Association of Anaesthetists

The SAS Handbook

5th edition | 2023

anaesthetists.org

Introduction

I am very pleased to introduce our new resource for SAS anaesthetists. This is replacing the previous SAS Handbook in a way that we hope is relevant, useful and accessible.

SAS doctors make up at least 20% of the anaesthetic workforce, and combined with locally-employed doctors are the fastest growing part of the medical workforce in the NHS. We have aimed to produce a resource that will be helpful to you in your career, tailored to the needs of those in the SAS grades but also providing useful general information for everyone. We know that those who work in these grades often feel isolated and have difficulty in gaining the support and recognition that they deserve. We hope that this resource will go a small way at least to assisting with this and will answer the more commonly occurring queries.

In recognition of the difficulties that many of the international medical graduates face when first joining the NHS we have added a chapter with information especially aimed at them for the first time.

I would like to take this opportunity to thank all those who have helped in putting this together: my fellow members of the SAS Committee at the Association, the president, officers, Board and all the staff of the Association. I would also like to thank all those who have taken the time to access this content; we are stronger together and the Association works hard on behalf of all of its members. As a membership organisation, we are very keen to reflect what our members would like us to do and if there are any queries or suggestions for future content then please do not hesitate to contact us.

Dr Emma Wain
Chair of the SAS Committee and Honorary Treasurer, Association of Anaesthetists

We have taken every effort to ensure that the information contained here is accurate and up to date at the time of publication. This has been designed to be an interactive source and we have linked wherever possible back to the relevant authority for accuracy; if any of these links have gone out of date or changed in the meantime, we apologise and always advise that you check with the relevant authority rather than relying absolutely on any information contained in these pages.

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The ‘alternative career pathways’

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Chapter 1 – The 'alternative career pathways'

Doctors who are not consultants, or part of a recognised training programme, may be employed on a number of different contracts. These include the nationally negotiated contracts, which are currently the 'Specialty Doctor' and 'Specialist.' Some doctors are also still employed on historical national contracts, which include the 'Staff Grade' and 'Associate Specialist.' Together, these groups are 'SAS doctors.'

There are also a group of doctors employed on non-standard, non-national contracts. These 'locally- employed' doctors have a variety of names, which vary from one organisation to the next, and include 'Trust Doctor' and 'Clinical Fellow.' It is the opinion of the Association of Anaesthetists that many of these doctors would be better served by being employed as SAS doctors, with the permanence and contractual protections associated with a substantive SAS contract.

Choosing a career as an SAS doctor should be a viable career choice, and offer several attractive additional pathways for a career in medicine. The SAS contracts potentially allow someone to have their career within one organisation, from an earlier stage, while working towards any one of a number of potential end points.

A new Specialty Doctor could choose to pursue any of the following:

- Remaining a Specialty Doctor, and broadening their role into the non-clinical
- Progressing to becoming a Specialist
- Progressing to becoming a consultant via entry into the Specialist register of the General Medical Council (GMC) through the Certificate of Eligibility for Specialist Registration (CESR)/portfolio pathway
- Progressing to becoming a consultant by (re-)entering a formal training programme

Each of the above reflects a different career pathway to the 'conventional' norm of formal training. Each career goal carries its own development needs, some of which overlap. Supporting each of these aspirations potentially benefits our services by improved recruitment and retention, as well as filling anticipatable future workforce need. These alternative career pathways therefore need 'parity of esteem,' and they should be an important part of future workforce planning.

The following sections cover the 2021 SAS contract reform in more detail. Unless otherwise stated, some of the detail within these sections is based around the contract negotiations in England. There are some small variations between these contracts, and the contracts in Scotland, Wales and Northern Ireland, but the themes remain the same.

The 2021 SAS contracts

Specialty Doctor (2021)

Eligibility:

- Full registration and a Licence to Practice with the GMC
- At least **4 years** full-time postgraduate training (or equivalent gained on a part-time or flexible basis)
- At least **2 years** of which is in a specialty training programme in a relevant specialty (or equivalent experience and competencies)

The Specialty Doctor role is the less senior SAS role, and new entrants to the role require supervision and support to develop in keeping with their existing level of experience. Doctors working as Specialty Doctors will have differing supervision needs, and different developmental needs.

New starters from another national contract, including doctors in formal training, should have their basic pay matched in keeping with the contract terms and conditions. Locally-employed doctors who exceed the above eligibility can seek to have their additional experience recognised if they become Specialty Doctors, in order to start at an appropriate pay point; however, this is currently at the discretion of employers. The start of the Specialty Doctor pay scale roughly aligns with the CT3 nodal point in the trainee contract, and the contract assumes that new Specialty Doctors will have the above experience only. Additional experience and existing seniority can be recognised.

Specialty Doctors have contractual rights to a job plan and a minimum of one unit of supporting professional activities (SPA) time. Additional SPA should be encouraged, allocated in a way commensurate with the activity and agreed at job planning meetings, the Royal College of Anaesthetists (RCoA) and the Academy of Royal Medical Colleges (AoMRC) recommend an allocation of 1.5 PAs for SPA in all SAS and consultant job plans. There is an expectation of ongoing professional development to greater seniority, less direct supervision and broadening their role into non-clinical domains built into the contract structure. Professional development should be the norm, and not the exception.

Each year, every SAS doctor should have a job planning meeting and an appraisal. Doctors on a 2021 SAS contract also require pay progression meetings before each potential pay point change. Each of these presents an opportunity to discuss career aspirations, how these might be achieved and what support might be required.

Some organisations offer Educational Supervisors for their Specialty Doctors, which may be valuable to their ongoing professional development. This would potentially be most beneficial to those earliest in their careers. Mentoring could likewise be very valuable to some of these doctors and should be offered. The Association mentoring scheme has been set up so that members interested in having a mentor, or receiving coaching, can access a team of trained Association of Anaesthetists mentors across the UK. The Association mentoring scheme is voluntary for both mentors and mentees and all services are free of charge.

Pay progression within the Specialty Doctor contract

There are two forms of pay progression within the specialty doctor grade: standard pay progression and progression through the higher threshold.

Standard pay progression with require a doctor having participated satisfactorily in the job planning and medical appraisal processes and having completed the employing organisations mandatory training requirements. There should also be no formal capability process or live disciplinary sanction on the doctor's record. Further details on the requirements and process can be found in the full Terms and Conditions of the Specialty doctor contract.

In order to pass through the higher threshold, doctors in addition should be able to demonstrate an increasing ability to take decisions and carry responsibility **without direct supervision**.

Doctors should also provide evidence to demonstrate their contributions to a **wider role**, for example, meaningful participation in or contribution to relevant:

- Management or leadership
- Teaching and training (of others)
- Representative work
- Audit
- Service development and modernisation
- Committee work
- Innovation

Progressing through the higher payment threshold marks an increase in 'seniority' within the career of Specialty Doctor. Working with less direct supervision is a step towards working independently. This is therefore potentially a step towards becoming a Specialist. Likewise, contribution to non-clinical activity in multiple domains is required in the progression to becoming a Specialist or a consultant via CESR/portfolio pathway. Regardless of a doctor's career aspirations, participation in non-clinical activity needs to be the norm, not the exception. Discussion of supervision arrangements, and progression to non-clinical activity therefore needs to be a normal part of job planning and appraisal.

Involvement in departmental business, leadership, delivering education, audit and quality improvement requires SAS doctors to be invited to departmental business and educational meetings, as well as this being factored into job planning.

Normalising progression in responsibility at this threshold, for example, by progression from a more 'junior' to a more 'senior' resident rota tier, would mark this threshold in a meaningful way for Specialty Doctors. This would be dependent on both the service need and the doctor in question.

Some organisations have policies for autonomous working for Specialty Doctors, which pre-date the creation of the Specialist role. Going forward, it is potentially more appropriate to normalise progression to a role that features an expectation of autonomy, such as becoming a Specialist (or consultant via CESR), than to normalise having autonomous Specialty Doctors.

The Specialist grade

Eligibility:

- Full registration and a Licence to Practice with the GMC
- A minimum of **12 years** medical work (either continuous period or in aggregate) since obtaining a primary medical qualification
- A minimum of **6 years** of which is in a relevant specialty in the Specialty Doctor and/or closed SAS grades (or equivalent years' experience from other medical grades including from overseas)
- Meets the criteria set out in the Specialist grade generic capabilities framework*

The Specialist is the more senior SAS role and is defined as a '**senior** and **experienced** clinician who will work **autonomously**' in a potentially narrower niche than a consultant. For some doctors, this niche may be as wide as that of a consultant colleague, allowing them to potentially progress to a 'consultant' non-resident on-call rota. Others may continue to contribute to a resident rota out of hours (OOH). On-call arrangements and frequency need to take into account the contractual protections, cost efficiency, the seniority of the doctors and their wellbeing and career sustainability. Some Specialists may have no OOH component to their role, as is the case for some existing Associate Specialists.

As with the higher payment threshold of the Specialty Doctor contract, becoming a Specialist reflects another progression in seniority, which ideally should be marked by a role that is distinct to Specialty Doctor colleagues. Progression should be visible in order to incentivise it for the next generation of SAS anaesthetists. Specialists also have contractual rights to a job plan and should have SPA time commensurate with their non-clinical activity and seniority.

The niche in which a Specialist works independently will vary from one individual to the next, and be based on the doctor, their background and the service need. Within many anaesthetic departments there are already doctors who are currently badged as Specialty Doctors, who would now be more appropriately be badged as Specialists. The most motivated Specialty Doctors may well have already met the criteria required to become Specialists, and already work independently within their clinical niche. This needs to be identified and addressed between the doctor and their line manager or clinical director.

In order for a Specialty Doctor to become a Specialist within their existing department, organisations need to identify them and create a process by which they are progressed to the right contract for their work. This should ideally be by advert, application and interview; however, there is no reason that these adverts cannot be internal, and a portfolio-based interview undertaken, where the doctor demonstrates they now meet the requirements. All processes for the creation of Specialists should be robust, transparent and fair. SAS doctors should be involved in the recruitment of SAS doctors.

The above is equally true for doctors currently employed within an organisation as 'locum consultants'. If these doctors are not on the Specialist Register, but are able to work in a senior capacity and meet the Specialist eligibility requirements, facilitating them onto Specialist contract might be appropriate. Doctors may also choose to apply for a Specialist post advertised in another organisation.

*Meeting the requirements of the Specialist Generic Capabilities Framework requires being a well-rounded senior doctor, by demonstrating evidence mapped to the following domains:

- Professional values and behaviours, skills and knowledge
- Leadership and teamworking
- Patient safety and quality improvement
- Safeguarding vulnerable groups
- Education and training
- Research and scholarship

Job planning and rotas

The 2008 and 2021 SAS contracts contain a contractual right to a mutually agreed job plan, in the same manner as the 2003 consultant contract. Broadly speaking, processes should be the same as for consultants, and the resulting job plans should not disadvantage SAS doctors. SAS doctors should have an appropriate and mutually beneficial balance between fixed and flexible sessions, and any arrangements for OOH activity should be agreed, job planned and in keeping with the contractual protections outlined below. Supervision arrangements for doctors who are not working autonomously should be discussed and formalised. Specialty Doctors should have their ongoing development planned for, and sessions within their job plan for this may be included. The mediation processes for situations where agreement cannot be reached are the same as for consultant colleagues.

The 2021 SAS contracts contain contractual protections against excessive OOH working designed to reduce fatigue and make the rota patterns of Specialty Doctors and Specialists on resident rotas more sustainable. These compliment the Association's 'Fight Fatigue' campaign and the 'Age and the Anaesthetist' Guideline.

For doctors working a full shift rota, unless otherwise mutually agreed, the following will apply:

- a maximum of four consecutive nights, where at least three hours each night fall between 23.00 and 06.00
- a maximum of four consecutive long day shifts
- a minimum period of 46 hours before and after transition between day and night shifts

The majority (i.e. no less than 60%) of work should normally take place in standard working hours, which are defined as 07.00 to 21.00 Monday to Friday, rather than OOH, which is all other times, unless otherwise mutually agreed. Where existing job plans contain in excess of 40% of work in OOH, the employer and doctor will work towards decreasing the percentage each year until a limit of 40% is reached, unless otherwise mutually agreed.

A doctor's Job Plan will not require work for more than 13 weekends, in whole or in part, (defined for this purpose only as any period between 00.01 Saturday and 23.59 Sunday where work is undertaken during an on call or shift), per year, averaged over 2 years, unless mutually agreed.

Where higher frequency rotas already exist, they will be subject to annual review; unless mutually agreed, the shared intention would be for this frequency to be reduced to 13 weekends as a maximum by a date in the future to be agreed between the doctor and employer.

These clauses potentially should be included in Trust job planning documents, in addition to the other items mentioned elsewhere within the document. While some SAS doctors may choose to remain on their existing contracts in the short-term, all new appointments will be onto a 2021 contract, and any existing SAS doctors may choose to transition to a 2021 contract at any time. It therefore seems appropriate to apply these protections to the entire SAS workforce in anaesthesia. These clauses exist to make rotas safer, because tired doctors make mistakes and fatigue is a patient safety issue.

