Anaesthesia News

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Trainee pay issue

Making the most of what you earn

Decoding your tax: An essential guide to tax codes

What to do if you have been paid incorrectly

Pay Survey 2019

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Welcome

I am delighted to present this special issue of *Anaesthesia News* dedicated to trainee pay.

This issue has been created to help trainees better understand the complexities of their pay. The articles have been researched and written by members of the Association Trainee Committee, explaining key areas in plain English and providing some practical advice. Ultimately, we hope that that this issue makes recognising and resolving errors in your pay and tax a little easier.

In January 2019, the Association of Anaesthetists and RCoA completed their second trainee pay survey. Keith Hodgson and Simon Denning explain the key findings. Pay scales, payslips and payment systems are explained by Lucy Powell and Matthew Tuck. The Chair of the Trainee Committee, Sally El-Ghazali, decodes your tax. Your legal rights are explained by Amanda Milligan and David Nesvadba. Karen Stacey provides advice on how to reduce your risk of pay issues, and Rhys Clyburn explains what to do if you have been paid incorrectly. But that's not all! Eireann Allen describes how to claim a tax rebate, and also provides some general considerations for your financial wellbeing. For trainees in the Republic of Ireland, Murray Connolly provides an overview of the pay situation there.

The Trainee Committee recognises the importance of financial wellbeing to trainee members. We understand that receiving the wrong pay and/or being taxed incorrectly is stressful and time-consuming but can also lead to financial hardship. We are committed to continuing our work to improve the wellbeing of trainee members, and we believe that financial wellbeing is an important part of this.

Educating and empowering trainees is only one part of the solution. The Trainee Committee appreciates that reducing the frequency with which these errors are made is key. We are therefore working closely with the RCoA and NHS Employers to explore system solutions to trainee pay problems.

I hope that you enjoy reading this issue, that you learn something new and that, just maybe, your financial wellbeing is improved.

Live long and prosper.

Will Rattenberry
Issue Editor
Elected Member of the Trainee Committee

Editors note: because of the logistical problems associated with printing and distributing paper versions during the Covid-19 pandemic, *Anaesthesia News* and *Anaesthesia* will be provided online-only until further notice. Normal service will be resumed as soon as possible.

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Decoding your tax: An essential guide to tax codes

Have you ever opened a payslip to reveal a new tax code that you do not understand? Has this happened to you more times than you would like to admit? Do you secretly hope that payroll and HMRC have it all in hand so you don't have to do anything?

Anaesthetic training is complex, normally involving many employers and plenty of P45s. There are so many opportunities for an incorrect or emergency tax code to find its way onto your payslip. Tax codes are complicated and I, like so many others, have personal experience of tax woes! In order to avoid tax problems, it is essential that you understand your tax code, and recognise when it is wrong.

Simply put, the tax code tells your employer what rate you should be taxed at. Your tax code will normally start with a number and end with a letter.

What do the numbers actually mean?!

The numbers in your tax code indicate how much tax-free income you get in that tax year. Each of us has a 'Personal Allowance'. Your Personal Allowance is, effectively, the amount of income you can have in that tax year before you start paying tax. The standard Personal Allowance is determined and published by the Government for each tax year and was set at £12,500 for the 2019/20 tax year. Table 1 shows the current tax rates you pay in each band if you have a standard Personal Allowance of **£12,500**.

Table 1

Band	Taxable income	Tax rate
Personal Allowance	Up to £12,500	0%
Basic rate	£12,501 to £50,000	20%
Higher rate	£50,001 to £150,000	40%
Additional rate	over £150,000	45%

Income that you have not paid tax on (such as untaxed interest or part-time earnings), and the value of any benefits from your job, are added up and taken away from your personal allowance. What's left is the tax-free income you are allowed in a tax year.

To find out how much income you can earn in a year before you need to pay tax, simply add a zero to the number shown. For example, a tax code 1250L means you can earn £12,500 a year before paying any income tax.

And what about the letters?!

Letters in your tax code refer to your situation and how it affects your Personal Allowance (Box 1).

Box 1

Letters	What they mean
L	You are entitled to the standard tax-free Personal Allowance. This means that you are under 65 and eligible for the standard tax-free Personal Allowance – this is the amount you can earn before Income Tax kicks in.
T	Your tax code includes other calculations to work out your Personal Allowance
0T	Your Personal Allowance has been used up, or you've started a new job and your employer does not have the details they need to give you a tax code.
BR	All your income from this job or pension is taxed at the basic rate
D0	All your income from this job or pension is taxed at the higher rate
D1	All your income from this job or pension is taxed at the additional rate
NT	You're not paying any tax on this income

S or C Prefix In Scotland, a prefix of S may be seen on your tax code. This indicates that your income or pension is taxed using the rates in Scotland. For example, SBR means all your income from this job or pension is taxed at the basic rate in Scotland.

Likewise, in Wales, a prefix of C denotes your income or pension is taxed using the rates in Wales, for example, CD0 means all your income from this job or pension is taxed at the higher rate in Wales.

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Tax Codes ending with W1 or M1 These are emergency tax codes, which are issued if HMRC does not have enough information about you to send your employer the correct code. The first part of the emergency tax code for 2019/20 is 1250 – the same as the basic Personal Allowance code. This normally ensures that you receive the basic amount of monthly tax-free pay. However, it doesn't take into account any other relief or allowances. Emergency tax codes are temporary.

K Code Another code that many people may have is the K code. This is essentially the reverse of an L code and is used when your level of untaxed additional income exceeds your Personal Allowance. This can happen if you are paying tax that you owe from a previous year through your wages or pension, getting State benefits on which you need to pay tax, or getting benefits from work.

Ok… how can I prevent or rectify incorrect tax codes?

If you think your tax code might be wrong, you can use the online 'Check your Income Tax' service to tell HMRC about a change in your circumstances. If you cannot use the online service, you can contact HMRC by phone or post. If you are put on an emergency tax code when you change jobs, do contact HMRC as soon as possible. When you receive your P45 form, provide a copy to your employer as soon as possible, so they can aid the process and contact HMRC early.

Then what happens?

After your tax code changes, HMRC will adjust your tax code so that you pay the right amount of tax across the year. They will write to you or email you when your tax code has been updated. They will also tell your employer or pension provider that your tax code has changed. Your next payslip should show your new tax code, and adjustments to your pay, if you were paying the wrong amount of tax.

This is only a brief guide from a fellow trainee. I hope it helps you spot the incorrect code on your payslip and fix it. However, if you have a specific question or problem regarding tax, I strongly recommend you seek the services of a regulated tax expert and contact the HMRC.

Sally El-Ghazali
Chair, Association of Anaesthetists Trainee Committee
Anaesthetics/ICM Registrar, London

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Pay issues in Ireland: a trainee perspective

At the Association of Anaesthetists Irish Standing Committee AGM last November, the local contingent were very interested to learn of the issues with pay, tax and pensions affecting our colleagues in the UK. It will come as no surprise that we are facing similar difficulties in Ireland, and these issues have recently gained importance given the unprecedented recruitment and retention crisis of both trainees and consultants.

Irish trainees are struggling with the system. The report from the Public Service Pay Commission on Recruitment and Retention was published over a year ago, and while progress has been made on some fronts, many issues remain. We have an uncompetitive, inconsistently implemented contract, a tax system which is difficult to navigate, high training costs, and what many would view as a punitive, two-tier consultant contract to look forward to.

The contract

Our base salary is subject to a 39-hour week. Sundays are paid at double time, and we are paid a premium of time-and-a-quarter for overtime and 'unsociable hours' between 5 P.M. and 8 A.M. - sometimes. I will come back to that later.

Whilst the concept of being paid for every hour we work sounds enticing, the reality is often frustrating. Payslips vary enormously from month to month and require forensic auditing to ensure we are paid on the correct scale, for the correct number of hours, with the correct premiums, and are taxed accurately.

Un-rostered overtime is par for the course in most departments, but Non-Consultant Hospital Doctors (NCHDs) frequently struggle to be paid for these hours, having to jump through ever-smaller hoops to get them approved by middle management.

There are also some unfortunate loopholes which have little logic to them. For example, the aforementioned 'unsociable hours' premium between 5 P.M. to 8 A.M. are paid for shorter shifts, but not if they comprise part of a 24-h shift. Hardly an incentive!

The politics

Historically, doctors in Ireland have been poor at engaging with unions to improve our contract. On the rare occasion we have gathered some momentum, such as the 2013 NCHD strikes, we fought for incremental improvements to our working conditions, but not our salaries. But is pay really an issue? It is an uncomfortable subject and many doctors in Ireland have questioned the public perception of a campaign to improve our salaries. Political discourse here is currently dominated by the substantial issues of the hospital waiting list crisis, homelessness, the housing crisis, and the rights of asylum seekers, so a relatively small group of relatively well-paid professionals seeking improvements to their salaries doesn't gain the support that we might hope for.

However, our issues must be viewed in the context of a complex, competitive environment where Irish doctors are highly sought after by other industries and jurisdictions. In recent years Ireland has trained the highest number of doctors per capita in the European Union [1], but an increasing number of graduates are leaving our workforce. Most of these travel to the UK and Australia, and as a result, Ireland is becoming increasingly reliant on recruiting overseas graduates, who now make up 42% of our NCHD workforce [2].

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A lost generation

Data from 2018 showed a 38% increase in voluntary withdrawals from the Medical Register. Three quarters were aged ≤ 44. Grievances raised by those withdrawing included remuneration and the costs of medical indemnity and registration, among others. We are losing a generation of doctors, and pay is a central issue.

The 2008 financial crisis has had a lasting impact on doctor recruitment and retention. Overnight cuts to salaries, overtime rates, pension conditions and expenses, combined with large increases in income tax, the introduction of a Universal Social Charge, and the Pension Levy, had an immediate and lasting impact on doctors' take-home pay.

During the crisis, an additional 30% salary cut was imposed on newly appointed hospital consultants, creating a two-tier salary scale where consultants with identical responsibilities may be earning up to €50,000 less than consultants appointed before 2012. This has been cited by the Irish Medical Organisation as the key factor in an extraordinary consultant recruitment crisis. Twenty per cent of permanent consultant posts in Ireland are currently vacant. Pay is certainly an issue.

System inefficiencies

Salary issues are never more evident than the months following changeover, where switching employers is rarely a straightforward event. Irish trainees rarely spent longer than 12 months in one institution. I personally have changed hospital 11 times in the last six years. Each move required repetitive paperwork, police vetting, P45s and new salary departments. After changeover, the dreaded Emergency Tax regularly rears its head, and NCHDs can often take home less than half the correct salary. It frequently takes up to six months to be corrected. The Emergency Tax issue was supposedly solved this year. A new national system was introduced which replaced P45s with an online employer registration system. Hallelujah. So presumably the last changeover was faultless? Hardly. Many of us remained on Emergency Tax even longer than usual and were eventually advised by our salary departments to physically phone the national Revenue Office en masse. Not a step forward.

