

Anaesthetists In Management



NEWSLETTER

A MESSAGE FROM THE CHAIR!



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Welcome to the autumn 2006 Newsletter from Anaesthetists in Management. The current NHS environment remains challenging to all those involved in the management of anaesthesia and critical care services. The recent General Medical Council guidance "Management for Doctors" provides much for us to reflect upon and seeks to clarify the duties of doctors undertaking any management role.

This guidance provides a definition of management - "Getting things done well through and with people, creating an environment in which people can perform as individuals and yet co-operate towards achieving group goals, and removing obstacles to such performance."

The GMC is also clear as to our primary responsibility as medical managers "You continue to have a duty of care for the safety and well-being of patients when you work as a manager. You remain accountable to the GMC for your decisions and actions even when a non-doctor could perform your management role"

Those who work in organisations with significant financial shortfalls will be facing many difficult decisions in the coming months, as will all departments as they identify changes resulting from the introduction of run through training



in August 2007 as part of Modernising Medical Careers.

AIM hopes that many of you will attend our 2006 conference on 16th November "MAKING SENSE OF CHANGES IN THE NHS" where many of the current issues affecting our daily lives in the NHS will be discussed. I look forward to seeing you there.

Dr Melanie Jones
Chair.

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We are on the web!

WWW.AIMGBI.ORG

'AiM would like to thank Janssen-Cilag Ltd, NAPP Pharmaceuticals Ltd and Pfizer Ltd for the educational grants which have assisted us in the publication of this newsletter.

A conversation with

..... ***Dr Ian Carson***

Dr Ian Carson is the current chairman of the Regulation and Quality Improvement Authority for Northern Ireland. He is a former Deputy (and for a time Acting) Chief Medical Officer of the Department of Health, Social Services & Public Safety (DHSSPS) in Northern Ireland. He was appointed as Consultant Anaesthetist in the Cardiac Surgical Unit of the Royal Victoria Hospital, Belfast in 1975, was first Clinical Director of Anaesthetics and Intensive Care Services and later Medical Director and Deputy Chief Executive to the Royal Group of Hospitals Trust.

Q. *What inspired you to develop an interest in Medical Leadership?*

A. I have enjoyed several career opportunities to demonstrate effective medical leadership. Firstly as Regional Educational Advisor on behalf of the Royal College of Anaesthetists, I particularly enjoyed the introduction of the structured training programme for Specialist Registrars.

Then, in the late 1980s, I was involved in a resource management initiative at the Royal Group of Hospitals. With the introduction of the Health and Social Service reforms this was an extremely interesting period and offered opportunities for personal and professional development as the hospital progressed towards full Trust status. With the expansion of the directorate it was my responsibility to encourage, motivate and involve my colleagues in the process of implementing systems and structures that enabled the directorate to function more efficiently while retaining high standards of quality and ensuring patient safety through effective risk management.

It was also a parallel objective to maintain the ethos of the Royal Hospitals as a centre of under graduate and postgraduate teaching and research.

Q. *In 1993 you became Medical Director of the Trust. What were the most challenging aspects of this role?*

A. As an executive member of the Trust Board of a major university teaching hospital the MD provides strategic and professional advice and leadership. This includes maintenance of standards of professional performance, workforce and clinical service planning, development of teaching and research, and development of effective external relations with the DHSSPS, the Health and Social Services (HPSS), GPs and the wider primary care sector. The development of effective liaison with the universities and training bodies, including the Medical Royal Colleges, GMC and BMA. In the latter part of the decade I had clinical lead responsibility for the introduction of Clinical Governance.

During my time as MD I took a particular interest in doctors and their contribution to Health Care Management. I was a founder member of the British Association of Medical Managers and was elected to the Board of the Association of Trust Medical Directors.

Subsequently I served on numerous regional and national Working Parties many with a particular interest on post-graduate education, operating theatre management and the prevention, detection and management of poor clinical performance in doctors. With increasing emphasis on clinical governance, I was invited to undertake a part-time secondment to the DHSSPS as a Special Advisor to the Chief Medical Officer, Dr Henrietta Campbell, on Clinical Governance.