While some Specialists may work on non-resident 'consultant' type rotas, others may contribute to a resident rota longer-term. The age profile of the SAS workforce typically mirrors that of the consultant workforce, and it is important that job planning processes allow discussion of modification of rotas as doctors age to reflect this. Offering a reduced on-call frequency to older doctors, for example, may allow them to pace their careers and remain in our workforce. Likewise, processes for offering transition off an on-call rota as doctors age should be the same for SAS doctors as they are for consultants. Some existing SAS doctors do not contribute to OOH rotas.

The 2008 and 2021 SAS contracts contain a contractual minimum of one programmed activity (PA) of SPA time, specifically for job planning, and meeting the requirements of appraisal and revalidation. Any additional non-clinical activity should carry additional SPA time in the same manner that it would for consultants in the same department. There is no contractual reason why SAS doctors undertaking the same non-clinical work should receive less SPA time for that work. As discussed elsewhere in this document, it is important that SAS doctors have the opportunity to progress their role into non-clinical domains and their SPA allocation should reflect this.

Language and culture

Arguably the single biggest barrier to the viability of alternative career pathways is existing culture, and this is reflected in the language that we use. The Association have produced a style guide for describing types of anaesthetists and staff groups. The following are described as 'derogatory' in national documents and should not be used to describe SAS doctors.

'Non-consultant career grades' (NCCGs)

This is a historical term that is still used occasionally but should not be. It is self-evidently better to be defined by what you are than what you are not. When describing all SAS doctors, the collective term 'SAS doctors' is preferable. Otherwise referring to doctors by their individual contract of employment e.g. 'Specialty Doctor,' 'Specialist' or 'Associate Specialist' is better.

'Non-training'/'non-trainees'

As with the above example, this defines doctors by what they are not and is unhelpful in the context of trying to normalise the importance of ongoing professional development and progression.

'Middle grades'

Defining the entire cohort as one group of perpetual 'middle grade' doctors is unhelpful in the context of the differing levels of seniority, independence and experience described by the 2021 SAS contract reform.

An early career Specialty Doctor, a mid-career Specialty Doctor and a Specialist each have different needs and abilities and should be managed as such. Where it is convenient to describe all the doctors contributing to a given rota, saying 'doctors on the middle tier rota' would be acceptable.

'Service roles'/'just for service'

The ongoing professional development of every doctor is important. This is reflected in the need for appraisal, revalidation and the formation of annual personal development plans. The 2021 SAS contract reform is reliant on SAS doctors being able to progress and develop, and achieve their individual potential. Although there is a vital service component to the role of any permanent employee, no one is 'just for service,' and the future service is increasingly dependent on the professional development of our existing anaesthetic workforce.

Exclusion by omission

The SAS workforce are frequently overlooked, and this leads to an assumption of exclusion when none was intended. Emails and other communications may currently be targeted to 'consultants,' or to 'consultants and trainees,' without realising that this excludes the Trust's SAS (and also potentially also its locally-employed) workforce. In the context of offering development opportunity or undertaking non-clinical roles, excluding Specialty Doctors may block their career progression. In the context of offering leadership opportunities, excluding Specialists and Associate Specialists will unnecessarily limit the pool of candidates applying for a role. Each of these may need a concerted effort to change existing culture, involving education of both medical and non-medical leaders with an organisation.

Appendix 1 – Further reading

The SAS charter – BMA (bma.org.uk)

Maximising the potential: essential measures to support SAS doctors - Health Education England and NHS Improvement

SAS doctor development guide – NHS Employers

SAS - A viable career choice – Academy of Medical Royal Colleges (aomrc.org.uk)

Wellbeing of the SAS workforce – Academy of Medical Royal Colleges (aomrc.org.uk)

SAS workforce - rhetoric vs reality – Academy of Medical Royal Colleges (aomrc.org.uk)

Engaging and empowering the SAS workforce – Academy of Medical Royal Colleges (aomrc.org.uk)

SAS doctors – Academy of Medical Royal Colleges (aomrc.org.uk)

Medical Workforce Race Equality Standard (MWRES); A commitment to collaborate - The First Five

Generic capabilities framework for the specialist grade – NHS Employers

SAS contract 2021 implementation guidance – NHS Employers

Supporting professional activities (SPA) time for SAS doctors – BMA (bma.org.uk)

Survey of specialty and associate specialist (SAS) and locally employed (LE) doctors – GMC (gmc-uk.org)

The state of medical education and practice in the UK archive. The workforce report 2022 – GMC (gmc-uk.org)

Unlocking the potential of the SAS workforce – GMC (gmc-uk.org)

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Chapter 2

Supervision, autonomy and asking for help

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Chapter 2 – Supervision, autonomy and asking for help

Different SAS anaesthetists will have different requirements for supervision, and these requirements will depend on the stage of their careers, their areas of expertise and the work they are undertaking. A career as an SAS doctor can take a doctor from more direct supervision, to less direct supervision, to autonomy.

The current SAS contracts are the Specialty Doctor, and the Specialist, which have different requirements and expectations associated with their eligibility criteria. In addition, the higher threshold within the Specialty Doctor pay scale delineates more experienced Specialty Doctors from less experienced Specialty Doctors, based partly on their supervision requirements. These two contracts therefore create three cohorts with the SAS workforce, with different expectations.

New entrants into the Specialty Doctor role are potentially early within their careers, and should therefore be expected to have supervision and support in keeping with their level of experience. This should be the same as that provided for a comparably experienced doctor in formal training.

Passing through the higher threshold of the Specialty Doctor pay scale carries a requirement to demonstrate an increasing ability to take decisions and carry responsibility **without direct supervision**. Doctors above this threshold should therefore have less direct supervision arrangements, but still be supervised unless otherwise agreed.

Becoming a Specialist carries an expectation of **autonomy** within that doctor's area or areas of expertise. Specialists should be empowered to work with responsibility for their patient workload, as consultant colleagues are. This is a defining characteristic of the senior role.

The above levels of supervision correspond with the levels defined by the Royal College of Anaesthetists, in the document 'Guidance on supervision arrangements for anaesthetists.'

1	Direct supervisor involvement, physically present in theatre throughout
2A	Supervisor in theatre suite, available to guide aspects of activity through monitoring at regular intervals
2B	Supervisor within hospital for queries, able to provide prompt direction/assistance
3	Supervisor on call from home for queries able to provide directions via phone or non-immediate attendance
4	Should be able to manage independently with no supervisor involvement (although should inform supervisor as appropriate to local protocols)
5	Autonomously practising anaesthetist requiring no supervision

Where there is an ongoing requirement for supervision, as described above, this supervision should meet the defined national guidelines for adequate supervision. The 'Cappuccini Test' (Cappuccini Test – The Royal College of Anaesthetists) exists to identify situations where supervision arrangements are inadequate or undefined.

The Cappuccini Test consists of the following questions:

Cappuccini Test

Questions for the doctor being supervised:

Who is supervising you (name)?

How would you get hold of them if you needed them now?

Questions for the supervising doctor (named above):

Which lists (i.e. who) are you currently supervising?

What surgical specialty are they doing now, do you know of any issues that they are concerned about?

If they required your help, would you be able to attend?

Where supervision arrangements would not pass the above test, this means one of two things: either ongoing supervision is required but it is currently inadequate or this doctor is now demonstrating an ability to work with autonomy. If the latter, this provides an excellent opportunity to discuss whether progression to the Specialist contract might be more appropriate.

Asking for help

For doctors who are working with an ongoing expectation of supervision, the ability to consult your supervising colleague and seek support forms part of the supervision standards. Some doctors are understandably apprehensive about progressing beyond this supervision and working autonomously; however, being responsible for your own patient workload does not mean you are unable to ask for help.

Becoming a Specialist, or a consultant, should not require working outside of your capabilities or being unempowered to seek support. The General Medical Council (GMC) guidance on this is very clear. Good doctors make the care of their patients their first concern, and this includes recognising and working within the limits of your competence. Everyone should be able, and empowered, to consult colleagues where appropriate. No one is an island.

The Royal College of Anaesthetists' Guidelines for the Provision of Anaesthesia Services: 'The good department 2023' chapter, suggests that departments should have a nominated anaesthetist immediately available to provide cover in clinical emergencies, as well as advice and support to other anaesthetists. It goes on to say that departments should positively encourage an overt culture of seeking support regardless of grade if working solo, or if a second opinion or some practical help would improve the situation.

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Chapter 3

Personal development planning for SAS anaesthetists

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Association of Anaesthetists

Chapter 3 – Personal development planning for SAS anaesthetists

In this section, we will highlight the importance of personal development planning for SAS doctors. Personal development is a process by which an individual becomes more self-aware, hence allowing them to improve performance and equip themselves with new skills. A personal development plan (PDP) is essential to identify your needs, set objectives and monitor progress. A PDP is an essential component of appraisal and revalidation.

What is appraisal and revalidation?

Revalidation is a mandatory process for every licensed doctor on the General Medical Council (GMC) register and the requirements for SAS doctors are no different than for consultants. One revalidation cycle is 5 years. Appraisal is an annual process of facilitated self-review. A responsible officer, usually the medical director in your Trust, will make recommendations to the GMC regarding your revalidation. Outputs from your annual medical appraisals, over a 5-year period, will help your responsible officer make these revalidation recommendations.

How difficult are appraisal and revalidation?

It may sound intimidating, particularly to colleagues who are new to the NHS. Indeed, failure to engage and participate in the appraisal and revalidation processes may put your medical licence at risk; however, the overwhelming majority of SAS doctors do not have difficulty. The standard to comply with appraisal and revalidation is not high. Appraisal should be developmental, and assurance focused, and it is not a pass or fail exercise.

Isn't appraisal and revalidation just a tick box exercise for SAS doctors?

If approached with this attitude, then appraisal and revalidation can be just an exercise in doing the bare minimum. This can be true for doctors of all grades. However, in these circumstances, it is unlikely that an SAS doctor will get much out of the process. On the contrary, many SAS doctors find it valuable to take the time to reflect and discuss their professional development and practice as a doctor. If done well, appraisal can prevent stagnation and spur an SAS doctor to improve their career and wellbeing. It can give focus, direction, and recognition to your professional development as an SAS doctor.

Other than appraisal and revalidation, why do I need professional development as an SAS anaesthetist?

Regardless of background or grade within the medical profession, all doctors should have the opportunity to develop themselves. When SAS doctors are allowed to reach their full potential, there are huge personal benefits. In addition, there are inevitably, benefits for patients and organisations. A fulfilling and satisfising SAS career is one where there is access to and engagement with development opportunities.

For individuals aspiring to become a Specialist they need to demonstrate that they can critically assess their own learning needs and have a PDP to enable them to lead and develop services.

Do I have access to an educational supervisor?

SAS doctors are by nature a very diverse group. Some are early in their SAS career and may only have a few years in the specialty, whereas others are more senior, with extensive experience. Some colleagues will have been in formal postgraduate training within the UK and many others will have been in training or completed training from abroad.

There is no obligation for Trusts to provide SAS doctors with an educational supervisor; however, some Trusts are leading the way and providing early career SAS with a dedicated educational supervisor and funding the role. You should ask your department if this is something they have or aspire to introduce.

Of course, many senior SAS doctors are themselves educational supervisors to undergraduate and postgraduate doctors. Medical education is itself a worthwhile and gratifying professional development activity. There are no educational roles that are off-limits to SAS doctors, as long as they can demonstrate they meet the specification required of the position.

How can I get time for professional development?

All SAS doctors have the contractual right to supporting professional activities (SPA) time. A common myth is that SAS doctors are only afforded one programmed activity (PA) of SPA per week. This would equate to 4 hours. However, this is an absolute minimum and not a target. The Academy of Royal Medical Colleges recommend a minimum of 1.5 PAs of SPA for all SAS doctors. The British Medical Association recommends a minimum of two PAs of SPA for the majority of SAS doctors over threshold two of their specialty doctor contract or for all Associate Specialists and Specialists. The appropriate SPA time for you should be agreed through job planning.

What should I do in my SPA time?

SPA time should not be used for direct clinical care or any admin related to direct clinical care. SPA time is an opportunity for you to do the non-clinical work necessary to fulfil your appraisal and revalidation requirements. In addition, you might want to undertake additional teaching, research, clinical management or medical education roles. All of these might well require additional SPA time. You are not expected to do professional development activities, including appraisal preparation, unpaid in your own time.

What if I am unable to use my SPA time?

You cannot be forced to give up your SPA time in order to do direct clinical care. If, due to extenuating circumstances and mutual agreement, you are unable to utilise your SPA time, then you should have this SPA time returned. If you find that you are regularly unable to take your SPA, then this is a contractual breach, and it should be raised urgently with your clinical director.

How much study leave do I get and what should I do with it?