These issues come at a time of significant expense. The major NCHD changeover in Ireland takes place in July. This frequently involves an intercity relocation, with the associated moving expenses, rental deposits and annual Irish Medical Council registration all coinciding. The Irish Medical Council does not facilitate paying the registration fee in instalments, and instead demands a lump sum > €600. This can put unnecessary strain on NCHDs, particularly those with mortgages and families who are trying to fund two households.

Are there any positives?

There are. The Irish Medical Organisation has recently achieved significant improvements in the training grants available to NCHDs. Certain mandatory courses and examinations are now fully refunded, and additional funding up to €2000 per year is available to fund other educational activities. The development of a national Lead NCHD network has vastly improved engagement with management, the emergency cuts to public service employees have been partially reversed, and the Irish Medical Organisation is in discussions with the Health Service Executive over the two-tier consultant pay scale.

Conclusions

The problems which we are facing are many and varied. They will not be solved easily, but the recent improvements in training grants should serve as a reminder of what can be achieved when we engage with our unions and management. Our salaries and tax burdens are unlikely to improve in the short-term, but there are other areas with potential solutions. The elimination of Emergency Tax, payment of overtime, facilitation of paying Irish Medical Council fees by instalment and consistency in the application of contracts are the next issues in line.

Murray Connolly
Elected member, Association of Anaesthetists Trainee Committee
SAT5 Anaesthesiology Specialist Registrar, Cork University Hospital

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1. Department of Public Expenditure and Reform. Staff Paper 2015. Medical Workforce Analysis: Ireland and the European Union compared, 2015. https://igees.gov.ie/wp-content/uploads/2014/11/Medical-Workforce-Analysis.pdf (accessed 03.03.2020).
2. Humphries N, Connell J, Negin J, Buchan J. Tracking the leavers: towards a better understanding of doctor migration from Ireland to Australia 2008–2018. *Human Resources for Health* 2019; **17:** 36.

Top tips for getting paid correctly:

1. **Know your contract!** All NCHDs in the Irish Public Health System are employed under the same contract. Get to know it in detail, as various hospitals implement it differently.
2. **Know your tax!** Do a deep dive into the Revenue.ie website. It is surprisingly informative and user-friendly. Here you will find summaries of all your previous income and tax payments. You can also check whether your new hospital has successfully registered you (or not!). You can request balancing statements, claim refunds, and find information on tax exemptions.
3. **Count your overtime.** Especially for the first month or two in a new hospital. Are the hours you are claiming matching what you are paid? If not, question them.
4. **Claim, claim, claim.** Keep receipts and claim for all relevant courses, exams and expenses. Ideally, claim within six months to avoid a battle.

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Pay problems: reducing your risk

Starting a new training rotation can be nerve-racking. Is the department friendly? Will the on-calls be manageable? But sometimes the most worrying aspect of a new job comes at the end of that first month – will I get paid correctly, or at all? Doctors have had to rotate frequently between several different hospital employers for many decades, but aside from the 'lead employer' model available in a few regions, little exists to make these transitions smoother. I have been in contact with HR managers and HMRC for advice on how best to help reduce the effects of these frequent employer changes on your tax code, and therefore increase the likelihood of being paid correctly.

HR

The HR department of your new employer will require a certain amount of information to allow them to 'open' an employment account for you. It can be frustrating to have to continually keep supplying the same information, and I often wonder how many copies of my passport and bank statements are floating around the country. Three documents are required for an identity and address check. At least one proof must be a photo ID. Have a scan of your passport saved to your smartphone or computer, the same for your driving licence if you hold one. Supplying proof of address is becoming increasingly challenging in a world of 'paperless' communication. Try to keep at least one utility bill (these contain minimal personal information when compared with a current account bank statement) as a paper statement to ease this process. These documents must be sent as PDFs and not photographs. If you do not have a 'scan' app on your smartphone, download one. This will convert photos to multi-page PDFs to send to HR. Don't forget that you will need to supply these same proofs in person on your first day, so remember which bill you sent! You will need to provide any visa proofs that may be required for your employment if applicable.

Other essential information includes documentation to be sent to payroll. This varies from employer to employer but will include a joining form with your personal information, bank account details, your declaration of previous service (also called an indemnity form) and a request for your most recent payslip. This is particularly relevant if you are paid according to a nodal point pay progression, or receive a Section 2 pay protection premium. Equally important is your 'new starter' HMRC form, which is explained below. To be deemed safe to work, and therefore eligible to be paid, you will also need to be cleared by occupational health, so these forms cannot be ignored. Your PDF proofs of vaccination and blood test results from previous employers can be requested and sent on.

There are a few important points worth noting. Firstly, forms that request a signature must be printed and signed by hand, then scanned before sending back. Merely writing your name in a calligraphy font or adding an electronic signature is not acceptable! Secondly, if you are returning from out-of-programme (OOP) employment or maternity leave or are on a supported return-to-work, you are strongly advised to call the HR department as additional documentation may be required. This is also true for less-than-full-time trainees and any trainees that have had a last-minute change of rotation. Finally, the workload strain that many of us experience on the front line is mirrored in non-clinical departments. Whilst HR departments will do their best to process everything, the time between induction day and the payroll cut-off date can sometimes be only a few days, so sending in your information prior to starting puts you in the best position to be paid on time.

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HMRC

When you leave a job a P45 is generated by your employer, usually after your final salary payment. If you start a new job, the tax code on your P45 will be used by your employer to work out how much tax needs to be deducted from your salary. Without the P45, you may end up paying too much or too little tax. Unfortunately, frequent rotations mean that the P45 procedure will not manage to keep up with you. Without your P45, your new employer is obliged to use a tax code that does not consider your personal circumstances and earnings, or taxes already paid. When it does finally arrive, you should send on Parts 2 and 3 to your new employer as soon as possible. Since you will be starting your new rotation before your P45 is available, your new employer will send a 'starter checklist' form (previously P46) that lets HMRC know that this is now your only job and aids your employer to allocate a tax code. Given the rotational dates of 'the first Wednesday of the month', you are likely to receive payment from two employers. This will very likely mean you will underpay your tax, and a correction will occur in the following month. HMRC could not give any suggestions on how to prevent this, so it would seem that some element of incorrect pay is sadly inevitable. HMRC have suggested that employees call them to notify them of the change of employer in advance, and that the P45 procedure can be expedited by employees requesting their P45 from payroll on the day of their final salary payment and informing HMRC of the details. This could prevent P45 delays pushing tax issues into more than the first month. Understanding your tax code is also important - please see 'Decoding your tax' in this issue.

Just when you thought that the problems were all over, pay issues can also occur even after you have left a hospital. Your department should notify HR in advance of the end of your rotation. This information is then cross-referenced to the training information grid the hospital receives from Health Education England (or devolved educational board) and the employment should be correctly terminated. If this does not occur, you might find yourself being paid by two employers, which is sadly not as much fun as it sounds, creating havoc with your tax code. As you approach the end of your rotation, confirm with your department that you have been flagged as a 'leaver'.

Whilst getting paid correctly can seem like a bit of a lottery, it is worth spending some time to ensure the odds are in your favour.

Thanks to HMRC and an HR department for this valuable information.

Karen Stacey
Elected Member, Association of Anaesthetists Trainee Committee
Locum Consultant Anaesthetist, Imperial College Healthcare NHS Trust

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Making the most of what you earn

Nine years of university, two degrees, a whopping great student loan, and a sunny elective later, I arrived bright eyed and bushy tailed for my first 'proper job'. The thought of having money left over to save after student loans, bills, courses and exam fees were paid was a bit of a fantasy. By the time I reached ST3, I finally put my maths degree to some use and claimed back tax relief on some of the expenses that had accumulated over the years. How hard could it be, right? To my surprise, it wasn't actually that taxing at all. A few thousand pounds later (yes thousands!) from those five previous years of exams, memberships and course fees helped pay for a honeymoon. Here are some of the things I've learned along the way.

How to claim a tax rebate

It's easy. HMRC have developed an online Government Gateway [1]. You are eligible to apply for a P87 – 'Claim Income tax relief for your employment expenses'. All you need to do is tot up your expenses for each tax year April-March (Table 1). Then access the gov.uk website and follow the questionnaire to work out if you are claiming less or more than £2500 per tax year. You will then need to create a Government Gateway ID and password. It usually takes 10 min (have your P60 and national insurance number handy). You will be asked for a PAYE tax reference from your employer (on your P45/P60). If you have moved NHS employers during each tax year, you may have to contact HMRC for these details if they're not readily available on your payslips. You can claim tax relief on the last five years of work-related expenses that have not been reimbursed elsewhere. Once you get the ball rolling, it is easier to keep on top of expenses in each tax year using a year-by-year P87.

If you claim under the £2500 threshold then the online PAYE form is easy to fill out. If you are claiming more than £2500 per year, it is advisable to employ the guidance of a tax accountant – but your rewards will potentially be greater. You must have paid tax on the earnings from your job in the year you are claiming for. You will get tax relief based on what you have spent and the rate at which you pay tax.

Top tips for financial wellbeing

I have become increasingly interested in pay, savings, and my financial wellbeing. It has helped that my husband is a financial advisor (conflict of interest declared here!). Here are some things he's taught me along the way.

Table 1

Examples of annual expenses:
GMC
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BMA
Medical Indemnity insurance
Other faculty/college fees (a full list is available on the government website)
Work-related expenses such as:
Examination fees (including resits)
Travel expenses (not already reimbursed by local deanery)
Travel and overnight expenses
Courses (there are some 'potentially allowable' courses that are approved as tax-deductible; check on an individual basis).

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Finances These are dependent on personal circumstances - no two people are the same. Have a plan and think about protecting what you earn, saving for emergencies and your long-term financial well-being. What is your long-term picture? Your dream home, kids' university fees, holiday home abroad are more easily achieved with a strong commitment to your financial plan.

Emergency funds An emergency fund is vital. It is recommended that you keep 3-6 months of expenses in an easily accessible cash account, such as a savings account. However, holding excess cash above this level can be detrimental to your long-term financial health because of inflation. Inflation is the increase in the average price of goods. If your cash account (Cash ISA, Current Account, Savings Account) is not giving interest returns above inflation (1.4% in December 2019) your money will lose its buying power.

ISAs Individual Savings Accounts are a government-endorsed means of tax-free saving. You may have heard of Cash ISA, Stocks & Shares ISA, and Lifetime ISAs. You have the ability to save up to £20,000 per tax year across all ISA savings.