Q. *You obviously enjoyed your work at the Department for in August 2002 you moved there on a permanent basis as Deputy Chief Medical Officer.*

A. Yes. In this role I reported directly to the CMO and provided regular briefings to the Minister and senior officials in the DHSSPS and other government departments. To this I brought my knowledge and experience of 'front-line' services. In particular I was helpful to the CMO in building effective communication with Trust Medical Directors, a key group of people necessary to lead modernisation within their respective organisations.

Q. *And you continued to pursue your interests in clinical governance and performance of doctors?*

A. My main responsibility within the Medical and Allied Branch of the DHSSPS was the area of professional standards and the development of the Quality and Safety agenda. I was the medical lead on the implementation of 'Best Practice, Best Care', which was Northern Ireland's Quality Framework policy document. This included a number of parallel quality issues which continue to be taken forward with Special Health Authorities and Agencies in England. I also chaired the advisory team that prepared 'Confidence in the Future', the consultation document into the prevention, recognition and management of poor performance in doctors, and have overseen the implementation of appraisal procedures for doctors as Chair of the Appraisal and Revalidation Steering Group in the Department.



Q. *What personal qualities have contributed to your success?*

A. I am personally committed to the seven principles of public life, namely: selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

I would cite as one example of how I have adhered to these principles, namely, through the implementation of the recommendations of the Human Organ Inquiry. I was charged with the chairmanship of the Department's Implementation Steering Group to take forward the 20 recommendations in the Report of the Northern Ireland Inquiry Team led by Mr John O'Hara QC. Following this most public and sensitive inquiry, it was essential that the Group tackled the complex inter-relationships, with their respective cultures that exist between the health service, the professionals that work within it, the university and research community, the coroners office and patients, their relatives and families. Following public consultation, we produced new consent forms and guidance documents for HPSS staff and relatives and families. We undertook to ensure that Northern Ireland was covered by the new legislation of the Human Tissue Act, including the appointment of a Northern Ireland member to the new Human Tissue Authority. We held numerous meetings with the Relative's Reference Group, established permanent memorials in Belfast and Londonderry, and have now introduced a new regional Bereavement Service

This development required the Group to work within the recommendations established by a public inquiry, to be responsive to public needs and sensitivities and at the same time develop policies and procedures that not only benefited the HPSS, but ensured that there should be no opportunity of similar events occurring again in the future.

Q. *You have recently retired from the Department of Health to take on a new role as Chairman of the Regulation and Quality Improvement Authority. Quality seems to be a thread that is interwoven in all of your leadership roles.*

A. I think that this new stage of my career brings together many strands and in a sense completes a circle. As a consultant anaesthetist, I was concerned with delivering a high quality service to my patients: as CD and MD, quality management of services within the Directorate and the organisation was the priority. At the Department, I was continually ensuring the quality of policy development. Throughout all of these stages, despite gaining a huge level of personal and professional satisfaction, I kept asking myself 'What is the evidence that I am making a difference and that am I doing any good?' This new role as Chairman of the RQIA, N. Ireland's equivalent of the Healthcare Commission, provides the opportunity to evaluate the quality of services to patients and service users, and thereby reassure the DHSSPS, the HPSS and the public. It also allows me to continue as an agent for change and to ensure that services are clinically effective, cost effective and responsive to the needs of the public. It is also an opportunity to ensure that health and social services in Northern Ireland are up to standard, and hopefully I can encourage our health and social service professionals to continually strive for improvement.

Dr Carson was interviewed by
Dr Pamela Bell
Editor
Anaesthetists In Management Newsletter

AIM TRAINEE ESSAY PRIZE

There is still an opportunity to submit your essay to the AIM 2006 Essay Competition

"10 management competencies I will need as a consultant (and why)"

No more than 1000 words should be submitted to the Specialist Societies Coordinator, AIM, 21 Portland Place, London, W1B 1PY by 30th September 2006.