SAS doctors also have a right to take up to 30 paid days for professional or study leave, with expenses, within a 3-year period. Some employers will interpret this as 10 days per year. Whatever the local circumstances, please try to utilise your full quota of professional and study leave. Some examples of things that you might consider doing with this leave include:

- Study, usually but not exclusively or necessarily on a course or programme
- Research
- Teaching
- Examining or taking examinations
- Visiting clinics and attending professional conferences
- Training

Who else will support my professional development?

Across England and the devolved nations there are colleagues appointed to support SAS professional development within each Trust or health board. In England and Wales, they are called SAS tutors, in Scotland they are SAS education advisors, and in Northern Ireland they are the SAS leads. These individuals are responsible for providing local support and guidance for SAS professional development. They are likely to work closely with your Director for Medical Education (DME), may arrange local SAS educational courses or webinars, and may organise an annual SAS professional development day. In England and Wales, the SAS tutors also work collaboratively with a regional Associate Dean for SAS doctors.

If you have a question, concern or any other issue with your professional development as an SAS doctor, your SAS tutor, SAS educational advisor, or SAS lead, can be approached to help you.

What funding is available to support my development as an SAS doctor?

Trusts will have a local policy on a study budget for consultants and SAS. The annual study budget allowance will vary from Trust to Trust but is in the range of £500–£1000 per year. This money can be spent on relevant courses, seminars and conferences, as well as any reasonable associated costs (travel, subsistence and accommodation). It is really important to keep receipts of all of these expenses and any certificates awarded, as these will be needed in order to claim reimbursement. It is not possible to use your study budget to pay for membership or examination fees.

What about other sources of funding available to SAS?

Additional to the individual SAS study budget, there is also central funding for SAS development. For example, in England, Associate Deans will administer a regional fund that will be allocated to Trusts and spent under the direction of SAS tutors. This SAS specific professional development funding is often used to create a programme of free SAS educational events within Trusts. Money from the fund might also be spent on SAS away days, SAS professional development days and in some cases, to fund the SAS tutor post.

If you have an additional professional development expense that cannot be met by your individual study budget, your SAS tutor (or equivalent) might consider an application to help cover these costs. An example might be funding to help cover the cost of a Postgraduate Certificate in Education (PGCE), Master of Business Administration, or other academic qualification. Your Trust may also have funding streams, separate to the SAS professional development fund, for such qualifications.

Do I have to have a specific consultant as my appraiser?

Appraisal should not be a hierarchical process and there is no reason why your appraiser could not, for example, be an SAS doctor. You should have the ability to have some choice in who appraises you. If you perceive that there is a conflict of interest in a particular person, then you have the right to ask for an alternative appraiser; this should not cause offence.

Can SAS doctors become appraisers?

Absolutely they can. In fact, more SAS appraisers are needed and encouraged. There are several benefits to becoming an SAS appraiser.

1. You should receive remuneration (within your job plan) for work as an appraiser.
2. Many SAS colleagues (and some consultants) will prefer to have you as their appraiser.
3. An increased understanding of the appraisal process will benefit you in your own appraisal.
4. Training is provided on communication and listening skills. These are applicable in other areas of your practice, e.g. in educational and clinical supervision.

What are the important components of appraisal?

The annual appraisal has three components:

1. Appraisal inputs

   This will include the preparation of an appraisal portfolio with supporting information. In most Trusts this will be on an electronic platform. It can take time to get familiar with these systems. It is recommended that you start your preparation early and submit in good time.

2. Appraisal meeting

   This is a confidential meeting with your appraiser. It is protected time for you to focus on the work that you have done over the past year. You should think about your achievements, challenges, aspirations, and personal development plan (PDP) for the next year.

3. Appraisal outputs

   This will include your agreed PDP objectives and an appraisal summary written by your appraiser.

How should I prepare for my appraisal?

You do need to provide supporting information on the following:

1. Continuing professional development (CPD)
2. Quality-improvement (QI) activity
3. Significant events
4. Feedback from patients
5. Feedback from colleagues
6. Compliments and complaints

You do not need to submit every possible certificate or piece of evidence that you have collected during the year. To do so may be hugely time consuming and is unnecessary. For example, if you have provided evidence of a skill or activity once, there is no need to provide multiple examples of the same skill or activity.

What is reflection?

An important aspect of appraisal is that it is a reflective process, and this should be demonstrated throughout. For instance, you might have extensive amounts of supporting information, demonstrating much time spent in CPD and QI activities, but without reflection it will be a poor-quality appraisal.

To reflect means to give serious and careful thought to one's own medical practice and to consider the learning from each piece of supporting information. Reflection is relevant for both positive and negative experiences and there is no one set way to reflect. It is important that there is evidence of this reflection both in the submitted appraisal and during your appraisal meeting.

Will my own reflection be used as evidence against me?

You should not include any identifiable patient information in your appraisal. In fact, your reflection does not need to include the full details of any particular event. It should however capture your learning outcomes. Everything discussed at an appraisal is confidential between the appraiser and the appraisee unless issues arise that may indicate a patient safety risk.

What are good CPD activities for an SAS anaesthetist?

Anything that materially contributes to your knowledge, skills, attitudes and behaviours as an SAS anaesthetist may be considered CPD. This might be formal and informal, internal or external learning activities. CPD is individual to you and should be relevant to your learning requirements. There is no single form of CPD and in fact doing a mix of different activities is likely to be more effective. Learn@ is an extremely valuable CPD resource exclusively available to members, containing more than 1000 videos of talks from Association events. These are categorised and searchable by date, speaker, event, title, keyword or any combination of those. The system will allow you to create and store a CPD record of your reflections on these videos, and to record any other CPD activities you undertake.

You should strongly consider joining the SAS professional development events at your local and regional level. You may also want to consider attending regional, national, and international meetings, webinars and conferences. As a member of the Association of Anaesthetists you will have discounted access to a full range of such professional events that are relevant to your practice.

How many annual CPD hours should I complete?

Again, appraisals are not pass or fail. Every college has different rules on what constitutes a CPD 'point' and how much one should accumulate each year. The Royal College of Anaesthetists (RCoA) recommends that every anaesthetist should complete a minimum of 50 hours of CPD per year. This includes a minimum of 20 hours of internal and 20 hours of external CPD. The GMC simply requires you to have enough CPD to remain up-to-date and fit to practise.

How often do I need to collect feedback?

You are required to collect patient feedback, using a formal feedback exercise, at least once in every revalidation cycle, i.e. once every 5 years. Similarly, you are required to collect formal colleague feedback, once every 5 years. You can include informal feedback as part of your appraisal at any point of the revalidation cycle.

What QI activity should I do as an SAS doctor?

You are required to demonstrate that you have participated in QI activity at least once in your revalidation cycle. This QI activity might be one of many forms:

1. Clinical audit
2. Audit of prescribing activity
3. Review of performance/morbidity and mortality statistics
4. Case review or discussion
5. Learning event analysis
6. Audit of effectiveness of teaching
7. Evaluating effectiveness of health policy or management practice
8. National audit projects, e.g. National Emergency Laparotomy Audit

There is no QI role that is outside the scope of an SAS anaesthetist. SAS doctors are ideally situated, as permanent members of staff, to identify issues where improvements can be made and to lead on such projects. Improving quality is about making healthcare safe, effective, patient-centred, timely, efficient and equitable. The best QI work involves patients and uses collaborative team-working within teams. Many SAS doctors have been locally and nationally recognised for their contributions to QI.

The RCoA has a QI compendium with useful recipes for audit and QI projects. In departments working towards gaining or maintaining Anaesthesia Clinical Services Accreditation (ACSA), all anaesthetists, of all grades, will be needed to contribute to the required QI. Many of the ACSA standards are reflected in the RCoA QI compendium.

What are appropriate PDP objectives for an SAS anaesthetist?

Your PDP objectives are entirely related to your learning and development needs as an individual. They are essentially an outcome-based learning plan for the next year of your practice. Appraisers will help and advise you on constructing PDP goals during your appraisal process. Your objectives should be SMART (specific, measurable, achievable, relevant and time-bound). There is no set minimum or maximum number of PDP objectives required by the GMC.

Although you should commit to completing all of your PDP objectives, it is recognised that circumstances and priorities may change during the year. At PDP review, some objectives may need to be discarded, revised or included again in the following year.

Summary

Every doctor is obliged to have an annual PDP that is reviewed at appraisal and discussed at job planning. SAS anaesthetists have access to paid time, reimbursement for expenses and other funding, and support from SAS tutors (or equivalent) for a range of generic and specific professional development activities. Your job satisfaction, career progression and own wellbeing can all be enhanced by embracing personal and professional development opportunities.

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Chapter 4

Sources of support

Dr Rob Fleming

Association of Anaesthetists

Chapter 4 – Sources of support

SAS anaesthetists should each have the opportunity to progress their careers and meet the level of their individual potential. Departments and organisations should be supportive of this progression and inclusive of their SAS workforce. No one should ever feel alone in a career as an SAS anaesthetist. Within departments and organisations, there should be named individuals empowered and responsible for providing support. Likewise, regionally and nationally there are structures that exist to represent SAS doctors and support their interests. This chapter will provide an overview of this support and these structures.

Sources of support within your department/organisation

Anaesthetic Department: SAS clinical lead/SAS mentor

The 'Good Department' chapter of the Royal College of Anaesthetists Guidelines for the Provision of Anaesthetic Services (GPAS) makes several recommendations about support for SAS anaesthetists. This includes that departments should have an SAS clinical lead, and an SAS mentor. In addition to this, some organisations offer educational supervisors to their Specialty Doctors, which would be particularly valuable to those earliest in their SAS careers.

SAS clinical lead

The SAS clinical lead should have 'clear and agreed responsibilities' relating to the department's SAS doctors. It seems reasonable that the SAS lead anaesthetist should be an SAS anaesthetist. Aspects of management falling under the remit of the SAS clinical lead might include overseeing out-of-hours rotas that include SAS anaesthetists. This should ensure that these rotas are compliant with the protections contained within the 2021 SAS contracts. To achieve this, they may also be involved in group job planning processes. Other responsibilities might include ensuring adequate supervision arrangements exist for non-autonomous SAS doctors, and being involved in recruitment of new SAS doctors to the department.

SAS mentor

The SAS mentor should be named, trained and have responsibility to 'oversee the wellbeing, career needs, educational and professional needs of the SAS doctors in the department.' It might be valuable for doctors in this role to undertake formal mentorship training. It is also important that the doctor in this role has knowledge about the opportunities contained within an SAS career, and is able to offer support and guidance surrounding career progression. As with the SAS clinical lead, it is anticipated that the SAS mentor will be a senior SAS doctor or a consultant with lived experience of having been employed in an SAS role within their career. In smaller organisations, one doctor could potentially undertake both of these roles. Adequate time should be allowed for this activity, and this should be reflected in job planning processes.

Organisation: SAS tutor, SAS advocate and SAS Local Negotiating Committee representative

Each organisation should have an SAS tutor, an SAS advocate and SAS representative to the Trust's Local Negotiating Committee (LNC). These roles are well described within national documents relating to a career as an SAS doctor, and it might be considered a marker of a good employer that all three roles are filled. In some organisations, one doctor may be currently undertaking more than one of these roles; however, ideally, they should be distinct from one another.

Some organisations currently have a 'SAS lead,' which may be instead of, or as well as, one or more of these roles. It is worth exploring the situation in your current organisation and making contact with one or more of these doctors. It is easier for them to support you if they know your circumstances and issues.

SAS tutor

The SAS tutor supports the education, training and professional development of all of an organisation's SAS doctors. Part of their role is the promotion of a consistent approach towards professional development and to offer support and advice regarding educational needs or further training.

Because their responsibility includes SAS doctors across multiple specialties, they commonly organise courses relating to generic skills. These may include teaching, leadership and communication skills. Your SAS tutor can also be a very useful source of support on a more individual basis. The SAS tutor works within an organisation's postgraduate medical education structures, working closely with the Director of Medical Education (DME). In most organisations, the SAS Tutor has responsibility for allocating the use of the Trust's SAS development fund.

Within a region, SAS tutors are supported by an SAS Associate Postgraduate Dean, with responsibility for the whole region. Each of these SAS Associate Postgraduate Deans is invited to attend 'COPSAS,' which is an advisory group and forum for sharing good practice. COPSAS is a sub-committee of 'CoPMED,' the Conference of Postgraduate Medical Deans.

SAS advocate

The SAS advocate role was recommended as part of the most recent SAS contract reform in all four nations. The focus of the SAS advocate is to promote the health and wellbeing of SAS doctors, including workforce issues. The role therefore has both proactive and reactive elements. The advocate is expected to work with both the local negotiating committee and Trust board, in order to create a unified approach to the SAS workforce.

Wellbeing is multifactorial and includes self-determination within one's working life; belonging within an organisation; maintenance and progression of professional competence; developmental support; and recognition and reward for excellence. Each of these things may involve challenging the existing culture as it relates to SAS doctors, and this is the role of the SAS advocate. The advocate is expected to be a point of contact for all SAS doctors within an organisation and to be empowered to respond to issues in a manner analogous to a 'freedom to speak up guardian' and/or 'guardian of safe working,' but specifically for SAS doctors.

