

ANAESTHETISTS IN MANAGEMENT

QUARTERLY NEWSLETTER

Aug. 07

A Message from the Chair!



Dr Pamela Bell

Plus ça change! Change is the eternal constant in our lives, and the pace of change is ever increasing. For those of us who lead anaesthesia and critical care services, the maintaining, and enhancing, quality in a climate of enhanced financial constraints, medical manpower and training issues, and (in Northern Ireland) new organisational structures remains challenging. As Medical Managers we have a duty of care for the safety and well-being of the patients using our services and in this are responsible to the GMC. With this in mind the AIM committee has taken 'Departmental Governance: Maintaining a Safe Service' as the theme for our annual conference in November, and I look forward to meeting many of you there.

Following on our successful conference last year, we will be returning to the Royal College of Anaesthetists. If you have not yet visited the new college in Red Lion Square, this is your opportunity to see the building and the excellent conference facilities for yourself. We are delighted that Prof Mike Harmer, recently appointed to the post of Deputy Chief Medical Officer in Wales, has agreed to address us on the European working time directive - 2009: The Impossible Dream? Prof Alastair Scotland, Medical Director of the National Clinical Assessment Service, will talk about his experience of working with medical managers who may be responsible for managing a 'failing doctor'. Other topics include managing intensive care services, hospital at night, and the nightmare of workforce planning.

There have been several changes in the AIM Committee. I have taken over the Chair from Dr Melanie Jones, who steered the committee with energy and enthusiasm during her term. She also took up the education lead following the resignation of Dr Grainne O'Dwyer and ran a highly successful Seminar at 21 Portland Place in June. My sincere and well-deserved thanks.

Dr Barbara Thornley will complete her term of office as Honorary Treasurer at the end of the year, and so we are seeking nominations for this post. A vacancy has also arisen on the committee and we will seek to fill this over the next few weeks.

Dr Pieter Bothma has agreed to take on the Education lead, an important one for this specialist society, and Dr Asha Chhatwani has taken over as Newsletter Editor and I do hope you enjoy her first edition.

Dr Bill Rawlinson is the new Honorary Secretary and continues to manage and develop our website, www.aimgbi.org. I hope that you find this a useful site; your comments and contributions to the website are gratefully received.

AIM exists for its members; your feedback has a powerful influence on our activity. If you have any suggestions for future seminars, conferences, newsletters or the website please get in touch.

Dr Pamela Bell
Chair, AIM

**JOIN US AT OUR ANNUAL CONFERENCE
ON 29TH NOVEMBER 2007, AT RCOA
CHURCHILL HOUSE LONDON.**



The conference programme will feature the following topics:

- Improving the Links with Non-Medical Management
- **Dr John Clark**
- Managing SPA's (Tbc)
- Managing A Failing Doctor
- **Professor Alastair Scotland**
- Hospital at Night
- **Dr John Coakley**
- 2009: The Impossible Dream
- **Professor Mike Harmer**
- Cost Effectiveness of Critical Care & Its Interventions
- **Dr Saxon Ridley**
- The Nightmare of Workforce Planning
- **Dr Andrew Tomlinson**

The programme will also feature a Trainee Prize Essay:
"10 Ways that a governance issue could affect my department or my career"

For further information and a registration form, please visit our

website www.aimgbi.org or contact the
Secretariat on +44 207 631 8891.
Alternatively, please email us at aim@aagbi.org

BENEFITS OF BEING A TRAINEE MEMBER

Management is now firmly on the agenda of post-graduate training, to achieve this most trainees attend few directorate meetings and short management courses towards the end of CCST. Subsequently, as a consultant when they are required to take on management role their experience is limited at best. It is important that management training for SpRs should provide the rare opportunity to develop the skills early in training and allow subsequent time to build on knowledge gained.

Becoming a member of management society, undertaking a management project, shadowing a manager are all good places to start to develop knowledge and skills of leadership and executives. Such management skills promote personal growth, intellectual stimulation, bring efficiency and effectiveness as trainee in theatre and ICU and prepares for future role as consultant.

AIM provides an opportunity to develop management leadership skills, solely for anaesthetists and its members are Clinical Directors, lead clinicians, consultants and trainees from anaesthesia.

As a trainee member one can have the following benefits:

- Insight and understanding of NHS management, changes in NHS and skills required to influence those changes.