The winner will be invited to present their essay at the AIM conference in November 2006 and receive a prize of £250.

INVESTING IN SERVICES

Most Anaesthetists enjoy the fact that anaesthesia is fundamentally a hospital based speciality at some remove from primary care and specifically from the requirement of engaging directly with PCT commissioners. They smile supportively but are nonetheless secretly bemused as the vagaries of choose and book and the havoc it can wreak on efficiently run clinics are related by their surgical colleagues. Some of us are of course more directly involved through pain management services, provision of intensive care services or as a consequence of management positions we may hold. More of us should be involved as whatever our chosen specialist interest or field of practice if the patients do not 'choose' and/or the 'commissioners' have not supported our hospital/Trust to provide that service then the nature or place of our practice must change if we wish to continue in our chosen field of interest.

So what can you do to ensure the future provision, perhaps development of existing services and establishment of new services?

Firstly, you must know your product and place it ... What exactly are you/do you want to provide? Are there any guidelines or national frameworks etc., relating to this service? How do your proposals fit with the national/regional/local strategic framework/direction relating to this service?

Secondly, you must recognise and assess your market. Is there a need for this service (other than on your personal wish list) locally/nationally? What is the demand? What capacity do/will you require or can you provide? Who is already providing this service locally/nationally? How does/will your service compare? Why should the patient/commissioners choose your service? Would you? Honestly!

Finally, funding is now tariff based, essentially a fee per item of care, can you provide this service within the tariffs set? Is your service economically viable in the long term? Many new services will be income consumers in the set up or short term but getting investment is not usually a problem if you can demonstrate income generation in the middle to long term. More difficult is the existing service operating outside reference costs; you will need to clearly show how you plan to turn it around. Simply asking for 'more money' is not usually sufficient in the current climate. Commitment to 'new ways of working', restructuring, hitting all the 'buzz' themes of the moment, (visit the NHS library to familiarize yourself with the

latest and greatest NHS papers/plans etc) is expected, nay, required.



It is a marketplace, though not entirely open and with some quaint rituals. You must convince patients and their PCT commissioners that they need and more importantly want you, and your hospital/Trust that you are or will soon be a 'cash cow'. If your service is a 'dog', expensive, limited in its 'customer' base and likely to always be so, you must convince your Trust, PCT commissioners and or Strategic Health Authority that the clinical need is such that this service must be provided. Good Luck!

Grainne O'Dwyer
Education Lead
AIM



HOW TO SURVIVE A PMETB VISIT

This year has seen the start of a new process for accreditation of training. The Royal Colleges no longer visit Trusts or Specialty Schools" to accredit training - this is now the responsibility of PMETB. Not only has the process changed but the format of the visits has also changed. PMETB visits are to a Deanery, not an individual Trust and within that visit they will usually look at more than one specialty. What they are in fact doing is examining the quality control and quality assurance processes set up by the Deanery to maintain standards of training. They look at the specialties to see how these processes are being applied and monitored. They may or may not visit every Trust involved in a specialty training programme and they most definitely will not meet every individual trainee. However the Trusts they do visit will be looked at in depth as to how they are meeting the training requirements and the educational contract. They will look carefully at the relationship between the Trust and the Deanery, the local processes such as induction programmes, the EWTD, attendance from that Trust at Regional training programmes and in particular the importance the Trust Board puts on the training of its' junior staff. They do look at the seniority of who represents education on the Trust Board!

You will be required to produce considerable information prior to a visit. The more evidence you can produce (such as policies, trainee surveys, audit of such things as appointments committees, registers of attendance at training for both trainees and trainers) the easier the visit will be. Don't forget however that they will meet some trainees and trainers and will question them about that evidence!