In England and Wales, SAS advocates are supported by SAS advocate networks, which new advocates are invited to join.

SAS LNC representative

The SAS representative to a Trust's LNC represents SAS doctors in relation to contractual issues. The SAS LNC representative receives training and support from a trade union, most commonly the British Medical Association (BMA). They work with the representatives from other professional groups and trade union Industrial Relations Officers (IROs), to negotiate with a Trust's other structures on behalf of their colleagues. These doctors are supported by regional SAS committees, and by the national SAS committee at the BMA.

Sources of support nationally

In addition to the structures outlined above, SAS anaesthetists benefit from representation at both the Association of Anaesthetists and the Royal College of Anaesthetists. Each of these organisations has two dedicated spaces for election of SAS doctors to their Board/Council. Each organisation also has an SAS Committee with a number of additional appointed SAS representatives and co-opted SAS representatives from other organisations or groups.

At the Association, the SAS Committee currently includes SAS representatives from the Association's Scottish Standing Committee (SSC), and NCHD representative from the Irish Standing Committee (ISC), the BMA and the Intensive Care Society. Members of the SAS Committee also represent SAS doctors in other committees and working parties. The intent is to ensure SAS viewpoints are heard at every level within the organisation, and everywhere decisions affecting SAS doctors are made.

Nationally there is also a network of Association 'SAS Links.' If your department has an SAS Link they can be a useful route to bring issues to the attention of the Association of Anaesthetists. If your organisation does not yet have an SAS Link, consider volunteering.

Other national organisations, including the Obstetric Anaesthetists' Association (OAA), the Society of Intravenous Anaesthesia (SIVA) and the Society for Obesity and Bariatric Anaesthesia (SOBA) each has an SAS representative. If you have an interest in a particular area of anaesthesia, consider becoming involved in national representative work. If an organisation does not currently have an SAS representative, feel free to get in touch with them and ask why not!

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Chapter 5

Wellbeing, dignity and respect in the workplace

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Chapter 5 – Wellbeing, dignity and respect in the workplace

Wellbeing encompasses many aspects of an individual's life. Essentially it is about feeling good and functioning well, and can be both objective and subjective. Objective wellbeing is based on assumptions about human needs and rights, and include matters such as access to adequate food, health, education and safety. Subjective wellbeing is based around how individuals think and feel about their own wellbeing. Fundamentally wellbeing is multifactorial and there is no one size fits all solution.

Within the NHS, staff wellbeing is a very important matter as it can affect patient experience and health outcomes as well as the staff who work within the organisation. NHS organisations with higher levels of staff wellbeing tend to have lower levels of staff absence, lower turnover of staff and higher patient satisfaction.[1]

In general, rules for a good work–life balance can be summarised as:

- Do not work more than full time unless you want to
- 'No' is a complete sentence
- Always know when your next set of annual leave is
- Use your full leave entitlement every year

Employers' responsibilities

Below are some general suggestions that would potentially improve the working environment for all anaesthetists working in the NHS. These might help remove some of the barriers we all face in doing our job, make life better for everybody and assist in fostering a good relationship between employer and employee:

- Providing enough lockers for personal belongings to be stored safely whilst in theatre
- Having an ID card available on an individual's first day at work
- Providing access to all areas in which an individual has to work
- Arranging a parking permit for an individual's first day at work
- Having enough car parking spaces so that all staff who wish to can have a permit and park at the hospital whatever their arrival time
- Providing facilities so that bikes can be left securely
- Providing sufficient changing facilities including showers
- Having a rota provided sufficiently in advance so that life outside work can be planned

For SAS doctors working within a department there are suggestions pertinent to them that can help foster a culture of belonging and positive wellbeing. These include:

- Inclusion in departmental email circulation lists and WhatsApp groups
- Inclusion in departmental business meetings
- Invitations to any Medical Advisory Committee (MAC)/senior staff meetings
- Ensuring roles within the department and wider Trust are open to application from SAS doctors as well as consultants
- As per Guidelines for the Provision of Anaesthesia Services (GPAS) The Good Department appoint an SAS lead in the department and provide details of who this is at induction
- Provision of details of the Trust's SAS tutor and SAS advocate, and how to contact them
- Ensuring all SAS doctors are on the correct contract for the work they are doing and that any rotas that they are on meet the contractual requirements
- Ensuring that all SAS doctors are allocated their supporting professional activities (SPA) time every week, and that the time is appropriate for the work they are doing. One SPA is a contractual minimum not a maximum
- Consider providing an SAS educational supervisor to all those who might benefit from advice and guidance as to their development and career
- Consider producing an SAS handbook containing all the relevant information for your department

[1] Raleigh VS, Hussey D, Seccombe I, Qi R. Do associations between staff and inpatient feedback have the potential for improving patient experience? An analysis of surveys in NHS acute trusts in England. *Quality and Safety in Health Care* 2009; **18:** 347–54.

Appraisal

SAS doctors can also help themselves by using their appraisal in a way that encourages their development. Appraisal is often viewed in a negative way, but it can be used to provide support for an individual's career:

- Ensure that any courses that you wish to attend in the next year are recorded in your personal development plan (PDP). This can help with applying for finance to cover expenses
- Any work that is done in an autonomous way should be recorded here; this will help with providing evidence of progression and could assist with moving onto becoming a Specialist
- Discuss with your appraiser any career aspirations that you may have and any additional roles or responsibilities that you would be interested in taking on. Word of mouth is often a very good way to find out about opportunities that are available, and often individuals are given roles because they have put themselves forward for them where they might not otherwise have been considered.

Fatigue

- This is a common feature of doctors' lives. It can be experienced at any stage of a doctor's career for different reason, for example working excessive hours, working night shifts, having young children, menopause and dealing with elderly parents.
- We all have a responsibility to ourselves, our colleagues and our patients not to work when excessively fatigued and to look after each other. If you do feel too fatigued to be at work, then you must declare this and not work.
- The Association led the way in raising this problem with the Fight Fatigue campaign which can be accessed here Fatigue (Association of Anaesthetists). Amongst the very useful information contained here, are standards for the provision of rest facilities and advice on how to approach night-shifts (Tips for night shifts).
- A full-time SAS contract consists of 10 PAs. There is no requirement to work more than this, additional PAs above this require the agreement of the doctor
- The 2021 SAS contract limits the amount of work that can be undertaken by SAS doctors in premium time. The amount of work that can be undertaken Monday to Friday between 21.00 and 07.00 (England, Wales and Northern Ireland) and 19.00 and 07.00 (Scotland) and all-day Saturday and Sunday (UK wide) is limited to 40%. This is a contractual requirement and SAS doctors are not required to undertake more work out of hours than this.
- In addition, SAS colleagues are no less susceptible to the effects of ageing than their consultant colleagues. They should be considered in any departmental arrangements made to allow individuals to relinquish on-call work. Useful information with regard to this can be found here Age and the anaesthetist: considerations for the individual anaesthetist and workforce planning (Association of Anaesthetists)

Leave

An important contributor to remaining well at work is the provision of leave. Leave is a period of (normally) paid time off granted to employees by their employer. There are several different types of leave available to SAS doctors under their terms and conditions of service. The main types are summarised below:

- Annual leave – all SAS doctors on first appointment to the SAS grade are entitled to 5 weeks + 2 days of annual leave (unless they already received 6 weeks in their immediately previous appointment in which case they are eligible for 6 weeks + 2 days on appointment). After 2 years of service as an SAS doctor, this increases to 6 weeks + 2 days. After 7 years of service as an SAS doctor, an additional day of leave is granted and therefore the entitlement increases to 6 weeks + 3 days. The rules on the booking and taking of annual leave can vary between Trusts, but 6 weeks' notice of the intention to take leave is required and leave needs to be approved.
- Study leave – this is time away from work granted by the employer for a specific educational purpose, for example to attend a course, study for an exam. It is granted with pay and expenses. All Trusts will have a study leave policy, which will detail the conditions under which it can be booked at that Trust, and most Trusts have a study leave budget for individuals setting out the maximum finance that can be claimed in any 1 year (normally within the financial year from April to March, but this can differ in some Trusts). The number of days allowed is 30 in any period of 3 years, although some Trusts do apply this as 10 days per year.
- Professional leave – the allowance for this is included within the 30 days described above. Examples of professional leave include sitting on committees, teaching, examining, duties in relation to postgraduate medical education.
- Sick leave – a doctor absent from work due to illness is entitled to receive an allowance. This increases with increasing length of service, and rises from 1 months' full pay and 2 months' half pay during the first year of service to 6 months on full pay and 6 months on half pay after 5 years of service.
- Parental leave – all NHS employees have the right to take 52 weeks of maternity and/or adoption leave, or up to 52 weeks of shared parental leave (minus any maternity or adoption leave taken). The terms around the payment for this leave will vary depending on the individual's length of service for the NHS. It is important to be aware of your rights around this, and there are some very specific requirements. It is all detailed in Part 3, Section 15 of the NHS Terms and Conditions of Service, which can be accessed here: NHS Terms and Conditions of Service Handbook - amendment 52 (nhsemployers.org)
- Statutory parental leave – this refers to parental leave that all parents have a right to take once they have worked for their employer for a minimum of 1 year. It is different from the parental leave referenced above. Each parent is entitled to 18 weeks leave in total per child. A maximum of 4 weeks' leave can be taken per child per year, up to a total of 18 overall and the leave must be taken in whole weeks. Twenty-one days' notice is required for this leave, and it can only be delayed if the employer can demonstrate a significant reason, for example that it would cause serious disruption to the business. It also cannot be delayed if this would mean the leave has to be taken after the child's 18th birthday. If it is delayed, a new date must be offered within 6 months of the requested date. Full details can be found here: https://www.gov.uk/parental-leave. In Scotland, in the NHS the first 4 weeks of this leave is paid, in the rest of the UK, it is all unpaid.
- Bereavement leave – all parents are entitled to 2 weeks' paid leave in the event of the death of their child. Full details can be found in Part5, Section 23 here NHS Terms and Conditions of Service Handbook-amendment 52 (nhsemployers.org)

Flexible working

Individual working needs are variable, and it is important that staff have options to work in ways that best suit their individual needs and preferences. All staff have the right to request flexible working arrangements from their employer from their first day of employment. Examples of flexible working include working less than full time, job sharing, working term time hours, working compressed or elongated hours. Trusts must consider all requests and each Trust will have a locally agreed policy with the process to follow when such a request is made. The emphasis when considering these requests should be on exploring and finding a mutually agreeable solution. Your Trust will have a local policy on flexible working and details can also be found in Part 5, Section 33 here NHS Terms and Conditions of Service Handbook - amendment 52 (nhsemployers.org).

Career break

The option to take a break away from work is one that could be very valuable to an individual to maintain their wellbeing. Trusts may have a local policy on employment breaks, but in essence, this allows an individual unpaid time away from work to pursue another purpose. This could include parental or caring responsibilities, additional training or study or work abroad. Paid work for another employer is not normally acceptable whilst on a career break unless work overseas or charitable activity could be viewed as broadening an individual's experience. Employees are generally entitled to request this after 12 months' service. The minimum career break is normally 3 months and the maximum is 5 years. Details can be found in Part 5, Section 34 here NHS Terms and Conditions of Service Handbook - amendment 52 (nhsemployers.org) and your Trust may have a local policy about this.

Bullying

Experiencing bullying is not unique to those of us working in the SAS grade, but it can be a significant problem for us. A General Medical Council (GMC) survey of SAS and locally-employed doctors (LEDs) in 2019 revealed that 30% of SAS and 23% of LEDs had been bullied in the past year. Only 25% of those who had suffered from this had reported it with over 30% from both groups stating that they did not know how to report it.

Suffering bullying and incivility at work can cause stress to the individual, low self-esteem, feelings of anxiety and depression, physical ill health, burnout and, in healthcare, can have a detrimental effect on patient safety. Witnessing unprofessional behaviours and incivility can cause performance to decrease by 20% and this also leads to individuals being less likely to assist others.

As well as the potential harm caused to individual patients and employees, there is a financial cost. The estimated cost to the NHS in 2020 of bullying at work was £2.28 billion due to sickness absence, staff turnover and lost productivity[2].

We provide some resources here to assist everyone at work with this issue. We describe what bullying is and give practical advice to those being bullied as well as those witnessing bullying – it is only by all of us being aware and acting on what we see that this can be stamped out.

What is bullying?

- 'a form of abusive behaviour where an individual or a group of people create an intimidating or humiliating work environment for another.'[3]

It consists of repeated inappropriate behaviour, which can be physical or verbal directed against one or more individuals by one person or a group of people. This can be through written communications including email, verbal contacts including telephone calls and can be witnessed by others or occur on a one-to-one unwitnessed basis.