- Seminars and conferences designed on specific themes - Effective Leadership, time management, negotiating skills, team building, clinical governance, etc gives an understanding of how these skills are crucial to delivery of health care services




Dr Asha Chhatwani

- Networking provides trainees an opportunity to meet and discuss specialty and topical issues with high profile speakers from NHS and other areas of health care
- Trainees acquire basic skills crucial to management success that could be put in practice at early stage e.g. team work, delegation, time management, decision making, effective communication, diplomatic and organizational skills.

- Presentation and publication of management topic at annual conference
- Addressing management issues affecting trainees by sending questions to AIMS committee on website.
- Knowledge of 'How to manage meetings', can be applied to ward rounds, meeting with patients and relatives
- Understanding of management process helps trainees to do the job effectively and breaks the barriers between managers and managed that could make a difference to department / trust

Most merit award winners and committee members of National bodies have worked in clinical management, this reflects skills gained early could have furthered their career. Many talented physicians fail in management position so start early to proceed to leadership post. AIMS offers all these skills to trainee anaesthetists and thus helps to integrate them into management of perioperative services.

Dr Asha Chhatwani
AIM committee member
Locum Consultant


AIM Trainee Prize Essay
Anaesthetists in Management

The title of the AIM 2007 Trainee Essay Competition is:

“10 ways that a governance issue could affect my department or my career”

No more than 1000 words should be submitted to aim@aaqbi.org
Or by post to
The Specialist Societies Coordinator, AIM, 21 Portland Place, London W1B 1PY
By
21st September 2007

The winner will be invited to present their essay at the Annual Conference on 29th November 2007, at the RCOA, London.

The winner will also receive a prize of £250.00

All Trainees are invited to take part in the Essay Competition. Please send an email to aim@aaqbi.org

SUDOKU PUZZLE

3	5		2					6
				3				2
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		1		7		5		9
	8		6		4		7	
6		7		1		2		
			4		5			
1				6				
7					1		3	8

The solution to this puzzle will be in the next issue of the newsletter

WHY SAS DOCTORS NEED TO KNOW ABOUT MANAGEMENT!

Many SAS doctors wonder what management is and why we need to know about it but managers and management are an integral part of our work that impacts on our professional life in the modern NHS.

My life and what I achieved professionally improved exponentially when I got involved in management and started using my knowledge of management in my daily practice. A Personal Development Plan (PDP) is one good example. Developing a PDP helped me to look at my current situation in detail and to review it periodically. I found it to be of great benefit in helping me to make appropriate changes to all aspects of my work. It taught me how important it is to have a framework for what we want to achieve in life and at work, otherwise I would have had flights of fancy whilst drifting aimlessly without really achieving anything.

It is essential to have a good knowledge of management of finance. Money determines the way we work, the things we can or can not do and enables us to plan for the future realistically. It helps you to put business cases and put them in an appropriate way that managers will understand and consider. For any clinician and especially anyone who is interested in introducing a change or new apparatus and technique this is essential.

Managing and dealing with colleagues needs some knowledge of personnel management skills. Dealing with young as well as experienced colleagues, coping with difficult colleagues and getting the best out of people and maximising their potential requires certain skills that the study of management techniques can give.

Interacting with non-medical professionals at work, understanding their jobs and their views, especially working as a member of the team with them and speaking their language needs practice and training.

Organising small as well as large committee meetings and chairing

them effectively is one of the basic functions of being a manager.

Chairing meetings and making your voice heard in these meetings also needs some knowledge which a study of management will provide.

Important aspects of the duties of any manager are 'Negotiating skills' and 'Conflict management'. It is



Dr Ramana Venkata Alladi
Chair, SAS Doctors

absolutely necessary to have some training in negotiating skills without which it is impossible to achieve new things.

Presentation and writing skills are essential for any manager. Public speaking and a good presentation manner help to achieve better and more.

I used to think that all this was common sense and it may be to a certain extent. One needs specialist skills to be an efficient and successful manager.

Some SAS doctors may wonder whether there is any point in learning about management as they do not seem to hold any managerial positions. On the other hand if one has knowledge of management nothing stops them from getting involved. There are SAS doctors in the NHS who are lead clinicians, clinical directors and medical directors only by virtue of their experience in management.

Otherwise knowledge of management gives us an insight into leadership and helps with

enhancement of our personal profile and status in the department and in the trusts.

How can an SAS doctor get involved in management?

We can get involved in the management of the operating theatres (looking into the organisation of operating lists, quality issues, avoiding cancellations just to mention a few) clinical audit, risk management and quality and clinical governance issues. It is exciting and rewarding to represent your group at the Trust level in LNC and as a member of

BMA, present business cases and organise specialist services.