Cash ISA A savings account without any tax on the interest gained. A range of Cash ISAs are offered in banks, building societies, and credit unions – there are plenty on the market so shop around for the best rate. The downside is that they remain in cash, and interest returns may not keep pace with inflation.

Lifetime ISA The Lifetime ISA (LISA) lets you save up to £4000 every tax year towards a first home or your retirement, with the government giving you a 25% bonus on top (Table 2). A fantastic way to help first-time buyers onto the property market. Alternatively, if you are not a first-time buyer, a LISA can be used as a pension savings account, although it cannot be accessed until the age of 60.

Table 2

Savings per year?	£4000
Government bonus?	25%
When is the bonus added?	Monthly
Maximum property value?	£450,000
Who can open it?	Anyone aged 18-39
Can a couple have one each?	Yes, if they intend on buying their first property together
Minimum holding period before access?	None, but will pay a 25% withdrawal charge if withdrawal is within the first 12 months of your first payment
What can I pay with the LISA?	Deposit for a mortgaged house only

Stocks & Shares ISA An option that can prevent your money from losing its buying power is to invest in the stock market. Stocks & Shares ISAs give you the opportunity to achieve tax free growth. You must first understand the level of risk you are willing to take, the length of time you wish to invest and the desire you have for any investment growth. With risk comes the potential for reward. The higher the risk level you are willing to take, the higher the potential for growth. Markets can be volatile but with a long-term plan, it is possible to withstand the bumps in the road. Keep your emotions neutral. Remaining level-headed can be difficult, but emotional investing can have a negative impact on your objectives. There is no perfect time to invest and trying to 'time' when is good or bad is less profitable than 'time in the market'. Seeking professional advice will allow an adviser to manage your fund and your expectations.

Insurance Insuring yourself and your health is the foundation of a strong financial plan and a way of protecting those you love. We all hope we plan for something that never happens, but we are all too aware of the unforeseen ahead. It is the same as your car insurance - you pay a monthly premium in the hope you never have an accident.

Life insurance Pays out a tax-free lump sum on death. It allows your family to continue their current standard of living. The sum assured can be used to repay any or all debts (mortgage, school fees, credit cards). The more you insure yourself for, the more expensive it will be. Again, everyone is different, and no two families have the same needs.

Critical illness cover Tax-free lump sum on diagnosis of specific critical illness (all providers offer different levels and areas covered). It is usually more expensive than life insurance and contains a 'survival period'. It could provide money needed to clear debt or cover home amendments, healthcare costs, travel or any other associated costs.

Income Protection The NHS scheme provides a salary of six months full pay and then six months half pay if you are on long-term sick leave. After that you are unpaid. Income protection pays you a monthly predetermined sum, or up to a maximum percentage of your salary. It is deliberately designed not to pay you your full salary and to encourage getting back to work.

Eireann Allen
Elected Member Association of Anaesthetists Trainee Committee ST6, South East Scotland

Conflict of interest declared: husband (Michael Allen) is a financial advisor.

Editorial note: this article is a guide only and not a substitute for professional advice; we remind readers that we take no responsibility for the contents or for any losses that result from the advice provided.

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1. GOV.UK. Claim tax relief for your job expenses, 2020. https://www.gov.uk/tax-relief-for-employees (accessed 28.02.2020).

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Trainee doctors pay – your rights explained

Two of the biggest hitters for trainee dissatisfaction are mix-ups with pay and rota. These issues can have a significant financial impact and affect your well-being and quality of life.

We asked Glasgow based employment lawyer Scott Milligan some common questions to enable a better understanding of our legal rights. The legal framework for employment law is common across the UK, therefore applicable to all trainees in the UK.

What is the correct pay for my stage of training?

Pay scales for the 2002/ 2016 contracts can be found online for specific nodal points in relation to your clinical experience or training year. The terms and conditions of service for Doctors and Dentists in England and Wales (2016) state a doctor 'shall be paid a basic salary at a nodal pay point linked to the grade and the level of responsibility required in the post to which they have been appointed' based on working 40 hours per week. Less than full-time trainees are paid pro rata based on the proportion of full-time work agreed [1].

Information on pay scales for trainees in the different countries can be found at: England [2]; Scotland [3]; Northern Ireland [4]; Wales [5].

The new RCoA curriculum 2020 is currently being reviewed by the GMC (as of January 2020), including how the additional core training year will affect (or not!) trainees transitioning between curricula. Discussions on pay protection for those on the 2016 trainee doctor contract are ongoing for the stand-alone CT3 year in transitioning to the new curriculum [6].

What's my study leave budget?

Health Education England has no specific annual allowance per se, but may limit the budget spend per course or event in some areas [7]. Trainees in Scotland have £500 p.a. [8] and in Northern Ireland trainees have a budget of £1250 p.a., with a maximum remuneration allowed per event depending on the necessity of training [9]. The budget for trainees in Wales is £600 p.a. [10].

It must be within my rights to be paid properly! What happens if I get paid incorrectly?

Unfortunately, mistakes in pay will happen. For those on fixed monthly salaries, it is unlikely to happen too often, but for those on shift work (or paid commission), it is more likely. There are often issues that arise when doctors in training move hospital during rotation without a lead employer. There are rights enshrined in law designed to offer redress both internally and externally, if ultimately required.

What are the internal options?
First, it would usually be to raise the matter informally, either with line management, through HR, or payroll department. If the error is not remedied, or you view the circumstances to be serious to warrant it, a formal grievance can be raised. This escalates the situation and requires your employer to carry out an investigation and hold a grievance meeting to hear your complaint. If you are not happy with the outcome, you are entitled to an appeal.

What are the external options?
If the internal process does not resolve the situation, and there has been an underpayment of wages, you can raise a claim in the employment tribunal for what is known as 'unlawful deduction from wages.' This is a claim under the Employment Rights Act 1996 that covers both underpayments and unauthorised deduction from wages.

An employment tribunal claim can be made for the shortfall in salary and subsequent financial loss as a result of underpayment (such as bank charges etc) and there is no limit to this amount. Time limits are strict, however. ACAS, the conciliation service, must be contacted to commence the early conciliation process (which is required before a tribunal claim is raised) within three months of the date of the underpayment. Note, an ongoing grievance process does not extend the deadline for raising a claim.

Do I have more rights if it keeps happening?

Ultimately, the employer is likely to be in breach of an express contractual term and the implied term of trust and confidence that is found in every employment contract. This could give rise to a right to resign and claim constructive dismissal, but this is very much a last case scenario.

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What if I get over-paid?

Unfortunately, there is no entitlement to keep an overpayment. An employer can deduct any overpayment from future salary, or otherwise sue for the return of the money, so don't treat any overpayment as a hard-earned bonus!

Is there a maximum in law that I can work – the contract says it's 48 hours per week?

Under the Working Time Regulations (WTR) 1998, the maximum average working week is 48 hours. This is an average over a 17-week period, so it is legal for this to be exceeded occasionally. It's possible to opt out of this maximum by signing specific opt-out paperwork, normally a separate document not within a contract of employment. It is possible to opt back into this average working week by giving appropriate notice that you wish to do so.

What about rest breaks?

In law, a worker is entitled to a 20 min unpaid break if they work for more than six hours [11]. Of course, most employers will offer an enhancement to this entitlement, and in fact, the England trainee contract (2016) states doctors should have a 30-min break for a shift of more than five hours; an additional 30-min break for a shift of more than nine hours; and a third 30-min break in night shifts rostered for more than 12 hours [1].

There is also an entitlement to a daily 11-h rest break per 24-h period, and a weekly rest period of 24 h (or 48 h per fortnight). Unlike the average working week, a worker cannot opt out of these rights (unless collectively negotiated), but there are exceptions that an employer can offer compensatory rest in some circumstances where these entitlements cannot be respected.

Are doctors different in law?

There is no distinction under the WTR for doctors as opposed to other workers, but there may be contractual provisions or workforce agreements that apply that will give further rights other than the above, for example in relation to night and rota working.

How far in advance should I receive my roster?

A rota is a template of working hours, a roster is a populated rota with trainees. The advanced roster should be received six weeks in advance in England [12] and four weeks in advance for those on the 2002 contract. Health Education England is aiming to increase advanced roster notification to eight weeks [13].

What if I work a bank holiday?

If scheduled to work at any time on a bank holiday or have a scheduled rest day on a bank holiday, you are entitled to a day in lieu – i.e. an extra day of annual leave [12].

Additionally, if exception reporting results in acquiring time off in lieu, and you are unable to take the time off in lieu within four weeks of agreement, it will be converted to pay after that 4-week period [14].

How many consecutive days can I legally work?

NHS employers state:

- Maximum of four consecutive shifts where the shift is > 10 h and must have 48 h continuous rest after the conclusion of the fourth shift.
- Maximum of seven consecutive shifts where the shift is < 10 h and must have 48 h continuous rest after the conclusion of the seventh shift.
- Maximum 72 h work in a consecutive 168-h period.
- Maximum of four consecutive night shifts.

Is there a statutory rest period after night shift?

The minimum rest period after any night shift duration, even a single night shift, is 46 hours [14].

What happens if there is a breach of my rights?

It depends on the type of breach. If it is a breach of WTR, an employment tribunal claim can be raised. If it is a breach of contract or workforce agreement, the options are more limited – remedy would primarily be through an internal grievance. Ultimately, the WTR is there to protect the health and safety of workers. Significant breaches can be reported to the Health and Safety Executive, who could take enforcement action in appropriate cases. Employees making disclosures of this type may be protected by the whistleblowing legislation, dependent on the circumstances.

Is anything going to change with Brexit?

The WTR are well-established in law and NHS Employers states WTR are embedded in the terms and conditions of NHS employment contracts; therefore even if repealed, the contractual provisions would continue to apply and thus protect employees.

Conclusions

- Keep up-to-date with your salary entitlement and check your payslip regularly.
- You are entitled to correct pay but sometimes errors occur; these can usually be resolved swiftly by raising the matter with payroll, human resources or your line manager.
- You should receive your roster between 4-6 weeks in advance, depending on which UK constituent country you work in.
- The contract terms and conditions control your employment rights, not Brexit.

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What to do if you have been paid incorrectly

Incorrect pay remains a major problem amongst anaesthetic trainees in the UK. The Association of Anaesthetists / RCoA 2018/2019 pay survey found that 55% of trainees received inaccurate or late pay, with approximately a third of this group suffering on multiple occasions [1]. I have been the victim of this, having been overpaid, underpaid and paid late (although never paid early!). So, what should you do if you are paid incorrectly?