Examples in the workplace include:

- Being set unreasonable targets/workloads
- Being humiliated in front of others
- Always being the individual highlighted/picked on
- Being shouted at
- Being overlooked for training opportunities
- Having your opinion derided or ignored

[2] Kline R, Lewis D. The price of fear: estimating the cost of workplace bullying and harassment to the NHS in England. *Public Money & Management* 2019; **39:** 166–74.
[3] Family Lives. What is bullying? https://www.familylives.org.uk/advice/bullying/bullying-at-work

What to do if you are being bullied?

1. Acknowledge the problem – often taking the first step and acknowledging there may be a problem is the most difficult to do. Try to evaluate the situation objectively to determine that it is bullying; it is important to try not to become emotional about it.
2. Keep a record – write down everything, who said what when to whom, who witnessed it, what your response was, what if any action was taken. Be as detailed and factual in this as possible.
3. Keep copies of all written documentation – print off any emails or store them off your employer's server, you need to know you can access these when necessary in the future.
4. Confide in a friend – allies in work are really important; one effect of bullying is to feel isolated and alone, so try to identify someone that you trust and in whom you can confide. This is helpful under any circumstances but particularly when you are under pressure like this.
5. Talk to the individual yourself if able – if it has just been a one-off incident and you feel safe and able to, then approaching the individual who has behaved in a detrimental manner may be reasonable, either yourself or through a trusted intermediary. This can be enough to provide individuals with insight into their behaviour to cause a change.
6. Speak to a manager or human resources representative – speaking to your clinical lead or head of department or even a representative from human resources, is a legitimate next move. Involving them informally can address the problem.
7. Take trade union advice if available – these are stressful situations and it is important to have support from outside your organisation. Belonging to a trade union is not compulsory, but in situations like these, they do provide an experienced and knowledgeable source of assistance.
8. Take formal action – this is not a decision to be taken lightly. These processes are stressful and the end result may not be the outcome that you want. Just going through this can have a significantly detrimental effect on you.
9. Be prepared to move on – if the situation remains unresolved, then you may need to leave your employer. This is not an admission of defeat, but actually is a brave thing to do – you are not beaten but are taking your skills and contribution elsewhere where they will be valued. And if it is resolved, then you will need to move on emotionally – behavioural change takes a long time and is often difficult to achieve. You will still be dependent on your employer to protect you and provide you with an acceptable working environment.

Responsibilities of others

This falls into two main categories: the responsibility of our employers to us as their employees, but also our responsibilities towards our own colleagues.

Our responsibilities

The greatest change will only come when we recognise these problems ourselves and more importantly choose to act on them:

1. If you witness what you think amounts to an individual being bullied, then do not ignore it. The individual themselves might be so demoralised at this point that they have stopped recognising it themselves as being aberrant behaviour.
2. If you are unable to raise it at the time, then speak to the person concerned afterwards. Ask them if they are ok. Reassure them that you are prepared to report what you have seen.
3. Speak to a manager, they have a responsibility to act on this and they may be aware of other incidents that you are not.
4. Choose to undertake some training so that you know how to act when you observe this happening to someone. An example of this is active bystander training. This infographic provides some idea of what this involves:

Association of Anaesthetists.
https://anaesthetists.org/Portals/0/PDFs/Wellbeing/become-an-active-bystander-infographic.jpg

Organisational responsibilities

1. Encourage a positive and open organisational culture from the top.
2. Encourage reporting – have true open-door policies, encourage managers to be available and accessible to their staff.
3. Create accessible and usable policies – these will only be effective if they are easy to find and easy to follow.
4. Robust leadership that will take action – appoint managers who understand the importance of recognising and addressing these issues effectively.
5. Behaviours/wellbeing lead – organisations should consider appointing a wellbeing/behaviours lead who individuals can go to with concerns. This individual will need very strong support from their organisation if it is not going to impact detrimentally on them.
6. Consider behaviours when appointing leaders – make any applicant's conduct at work a priority when appointing into leadership roles: if a bully is appointed then it can only lead to the continuation of the bullying culture.
7. Training across organisation
    i. Active bystander
    ii. Constructive feedback
    iii. Recognising and reacting to inappropriate behaviour.

It is important that we all try to make this a safer space for all:

Association of Anaesthetists. https://anaesthetists.org/Portals/0/PDFs/Wellbeing/SAFER-infographic.jpg

Links to further resources:

Wellbeing & support – Association of Anaesthetists

#KnockItOut: tackling workplace bullying, harassment and undermining – Association of Anaesthetists

The SAS charter – BMA

Bullying in healthcare – NHS Employers

#KnockItOut FAQs – The Royal College of Anaesthetists

Anti-Bullying and Undermining Campaign – The Royal College of Surgeons of Edinburgh

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Chapter 6

Leadership and management for SAS doctors

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Association of Anaesthetists

Chapter 6 – Leadership and management for SAS doctors

The 2021 SAS contracts set a clear expectation that Specialty Doctors should get involved in non-clinical activities to develop their range of expertise as well as ensure their progress through the pay scale threshold 2. Varied and relevant non-clinical experience and activity is an essential requirement for appointment as a Specialist. Our appraisal and revalidation system sets an expectation of all doctors, regardless of grade, to be active in quality improvement, and encourages teaching, leadership, management, research and innovation. Such parity of expectation must come with parity of esteem and opportunity. Many employers have recognised the change in culture and expectation from and for SAS doctors, and now regularly advertise training opportunities and leadership roles to SAS as well as consultant grades. Where this is not done, it is commonly oversight or ignorance, rather than malicious intent, and could and should be challenged.

Experienced anaesthetists are all leaders in daily theatre activities, and this is an excellent foundation for other leadership roles. Anaesthetic departments need a variety of clinical leaders and the General Provision of Anaesthetic Services (GPAS) guidelines ask departments to actively encourage SAS doctors to engage with leadership opportunities. Senior and experienced SAS doctors should be given the opportunity to take on additional roles within the department. GPAS explicitly expects a lead role to be filled by an autonomously practising anaesthetist, without requiring consultant status. There should not be any leadership roles that require consultant status, if person specification and criteria are otherwise met, and such criteria should not systematically exclude or disadvantage SAS doctors. There are many examples of SAS doctors in leadership roles such as clinical leads and directors, appraisers and appraisal leads, clinical governance leads, principle investigators in research, educational supervisors, training programme directors, Association Board members and Officers, RCoA Council members and Board Chairs, etc.

Leadership theory and learning

Theoretical courses are offered in many regions via SAS tutors and may increase your self-confidence. Whilst they might underpin your lived experience, they cannot be a substitute for leadership in action. Many Trusts run internal leadership programmes to identify and nurture talent, and these should be open to SAS doctors. Some Trusts have programmes allowing senior executives or board members to be shadowed by emerging leaders.
The Association runs events with non-clinical content (Find an event – Association of Anaesthetists). The Royal College of Anaesthetists runs a lecture series in leadership and management as well as hosts a network of clinical leaders (Clinical Leaders – The Royal College of Anaesthetists). Together the College and Association run regular networking events.

The British Medical Association (BMA) also offers non-clinical education to its members. If you are an accredited trade union representative, the BMA offers a wide range of leadership and negotiation training to you.

All the UK medical royal colleges in 2011 established the Faculty of Medical Leadership and Management (FMLM) as the professional home for medical leadership, offering education, peer support and networking.

How to get started in leadership

With clinical leadership roles come responsibilities for teaching, governance, liaison with other staff groups, recruitment, complaint handling. etc, so all of these areas can be good starting points to gain experience and show talent for wider roles. Teaching is often seen as the most accessible area for self-development. There is huge demand for teaching from less experienced doctors and other members of the team. Teaching can also usefully develop your public speaking skills and confidence, as well as show your enthusiasm, talent and potential outside the operating theatre.

To start with, small amounts of leadership activity may fit within your supporting professional activities (SPA) time, which is allocated to fulfil your appraisal and revalidation requirements. As workload and responsibility grows, so must the time allocated to such activity in job plans. This is reflected in the 2021 SAS contracts through an increase in expected SPA time. Many non-clinical roles also carry a locally agreed time tariff for job plans, which should be the same regardless of the grade of the post-holder. If you feel you should be allocated time to carry out non-clinical work but are not, or you feel the time allocated does not reflect your role, it is useful to keep track of the time required and work done to inform the next round of annual job planning.

Often ability and talent are not matched by confidence. A personal mentor in your workplace can help. Every doctor should have the opportunity to access mentoring and coaching through their employer and many Trusts have a network to offer this. The Association also has a mentorship scheme for its members (Mentoring – Association of Anaesthetists). NHS England offers mentoring through the NHS Leadership Academy free to the user (Coaching and Mentoring – Leadership Academy).

Chapter 7 – Financial matters

Financial matters can be a very complicated and poorly understood subject. Money is however currently a vital part of life. Pay is the compensation with which your employer rewards you for the provision of your time and expertise, but with that comes additional issues like tax and pensions. Many people will be able to understand and calculate these correctly for themselves, but lots will not, and there will be times during a career when all of us may need additional help. There are particular idiosyncrasies associated with working for the NHS, in particular with relation to the pension scheme, so if you do think you need advice, then it might be sensible in the first instance to ask your colleagues if they have needed assistance, and if so, where they found this. There are lots of financial advisors available, but a personal recommendation goes a long way in providing reassurance that the help you receive will be appropriate.

Contracts and salaries

- Contract of employment – all employees have a contract of employment with their employer. This sets out the employee's rights, responsibilities, employment conditions and duties. It is legally binding and must be adhered to until it ends. It does not have to be written down, but in the NHS, a written contract should be provided to you on or before your first day of employment. There are terms and conditions of service available on both NHS Employers and the British Medical Association (BMA) website for all nationally negotiated contracts. There are currently SAS doctors employed on what are known as the pre-2008, the 2008 and the 2021 contracts (Staff, associate specialist and specialty doctor contract (bma.org.uk)).
- Pay scales – all nationally negotiated contracts have an agreed pay scale, which is available on the NHS Employers and BMA websites. These are different in the four nations of the UK. Pay scales for SAS doctors in England (bma.org.uk); Pay scales for SAS doctors in Scotland (bma.org.uk); Pay scales for SAS doctors in Wales (bma.org.uk) and Pay scales for SAS doctors in Northern Ireland (bma.org.uk).
- Increment – this describes the increase in pay that occurs with increasing time in a role. All nationally negotiated contracts have an incremental pay scale that an individual will have the opportunity to progress through. Different grades have different criteria for progression. The date on which progression occurs is different for every individual and generally reflects an individual's starting date of employment in the NHS. The starting point on any pay scale will be dependent on previous experience.
- Salary – This is the *fixed amount of money or compensation paid to an employee by an employer in return for work performed*. It is usually quoted on an annual basis and paid monthly in 12 equal instalments on a fixed day each month.
- Gross – this is the salary paid before any deduction.
- Net – this is the amount paid after deductions, i.e. the amount received into an individual's bank account.
- Deductions – this is the term used to describe all amounts paid from your salary at source before you receive it, e.g. tax, national insurance, pension contributions. Your employer cannot make deductions from your pay unless it is allowed for by law, you have agreed in writing, it is allowed for in your contract, it is the result of strike action, a court has told your employer to or it is to repay a previous overpayment.
- Leave – this represents a period of time for which an employee is not at work. There are several different types of leave including annual, sick, study, parental and unpaid. Entitlements to leave are defined in advance; some will be determined nationally and set out in your contract of employment and others are determined by law. Some entitlements change with length of service, for example, additional annual leave with increasing years served, entitlement to additional maternity leave. Some Trusts allow employees to purchase additional annual leave. There is helpful information about annual leave here: Doctors' annual leave entitlements (bma.org.uk), maternity/parental leave here: Maternity, paternity and adoption advice and support (bma.org.uk). Sick leave entitlement also builds up with length of service but may also be extended by your employer. NHS entitlements are as follow:

    i. During your first year of NHS employment: 1 month's full pay; 2 months' half pay if you have completed 4 months
    ii. During your second year: 2 months' full pay and 2 months' half pay
    iii. During your third year: 4 months' full pay and 4 months' half pay.
    iv. During your fourth and fifth years: 5 months' full pay and 5 months' half pay.
    v. After completing 5 years of service: 6 months' full pay and 6 months' half pay.

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Chapter 7

Financial matters

Dr Emma Wain

Association of Anaesthetists

Pensions

A pension forms part of your overall pay reward and reflects a deferred income. It is a way of saving for your retirement that is arranged by your employer. The NHS has a pension scheme that both employers and employees make contributions to, which will provide an income in retirement in line with the rules of that particular scheme.

