to the Privy Council against the decision, on the basis of his not being a practising clinician, was dismissed. The Medical Defence Union advised its members as a consequence that *'doctors with dual roles have duties as a registered medical practitioner over and above their contractual responsibilities and they may be held accountable to the GMC if they fail to take all reasonable steps to protect patients' interests. This applies equally to doctors who have no direct patient contact, for example scientists or managers.'*

This effectively means that clinical managers can be held to account as a clinician for the areas under their managerial responsibility rather than their direct clinical responsibility. This responsibility on clinicians outside the specific doctor-patient responsibility broadens further the accountability mechanisms in hospitals. With clinical governance, managers, whether clinically qualified or not, are responsible for clinical standards under their authority.

Medical managers have several codes of conduct that they must adhere to: Good Medical Practice [4] sets out the fundamental principles that should underpin the practice of all doctors; the recommendations of the Committee on Standards in Public Life (the Nolan Committee); the guidance from the GMC Management for Doctors [5]; and the Department of Health's Code of Conduct for NHS Managers [6].

The Corporate Manslaughter and Corporate Homicide Act 2007 [7] would allow NHS organisations to be charged if the way in which its activities are managed or organised by its senior management lead to a breach in its duty of care and the death of a patient or member of staff.

## 9. Defence Medical Services

The Defence Medical Services provide publicly funded healthcare parallel to, and in association with, the NHS.

### Structures

The head of the Defence Medical Services (DMS), the surgeon general, is based at the Ministry of Defence. Within the surgeon general's department are teams dealing with operations, policy, capability and associated issues, together with liaison with the Department of Health.

The surgeon general post is 'triservice' in that it covers the Army, Navy and Air Force. Each of the Armed Services has a medical service or branch headed by a director general or equivalent.

Each single service has a consultant adviser in anaesthesia, answering to the respective medical director general of that service. These in turn link with the defence consultant adviser, a 'triservice' appointment who oversees operational, equipment and personnel issues.

The defence professor anaesthesia and critical care is another triservice appointment with a remit for developing academic military anaesthesia in its widest sense.

### Links to the NHS

One of the main links to the NHS is Joint Medical Command which co-ordinates the placement of defence consultants within NHS hospitals and organises overseas deployments.

Military anaesthetists may achieve a consultant post at:

- A Ministry of Defence Hospital Unit (MDHU) co-located with a NHS hospital where there is a military administration and clinical presence. The main clinical link between the military and the NHS at an MDHU is the military clinical director. MDHUs are currently located at Derriford, Frimley Park, Peterborough, Portsmouth, and South Tees Hospital NHS Foundation Trust.
- Royal Centre for Defence Medicine in Birmingham, which includes the above plus care for operational casualties (evacuated from overseas operations) and academic placements.

- As NHS hospital, albeit with a (distant) military unit providing administrative support.
- In a specialised military post – such as with a field hospital or medical regiment or staff officer post. These latter require individual arrangements to allow clinical time to maintain an individual's operational deployability.

With all of the above placements there is a varying degree of military duty and clinical duty.

## **Operational interfaces**

2 Medical Brigade based near York owns the Regular (full time) and Territorial Army (part time) field hospitals and is responsible for preparing them for deployment.

DMS anaesthetists undergo individual operational pre-deployment training and exercise with the hospital with which they will be working.

The Role 3 Field Hospital in Camp Bastion, Helmand Province, Afghanistan is the current main location to which DMS consultants are deployed. Within this structure consultant anaesthetists are responsible militarily to a commanding officer and for clinical or governance issues to a deployed medical director (DMD). The role of DMD has, to date (2010), been fulfilled by anaesthesia and emergency medicine consultants who have the ability to work within high intensity trauma systems and see system issues as a whole. The hospital has operational responsibility to command structures within the deployed area and to Permanent Joint Headquarters in the UK.



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3. World Health Organisation The principles of quality assurance (report on a WHO meeting). Geneva: WHO, 1993.
4. General Medical Council. Good Medical Practice Guide. London: GMC, 2006.
5. General Medical Council. Management for Doctors. London: GMC, 2006.
6. Department of Health. Code of Conduct for NHS Managers. London: DoH, 2002.
7. Corporate Manslaughter and Corporate Homicide Act 2007.  
[http://www.uk-legislation.hmso.gov.uk/acts/acts2007/ukpga\\_20070019\\_en\\_1](http://www.uk-legislation.hmso.gov.uk/acts/acts2007/ukpga_20070019_en_1) (accessed 30.03.10).