Becoming involved in all these only helps one to contribute to the organisation in a big way and the managers appreciate your contribution. Otherwise just administering anaesthetics can become monotonous.

The first step is to attend courses organised by AIM and AAGBI on management and to start networking. There are several courses conducted specially for healthcare professionals at all levels during weekends or one-week residential courses in the local universities and business management schools. Local universities and the Open University hold correspondence courses on health service management. These are tailored to the needs of doctors and give a broader view of NHS and management.

So get involved and broaden your career.

Ramana Alladi
AIM Member
Representing the SAS Group
Tameside General Hospital
Cheshire

“10 Management Competencies I will need as a Consultant (and Why)”

My Day as an Anaesthetic Consultant

06.30 – Wake up. Try and arrange time to pay bills, sort kids, visit dentist, exercise, visit ageing relatives and watch Bath playing rugby at weekend. Balancing home life with working commitments’ - 1st management decision of the day - done.

07.30 - The departmental morning meeting. I am implementing a rota change for the juniors to comply with the new banding proposal. To manage this change I will need to be aware of my colleague's hopes and expectations, hospital limitations and financial recourses - Difficult. I need to be able to communicate to my junior staff the reasons for the change, understand and appreciate their concerns and worries and as a department we need to be able to come to an amicable decision and a reasonable way to implement the change - not easy.

09.00 - Due to the prolonged meeting the lists now start late and the patients who were told they were having there operations at 9am are now displeased and complaining. Managing complaints and litigation requires me to constantly work on good communication skills. I've learnt that grievance dealt with early on can hopefully prevent complaints going any further, which are a drain on hospital resources and can cause negative communication between staff and patients in the future.

09.30 - I then start my list a little delayed and distracted. I have now five cases on the list and minimal theatre time. I am now acutely aware of the time management; I need this list to be running efficiently. I do this by making sure the theatre staff, myself and the surgeons are all working as a team. I need to delegate efficiently, ensure my staff have what they need to get their jobs done and avoid micromanaging. By proper organisation of the team this list can be completed on time. I also need to show appreciation to the team and for them to feel empowered and that a

good morning work has been completed.

12.00 - Just as I finish the list I get called to recovery, where a patient is apnoeic and peri-arrest. I must quickly, calmly and assertively become a leader and deal with this situation. I need to combine my technical skills, making the diagnosis and commencing treatment, with my interpersonal skills of delegating and clearly communicating jobs to team members that are within their capability.

12.30 -The patient recovers and I go to the theatre the patient came from to find a stressed and upset senior house officer. I have to be able to manage stressed and upset colleague, without disrupting the list. I find another colleague to continue the list and the senior house officer and I go to the anaesthetic department for a debriefing of the case. In their recent appraisal (which I think are very important) I was aware that this senior house officer had a close relative with a terminal illness, I now find out the situation is worse. I use my interpersonal relationship to allow them to discuss their fears and worries, in an environment where there is mutual respect, open and honest communication and trust. We decided together that the senior house officer should take some compassionate leave.

13.30 - Brief lunch.

14.00 - I then spend the next few hours teaching the fourth year medical students. I need to be able to put the events of the day so far to one side and concentrate on education. Over the prior week I had prepared the teaching session, so that I felt I was putting all I could into educating our future doctors. Developing and retaining these medical students is helping in long term management plans of the NHS organisation.

16.00 - The final part of the day is spent in chairing a meeting with the

“theatre user group”. At the meeting we discuss the purchasing of different drugs and equipment. Managing resources within the limitation which are impose locally by the trust and nationally by the government makes our jobs very difficult in this group. Despite reading the positive reviews about certain drugs and equipment, we are denied the use, due to their ever increasing costs. Negotiation skills are really important at this meeting as there is a tendency for the certain departments to want the latest equipments to the detriment of other departments. I need to be able to work well within a committee that aims to match resources to the requirements of the hospital.

18.00 - As I am on call tonight I need to check with my junior staff that they are happy with the evening case load, that they feel they can communicate with me overnight if they feel out of their comfort zone of responsibility and that I will support their actions so that they don't feel solely accountable. I want them to feel that the department is a decentralized organisation.

19.00 - As I return home I reflect on the day's events. I think about my personal appraisal, what I did well during the day and where I could improve. I think about all the management competencies I have used hourly during the day and wonder what competencies I may need tomorrow.