- There are currently three different NHS pension schemes known as the 1995, 2008 and 2015 schemes. They are all defined benefit schemes, i.e. the pension provides you with a guaranteed income for life based on your salary and number of years you have paid into the pension scheme. Both the 1995 and 2008 schemes pay a pension based on your final NHS salary, whereas the 2015 scheme pays a pension based on your career average salary. An overview of the schemes can be found here: NHS Pensions Schemes – an overview (nhsbsa.nhs.uk)
- Pension contributions are paid from gross income, i.e. before your income is assessed for tax due and, in the NHS scheme, are currently on a tiered basis with the percentage of your salary paid increasing as your s alary increases. The current contribution rates can be found here: NHS pension contribution rates (bma.org.uk)
- You do not have to be a member of the NHS pension scheme but there is a useful overview of the benefits of being in the NHS pension scheme here: NHS Pension Scheme. The value of membership (nhsbsa.nhs.uk)
- As well as providing a pension, membership of the NHS pension scheme also provides death in service benefits. Again, these benefits are different for the different schemes but broadly the benefits are composed of a lump sum payment and an ongoing monthly pension for dependents. Details of this can be found here: Death in service and your pension (bma.org.uk)
- The McCloud judgment – which NHS pension scheme you are in depends on when you started working in the NHS. Anyone who started working in the NHS since March 2012 will have all of their pension in the 2015 NHS scheme. The situation is more complicated for those that joined the NHS pension scheme before then following the ruling that the introduction of the 2015 scheme was discriminatory on the grounds of age (the McCloud judgment). Everyone employed prior to March 2012 will be a member of either the 1995 and 2015 schemes or the 2008 and 2015 schemes. Currently, all service between 2015 and 2022 is being moved back into the employee's original scheme, but at retirement, an individual will be able to make the choice on whether to keep these 7 years of contributions in either the 1995 or 2008 scheme (whichever one they were in originally), or transfer it to the 2015 scheme. This is a unique calculation and what is right for one person may not be for another. This is an evolving situation and may be subject to further amendment
- Annual allowance tax – the annual allowance is the maximum amount of pension savings an individual can make each year without an annual allowance charge and was introduced in 2006. However, it was the introduction of the annual allowance taper in 2016 (which reduced the amount your pension was allowed to grow by free of tax once you earned over £150,000) that really caused problems for doctors in the NHS pension scheme. This has been partially addressed in the budget in 2023 with an increase in the annual allowance to £60,000 with a concomitant increase in the taper. As this tax was not abolished, it is still important to be aware of it as further changes may occur in the future. Calculating this tax charge yourself is very complicated as it does not fit into a defined benefit scheme in a straightforward way. It is a good habit to ask the NHS Business Services Authority for an annual allowance statement every year. This can be done by emailing nhsbsa.pensionsmember@nhsbsa.nhs.uk and including your full name, date of birth, full address and postcode, superannuation division (SD) number (this can be found on your NHS total rewards statement found through the electronic staff record (ESR) or on your payslip if your Trust issues this through ESR)
- Amendments to the NHS pension scheme were also announced in December 2022, which will allow partial retirement in all schemes, i.e. you can draw up to 100% of your pension from the 1995 scheme and continue to work without a break in employment and still contribute to the 2015 scheme. The 2008 and 2015 schemes have been amended too to allow you to draw 100% of the benefit (previously only 80% was allowed). This will take effect from October 2023 and at the time of writing the full details of this have not yet been announced, but it will require a drop in pensionable pay of at least 10% for the first year after taking your pension benefits. This letter explains the current situation: NHSPensions_FlexibleRetirement_DisclosureLetter_202301.pdf (nhsbsa.nhs.uk). Additional information is available here: Partial retirement (nhsbsa.nhs.uk).

Tax matters

We pay tax in all sorts of ways, some very obvious, for example, income tax on salary, and some not so obvious, for example, value-added tax (VAT) on certain goods. There are also taxes paid to local government as well as national, for example, council tax, which is based on the value of the property in which you live. The information below is an attempt to give an understandable overview of the tax system in relation to tax on income.

Income tax – this reflects deductions made in payment to His Majesty's Revenue & Customs (HMRC; i.e. the government of the day) as tax based on the amount earned. Different proportions of tax are taken at different salary levels. Income paid directly by your employer is subject to Pay as you Earn (PAYE) so will have tax taken off before it is paid to you. All income is subject to assessment for tax including interest earned on savings and share dividend income. Income Tax rates and Personal Allowances : Current rates and allowances – GOV.UK (www.gov.uk) (England, Wales and Northern Ireland) Income Tax in Scotland: Current rates – GOV.UK (www.gov.uk) (Scotland)

National Insurance – this is a specific type of tax that is paid on income earned through employment by both employees and employers. It is used to qualify for and fund social security benefits and is paid as a proportion of your gross income. This is deducted directly from your salary by your employer. National Insurance rates and categories: Contribution rates – GOV.UK (www.gov.uk)

Personal Allowance – this is the amount of any income that is allowed to be paid without any tax being due. Currently, up to £12,570 can be earned before any tax is due. Once an individual earns over £100,000 this allowance is reduced by £1 for every £2 earned over this amount until all of the allowance is lost. Income Tax rates and Personal Allowances: Current rates and allowances – GOV.UK (www.gov.uk)

Tax code – this can be found on your payslip and essentially represents the portion of your income that will be paid before tax is applied. It will differ depending on how much your personal allowance is worth. When you move jobs, you may be put on an emergency tax code as your employer will not know how much of your personal allowance you have left for that tax year. This can mean that you pay tax on your entire salary (often called emergency tax), so it is important to check this and make sure you claim back any overpaid tax on a tax return.

P60 – this is an annual statement from your employer of income earned and tax paid in a particular tax year. It is normally issued around May and is important for you to be able to file a correct tax return.

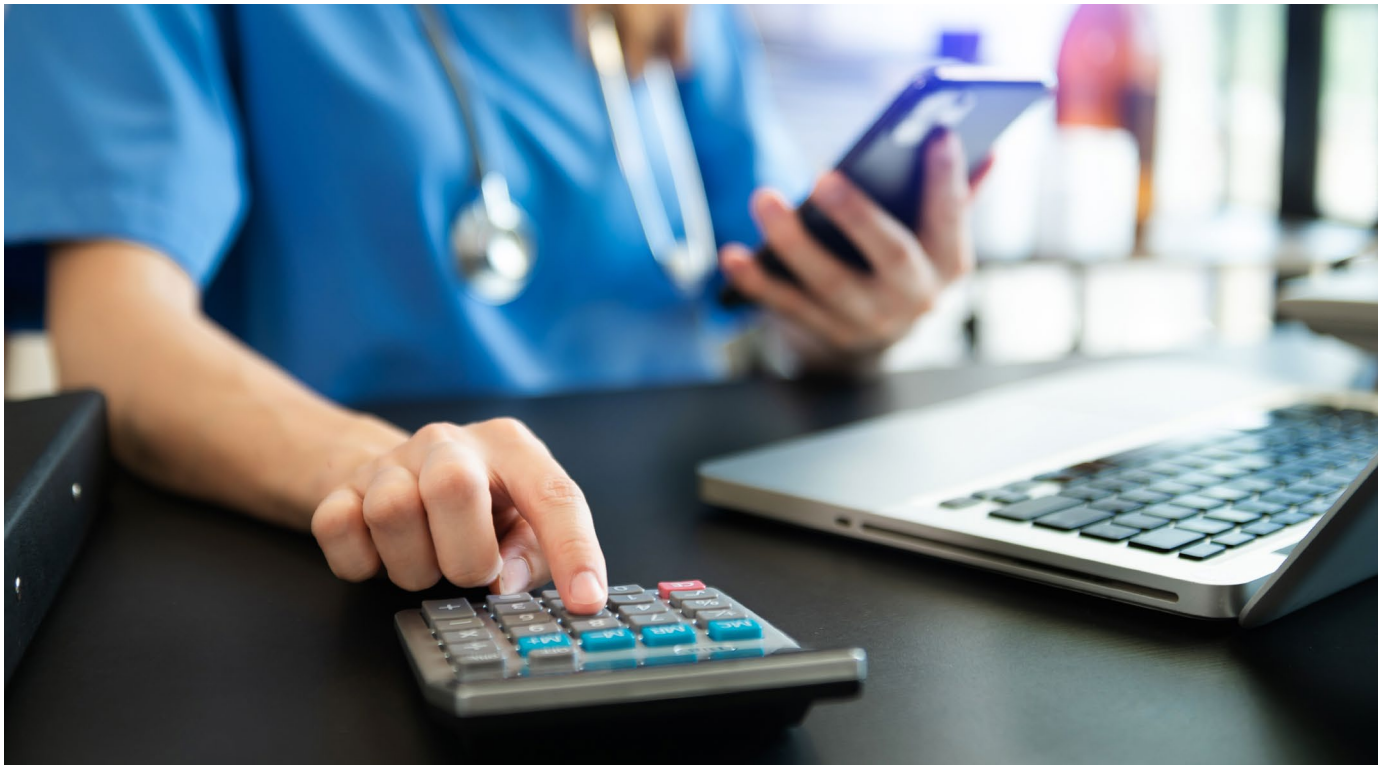
P45 – this is the statement issued at the end of your employment with a particular employer that will give information about the amount earned and the amount of tax paid. It is important for your next employer to have this information so that you are paid using the correct tax code and do not pay too much tax.
Tax year – this describes the period of 12 months, which is used by the government as a basis for calculating taxes and for organising its finances and accounts. In the UK, this runs from 6 April of one year to 5 April of the next and, in practice, it is this period that is covered by an individual's tax return.

Tax return – this is a form used by the taxpayer to make an individual submission of income and personal circumstances that is used to assess the tax due. This can be submitted as a paper version or online through the HMRC self-assessment service. If submitted online, this will calculate the tax due for you on the basis of the figures you enter. Not everyone has to submit a tax return but there are several requirements for doing so including if one is requested by HMRC, if an individual believes that they owe more tax than has been paid at the end of the tax year or if an individual has been paid more than £100,000. The deadline for submission of a paper tax return is 31 October after the relevant tax year and for online submission 31 January of the year after the relevant tax year, e.g. for the tax year from 6 April 2023 to 5 April 2024, the online tax return is due by 31 January 2025. All tax is due by 31 January of the year after the relevant tax year. To send in a tax return online, you need to register with HMRC. This is very straightforward and can be done here: Register for Self Assessment: Register if you're not self-employed – GOV.UK (www.gov.uk). There are penalties for late submission and interest can be charged on any tax owed. You can pay an accountant to do it for you, but if your tax affairs are simple (e.g. your income is all PAYE with straightforward savings accounts), then it is very easy to do it yourself. Do not spend money if you do not have to. Self Assessment tax returns: Overview – GOV.UK (www.gov.uk)

Tax-deductible expenses – some professional expenses can be offset against tax, which means that you can pay them out of your gross income before it is assessed for tax due. These expenses broadly cover the cost of going to work and must be incurred wholly and necessarily to enable you to do your job. They include membership of professional bodies including the Association of Anaesthetists, indemnity insurance, General Medical Council (GMC) fees. A list can be found here of eligible organisations: List of approved professional organisations and learned societies (List 3) – GOV.UK (www.gov.uk). These must be claimed back through your tax return if you need to submit one, but if you do not they can be claimed back separately here: Claim tax relief for your job expenses. Professional fees and subscriptions – GOV.UK (www.gov.uk)

Miscellaneous financial matters

- Financial year – this is a term used by government, business and other organisations to describe a 12-month period over which they calculate their budgets, profits and losses. For the UK government this runs from 1 April of one year to 31 March of the next
- Government financial statements – The Chancellor of the Exchequer makes two statements to the House of Commons about the nation's finances and proposals for changes to taxation annually in the spring and the autumn. These are normally known as the budget and the autumn statement, respectively, although the autumn statement was renamed as the budget in 2016. These are important in that any changes to personal taxes and allowances are announced in these
- Salary sacrifice – this describes a reduction in income paid as cash in return for a non-cash benefit. This can be used in different ways depending on what your employers offer but examples include car parking charges at work, childcare vouchers, additional annual leave, cycle to work scheme. In general, tax and national insurance is then not paid on the part of your income that is used for this purpose; however, it will also reduce the salary on which pension contributions are paid so will reduce pension in retirement (Salary sacrifice and tax-free childcare – NHS Employers)
- Childcare – employers can no longer offer salary sacrifice childcare vouchers to new employees. Instead, a tax-free childcare scheme was introduced in 2017 that is independent of employers. This gives parents with children under the age of 12 or 17 for those with disabilities support with the cost of childcare. For every £8 paid in, the government will top it up by £2 up to a maximum top-up of £2000. Once an individual earns over £100,000, entitlement to this is lost on an all or nothing basis, i.e. if you earn £100.001, you will no longer be eligible for any of this assistance. In addition to this, children aged 3 and 4 are entitled to up to 30 hours free childcare each week for up to 38 weeks of the year. The schemes differ slightly in each of the different nations of the UK but again you are not eligible for this as soon as one parent's gross income is over £100.000 (except in Scotland where this free childcare is maintained whatever your level of income)



How to interpret your payslip

Your employer will provide you with a monthly record of the money you have received and any deductions they have made. This is called your payslip, and it can be sent in paper form or electronically. All payslips are visible on the ERS along with other information so it is important to set up access to this: Home - ESR Hub - NHS Electronic Staff Record

There is a lot of financial information on a payslip and it is important to know how to interpret this.