The visiting team is very different. There is a chairman, a postgraduate dean, two specialty representatives for each specialty being accredited and two lay visitors from a wide variety of backgrounds. Not every member of the team will visit every Trust. If your Trust is involved in the visit for your specialty try to ensure they take the visit as seriously as they did a college visit. Make sure senior man-

agement (preferably the CEO) and the Medical Director are available to meet the visitors and that the overall organisation of the visit runs smoothly i.e., there is car parking space available, they are greeted at the door, everything happens on time and those who should be there turn up!



Don't panic!

Remember this is a new process, there will be mishaps and misunderstandings - but you are given the opportunity to feed back to PMETB any concerns you have so make a note of anything significant you feel they should know about.

In conclusion - DON'T PANIC - just make sure everyone who possibly can is available to meet them even if they haven't specifically asked that they be there, if you can't produce the evidence they ask for look worried and tell them you are working on it, make sure the taxis turn up on time and the drivers know where to go, that there is plenty of refreshments and that their hotel is to the expected standard and you can't go wrong.

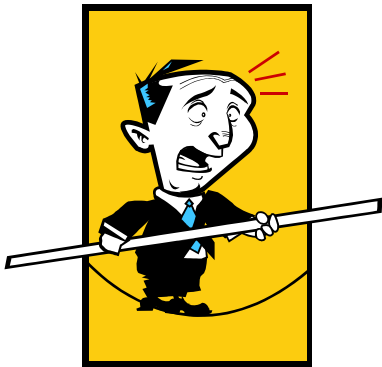
Barbara Thornley,
Associate Postgraduate Dean,
Oxford.

"They may or may not visit every Trust involved in a specialty training programme and they most definitely will not meet every individual trainee. However the Trusts they do visit will be looked at in depth"

A Personal view

The Balance between Managing and Representing....

Most medical managers probably went into their leadership role via the representational route. A department needed someone to be a voice on some hospital committee or other, and the new recruit either didn't jump back quickly enough when volunteers were sought, or he/she just happened to be the only one free to go to the meeting that afternoon. Many get a little further down the organisational road, but some, and probably most of you reading this, have found the challenge interesting, and progressed into more responsibility. In the early 1980s, when I was first a consultant, there was a clearer demarcation between managers (we called them, and they were, administrators in those days) and clinicians. The nursing profession had taken up management as part of the Salmon process, and promotion was away from the wards into Nursing Officer roles; but the doctors stayed as representatives of their peers, albeit within Unit Management Teams.



The Griffiths report changed all that in the mid-eighties, and general management was born. Hospitals had overall managers who were responsible for all services, not just their professional team. As well as the ex-administrators and the nurse-managers, a number of these Unit General Managers (UGMs) were doctors, most of whom retained a reduced clinical workload, but took on responsibility, to the District Management, for all services, clinical and non-clinical.

This system evolved in the 1990s through Clinical Directorships to Trusts (which have to have Medical Directors, by statute), and now through combinations, amalgamations, absorptions, take-overs etc to new forms of management where the speciality barriers themselves are breaking down, and sub-medical-directorships are appearing in the larger Trusts. Nevertheless there is still the need for a medical manager to retain the overall support of his/her clinical colleagues including that of other clinical professions.

Medical management at different levels, however, involves differing balances between the authoritarian and the representative role. The principle, though, should be that management is a two-way process. A medical manager at any level needs to prioritise the various calls on resource, much as a doctor has to prioritise his time between clinical urgencies.

At the lower levels this means that the local lead (say the Lead of Cardiac Anaesthesia) has to advise on the most important needs of his sub-speciality, to his seniors in the structure. He is negating the value of his role if he simply produces a shopping list of all needs, and leaves his seniors (even if they are anaesthetists) to choose without the specialist knowledge. Conversely more senior medical managers should not simply pass down diktats from above. They should have the courage to challenge, not by shroud-waving, but by reasoned argument, based on the support and advice of their team and on their own experience. They do, however, have to recognise the limitation of resources, even in the most perfect system, and be prepared to prioritise, and also be prepared to point out the limit of resources to their colleagues. This latter can often be a source of ill-feeling and loss of confidence in medical managers by the medical professionals.