Check your payslip

If you think that you have been paid incorrectly, it is important that you study your payslip to identify the cause of incorrect pay as soon as possible. Causes of incorrect pay include:

- An incorrect tax code
- Incorrect pay banding
- Incorrect repayment of student loan
- Incorrect pension contribution
- Incorrect locum payment

It is important that you identify the cause of your incorrect pay, as this will assist you in identifying what you need to do to rectify it. If you are unsure how to interpret your payslip, please see the 'Knowing your payslip' article from the June 2018 issue of *Anaesthesia News* (371).

Who should I speak to?

Contact your payroll department to notify them of the error as soon as possible. If you have been underpaid, this will give you the best chance of receiving the money you are owed in a timely manner. If you have been overpaid, don't be tempted to stay quiet. Failing to notify your employer of an overpayment could be viewed as fraudulent, so honesty is the best policy!
You should also speak to an appropriate figure within your department who has experience of dealing with payroll. They will be able to take up the issue, and also offer support and advice.

If the error is related to taxation, this is likely to be due to an incorrect (often emergency) tax code. In this instance, you should speak to HMRC to correct this, who will notify your employer of the error.

Timescale for payment/repayment

It is important to agree a clear time scale for payment of money owed, or return of overpayment. An employer will typically wish to pay any money owed to an employee on the next payday. If the underpayment leaves you at risk of financial hardship, such as missing rent or mortgage payments, communicate this to payroll - it may be possible to arrange an earlier payment.
When an employee has been overpaid, trusts will recover the amount owed by deduction of salary on the next payday. If the amount owed is large, request that a repayment plan be put in place, in which a smaller amount is deducted over several months. When discussing repayment, remain calm and professional – but do not allow yourself to be put in a position of financial hardship.

Escalation strategy

Make sure that you chase the payroll department regarding errors in pay – a single phone call is rarely enough. Writing an email to follow up any phone calls ensures that there is written evidence of any discussions. If you feel that your concerns are not being listened to, ask to speak to a member of payroll management. If you are still unhappy with what is being offered, seek advice and support from senior figures within your department. External organisations, such as the Association of Anaesthetists or BMA, are another useful source of support. If you still do not think that you are being treated appropriately, submit your grievances in writing to senior payroll management. Many hospitals have a grievance procedure which should be followed, so check first.

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Pay Survey 2019

Many of you will know the heart-sink feeling when you look at your bank account or payslip and get the awful realisation that you have been paid incorrectly. Despite not being at fault personally, the next steps include multiple phone calls and emails, valuable time wasted in search of fairness and resolution, not to mention the HMRC's 'hold music'. For many, this is more than a slight inconvenience and can lead to significant financial hardship.

The Association of Anaesthetists and RCoA first investigated this issue in 2017, aiming to establish the extent to which anaesthetists in training were experiencing difficulties with their pay [1]. More than statistics, the nine pages of free text comments made for difficult reading. In response to the survey, we met with NHS Employers and highlighted resources for anaesthetists in training. Although well received, we wanted to see whether these had led to any tangible improvement as shown by a reduction in the number of issues encountered.

A repeat joint survey was therefore completed in 2019 to assess the current situation [2].

Key findings

- 55% of respondents had received late or inaccurate salary in the previous 12 months (down from 73% in 2017).
- 30% of this group had suffered on multiple occasions.
- 15% of respondents had suffered financial hardship as a result of receiving an inaccurate salary payment.
- 66% of respondents had been given an emergency tax code, of whom 50% had experienced this on multiple occasions.
- 37% of respondents did not know their current tax code.
- 22% of respondents believed that their tax code was incorrect.
- 50% of respondents had inaccurate additional pay noticed retrospectively.
- 52% of respondents report little or no understanding of their payslip.
- As in 2017, the qualitative data from the free text sections (a further nine pages of grim reading) brought the issue into sharp focus, and thematic analysis highlighted some common problems:
- Communication issues with HR departments.
- Issues involving HMRC, predominantly relating to emergency tax codes.
- A desire to adopt a lead employer trust system to mitigate some of these issues.

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Regardless of the exact cause, the consequences of receiving incorrect pay, and the time and effort required to resolve it, leads to low morale and feelings of being undervalued. The following submission summarises our main concerns:

"Incredibly stressful getting underpaid every time I rotate, which often is every three months. It is a massive waste of my time (often unsuccessfully) chasing my missing pay. It is affecting my wellbeing and has affected me financially negatively."

Improving the situation

We are committed to working on your behalf to improve your financial wellbeing – indeed we feel that this is such an important issue that we have devoted this entire edition of *Anaesthesia News* to it. We hope this serves as a resource to help you address pay related issues whenever they occur, with additional resources and links available on the Association website.

We are working with our advocacy and campaigns manager, in coordination with the RCoA, to highlight the issue and how it affects a workforce already under pressure. Through both organisations, we have links with decision-makers at Trust, deanery and national level. Building on the relationships formed following the last survey, we aim to influence those in positions of power to embrace solutions such as the lead employer model, leading to positive system change. We hope you find the resources useful and, as ever, are keen to hear about the issues that affect you.

If you are in financial difficulty, free impartial advice can be found at: https://www.moneyadviceservice.org.uk/en.

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Vice-Chair, Association of Anaesthetists Trainee Committee
ST6 Anaesthetics, South East Scotland School of Anaesthesia

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Past Honorary Secretary, Association of Anaesthetists Trainee Committee
Clinical Fellow in Paediatric Anaesthesia, The Hospital for Sick Children, Toronto

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Particles

Forget P, Borovac JA, Thackeray EM, Pace NL.

Transient neurological symptoms (TNS) following spinal anaesthesia with lidocaine versus other local anaesthetics in adult surgical patients: a network meta-analysis.

Cochrane Database of Systematic Reviews 2019, Issue 12. Art. No.: CD003006. DOI: 10.1002/14651858.CD003006.pub4.

Introduction

Many different local anaesthetics have been used for spinal anaesthesia with differing effects, duration and toxicity. The increasing use of day case surgery has created a greater need for spinal anaesthesia that is short acting with rapid onset and offset, but there are limited local anaesthetics that provide this pharmacokinetic profile. One local anaesthetic which would potentially provide this would be lidocaine; however it has previously been linked with transient neurological symptoms (TNS), defined as *'pain originating in the gluteal region and radiating to both lower extremities, in the absence of abnormal neurological examination or imaging'* [1]. It can occur up to 24 h after recovery from a spinal anaesthetic, and these patients have higher pain scores, use more analgesics, have more functional impairment for the first 48 h post procedure. and have lower satisfaction rates [2]. This review examines the latest evidence for the frequency of TNS with lidocaine and other local anaesthetics when used spinally.

Methods

This review conducted a conventional pairwise meta-analysis comparing lidocaine to seven other local anaesthetics. The authors also performed a network meta-analysis, a newer technique that allows indirect comparisons to be deduced even there were no direct comparisons. It also enables ranking of different combinations of interventions. MEDLINE ALL, Ovid SP, Cochrane Central Register of Controlled Trials Register, Embase and LILACS were searched for randomised controlled trials (RCTs) and quasi-RCTs that compared local anaesthetics for spinal anaesthesia. Studies were excluded if spinal opioids or combined spinal-epidural anaesthesia were used.

The primary outcome measure was the presence of TNS starting within 24 h after recovery from spinal anaesthesia. Studies were assessed for the risk of bias, and risk ratio (RR) was selected to measure treatment effect. The meta-analysis was only performed where the heterogeneity of studies was low.

Results

24 studies including 2226 patients, of low to moderate quality evidence, were included in the meta-analysis. Risk of bias was deemed to range from uncertain to high. Overall 18% of patients who received lidocaine in their spinal developed TNS. The analysis showed that, compared with lidocaine, the RR of TNS was lower for bupivacaine, levobupivacaine, prilocaine, procaine and ropivacaine, with RRs in the range of 0.10 to 0.23, while 2-chloroprocaine and mepivacaine did not significantly differ.

Conclusion

Spinal lidocaine is associated with significantly higher rates of TNS when compared with bupivacaine, levobupicaine, prilocaine, procaine and ropivacaine. Although the symptoms usually resolved within 5 days, the authors suggest that the risks of TNS should be weighed against the benefit of rapid short-acting anaesthesia, and the patient's viewpoint must be considered in the decision as to whether to use lidocaine for ambulatory anaesthesia.

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Cochrane Anaesthesia Research Dissemination Fellow

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Webinars

You can log in from the comfort of your own home, your office, or anywhere else that is convenient. All you need is a decent internet connection and a quiet room. If you are unable to attend live do not worry, you will be automatically sent the recording 24 hours after the webinar whether you attend or not.

June

Paediatric CC and surgical review

Wednesday 3 June 2020 6:00pm - 8:30pm (Login 5:45pm)

Organiser: Dr Ann Harvey

Speakers to include:
Dr Peter Wilson, Medical Director (Commissioning), NHS England & NHS Improvement
Dr Simon Courtman, lead for the paed surgery ODN in South west

Neuromuscular blockade (NMB) monitoring: enhancing clinical practice

Tuesday 16 June 2020 6:00pm - 8:30pm (Login 5:45pm)

From curare to sugammadex. From clinical monitoring to nerve stimulators and quantitative devices. Which, when and how? Please join this webinar and discussion, highlighting the background, monitoring and planning necessary to deliver effective clinical practice and to enhance patient safety. Speakers include experts in this field from the USA, Europe and the UK, giving a truly global experience

Organiser: Dr Grant Rodney

TOPICS: with 4 speakers, 15 minutes apiece, allowing for 20-30 minutes of discussion / Q&A

- THE BASICS: Myths and facts: why current practice fails (Glen Murphy, Chicago)
- THE MONITORS: Quantitative; Acceleromyography (AMG), Electromyography (EMG), Kinemyography (KMG) (J. Ross Renew, Mayo Clinic, Florida)
- THE CONSEQUENCES: respiratory and other systems (Lars Eriksson, Karolinska, Sweden)
- THE STRATEGY: putting it all together; planning, monitoring, drugs (Sorin Brull, Mayo Clinic Florida and Grant Rodney)

October

Focused Trans-thoracic echocardiography for Anaesthetists

Thursday 1 October 2020 6:00pm - 8:30pm (Login 5:45pm)

Overall goal: To enthuse anaesthetists to consider introducing TTE into aspects of their clinical practice

Organiser: Dr Paul Diprose

Topics:
Presentation 1 – Dr Justin Kirk-Bayley (Royal Surrey County Hospital, Guildford)
Introduction to TTE for anaesthetists

Presentation 2 – Dr Ashley Miller (Royal Shrewsbury Hospital, Shrewsbury)
Use of TTE to identify life threatening intra-op complications
Use of focused echo to manage patients who are acutely unstable

Presentation 3 – Dr Marcus Peck (Frimley Park Hospital, Frimley)
Beyond focused echo and potential future developments

Presentation 4 – Dr Nick Fletcher (St George's Hospital, London)
Governance and safe introduction of focused TTE into practice

Fees: Members £25 | Trainee members £20 | Non-members £55

Association of Anaesthetists

Please visit website for full details
www.anaesthetists.org/education

Pay scales, payslips and payment systems explained

This article aims to explain how your pay works, including how it is calculated and administered. Hopefully, it will leave you with a better understanding of your pay, and better equipped to tackle any problems that may arise.