There is a good explanation of this on this website here:
Doctors pay slip – a guide to understanding your payslip – Medics Money

In summary, the important information your payslip will include:

Your employment/payroll number that will need to be quoted on any correspondence with your employer regarding salary or expenses claims.

Your employer's PAYE reference for HMRC, which will need to be entered on your tax return if you complete one.

1. Your National Insurance number – this is used to coordinate your NI payments and hence your entitlements to benefits such as the state pension.
2. Your tax code – it is important to check this to make sure that you are not put on an emergency tax code (this takes no account of any personal allowance you may have and means that you will overpay tax).
3. Your grade and increment date – check that you are being paid on the correct contract. Your increment date reflects the date on which you will move onto the next pay point and generally reflects the date you started work in a new grade or post. Check this is correct when you move from one employer to the next.
4. Your gross basic salary – check that this corresponds to the point on the pay scale that you believe you should be on.
5. Your job title and pay scale – a two-figure two-digit code that will tell you the pay scale you are employed on.
6. Deductions – this will show the tax paid, the National Insurance paid and your pension contributions.
7. At the bottom there will be a summary of all the amounts paid for the tax year to date.
8. Also at the bottom is your SD identification number, which is required when requesting information relating to your pension.
9. Finally, the last box will show your net pay for that month, which can be checked against pay received.

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Chapter 8

The Fellowship of the Royal College (FRCA) examination

Dr Kirstin May

Association of Anaesthetists

Chapter 8 – The Fellowship of the Royal College (FRCA) examination

The examination for the Fellowship of the Royal College of Anaesthetists (FRCA) consists of two parts: the Primary and the Final FRCA exams, with usually three and two sittings per year, respectively. These exams are open to SAS and locally employed anaesthetists (conditions apply). Passing these exams can further your career, fulfil the requirements for a test of knowledge for a Certificate of Eligibility for Specialist registration (CESR)/portfolio pathway application or increase your personal satisfaction.

Details about the eligibility criteria, regulations, dates, fees, exam processes and potential recent changes can be found at Fellowship of the Royal College of Anaesthetists – The Royal College of Anaesthetists (rcoa.ac.uk).
Both the Primary and Final exams consist of several components:

The Primary Examination consists of a Written Single Best answer (SBA) component and in-person Objective Structured Clinical Examination (OSCE) and Structured Oral Examination (SOE). The written part must be passed before sitting the others. The syllabus can be found in the Core level training document.

The Final examination is aligned to the Intermediate Level training syllabus and consists of a written component and a Structured Oral Examination (SOE). Candidates must pass the Primary FRCA, within validity time frames, or have a recognised exemption before applying.

Overall, the syllabus is detailed and comprehensive and the required preparation is arduous. The financial cost is significant. The number of attempts you can have is limited, as is the validity time frame of individual components. An intensive period of study as well as adequate clinical exposure is required for success.

The exam website gives detailed information on how the exams are conducted and what to expect on the day. Beware that some written components are delivered online and the candidates have to meet the required system and internet connection requirements. The regulations are complicated. The College tries to help candidates by giving a lot of information about the exams on its website, in a written study guide available through the College as well as in video resources Royal College of Anaesthetists – YouTube and Primary OSCE video series – The Royal College of Anaesthetists (rcoa.ac.uk)

Candidates outside of formal training programmes should seek advice from colleagues, educational supervisors and local college tutors. You should prepare together with other candidates and optimise performance, in particular, for the in-person components, by having lots of practice. There are courses run by the College and by other organisations. For candidates from abroad, it is noteworthy that the exams test not just scientific and technical knowledge but also communication skills and interaction with patients. Therefore, international graduates may find a period of working in the UK beneficial for their exam preparation and success.

SAS and locally employed anaesthetists who have passed the FRCA examination are eligible to become an FRCA examiner, provided they meet the eligibility criteria. Vacancies on the Board of Examiners are advertised annually. Good luck!

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Chapter 9

The portfolio pathway to Specialist registration

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Chapter 9 – The portfolio pathway to Specialist registration

Please be aware that new processes for the portfolio pathway to Specialist registration (formerly Certificate of Eligibility for Specialist Registration (CESR)) entry will be announced by the General Medical Council (GMC) in November 2023. Please see Changes to how doctors demonstrate the standard required for specialist and GP registration – GMC (gmc-uk.org) and similar part of the GMC website for updates on the changes. This chapter will be reviewed and updated as necessary after November 2023.

Introduction

To become a substantive consultant in the UK, one needs to be on the GMC Specialist Register. Some SAS doctors may wish to submit an application for specialist registration using the portfolio pathway, to be introduced in November 2023. This process replaces the former CESR process, and completion will ultimately allow successful applicants to apply for substantive consultant posts. The benefits of achieving the traditional career end point of consultant appointment, such as earning a higher salary and potentially having greater access to private practice, may appeal.

The portfolio pathway route to specialist registration is open to applicants who have not completed a GMC approved training programme. Those who apply for specialist registration under the portfolio pathway route must demonstrate their equivalence to a newly trained Certificate of Completion of Training (CCT) holder by providing the GMC with evidence of the requisite standard of knowledge, skills and experience. The evidence must aligned to the Royal College of Anaesthetists (RCoA) CCT curriculum 2021, but will no longer have to be mapped against it in detail. The application must be made and evidence provided to the GMC, whilst the RCoA acts as the assessing body.

Many SAS doctors will have undertaken some training before moving into a substantive post and the experience and evidence gained from any formal training may be submitted for consideration, along with any evidence acquired while in a SAS, locally-employed or locum consultant post; however, all evidence submitted must fulfil the requirements as set out in the GMC Specialty Specific Guidance.

If some of your evidence of training, knowledge and skills is many years old, you may be required to undertake further training or assessments to demonstrate ongoing competence. If you have no evidence to provide in a specific domain or against a mandatory training requirement, your application will fail, hence further training or evidence collection to correct any such deficits must be sought.

While gaining your specialist registration through the portfolio pathway will offer you the opportunity to apply for UK consultant roles, your success at being appointed as a consultant will depend on your performance in competition for these posts, and the international recognition of the portfolio pathway route to specialist registration will depend on the specialty and the country in question should you ever consider relocating overseas.

Demonstrating the required standard

Should you decide to pursue the portfolio pathway to Specialist registration the first ports of call should be the following four important documents:

1. GMC Anaesthetic Specialty Specific Guidance 2021
2. Online GMC CESR Applicant Guide
3. GMC Good Medical Practice
4. RCoA CCT Curriculum 2021

These are all essential reading prior to embarking on a portfolio pathway application as they provide the template against which you must match your application. If you cannot demonstrate the required standard with the experience/ evidence you have currently, discuss the possibility of obtaining the necessary further training with your Clinical Tutor,

College Tutor, Regional Adviser, local Training Programme Director or local portfolio pathway programme coordinator. Also speak to colleagues in formal training and other recent successful portfolio pathway applicants to understand how they achieved their competencies. Some of the necessary training may be achievable within your organisation, some may require time at another organisation to gain experience in other subspecialty areas.

The aforementioned documents also provide details on how you should collate and structure the evidence in your application. It is important to present the information in a manner that satisfies the GMC requirements, which are based on the domains set out in the Good Medical Practice document, yet it also needs to appear intuitive to the RCoA who will be matching your application to the CCT curriculum 2021.

As well as presenting evidence of training and experience, the requirements for CESR include a test of knowledge. A list of the various anaesthetic qualifications deemed acceptable in this regard is available via the RCoA.

Gathering the relevant competencies

You will need to compare any existing documentation you have with the corresponding CCT evidence requirements. Providing contemporaneous assessments is extremely useful to the assessors, as is an indication of complexity of workload, levels of supervision, independent work and supervision of others. Structured references are very helpful to assessors.

Should you feel that your current experience/body of evidence in any particular areas will not be sufficient for a successful portfolio pathway application, you will need to acquire further experience in these areas and demonstrate your competence with the corresponding online assessment forms.

These forms are known as Supervised Learning Events (SLEs) and are available on the RCoA Lifelong Learning Platform (LLP). They take a variety of guises known by various acronyms (e.g. Anaesthesia Clinical Evaluation Exercise (A-CEX), Anaesthesia Quality Improvement Project Assessment Tool (A-QIPAT), Anaesthetic List Management Assessment Tool (ALMAT), Case-Based Discussion (CBD), Direct Observation of Procedural Skills (DOPS)) all of which are explained in the RCoA CCT curriculum 2021 document.

After reviewing the curriculum and perusing the RCoA LLP website, you will understand the nature of each of these assessments and know how many of them you will need to gather to be able to demonstrate competence in each area of the syllabus.

Clearly, therefore, you will need to be in a workplace where you can have all these assessments signed off. This may involve you leaving your current Trust and hence possibly your substantive SAS role, and that may be a hard decision. You will need to acquire and demonstrate the necessary competence to an equal standard to a trainee of corresponding seniority and, depending on your prior demonstrable experience and competence, this might take some time to acquire.

When collating evidence, aim to summit an SLE each day that you acquire a new competency or undertake a relevant subspecialty list. You should ensure this becomes a habit. Alert your supervisors of your need to acquire particular SLEs from the outset (i.e., before undertaking jobs, placements, subspecialty blocks or theatre lists) to ensure you are both agreed on achieving this. Check the minimum requirements for SLEs for each module on the LLP and aim to exceed them. Also, if your hospital has them, ask the relevant module supervisors for any specific Holistic Assessment of Learning Outcomes (HALO) requirements the department may have.

Submitting your application

Focus your evidence on documentation that will demonstrate coverage of the GMC Good Medical Practice domains when considered against the requirements of the 2021 CCT in anaesthetics curriculum. More specifically, the GMC wishes to see demonstration of equivalence of the CCT curriculum 2021 for all Stage 3 modules; some of the stage 2 modules and one special interest area (SIA). Further details regarding the types of evidence required are available in the aforementioned GMC Specialty Specific Guidance for Anaesthetics, 2021.

If you are able to do so, the best way to demonstrate equivalence is to replicate the relevant CCT curriculum 2021 training modules and corresponding paperwork (e.g. logbooks and assessments) that an aspiring trainee would provide. The best format for acquiring and collating such evidence is the RCoA LLP.

The portfolio pathway application process is conducted by the GMC, with the RCoA acting as the assessor for the GMC. Your application must be uploaded onto the GMC website, whereupon it will be reviewed by a GMC adviser. The average amount of evidence expected for a CESR application was 800–1000 pages or 100–150 submitted files, so expect to submit around this volume of evidence for the portfolio pathway process. At this review stage, there may be revisions that need to be made to your application, after which it should hopefully be approved for submission. Your application is then sent onto the RCoA for assessment and they will provide the GMC with their recommendations on your application.

While the process from the GMC submitting the application to the RCoA to you receiving the GMC recommendation should take no longer than 6 months, it is important to additionally factor in the time needed for evidence acquisition, the uploading of your evidence, plus any revisions the GMC deem necessary prior to your application being submitted by the GMC for assessment.

Considerations

Before embarking on a portfolio pathway application, ensure that you understand what might be involved in your particular situation. Avail yourself to the webinars on portfolio pathway applications run by multiple organisations, including the Association of Anaesthetists' SAS Committee. Talk to your clinical and education supervisors and anyone you may consider a mentor. Speak to other portfolio pathway candidates past and present, and try to realistically gauge what further training and demonstrations of competency you may need to acquire.

Examine your own motivations and energy for the task at hand. Discuss this decision with colleagues and friends and, importantly, your family. Plan how you will tackle this logistically and do consider your job security and financial circumstances. What is right for you will be the correct decision. Good luck.

Useful sources of information

Association of Anaesthetists SAS Committee sas@anaesthetists.org
Registration and Revalidation Directorate equivalence@gmc-uk.org
Royal College of Anaesthetists equivalence@rcoa.ac.uk

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Chapter 10

Support for international medical graduates coming to the UK

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Chapter 10 – Support for international medical graduates coming to the UK

Help to settle into the NHS

Even if you are an experienced doctor, it can be difficult to settle into a new healthcare system. As soon as you have your General Medical Council (GMC) registration, we suggest you book into one of their free workshops for doctors new to the National Health Service (NHS) Welcome to UK practice – GMC (gmc-uk.org), ideal for doctors within their first 12 months of NHS practice. Attendance is optional but many doctors have found this very helpful in the past. The workshop can be attended online or in person. It will give you guidance, a chance to connect with other international doctors and explore ethical issues and how we deal with them in the UK. You will need a GMC account to register. The Royal College of Anaesthetists (RCoA) is also offering introductory days incorporating the GMC workshop; please look out for them on the events pages of the RCoA.

Once you have a work email address, we also recommend you register for an account with NHS England's e-learning for Health Home – elearning for healthcare (e-lfh.org.uk). Here you will find a wealth of free educational resources, including many specifically for anaesthetists. There is a valuable programme with induction resources for international doctors NHS Induction Programme for International Medical Graduates – NHS England elearning for healthcare (e-lfh.org.uk). Many areas that new staff struggle with are covered here.