It is probably at this stage that the concept of leadership becomes best defined. A leader should not be simply someone who takes his troops forward as ordered, whatever the probable outcome, but someone who is prepared to choose the most successful route to that outcome. That is Leadership, as opposed to Management. On the other hand he should not be so concerned with the negatives that he makes no progress at all. That is the traditional concept of the Administrator.

What worries me at the moment is that, while doctors are being encouraged to become more involved in management, all too often this means more management involvement by, actually, fewer doctors. We are in great danger of moving back to the 1980s, with only a few consultant-managers who "do the admin", and a greater number of doctors who are "switched-off" from any managerial role, interest or involvement. What is really needed, for the benefit of all staff, patients and the service, is a greater encouragement of all doctors to get involved in some way with the running of their service, and be prepared to engage with managers as colleagues. This demands a two-way management process, whereby all doctors feel their views are important, although, of course, they cannot all be accommodated all the time.

But it has to be made worthwhile for consultants to express their opinions and give their advice, for if the advice is not listened to, it may not be offered again. Doctors may well have ideas on how the system should develop. Managers may well have different options that should be considered. But the pace of change now is such that it becomes all too easy to have an imposed revolution rather than a negotiated evolution. This explains the apparent barriers that have, tragically, re-emerged between, on the one hand, a political agenda demanding instant solutions on a short-term timescale, and, on the other hand, a medical body who feel that not everything we have done for some time has therefore necessarily to be wrong.

The medical managers are left in the middle of all this, and this is why they often feel isolated, and why colleagues such as fellow AIM-members can be useful in Support. In an ideal system, all consultants should feel involved in the running of their service, and therefore all consultant anaesthetists should feel that AIM has something for them.

The most reliable way to get the confidence of your medical peers, when you are in a managerial role, is to ensure, and demonstrate, fairness. That way you will achieve respect. You will have to make difficult decisions and cannot expect to be popular. When all else fails, remember that someone once said that if you cannot make everyone happy, then make sure that everyone is equally miserable.

Dr Bill Rawlinson
AIM Committee Member
Medical Manager 1982-2005
UGM 1986; Medical Director 1997-2002



Medical managers often
feel isolated.

SUPPORT FOR ANAESTHETISTS WITH A MANAGEMENT ROLE

It is often said by those doctors with a management role that they find it difficult to informally discuss issues with anyone who truly understands what they are doing. Indeed, it was a recognition of this that first brought a group of anaesthetic clinical directors from across the UK together for networking and this group subsequently evolved into Anaesthetists in Management.

In an ideal world the solutions to problems may be found locally but to avoid re-inventing wheels a network of experienced support may assist. For a clinical director to approach the medical director may seem too formal. Within an anaesthetic department it can be difficult to discuss management issues with consultant colleagues, it may even be impossible if confidential matters are involved. Individuals with a management role may prefer to discuss matters impartially with someone from outside the organisation. Sometimes you may just need someone to off load to.

Consultants who are considering taking on a management role may wish to talk through their personal challenges with someone who listens and can help the individual reach a decision. It is also useful to be part of a network of those in a similar situation or with experience of similar situations who can provide advice and support.



We provide a listening ear!

In order to deliver this network AIM would like to encourage members who wish to access advice and support to contact us by e-mail. Your request / query / problem will then be passed to one of a group who have volunteered to reply to e-mails. Contact will be made initially by e-mail and then by phone if necessary. This service can also be accessed by anaesthetists who are not members, on the understanding that members must take priority. Let us know if you would like our assistance.

And finally, if you are prepared to join the list of those willing share their expertise and provide support, please let us know.

Melanie Jones
Chair.