2002 Pay scale and contract (different in England to the devolved nations)

The premise of pay on all variants of the 2002 terms and conditions is that there is a basic pay commensurate with grade and yearly increment, which is multiplied by a percentage known as 'banding'. The percentage uplift per band is: 3 – 100%; 2A – 80%; 2B – 50%; 1A – 50%; 1B – 40%; 1C – 20%. Details on how to check the banding of your rota is available online [1]. Each nation will have a different base salary, as each government has given different pay rises over the last 18 years. You need to check the pay circular for your particular nation (see the relevant online NHS employer website). Posts can be un-banded if you work a total of 40 hours, with all these worked between 7 A.M. - 7 P.M. For Wales, Scotland and Northern Ireland, banding can be challenged by monitoring exercises at any time and employers must run two monitoring exercises per year on each rota.

Amended 2016 pay scale explained (only applies to England)

The calculation for pay on the 'new' English pay scale starts with the question "Were you ST3 *or above in August 2016*?". If you were, then you will still be paid according to the old 2002 pay scale as explained above. Crucially, you will now use exception reporting and work schedule reviews to challenge your pay, rather than monitoring exercises. This is a new change as of February 2020.

This will change if you end your contract or if you were in a devolved nation at this time as ST3+. If you were below ST3 in August 2016 then you will be paid on the amended 2016 contract pay scale.

There are currently four basic pay nodes: F1 - £27,689; F2 - £32,050; CT1-2 - £37,935; CT/ST3+ - £48,075. All are subject to annual pay uplifts of 2% until the financial year starting April 2022. There will soon be a fifth node introduced at ST6 with salary: October 2020 £51,075; October 2021 £54,075; April 2022 £56,075.

The majority of contracts include, on average, six additional hours per week which will increase your basic pay by 6/40ths of the basic pay for the 40-hour contract. In England your contract should never exceed an average of 48 hours per week.

You receive a 37% hourly enhancement for any of your weekly hours worked: between 9 P.M. and 7 A.M.; hours worked until 10 A.M. in shifts of eight hours or longer which start between 8 P.M. and 11.59 P.M.; any shift which ends between 12 A.M. and 4 A.M. The frequency of weekends you work also attracts an enhancement on your basic pay for hours worked (40 + additional): 1 in 2 - 15%; ≥ 1 in 3 - 10%; ≥ 1 in 4 - 7.5%; ≥ 1 in 5 - 6%; ≥ 1 in 6 - 5%; ≥ 1 in 7 - 4%.

You may now need to add flexible pay premia – for anaesthetists this may be applied if you have been out of clinical work on an approved academic programme such as the Academic Clinical Fellowship. Other premia are tailored to shortage specialties or general practice, which are not covered here.

Finally, any trainee who is less-than-full-time on the 2016 pay scale will now receive £1000 a year extra to cover fixed costs of training such as exams or courses.

With the 2% pay uplifts each year and the introduction of the new node at ST6, an ST6+ trainee in Oct 2022 and beyond can expect (on average) to earn £79,000.

Examples of two payslips as diagrams – 2002 and Amended 2016 Contract

By now, all junior doctors will have been moved onto the terms of the 2016 contract; however, some will still be paid according to the 2002 contract, as described earlier. We have therefore updated previous guidance [2] according to the 2002 and 2016 contracts. The main differences are around the way your Basic Pay and Allowances are described – all other elements of the payslip are essentially the same (Figures 1 and 2).

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ST6, Royal Victoria Infirmary Newcastle upon Tyne

Matthew Tuck
BMA JDC Deputy Chair and BMA co-opt to Association of Anaesthetists Trainee Committee
Anaesthetic Clinical Fellow

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Figure 1. Junior doctor payslip explained, for those on 2002 pay scale

Junior doctor payslip explained (2002)

ASSIGNMENT NUMBER Also known as 'payroll' or 'employee number' – used to identify you on the payroll.	**EMPLOYER NAME** You!		**LOCATION** This should match your current place of work.	
DEPARTMENT This should match your current workplace.	**JOB TITLE** Should describe your role e.g. 'Registrar Anaesthetics'		**PAYSCALE DESCRIPTION** Usually 'Specialty Registrar' or 'Specialty Doctor', depending on whether or not you're in training.	
NHS	**SAL/WAGE** Your basic salary. There are different pay scales across the four nations.	**INC. DATE** Refers to Increment Date i.e. the date you move up the pay scale/date you reached top increment! Usually August.	**STANDARD HRS.** The number of hours you're *contracted* to work. Usually 40 – 48 hours.	**PT SAL/WAGE** This shows your actual salary paid. The amount will be pro rata for LTFT staff.
	TAX OFFICE NAME	**TAX OFFICE REF** This is your employer's PAYE reference with HMRC. This will be required if you claim expenses using a Personal Tax Account or complete a Self Assessment Tax Return.	**TAX CODE** Tells your employer how much tax-free pay you should get. If the code is wrong, you could end up paying too much or too little tax, so you should check this against your latest tax code letter.	**NI NUMBER** You have the same NI number throughout your life.

PAY AND ALLOWANCES (- = MINUS AMOUNT)					**DEDUCTIONS (R= Refunded amount)**		
DESCRIPTION	**WKD/EARNED**	**PAID/DUE**	**RATE**	**AMOUNT**	**DESCRIPTION**	**AMOUNT**	**BALANCE C/F**
These figures give your gross pay for the month: **Basic pay:** 1/12th of your salary for the year **Banding**: indicates amount of banding awarded on top of Basic Pay (see article.)	Relevant information on hours worked, rates of pay, and what is being paid this month will be contained here.				**PAYE** 'Pay As You Earn' - employer deducts tax and NI contributions from your wages or occupational pension before paying your wages or pension. **NI A** – National Insurance letter. **NHS PENSION (%)** Your tax contribution % is based on your Pensionable Pay (whole time equivalent.) See NHS Employers for more info. **STUDENT LOAN** - If you're making repayments on a student loan, this will be shown on your payslip. HMRC tells the Student Loans Company what has been repaid once a year. This means it's a good idea to keep your payslips and P60 as a record of the repayments in case of any problems.		

Year To Date Balances (This Employer Only) This area shows totals for income tax, national insurance and pension from the beginning of the tax-year, up to and including the current pay period.			This Period Summary This section provides details relating to your current payment. Total payments and deductions are shown together with details about the pay period itself and when you can expect your Net Pay to be paid.	
GROSS PAY Total amount of money an employee receives before taxes and deductions are taken out. **NI LETTER** Most employees registered under 'A' – other letters exist, e.g. for those entitled to deferred or reduced NI.		**TAXABLE PAY** Gross Pay minus any tax-free elements **TAX PAID** **PREVIOUS TAXABLE PAY** **PENSION CONTS** **EMPLOYEE NUMBER.** Same as 'Assignment or Payroll number'	**PENSIONABLE PAY** **TAX PERIOD** **FREQUENCY** **PERIOD END DATE** **PAY DATE** **PAY METHOD**	**TAXABLE PAY** **NON-TAXABLE PAY** **TOTAL PAYMENTS** **TOTAL DEDUCTIONS** **NET PAY** This is your take-home pay, after tax and deductions. This should match what is paid into your bank account.
NI PAY **NI CONTS**	**OTHER NI PAY** **OTHER NI CONTS**			
PENSIONABLE PAY **SD REF NUMBER**				

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Figure 2. Junior doctor payslip explained, for those on 2016 pay scale

Junior doctor payslip explained (2016)

ASSIGNMENT NUMBER Also known as 'payroll' or 'employee number' – used to identify you on the payroll.	**EMPLOYER NAME** You!		**LOCATION** This should match your current place of work.	
DEPARTMENT This should match your current workplace.	**JOB TITLE** Should describe your role e.g. 'Registrar Anaesthetics'		**PAYSCALE DESCRIPTION** Usually 'Specialty Registrar' or 'Specialty Doctor', depending on whether or not you're in training.	
NHS	**SAL/WAGE** Your basic salary. Your basic salary. There are different pay scales across the four nations.	**INC. DATE** Refers to Increment Date i.e. the date you move up the pay scale/date you reached top increment! Usually August.	**STANDARD HRS.** The number of hours you're *contracted* to work. Usually 40 – 48 hours.	**PT SAL/WAGE** This shows your actual salary paid. The amount will be pro rata for LTFT staff.
	TAX OFFICE NAME	**TAX OFFICE REF** This is your employer's PAYE reference with HMRC. This will be required if you claim expenses using a Personal Tax Account or complete a Self Assessment Tax Return.	**TAX CODE** The code tells your employer how much tax-free pay you should get before deducting tax from the rest. If the code is wrong, you could end up paying too much or too little tax, so you should check this against your latest tax code letter.	**NI NUMBER** You have the same NI number throughout your whole life. It's your personal number for the whole of the social security system. It's used to make sure all your contributions are recorded properly and helps to build up your entitlement to state benefits – like a pension.

PAY AND ALLOWANCES (- = MINUS AMOUNT)					**DEDUCTIONS (R= Refunded amount)**		
DESCRIPTION	**WKD/EARNED**	**PAID/DUE**	**RATE**	**AMOUNT**	**DESCRIPTION**	**AMOUNT**	**BALANCE C/F**
These figures give your gross pay for the month: **Basic pay:** The relevant nodal pay point for your grade, calculated on an average of 40 hours' work per week. **Additional rostered hours:** Any additional contracted hours over 40 (up to max 48.) **Night duty:** Any hours receiving an enhanced rate of 37% of your hourly basic pay. **Weekend allowance:** An allowance set as a percentage of your basic salary for working 1 in 8 or more frequent weekends. **Flexible pay premia**: Any flexible pay premia that apply – currently for emergency medicine, psychiatry, OMFS, academia and GP, as well as current LTFT trainees. Paid annually. **Pay protection:** Dependent on where you were in training in August 2016, you may receive one of two types of pay-protection.	Relevant information on hours worked, rates of pay, and what is being paid this month will be contained here.		Self-explanatory; the hourly rate you receive.		**PAYE** 'Pay As You Earn' - employer deducts tax and NI contributions from your wages or occupational pension before paying your wages or pension. **NI A** – National Insurance letter. **NHS PENSION (%)** Your tax contribution % is based on your Pensionable Pay (whole time equivalent.) See NHS Employers for more info. **STUDENT LOAN** - If you're making repayments on a student loan, this will be shown on your payslip. HMRC tells the Student Loans Company what has been repaid once a year. This means it's a good idea to keep your payslips and P60 as a record of the repayments in case of any problems.		