Your workplace should help you by offering you an induction to understand the place, procedures, working practices, staffing structures and local processes. You will also need to be taught how to use written paper and electronic patient records correctly. Ideally, you should be integrated into induction arrangements made for other doctors who commonly rotate into new jobs in August and February each year. You should also be offered a clinical supervisor or mentor, and maybe a buddy who might be able to support you with non-work-related issues. Recommendations on what should be included in your induction can be found at Welcoming-and-Valuing-International-Medical-Graduates-A-guide-to-induction-for-IMGs-WEB.pdf (e-lfh.org.uk). A good introduction to UK practice will not only make your life easier but also your professional practice safer.

Common difficulties: consent, confidentiality, record keeping, duty of candour

International doctors often experience difficulties of a non-technical nature for which they were not prepared before their arrival. The professional standards for the interaction between doctors and patients, relatives and the public are outlined by the GMC: https://www.gmc-uk.org/ethical-guidance. The GMC website covers not only the skills and knowledge required by doctors but also the values and behaviours required from medical professionals. It contains educational resources, flowcharts and decision tools to inform and guide what is expected from you in the UK. If you have any doubts how these standards should be applied to a particular situation in the workplace, it is wise to seek advice from your seniors. Commonly difficulties are encountered in the following areas:

A) Confidentiality

The patient's right for their personal and medical information to be kept private is an important principle in the UK. It is a doctor's legal and ethical duty to protect patients' personal information and medical details. Unlike in many other countries, this includes information that may be given to close family and next of kin, but also what can be shared with other healthcare providers. It is important to familiarise yourself with the rules of confidentiality, but also with when, how and to whom information can and should be disclosed.

B) Consent

Doctors in the UK are expected to give patients the information they need to make informed decisions about their healthcare, as well as the time and support to understand the information. Patient autonomy is a very important principle in the UK. The provision of information and the support given by the professional should be tailored to the individual patient. Treatment options and alternatives, potentially including non-treatment, should be explained. This is often described as shared decision-making.

Unlike in many other healthcare systems, relatives in most circumstances cannot agree or refuse treatment on behalf of a patient who lacks capacity. This is a complex legal area within healthcare and you are likely to require support from more experienced colleagues to navigate this correctly. For such situations, there is a legal framework called the 'Mental Capacity Act 2005.' You should learn about this in the guidance from the GMC, during your induction, through your statutory and mandatory training via your employer and from your colleagues.

C) Duty of candour

It is an important requirement in the UK for a healthcare professional to be open and honest with patients (or, where appropriate, their advocate, carer or family) when something has gone wrong. You must also be open and honest with colleagues, employers and regulators. This includes reporting incidents and 'near misses' and taking part in investigations. Employers have systems through which untoward incidents should be reported, and you should be introduced to these during your induction. You may wish to enlist a colleague for help if you have to report an incident for the first time. Incidents are also often shared and discussed in departmental meetings, to share learning and avoid future repeats, rather than to apportion blame. Your duty of candour includes a duty to raise concerns where appropriate and not stop others from doing so.

D) Technical aspects of working

You may come across many pieces of anaesthetic equipment that are unfamiliar to you. Please do not be afraid to ask questions and please insist on being properly familiarised with your professional tools. Prescribing rules can also be very different and this includes how medicines are administered, by whom and how administration is recorded. Some drugs, notably opiates, but also ketamine and some benzodiazepines, are subject to secure storage and recording rules.

When and how to ask for help

It is not only acceptable but considered important to ask for help from your seniors when you feel unsure or out of your depth about a patient and their treatment. The GMC 'Good Medical Practice' guidance states that you must recognise the limits of your competence and ask for help when necessary. If you are asked to work outside your competence you must raise your concern. You should never be 'too proud' or embarrassed to ask for a second opinion or help. This includes asking a senior to come into the workplace from home when on call out of hours.

If you ask for assistance, it is useful to state clearly what you are looking for, particularly if waking someone from sleep: do you feel you just need to inform a senior about a given situation, are you seeking advice or are you requesting their presence for in-person assistance?

Medical students and doctors in training in the UK are taught to assess patients in formal and systematic ways. This can include how they as doctors communicate with colleagues and seniors in the most efficient way. There are different techniques for such systematic communication and your employer may have preferred ones they wish you to learn and use.

Example SBAR: SBAR stands for situation, background, assessment and recommendation. You may receive handovers from other staff in this format or give information and requests for help following this to your seniors. https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/SBAR-Implementation-and-Training-Guide.pdf

Situation: what is happening?

Background: what are the circumstances, or maybe the past medical history, leading to this situation?

Assessment: what is your assessment of the patient? Ideally this should also be systematic, for example following an A (airway), B (breathing), C, D, E model.

Recommendation: what is your recommendation to improve the situation? This may include the request for in-person assistance.

Protecting yourself and your family

A) Indemnity

NHS bodies and organisations are financially responsible for the clinical negligence of their employees. Your professional practice in the NHS comes with indemnity provision details of which can be found here: https://resolution.nhs.uk/wp-content/uploads/2018/10/NHS-Indemnity.pdf

Medical students and doctors in the UK usually take out their own professional indemnity insurance in addition to this to cover private work, non-clinical negligence, unpaid medical volunteering outside the NHS, etc. Your own personal indemnity cover also gives access to medico-legal support should you receive a complaint, advice should you have to appear in court or at an inquest, and support in the event of an investigation by the regulator. Insurance, indemnity and medico-legal support - information for doctors on the register – GMC (gmc-uk.org). The cost for this is tax deductible and varies between specialties and grades of doctors. The main providers are the Medical Defence Union (MDU), https://www.themdu.com), Medical Protection Society (MPS), https://www.medicalprotection.org and Medical and Dental Defence Union of Scotland (MDDUS), www.mddus.com).

Should you be unlucky enough for a patient to complain about you or the treatment you have offered or given, please seek help from seniors in answering to this. There are rules requiring Trusts to respond to complaints within defined and quite short timescales, so you may have to answer very quickly, so do not put this off.

B) Healthcare

You and your family should register with a family doctor (GP 'general practitioner') as the GMC *strongly* discourages you to provide medical care for yourself or members of your family. (https://www.nhs.uk/nhs-services/gps/how-to-register-with-a-gp-surgery/). You are also not allowed to prescribe or send medicines for friends and family back home, whom you may have treated in the past. As GP practices usually have catchment areas you would usually choose one local to where you live. You should register as early as possible, do not wait until you are ill. The rules around free healthcare provision are complex and may change: https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide. If you are entitled to NHS treatment it is mostly free at the point of use. This includes hospital visits, family doctor consultations and preventative care, but in most circumstances, there is a fee for prescriptions. There are also costs associated with NHS Dental care.

In the case of minor ailments, some medicines are available in supermarkets and pharmacies over the counter. Some other medicines can be accessed via prescriptions at pharmacists.

Help if you are in difficulty

If you are experiencing personal or professional difficulties, which may affect your work, please do not hesitate to seek help. Your educational supervisor/mentor or line manager may be your first port of call. If you are looking for support from the outside, there are a number of other options. View the wellbeing pages on the Association website.

Every NHS Trust has access to an occupational health department, which keeps people well at work: physically and mentally. If you have a health problem that caused you to be absent from work or may affect how you are able to work, you may be referred for an occupational health assessment. Some occupational health departments also accept self-referrals (Occupational health – NHS Employers).

There are over 1000 'Freedom to speak up guardians' in the NHS who support workers to speak up about things in the work place that get in the way of doing a great job. For details and to find out who they are see: https://nationalguardian.org.uk/. Speaking up can be about processes or behaviours that may have an impact on your wellbeing or that of the people you work with or patients. You can speak up openly, confidentially or anonymously.

Work admin

Every NHS employee should have access to the Electronic Staff Record, via a computer or the App. Home – ESR Hub – NHS Electronic Staff Record. You need an NHS email account to access it. Here you find the HR and payroll information your employer holds for you and importantly your payslip and P60.

The NHS pay day is the 27th of the month, or the last working day before the 27th. Pay in the NHS for doctors is usually monthly. Pay and tax are not always correctly calculated, so check your payslip carefully.

The GMC requires licensed UK doctors to undergo annual appraisals and revalidation every 5 years. Your employer will identify an appraiser for you and is likely to have a preferred platform to present the relevant evidence for your appraisal. It is your professional responsibility to ensure you collect and present the required evidence, actively participate in and complete this process as required.

Your employer will require you to take part in statutory training, which is required to ensure the Trust is meeting any legislative duties. In addition, mandatory training is an important organisational requirement to limit risk and maintain safe working practice.

Life outside of work

A) Financial services, banking, money transfers

To receive your salary, you must be able to provide details of a UK bank account, so therefore this is a priority to sort out. There are likely a number of banks that have branches in the area local to you. They may ask for confirmation of your employment status to open an account, which you can ask your employer's human resources (HR) department for. There are also a number of internet-based banks but beware potential scams and consider asking local colleagues for advice. Financial services are competitive businesses and tightly regulated in this country, it is worth shopping around. Always read the small print.

If you plan to send money abroad or receive money from abroad shop around for a reliable and economical transfer provider. The fees and the exchange rates for international money transfers vary greatly. This is a competitive market but beware, there are scams.

B) Shopping

Internet shopping is widespread in the UK and can include, for a fee, even shopping for groceries. Supermarkets differ in size and price range, often sell more than just groceries and have reasonably generous opening hours, 7 days per week. On Christmas Day (25 December) almost everything is shut. Small corner shops often have even longer opening hours but beware they can be an expensive option. In larger towns, you may be able to find international food stuffs in supermarket or specialised corner shops.

Some shops offer loyalty cards which entitle you to discounts on some products or to collect points towards future discounts, in exchange for your shopping data. Some retailers also offer 'store cards,' which are essentially store-based credit cards, often with a high rate of interest to pay on the incurred debt – beware! Shopping on credit cards and other deferred payment methods is popular in the UK and can easily lead to financial problems through temptation.

C) Rent and housing

Many hospitals have a number of rooms, flats or even houses they rent out to staff. Availability is usually very limited, but this can be a good option to start with until you have settled in. Some employers have employee } chat facilities on their intranet sites where staff can search for others to share flats or houses with. For rental properties popular websites to search are 'Zoopla' and 'Rightmove,' for medium/long term or to buy a house or a flat. For short-term housing needs start with Airbnb or SpareRoom. In many parts of the country housing is not easy to find, can be very expensive and there are some landlords attempting to take advantage of tenants – beware! It is common to be asked to provide a substantial security deposit. You will have to factor in utility bills, heating and energy into your housing costs as well.

To work out how to find housing and how it works, this is a good place to start: https://www.gov.uk/browse/housing-local-services. To find out more about your rights as a tenant also see: https://www.citizensadvice.org.uk/housing/.

Please take note of issues like council tax, utility bills and rent deposit rules. Citizens Advice is an amazing organisation (for anyone, not just for citizens!) that gives free advice online and in person on many things such as work, benefits, debt, housing, legal matter, etc and their website is excellent. They also have local offices in many places.

D) Transport and driving

In very big cities you may find good public transport options and having a car can be hindrance rather than help, and even parking options can be limited and expensive. In many rural areas the opposite is true. Transport requirements are important to factor into your search for accommodation. Some big cities have restricted access zones for cars. Cycling can be dangerous in many places. Taxis, ride-sharing platforms and trains are generally expensive compared to other countries. For further information on car ownership, costs associated and driving licence requirements please see Driving and transport - GOV.UK (www.gov.uk)

E) Childcare and education

For information on birth, caring for children and how to access education for children please see: https://www.gov.uk/browse/childcare-parenting.

F) Interactions with local or central government

Most official interaction with these can be done online (www.gov.uk). Some websites, emails or phone numbers look like they are part of an official government service when they are not. Some make you pay for things that are cheaper or free if you used the official government service. Search the above site for government services and phone numbers. Official channels in this country are quite well set up to be navigated by individuals themselves (for example, without requiring professional assistance from tax advisers). Beware scams! If in doubt seek advice from a trusted colleague, particularly if asked for money or bank details.

G) Consumer rights and scams

Fraudulent activity and scams are commonplace and can be harder to spot if you are new to the UK. Many criminals can be very convincing and scams are hard to recognise. Watch out for:

Something that seems too good to be true, someone you do not know contacting you unexpectedly, being asked to transfer money quickly or pay for something in an unusual way (for example, by internet vouchers), being asked for personal information, etc. If shopping online check for signs of fake online shops and do not click or download anything you do not trust. There is also a proliferation of 'Hi mum' scams, where criminals pose as relatives or friends, pretending to be in need and asking for urgent monetary assistance. If you have fallen victim to fraud or a scam, please report to Action Fraud: https://www.actionfraud.police.uk/contact-us.

For further advice on scams and consumer rights as well as money saving tips see Check if something might be a scam - Citizens Advice and https://www.moneysavingexpert.com.

Safer, for everyone

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

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

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

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

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

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

Association of Anaesthetists