ENTERTAINMENT ZONE

| SUDOKU | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AUTUMN PUZZLE (The Solution will be printed in the next issue of the newsletter) | | | | | | | | |
| A | H | | | | | D | | |
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| | | I | | C | | E | | |
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| Solution to sudoku puzzle in March 2006 Newsletter | | | | | | | | |
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| D | H | B | G | F | E | A | I | C |
| I | E | A | B | D | C | F | G | H |
| F | C | E | H | A | G | B | D | I |
| B | I | G | C | F | D | H | A | F |
| A | D | H | F | B | I | E | C | G |
| H | G | F | A | I | B | C | E | D |
| C | B | D | E | G | H | I | F | A |

ENCOURAGING SAS DOCTORS TO DEVELOP SPECIAL INTERESTS

The main reason some doctors elect to work in hospitals is because it gives an opportunity to practice as specialists. And some hospital doctors join SAS grade by choice but mainly because they cannot get into higher professional training and still remain attached to the speciality.

Anaesthetics is a procedure oriented speciality. The longer one works, the greater the skills that can be demonstrated. SAS doctors are involved very actively day to day in the management of patients that are acutely ill and probably involved more in the patient's care in the field. Some senior SAS doctors have vast experience and skills, in some cases, more than a younger consultant.



According to a recent survey seventy percent of SAS doctors have post-graduate qualifications. However, in the NHS they are not allowed to practise independently, as they can only do so under the supervision of a consultant. Once they elect to be SAS doctors it is difficult to find time and opportunities to

acquire training and qualifications whilst working as full time doctors. Whereas during specialist registrar training there is specific training and time provided. This means that SAS doctors have to get training on the job.

The study leave period allowed may be insufficient to obtain adequate experience and knowledge of a sub-speciality to have enough confidence to practise as a specialist.

However, I believe that it is possible to develop a special interest as an SAS doctor. The nature of working conditions in the speciality of anaesthetics actually affords excellent opportunities to develop specialist experience. With the right choice of speciality that helps to give enough exposure in the department it will be easier to acquire the skills and to specialise.

It is advisable to consider a speciality that figures prominently in the department. There is no point in having knowledge of a speciality in which no consultant has expertise as the trust will not allow you to introduce and practice the skill without consultant supervision.

I had experience in acupuncture and NLP and yet I could not practice my skills as there was no no-acute pain service and none of the consultants had expertise in that field. It could be frustrating. I believe, however, in future, there should be provision for limited accreditation whereby those doctors who have specialist

skills and qualifications could be assessed for their sub-speciality skills (competency based assessment) so that they can practise their skills independently.

The other aspects of being a specialist and practice specialist skills are:

1. Keep in touch with current trends by studying appropriate literature and attending refresher courses
2. Join the appropriate specialist society and if possible take active part in its activities by presenting papers, posters and attending meetings regularly.
3. Attending meetings help to meet colleagues with similar interests and compare notes and exchange ideas. It also helps to develop meaningful contacts.
4. Develop some research interest in some aspect of the work. This will help you to improve the quality of work.
5. Regularly audit the work. This will help to assess your performance and justify the Trust administrators
6. Teaching the skills to trainees, colleagues and organising workshops and lecturing are the best ways to maintain touch with the speciality

Most of the subspecialties in anaesthetics have proper training facilities organised by the respective professional bodies and offer recognised qualifications. For example air-way management, regional anaesthetic techniques, acute and non-acute pain management, acupuncture, intensive care and obstetric anaesthetics are just a few.

It is advisable to consider a speciality that figures prominently in the department.

It is not my intention to explain in detail how to develop skills in an individual speciality but to explain how as an SAS doctor, one can develop as a specialist. In my experience, being an SAS doctor is no real hindrance to continuing professional development. With the right choice of subspecialty, active, on-going interest, sincere commitment and full consultant support, it is possible to succeed.

Dr Venkata Ramana Alladi
SAS, Chair

MEDICAL MANAGEMENT COMPETENCIES FOR ANAESTHETIC SPECIALIST REGISTRARS

With the introduction of competency based training firmly established, specialist registrars are required by the Royal College of Anaesthetists, as part of their training, to obtain competencies in the "Development of Professional Knowledge, Skills and Attitudes". This requirement encompasses Health Care Management along with Teaching and Medical Education, Information Technology and Medical Law and Ethics. Unfortunately, unlike clinical competencies which can be acquired through clinical practice and accompanied lists, obtaining such Professional Knowledge competencies is more problematic, time consuming and costly.