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GROSS PAY Total amount of money an employee receives before taxes and deductions are taken out. **NI LETTER** Most employees registered under 'A' – other letters exist, e.g. for those entitled to deferred or reduced NI.		**TAXABLE PAY** Gross Pay minus and tax-free elements **TAX PAID** **PREVIOUS TAXABLE PAY** **PENSION CONTS** **EMPLOYEE NUMBER.** Same as 'Assignment or Payroll number'	**PENSIONABLE PAY** **TAX PERIOD** **FREQUENCY** **PERIOD END DATE** **PAY DATE** **PAY METHOD**	**TAXABLE PAY** **NON-TAXABLE PAY** **TOTAL PAYMENTS** **TOTAL DEDUCTIONS** **NET PAY** This is your take-home pay, after tax and deductions. This should match what is paid into your bank account.
NI PAY **NI CONTS**	**OTHER NI PAY** **OTHER NI CONTS**			
PENSIONABLE PAY **SD REF NUMBER**				

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Anaesthesia Digested

May 2020

An analysis of citations of publications in anaesthesia journals.

McHugh UN, Yentis SM.

Rightly or wrongly, Impact Factors remains the most widely used performance metric against which the importance of scientific journals is judged. In 2016, *Anaesthesia* published 115 original articles, 22 reviews, 56 editorials and 186 letters. In the following two years, these 379 articles were cited in 1506 articles. Of these, 476 (32%) were from *Anaesthesia* and 1030 (68%) were from elsewhere. Some might argue 32% is too high, but there is currently no consensus on what an 'optimal' self-citation rate should be. Too low, and the relevance or appropriateness of the journal comes into question. Too high, and there might be a suggestion of Impact Factor gaming. One possible solution is transparency, and it is the policy for all *Anaesthesia* editors and reviewers not to ask authors to add or remove specific references/citations to any journal, including *Anaesthesia*, in their final revisions.

Guidelines for the management of glucocorticoids during the peri-operative period for patients with adrenal insufficiency

Woodcock T, Barker P, Daniel S, et al.

The impetus for this new multidisciplinary guideline was a 2012 'Report to Prevent Future Deaths' issued from HM Coroner Sheffield, expressing concern about the standards of care for patients with adrenal insufficiency undergoing surgery. The Working Party has undertaken an extraordinary amount of work putting together this excellent new summary of evidence, from which eight clinical recommendations were derived. Standout points include: the use of 100 mg intravenous hydrocortisone at induction of anaesthesia for adult patients with adrenal insufficiency followed by a continuous infusion of 200 mg.24 h^{-1}; a reminder that dexamethasone has no mineralocorticoid activity; and separate specific recommendations for children and obstetric patients. The paper has performed extremely well on social media with an Altmetric score of ~350 and is already our 14^{s} highest scoring paper, ever!

A cricket with no legs cannot hear

Avidan MS.

Data can tell a story, and stories are an effective form of human communication. The problem is, the desire to communicate science with stories might trick us into drawing a wrong inference from a correct observation. Drawing on data reported by Le Guen et al. in their paper from the same issue, there are three possibilities. Sugammadex administration for the reversal of rocuronium during total intravenous anaesthesia might lead to sudden arousal; limiting the use of rocuronium may lead to less awareness during general anaesthesia; or sugammadex might reverse hypnosis. Considering the relative biological plausibility of these options to arrive at what we think is the correct answer demonstrates perfectly how the way we all interpret the results of any clinical study is in fact Bayesian.

N.B. the articles referred to can be found in either the latest issue of *Anaesthesia* or on Early View (ePub ahead of print)

Mike Charlesworth, Editor, *Anaesthesia*

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Preparation for SARS-CoV-2 pandemic in South Wales: practical steps

On the 28th February 2020, the first case of the novel severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) originating from Wuhan, China was diagnosed in Wales [1]. The patient contracted the infection during his visit to Lombardy, where the outbreak in Northern Italy started to get a foothold [2]. At this stage, the official Welsh strategy was containment and preparation for a potential outbreak, in line with the rest of the UK. The Welsh NHS was asked to revisit plans for increasing critical care capacity by 100%, based on previous pandemic responses in the UK [3]. Based on the emerging data from Italy, where existing critical care capacity was quickly overwhelmed, decided to start preparations not just to plan, but actually execute the necessary increase of critical care beds on the 6th March 2020.

Aneurin Bevan University Health Board in South East Wales provides services for approximately 639,000 residents, about 20% of the population of Wales. In this organisation there are a total of 23 critical care beds, 16 within the Royal Gwent Hospital and seven within Nevill Hall Hospital, with capacity to provide invasive mechanical ventilation in 13 and six beds respectively. This translates to approximately 3.6 beds/ 100,000 population, one of the lowest in Europe and a stark contrast to the 7.2 beds/ 100,000 population at the start of the outbreak in Lombardy. Similarly to Northern Italy, the typical bed occupancy in Wales is close to 90-95%. We estimated that, even doubling capacity, we would not be able to meet the projected demand for critical care from this low baseline.

To try to mitigate the situation, we started several parallel activities on the 6th March: identification of appropriate physical areas to provide care for both SARS-CoV-2 positive and uninfected patients; development of processes for safe donning and doffing the personal protective equipment (PPE) at various levels of capacity on the SARS-CoV-2 ICU; training including simulation and other practical sessions to train the whole critical care multidisciplinary team on appropriate use of PPE, infection control practices and respiratory interventions such as prone positioning.

One of our Consultants took the lead on developing detailed guidelines for the above issues, and for general care of patients with SARS-CoV-2 infection based on the best available evidence [4]. Nursing staff and allied healthcare professionals worked over the weekend to map workflows, mostly around safe PPE use based on different scenarios and patient numbers. Plans were circulated electronically using WhatsApp groups, and the first official version of the ICU plan was ready by Monday morning. As clinical workload allowed, we started simulation and practical training of all critical care staff.

This has paid off as on the 9th March the first patient with suspected (later confirmed) SARS-CoV-2 infection was admitted to the hospital. He showed the typical clinical signs and clinical course of the severe disease, and was intubated using full PPE precautions in the negative pressure side room of the ICU.

The Critical Care team realised that any escalation of patient numbers could quickly overwhelm the original footprint, and presented the plans to the monthly Quality Improvement meeting of the Anaesthetic Directorate with an invitation to anaesthetic colleagues to form a united front for the challenge. Members of the anaesthetic department have a very broad range of skills ranging from pre-hospital military background to specialists in several subspecialty areas, and the department includes members of the senior hospital management team. In addition, several of them have been contributing to the Critical Care rota until recently. We have drawn upon their specific expertise and formed several groups to initiate rapid training of medical and theatre staff so that they can contribute to the critical care of SARS-CoV-2 and non-SARS-CoV-2 patients, whilst maintaining core emergency anaesthesia service in the hospital. Via close liaison with the Executive Team of the Health Board, elective inpatient surgery was stopped, whilst urgent cancer and day-case surgery continued to free up staff time and to help reducing the burden of inpatient beds.

In the next two days, we ensured that PPE training was completed for all clinical staff in the anaesthetic and theatre teams, rapidly developed a simple protocol for safe and effective mechanical ventilation using the ventilators in the anaesthetic machines, whilst adhering to best practice guidance and simulation scenarios for practical procedures and mechanical ventilation problems [4]. We adapted a daily checklist tool, reflecting local guidance to streamline and standardise the care of SARS-CoV-2 infected patients (checklist courtesy of Dr Matt Morgan, Consultant Intensivist, Cardiff). A communication hub was developed, with the help of the administrative staff of the department, using existing hospital infrastructure and secure mobile messaging tools. We have reached out to the hospital informatics service to ensure appropriate communication devices are available at the bedside and for telepresence as appropriate.

In the meantime, members of the anaesthetic department started liaising with other specialties such as obstetrics and paediatrics to ensure that core services could be maintained, and that these more remote areas were also prepared for the care of infected patients.

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Strategic aspects of disaster management are well described in the literature, and we would only like to offer some very practical points to consider when looking at expanding the critical care footprint into operating theatres [5].

Operating theatres normally have linked airflow management and are positive pressure areas. It is important to liaise with estates management on the optimal sequence of turning these positive pressure areas off to minimise infection spread and contamination. Increasing the flow through anaesthetic ventilators plus expanding the Critical Care footprint, together with increased oxygen use on the general wards, can deplete the oxygen stores of the hospital. Close collaboration with estates and oxygen suppliers is vital to maintain operational capabilities. Operating theatre complexes usually have adjacent changing facilities, which can make them ideal for safe donning and doffing of PPE and also offer some rest facilities for the staff. There are challenges in stocking appropriate pharmaceuticals throughout a large area, and our plan involves using volatile anaesthetic agents for sedation in patients looked after in the operating theatres, partly to maintain a more familiar environment for the anaesthetic staff and partly to reserve intravenous sedatives for other Critical Care areas. We have developed grab bags for airway management, dedicated trolleys for invasive line insertion for the SARS-CoV-2 infected patients, and recommissioned ultrasound machines for this and other rapid assessment purposes. Although most of the imaging information to date comes from CT, anecdotal reports from China confirmed that lung ultrasound can be useful to distinguish whether higher PEEP or prone positioning is more appropriate [6-8]. As this modality is readily available for us, rapid, focused teaching of the recognition of major lung pathologies is ongoing by the accredited ultrasound trainers of the group, using teaching materials from the national point-of-care ultrasound course [9].

Staffing is the biggest concern, as absence due to sickness and other personal emergencies is inevitable. Working with the UK national bodies, we have adopted a safe practice guidance for non-critical care staff working in an unfamiliar environment. We continue to use all available resources including in-situ simulation, online and other distance learning methods, developed either in-house or nationally, to be best prepared for the care of SARS-CoV-2 infected patients and to maintain the highest standards possible for our general critical care and anaesthesia population.

Current official UK predictions state that the peak of the pandemic is approximately 10-13 weeks away, with a considerable tail behind. To maintain our operational capacity throughout this period, staff wellbeing is paramount. We have adopted and continue to promote the national guidance on this issue, and will utilise our well-developed internal resources [10]. Prof Maurizio Cecconi, the President-Elect of ESICM, issued a dramatic warning and plea to the world-wide critical care community on the 4th March 2020. He urged us to prepare and get ready as we are lagging a few weeks behind Italy. We agree that training and support of medical nursing and allied health care professionals is paramount in the short window we have before the patient numbers increase. We have identified that, instead of increasing capacity by 100% as requested by the Welsh Government, we have a possibility to quadruple the number of critical care beds within our organisation.