# Glossary and resources

AAGBI	The Association of Anaesthetists of Great Britain and Ireland <a href="http://www.aagbi.org">www.aagbi.org</a>
AC	Audit Commission <a href="http://www.audit-commission.gov.uk">www.audit-commission.gov.uk</a>
ACCEA	Advisory Committee on Clinical Excellence Awards <a href="http://www.dh.gov.uk/ab/ACCEA/index.htm">www.dh.gov.uk/ab/ACCEA/index.htm</a>
AIM	Anaesthetists in Management <a href="http://www.aimgbi.org">www.aimgbi.org</a>
ALB	Arm's Length Bodies
AOMRC	Academy of Medical Royal Colleges <a href="http://www.aomrc.org.uk">www.aomrc.org.uk</a>
BAMM	British Association of Medical Managers <a href="http://www.bamm.co.uk">www.bamm.co.uk</a>
BAMMbin0	Trainee arm of BAMM <a href="http://www.bamm.co.uk/Services/Support_%26_Development/BAMMbin0_2007072440">www.bamm.co.uk/Services/Support_%26_Development/BAMMbin0_2007072440</a>
BMA	British Medical Association <a href="http://www.bma.org.uk">www.bma.org.uk</a>
CHPs	Community Health Partnerships (Scotland) <a href="http://www.sehd.scot.nhs.uk/chp">www.sehd.scot.nhs.uk/chp</a>
CML	Clinical Management and Leadership (Keele University) <a href="http://www.keele.ac.uk/depts/hm/cml/index.htm">www.keele.ac.uk/depts/hm/cml/index.htm</a>
CMO (E)	Chief Medical Officer (England) <a href="http://www.dh.gov.uk/en/AboutusMinistersandDepartmentLeaders/ChiefMedicalOfficer/index.htm">www.dh.gov.uk/en/AboutusMinistersandDepartmentLeaders/ChiefMedicalOfficer/index.htm</a>
CMO (NI)	Chief Medical Officer (Northern Ireland) <a href="http://www.dhsspsni.gov.uk/index/phealth.htm">www.dhsspsni.gov.uk/index/phealth.htm</a>

CMO (S)	Chief Medical Officer (Scotland) <a href="http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/17914">www.scotland.gov.uk/Topics/Health/NHS-Scotland/17914</a>
CMO (W)	Chief Medical Officer (Wales) <a href="http://www.cmo.wales.gov.uk">www.cmo.wales.gov.uk</a>
CNST	Clinical Negligence Scheme for Trusts <a href="http://www.nhsla.com/Claims/Schemes/CNST">www.nhsla.com/Claims/Schemes/CNST</a>
COPMeD	Conference of Postgraduate Medical Deans <a href="http://www.copmed.org.uk">www.copmed.org.uk</a>
CQC	Care Quality Commission <a href="http://www.cqc.org.uk">www.cqc.org.uk</a>
CSM	Clinical Services Manager
Darzi Fellowship	Leading for Health (NHS London) <a href="http://www.london.nhs.uk/what-we-do/developing-nhs-staff/leading-for-health/darzi-fellowship">www.london.nhs.uk/what-we-do/developing-nhs-staff/leading-for-health/darzi-fellowship</a>
DHSSPS	Department of Health, Social Services and Public Safety (Northern Ireland) <a href="http://www.dhsspsni.gov.uk">www.dhsspsni.gov.uk</a>
DoH	Department of Health (NHS England) <a href="http://www.dh.gov.uk/en/home">www.dh.gov.uk/en/home</a>
DOHC	Department of Health and Children (Republic of Ireland) <a href="http://www.dohc.ie">www.dohc.ie</a>
GAIN	Guidelines and Audit Implementation Network (Northern Ireland) <a href="http://www.gain-ni.org">www.gain-ni.org</a>
GAT	Group of Anaesthetists in Training <a href="http://www.aagbi.org/gat.htm">www.aagbi.org/gat.htm</a>
GMC	General Medical Council <a href="http://www.gmc-uk.org">www.gmc-uk.org</a>
HBs	Health Boards (Wales) <a href="http://www.nhsdirect.wales.nhs.uk/healthinformation/localhealthboards">http://www.nhsdirect.wales.nhs.uk/healthinformation/localhealthboards</a>