Dr Juliet Hull
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Dr Hull's essay won the runner-up prize in the 2006 Annual Trainee Prize Essay Competition

QUESTIONS THAT COULD BE ASKED AT A CONSULTANT INTERVIEW

1. Anything related to a NICE guideline relevant to your speciality
2. Anything related to an NSF relevant to your speciality
3. Audit
4. Research
5. Dealing with a local service problem (which might be mentioned in a Health Commission report for that Trust)
6. Possible service developments
7. Dealing with a complaint
8. Dealing with a difficult colleague/trainee
9. Developing an using non-medical clinicians in an expanded role e.g., prescribing, nurse consultants, nurse anaesthetists
10. Your personal strengths and weaknesses
11. MMC and run through training
12. Development of a team
13. Payment by results
14. Independent treatment centres
15. Foundation status for the Trust—the implication
16. Achieving EWTD hours for trainees for 2009
17. Anything relating to Clinical Governance besides complaints such as staff training, supervision etc.
18. Revalidation and appraisal for Consultants
19. Any new Government proposal that has recently hit the headlines
20. Achieving targets
21. An understanding of the commissioning of services including Practice Based Commissioning
22. Improving the primary/secondary care interface
23. Redesigning a service, especially for efficiency and financial savings!
24. Reconfiguration of services, especially a local proposal
25. Explain your research/audit/treatment in lay terms i.e., to a patient/carer “Sell” your speciality to a group of school leavers.

Who might ask -

University representative – items from your C.V.,4

Specialty representative –

1,2,5,6,9,15,19,21,22,23,24

Medical Director –

1,2,3,6,7,11,12,13,14,16,17,18,20

CEO –

1,2,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,2

3,24

Lay chairman – 14,15,18,25,26

PCT representative – 5,6,20,21,22,24

'NETWORKING' IN ANAESTHESIA'

Managed clinical networks have been defined as a formally organised network of clinicians. The main function of which is to audit performance on the basis of standards and guidelines with the aim of improving healthcare across a wide geographical area for specific conditions. Examples include cancer networks and renal medicine networks, but how might they apply in anaesthesia.

In June the 'Guide to Effective Managed Care Networks for Critical Care' was published. Commissioned jointly by the National Critical Care Network Managers' Group (England) and the Department of Health to determine the benefits of Managed Care Networks for Critical Care.

The report provides evidence of improvements in diabetic care and childhood cancer through the introduction of care networks but there is as yet little robust evidence of effectiveness of critical care networks. Three new studies have been commissioned (due to report 2008-09) but none are specific to Critical Care Networks.

Potential benefits of Critical Care Networks include better and more consistent clinical outcomes for patients with safer and faster access to patient sensitive services. For clinicians there should be improvements in service performance through shared learning and open and inclusive clinical engagement in service development. Development of new ways of working and quicker translation of research into practice facilitates modernisation. Networking also fosters the development of strong clinical leadership through the use of clinical champions and clear roles and responsibilities, opportunities for development, coaching, mentoring and the development of robust governance systems.

From an organisational perspective, better management of resources across sites and between multi-disciplinary teams, enhanced financial control and systematic use of information, benchmarking and peer review are some of the perceived benefits.

Commissioners consider networks to encourage more efficient commissioning of services ensuring quality and service equity and as being effective conduits for communication of a compelling vision and clear direction for service reform. They also permit development of realistic, robust and collaborative arrangements to enable system wide/ regional response to major incidents.

Factors determining success of clinical networks are listed as, network centrality, accountability, leadership, workforce, network cohesion, stakeholder support and ownership, mutual trust, measurable improvements, continuous improvement, improved patient experience, knowledge management, information management, assurance and civil contingency.

Advice is given to Strategic Health Authorities, Primary Care Trusts, Health Care Providers, Local Government, and Medical Schools, Universities and Workforce Development Confederations of ways in which they should support development of Critical Care Networks.



Those anaesthetists with clinical leadership responsibilities for critical care services in all parts of our islands would do well to study this document in detail and reflect upon their local service delivery.

There are also potential lessons for other anaesthesia services (pain medicine, paediatric anaesthesia?). If the prime motivation for the establishment of Clinical Networks is delivery of enhanced patient care through service improvement we should support them.

Ref: 'Guide to Effective Managed Care Networks for Critical Care' Ed. Alan Kennedy, Fusion Healthcare Consultancy. Commissioned by the National Critical Care Network Managers' Group (England) and the Department of Health to determine the benefits of Managed Care Networks for Critical Care. Pub. June 2007

Pamela F Bell
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