Our experience is that with shared understanding, clearly delegated tasks and using the social network and camaraderie of the critical care and anaesthesia community we can prepare for the SARS-CoV-2 pandemic.

SUPPLEMENTARY CONTENT AVAILABLE AT: grangecriticalcare.com

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Acknowledgements: members of the Critical Care and Anaesthesia Groups.

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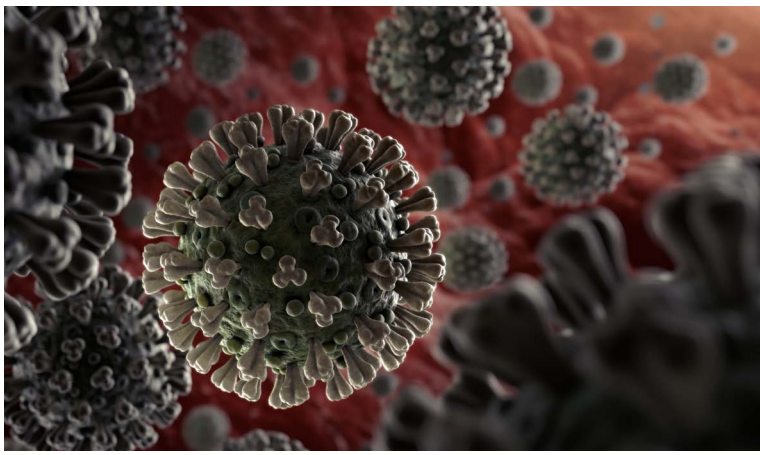
First posted 19/3/2020 on Association of Anaesthetists website / COVID-19 guidance



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Dear Editor

Central venous catheter guidewire – a length mismatch

When I started in ITU, I distinctly remember being told "Never, ever let go of the wire!", a message I have passed to every trainee passing through the unit. So, image my absolute horror when in the middle of a night shift I thought I had lost a central venous catheter (CVC) wire in a patient!

We had recently introduced the 16 cm long ARROWg+ard Blue PLUS® Pressure Injectable Quad-Lumen CVC kit (Teleflex®, Reading, PA, USA) into our unit to facilitate administration of CT contrast. We had previously trialled the 20 cm CVCs, with good feedback.

I was performing insertion of a CVC into the right internal jugular vein of a patient who was having his lungs ventilated. I accessed the vein under ultrasound guidance, passed the guidewire, and removed the plastic guidewire holder. The guidewire looked to have been inserted too far, so I withdrew it to the point where the normal length of wire remained outside the vein. However, I was now unable to insert the dilator over the wire, as the wire was no longer in the vein (as it transpired).

On my second attempt I accessed the vein but left more wire 'inside'. I dilated the vein and then inserted the CVC. As the wire did not protrude through the distal Luer connector, I started to pull the wire out of the vein and feed it up the CVC. As I took hold of the wire coming out of the connector, the distal end of the wire came out from the skin puncture, and then the whole length of wire slipped out of the CVC and fell on the drapes.

I now realised that the wire was considerably shorter than those I had used previously. Armed with this knowledge, I successfully inserted the CVC without problems.

Previously, both 16 cm and 20 cm CVCs had been supplied with 60 cm guidewires; however the new 16 cm CVC was supplied with a 45 cm guidewire. The total length of the 16 cm CVC from tip to distal (brown) connector is 29 cm, therefore the wire only exceeds this by 16 cm (Figure 1). This is much shorter than most practitioners are used to and shorter than the recommendations set out in several anaesthetic and ITU journals [1-3]. Rufener et al. suggested that the appropriate length inserted during CVC placement via the internal jugular vein should be 18 cm, with an additional 5 cm for the operator to hold [1]. These values would suggest that a 52 cm guidewire would be appropriate for this device (29 + 18 + 5 cm).

The incident was escalated within our internal reporting system, and the 16 cm CVCs were removed from use. The problem was reported to the MHRA and Teleflex UK; the latter will now supply the 16 cm CVC with a 60 cm guidewire.

This case served as a reminder to me that we should take time to familiarise ourselves with all new equipment prior to use.

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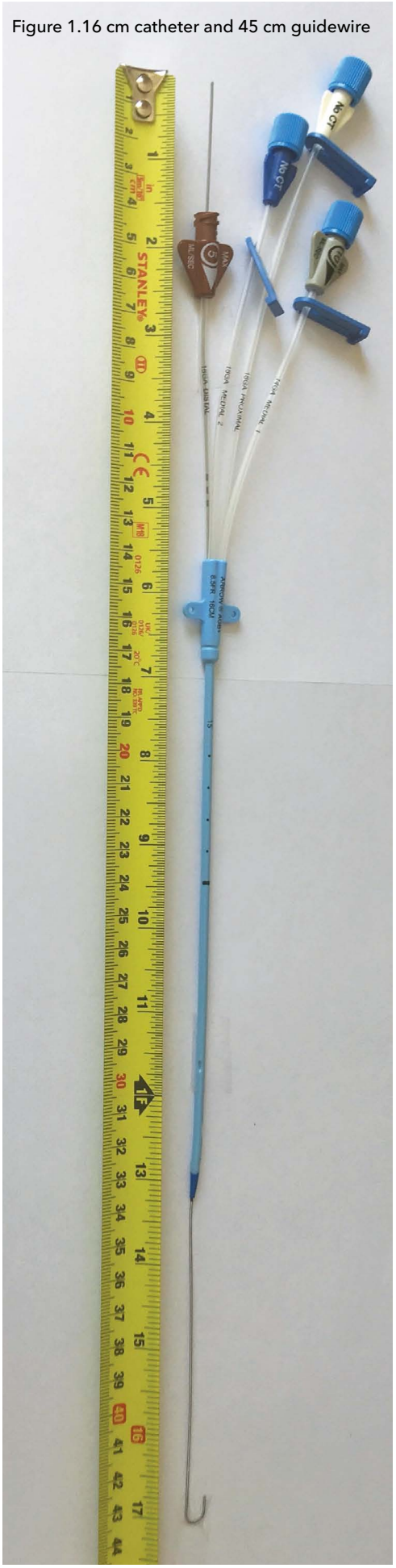
Figure 1.16 cm catheter and 45 cm guidewire



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Your letters

Send your letters to: The Editor, *Anaesthesia News* at **anaenews.editor@anaesthetists.org**

Please see instructions for authors on the Association's website **www.anaesthetists.org**

Dear Editor

COVID-19: hoodwinked? The view from the other side of the mask.

As the hospital Trust serving the region at the centre of the UK's cluster of COVID-19 cases, it is fair to say that the management of these patients has generated a great deal of discussion within our anaesthetic department. In a recent study of 138 hospitalised patients, 17 (12.3%) of patients required invasive lung ventilation, and hospital-related transmission was suspected in 51 (41%) cases including 40 (29%) healthcare workers [1].

There had been much speculation that the use of full-face visors such as those found on the 3M Scott FH1 Half Hood Headtop powered air respirator (PAPR) used in our trust would impair laryngoscopic view during tracheal intubation. We, therefore, set up a session for trainee anaesthetists with two aims: familiarisation with the PAPR; and practice intubation of a manikin using direct and C-MAC videolaryngoscopy whilst wearing the PAPR.

Trainees whose beards preclude the use of an FFP3 mask were particularly keen to try the PAPR. Informal feedback suggested operators did not find that using the PAPR impaired their ability to obtain a satisfactory view at direct laryngoscopy. However it was felt that videolaryngoscopy might still be a sensible choice, as it increased the distance between the intubator's face and the patient during this aerosol-generating procedure (Figures 1 and 2).

WHO, NHS and Trust policy regarding COVID-19 is a rapidly evolving field. Our discussions were not intended to agree on a definitive Standard Operating Procedure, but to give an opportunity for individuals to consider the issues they might encounter. This is likely to be relevant to future pandemics.

We would encourage all anaesthetists to consider similar training and discussion.

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Richard Stoddart
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Figure 1

Figure 2

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Your letters

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Please see instructions for authors on the Association's website **www.anaesthetists.org**

Dear Editor

NI - Never Ignore?

We often leave National Insurance (NI) to play on its own in the corner of our payslips whilst the ever-troublesome PAYE gets all the attention. But if we take the time to really understand our NI contributions, we may unfortunately find it needs as much of our precious personal time.

Much like tax, NI is based on thresholds. You pay 12% of your earnings between £166 - £962 a week (2019 - 2020 figures). The rate then drops to 2% of your earnings on everything above £962 a week. It therefore matters whether the employer thinks they are deducting NI as your main employer, or otherwise.

If you regularly rotate between Trusts, or do any bank/locum work, you may receive multiple payslips per month. Unfortunately, every employer may assume that they are your lead employer. So, much like your tax, your NI can be deducted incorrectly.

HMRC don't flag this up readily. Even self-assessment tax returns don't deal with this issue in the same way that they can amend incorrect tax at the end of the year.

Over a busy training scheme, this error can accumulate. So, whilst a refund is not guaranteed, it's worth sitting down with a calculator and working out if you have a nest egg being carefully guarded by HMRC. You can claim within six years of any overpayments, and you can do so through HMRC, rather than tackling multiple employers individually.

Top tip: final/March payslips will have your accumulated NI payment for each job. You won't find it on your P45s.

Resources:
1) NI information pages from HMRC:
https://www.gov.uk/browse/tax/national-insurance
https://www.gov.uk/claim-national-insurance-refund/y/class-1

2) NI and PAYE calculator:
https://www.tax.service.gov.uk/estimate-paye-take-home-pay/your-pay

Harry Thompson
ST6 Anaesthetist
Imperial School of Anaesthesia

Congratulations to Harry Thompson for winning May's Letter of the Month prize.

Dear Editor

Preoperative gum chewing - fasting is not all that matters

We recently encountered a case of impossible mask ventilation after induction of anaesthesia in a female patient. A size 3 oropharyngeal airway had been inserted once the induction drugs were given, and when the airway was removed with the intent to replace it with a laryngeal mask we found that the distal hole of the airway was completely occluded by chewing gum (Figure 1).