HIW	Healthcare Inspectorate Wales <a href="http://www.hiw.org.uk">www.hiw.org.uk</a>
HOWIS	Health of Wales Information Service (NHS Wales) <a href="http://www.wales.nhs.uk">www.wales.nhs.uk</a>
HSC	Health and Social Care (Northern Ireland) <a href="http://www.healthandcareni.co.uk">www.healthandcareni.co.uk</a>
HSE	Health Service Executive (Rep of Ireland) <a href="http://www.hse.ie/eng">www.hse.ie/eng</a>
IHM	Institute of Health Care Management <a href="http://www.ihm.org.uk">www.ihm.org.uk</a>
King's Fund	King's Fund (England) <a href="http://www.kingsfund.org.uk">www.kingsfund.org.uk</a>
LNC	Local Negotiating Committee
MBA	Master of Business Administration
MHRA	Medical and Healthcare Products Regulatory Agency <a href="http://www.mhra.gov.uk">www.mhra.gov.uk</a>
Monitor	Monitor-Independent regulator of NHS Foundation Trusts <a href="http://www.monitor-nhsft.gov.uk">www.monitor-nhsft.gov.uk</a>
NACT-UK	National Association of Clinical Tutors UK <a href="http://www.nact.org.uk">www.nact.org.uk</a>
NCAA	National Clinical Assessment Authority <a href="http://www.ncas.npsa.nhs.uk">www.ncas.npsa.nhs.uk</a>
NEDs	Non-Executive Directors
NHS Boards	NHS Boards (Scotland) <a href="http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/Boards">www.scotland.gov.uk/Topics/Health/NHS-Scotland/Boards</a>
NHS Employers	NHS Employers <a href="http://www.nhsemployers.org">www.nhsemployers.org</a>

NHS Institute	National Institute for Innovation and Improvement <a href="http://www.institute.nhs.uk">www.institute.nhs.uk</a>
NHSConfed	NHS Confederation <a href="http://www.nhsconfed.org">www.nhsconfed.org</a>
NHSLA	National Health Service Litigation Authority <a href="http://www.nhsla.com">www.nhsla.com</a>
NHSNSS	NHS National Services Scotland <a href="http://www.nhsnss.org">www.nhsnss.org</a>
NIAA	National Institute for Academic Anaesthesia <a href="http://www.niaa.org.uk">www.niaa.org.uk</a>
NICE	National Institute for Health and Clinical Excellence <a href="http://www.nice.org.uk">www.nice.org.uk</a>
Nolan Committee	Committee on Standards in Public Life <a href="http://www.public-standards.org.uk">www.public-standards.org.uk</a>
NPSA	National Patient Safety Agency <a href="http://www.npsa.nhs.uk">www.npsa.nhs.uk</a>
NRES	National Research Ethics Service <a href="http://www.nres.npsa.nhs.uk">www.nres.npsa.nhs.uk</a>
PALS	Patient Advice and Liaison Service <a href="http://www.pals.nhs.uk">www.pals.nhs.uk</a>
PASA	NHS Purchasing and Supply Agency <a href="http://www.pasa.nhs.uk/PASAwab">www.pasa.nhs.uk/PASAwab</a>
PCC	Patient Client Council (Northern Ireland) <a href="http://www.patientclientcouncil.hscni.net">www.patientclientcouncil.hscni.net</a>
PCT	Primary Care Trust
PHSO	Parliamentary and Health Service Ombudsman <a href="http://www.ombudsman.org.uk">www.ombudsman.org.uk</a>
QIS	NHS Quality Improvement Scotland <a href="http://www.nhshealthquality.org">www.nhshealthquality.org</a>

RCOA	The Royal College of Anaesthetists <a href="http://www.rcoa.ac.uk">www.rcoa.ac.uk</a>
RQIA	Regulation and Quality Improvement Authority (Northern Ireland) <a href="http://www.rqia.org.uk">www.rqia.org.uk</a>
RQIA	Regulation and Quality Improvement Authority (Northern Ireland) <a href="http://www.rqia.org.uk/home/index.cfm">www.rqia.org.uk/home/index.cfm</a>
SHA	Strategic Health Authority (England) <a href="http://www.nhs.uk/ServiceDirectories/Pages/StrategicHealthAuthorityListing.aspx">www.nhs.uk/ServiceDirectories/Pages/StrategicHealthAuthorityListing.aspx</a>
SHOW	Scotland's Health on the Web (NHS Scotland) <a href="http://www.show.scot.nhs.uk">www.show.scot.nhs.uk</a>
WHO	World Health Organization <a href="http://www.who.int/en">www.who.int/en</a>

# Anaesthetic workforce in United Kingdom & Republic of Ireland

(all data from 2007 figures)

	Trusts/ hospitals	Consultant posts established	Percentage of UK consultant anaesthetic workforce	SAS doctors established (filled)	Trainees
England	222	5293	82.1%	1791	3668
Scotland	32	619	9.5%	113	442
Wales	15	331	5.1%	127	262
Northern Ireland	16	220	3.3%	39	116
Republic of Ireland*	40	275			369

Royal College of Anaesthetists Census Report 2008

\* Data from Republic of Ireland relates to Public Health Service only.









**The Association of Anaesthetists**  
*of Great Britain & Ireland*

21 Portland Place, London, W1B 1PY  
Tel: 020 7631 1650  
Fax: 020 7631 4352  
Email: [info@aagbi.org](mailto:info@aagbi.org)  
[www.aagbi.org](http://www.aagbi.org)