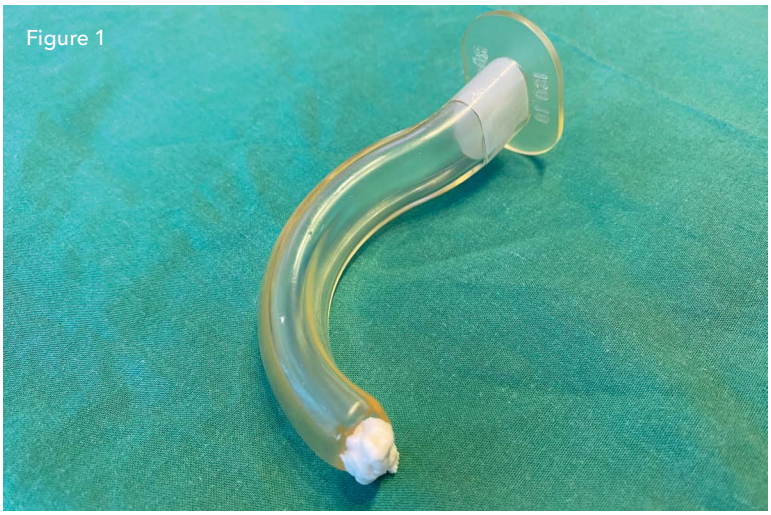
Figure 1

A comprehensive review on peri-operative gum chewing has been published recently [1]. Studies in this area have almost exclusively focused on fasting issues, gastric emptying, peristalsis and postoperative nausea and vomiting [2-4].

The issue of possible airway obstruction by gum has only been discussed in occasional case reports. Two authors reported gum sticking to the side of a tracheal tube without creating ventilation problems [5, 6], but in another case, attachment of gum to the cuff of a tracheal tube led to displacement with a large air leak, requiring tube replacement [7]. Other authors reported attachment of gum to the side of a laryngeal mask [8] and an oropharyngeal airway [9], without creating ventilation problems. Interestingly, recent national fasting guidelines do not mention the risk of airway obstruction by gum forgotten in the patient's mouth [10-13].

A vigilant approach would be to forbid gum chewing in sedated (premedicated) patients [14], and to include a question about gum chewing in the 'Sign in' phase of the surgical checklist.

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References available from the author (tezri@bezeqint.net).

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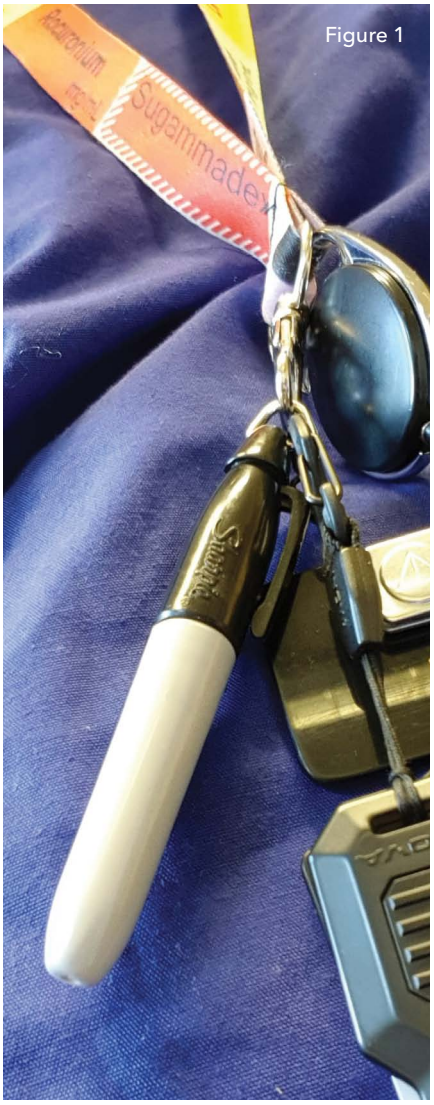

Figure 1

Dear Editor

Using mini permanent markers to improve remote anaesthesia safety

Providing anaesthesia services in an acute hospital involves working in many areas outside theatres and ICU, including wards and the Emergency Department (ED). This can be fraught, as the environments are unfamiliar with work areas not set up to provide anaesthesia. Imagine the scene: you are called to the Resuscitation Room for an unconscious patient who needs tracheal intubation. You, the Second-on, and the First-on on go to Resus together; you employ your human factors training and divide the work. You assess the patient while your colleague draws up emergency and induction drugs. Your colleague can only find some generic labels and so hands you some syringes labelled 'Induction agent', 'Muscle relaxant' and 'Vasopressor'. Before he can say anything more, he is called away to a cardiac arrest on the wards. What is in the syringes?

In this slightly exaggerated, but not impossible, scenario you would be forced to draw up all of the drugs again as the only safe option. Our solution to improve safety when drawing up medications in these environments? We have obtained these mini permanent markers (Figure 1). We have these attached to our lanyards, so they are always available where we go!

These permanent markers allow us to label, immediately and legibly, all our syringes. They also allow us to write the concentration directly on the syringe, which is particularly useful when paediatric cases present to our District General Hospital ED. Finally, we can also improve our documentation by writing the timing of important events on our gloves as they happen. We have even used these in our normal anaesthetic practise when the right labels were not available!

The feedback we have received has been extremely positive, and we believe that this is a very low-cost intervention that could improve safety in remote work areas.

Toby Chanin
Clinical Simulation Fellow
Liverpool University Hospitals

Katherine Gillespie
Regional Clinical Fellow
Countess of Chester Hospital

Letter of the Month prize

It's your *Anaesthesia News*… and we'd love to encourage more of our readers to share their opinions and experiences. A Letter of the Month prize will be awarded to the best letter each month. The winner will receive a £50 voucher to use against the cost of one of the Association of Anaesthetists educational events.

To increase your chances of winning:

- Keep it short (no more than 300 words)
- Be clear and accurate
- Use humour where appropriate
- Keep it topical

The award will be made at the discretion of the Editor, and his/her opinion will be final. No cash alternative will be available. The voucher will remain valid for one year.

Send your letters to:The Editor, *Anaesthesia News* at **anaenews.editor@anaesthetists.org**

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Association of Anaesthetists
Heritage Centre

The leading museum dedicated to the history of anaesthesia in the UK

Visit our centre to explore the inspiring stories of the people, past and present, who have done so much to keep patients safe and pain-free.

Free entry

Currently closed. Please visit our website for opening times.

www.anaesthetists.org/heritage

Up to £2,000

SAS professional development grant 2020

The Association of Anaesthetists awards this grant to enthusiastic SAS doctors who are Association members, for training and professional development opportunities.

The grant is intended to enhance the individual's experience, for example in attending clinical management, leadership and other educational skills courses or acquiring new skills which are relevant to the workplace, in particular where this improves the quality of patient care and improves service development. The total fund available is £2,000 and the awarding Committee may decide to grant multiple awards within the total available but in exceptional circumstances may award the full amount to one applicant.

The grant must not fund routine CPD activities which should be funded through normal study leave budgets, nor examination fees, exam preparation courses or college related fees.

For more details and to apply visit the website **http://anaesthetists.org/sas-grant**

Association of Anaesthetists

The closing date for applications is 20 May 2020 for consideration at the June meeting of the SAS Committee.

Call for nominations for the Featherstone Professorship

Nominations are sought for the Association's 2020 Featherstone Professorship, which is awarded to practising clinicians and scientists who have made a substantial contribution to anaesthesia and its related subspecialties in the fields of safety, education, research, innovation, international development, leadership, or a combination of these.

Applications should be submitted using the application form available on the website **https://anaesthetists.org/Home/About-us/Honours-awards/Featherstone-Professorship**. Completed forms should be emailed to **honsecretary@anaesthetists.org** by **17:00 on 22 May 2020**.

The Association's Honours and Awards Committee will consider nominations at its meeting on 5 June 2020, and will make recommendations to the Board of Directors, which will determine the recipient of the 2020 Featherstone Professorship (if any) at its meeting on the same date. The successful nominee will be informed shortly afterwards. The award will be made at an Association conference.

Featherstone Professorships are held for two years, during which the holder will be required to deliver a Featherstone Oration at a major Association meeting.

Association of Anaesthetists

Call for nominations for the Association of Anaesthetists Award

The Association of Anaesthetists award is made by the Board to those who have made significant contributions to the Association of Anaesthetists and its charitable foundation, its objects and goals, or its members. The award is not restricted to members of the Association. The combined current objectives of the Association of Anaesthetists and its charitable foundation are:

a) to advance and improve patient care and safety in the field of anaesthesia and disciplines allied to anaesthesia in the UK, Ireland and worldwide;
b) to promote and support education and research in anaesthesia, medical specialties allied to anaesthesia and related sciences and the publication of the results of such studies and research;
c) to represent, protect, support and advance the interests of members;
d) to encourage and support worldwide co-operation between anaesthetists;
e) the advancement of public education in and the promotion of those branches of medical science concerned with anaesthesia, including its history.

Nominations should take the form of a short description of the nominee's contributions (maximum 500 words). Self-nomination is acceptable. If you nominate someone else, you should gain their approval for your nomination. Nominations should be emailed to **honsecretary@anaesthetists.org** by **17:00** on **22 May 2020.**

Association of Anaesthetists

The Association's Honours and Awards Committee will consider nominations at its meeting on 5 June 2020, and will make recommendations to the Board, who will determine the recipients of the 2020 awards. The successful nominees will be informed shortly afterwards. The awards will be made at the Association's WSM London 2021 (13-15 January 2021).

Evelyn Baker Award

An award recognising the 'unsung heroes' of anaesthetic departments.

The Evelyn Baker Award was instigated by Dr Margaret Branthwaite in 1998, dedicated to the memory of one of her former patients at the Royal Brompton Hospital. The award recognises the 'unsung heroes' of anaesthetic departments, the often unspoken backbone of the department who is the 'go to' person for clinical or other advice. The award is given to individuals who set themselves apart from peers by demonstrating an exemplary track record in clinical excellence, teaching and training, and supporting colleagues.

To be eligible, a nominee:

- Must be a consultant or SAS doctor in anaesthesia, usually with more than ten years in post
- Must be in clinical practice at the time the nomination is submitted (but can have retired by the time the award is presented)
- Must be a current member of the Association
- Must NOT be in possession of a NATIONAL Clinical Excellence Award.

Nomination is by citation, which:

- Must be submitted by a current member of the Association
- Should include an indication that the nominee has broad support within their department
- May include additional comments from departmental and other colleagues.

The citation which should be of 1000 words or fewer, should explain how the nominee demonstrates outstanding competence that sets them apart from others, under the following headings:

- Clinical excellence (encompassing technical proficiency, consistently reliable clinical judgement and wisdom, and skill in communicating with patients, their relatives and colleagues)
- Teaching and training (encompassing the ability to train and enthuse trainee colleagues is seen as an integral part of communication skill, extending beyond formal teaching or academic presentation)
- Supporting colleagues and co-workers

The Evelyn Baker Award will be presented at WSM London in January 2021.
Details of previous winners and further information can be found on the website
https://anaesthetists.org/Home/About-us/Honours-awards/Evelyn-Baker-Medal-recipients

Association of Anaesthetists

The nomination and citation of up to 1000 words, should be sent to the Honorary Secretary at **honsecretary@anaesthetists.org** by **17:00 on 31 July 2020**.

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www.ebpom.org

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