In today's consultant job climate it is clearly not enough to apply for appointment with just one's clinical competencies ticked off. New consultants are expected to participate fully in the running, management and development of today's National Health Service. Indeed, time dedicated to this is recognised within job planning activities. Such commitments can range from a departmental level, for example taking responsibility for rota writing, to a role at hospital level such as a clinical director of the department representing one's colleagues within the hospital. Anaesthetic consultants have become their hospital Medical Directors and a full range of opportunities exist at national level through organisations such as the Royal College of Anaesthetists, the Association of Anaesthetists and the British Medical Association.

The required competencies are provided in Section 16 of the RCA Competency Based Training, Book IV. This is downloadable from the RCA website. Section 16 can be divided into two parts.

The first part deals with those competencies, which should really be able to be acquired at a local departmental level with a little planning and foresight. Such management competencies extend from the knowledge of terms and conditions of employment of medical staff, fitness to practice, equal opportunities and through to roles such as the college tutor. In the past such roles that have been traditionally associated with a mainly educational component, now require a greater understanding of management issues.

The Specialist Registrar's department and college tutor should be supportive in one's attempts to acquire the appropriate experience even if it takes away one's availability for service commitment for a limited period of time. Some of the competencies are clearly more easily achievable than others. How the HR Directors will feel if all the hospital registrars spent a week or two following them around is yet to be seen. Any problems encountered should be raised at the

annual RITA, which at the very least may ease the path for future registrars.

The second part of Section 16 starts by clearly stating that a trainee should attend a formal NHS Management course. Several national courses exist. One of the most popular and long standing is the Keele Management Course, which runs several times a year. PasTest also runs a national management course but with some emphasis on other aspects such as medical law. These three or four day courses tend to be popular but expensive. With an ever decreasing study budget available to trainees, and reduced study leave time, over the last couple of years more 'in-house' deanery courses have been developed to meet the needs of the trainees. The AAGBI runs a management seminar throughout the year and Anaesthetists in Management go some way to meeting requirements through its annual meetings.

As with the first part of S 16, some of the competencies within the second section, such as the role and responsibilities of occupational health, will be achievable within one's local hospital. However many competencies are more orientated to the National Health Service as a national organisation. The ability of a department to provide teaching geared towards these competencies is very dependent upon the level of experience within that department and is very hit and miss.

Early planning from Year 3 onwards is essential in order to be certain of achieving all the Section 16 competencies. Whilst attending a national management course may be more appropriate in one's final year of training, many of the competencies laid down are eminently achievable at a local level. More information is provided in the GAT Handbook in the chapter written by Dr Sian Jagger. If no deanery course is available locally then it would be very appropriate to consider setting one up. Both AIM and GAT would be happy to provide further information and advice.

References

RCA Competency Based Training, Book IV
AIM website
Management Training for Anaesthetists, Dr Sian Jagger, GAT Handbook 2005

Useful Websites

www.rcoa.uk
www.cmu-keele.org.uk
www.pastest.co.uk
www.aagbi.org

Dr Michael Parris

CONFERENCE REGISTRATION FORM

PERSONAL DETAILS

PLEASE WRITE CLEARLY IN BLOCK CAPITALS



Title* Surname*

First Name* Daytime Telephone

Address

..... Postcode

Email address

Title of post held (or other as applicable)*

Name of Hospital (if applicable)*

Dietary requirements

Any further requirements

***These details will be used on your conference badge, the attendance list and all conference literature.**

REGISTRATION FEES

(Please tick appropriate box)

| | |
|-------------------|---------|
| <i>AIM Member</i> | £110.00 |
| <i>Non-Member</i> | £120.00 |

Registration fees include refreshments and lunch.

Payment may be made by Sterling cheque drawn on a UK bank and made payable to *"AAGBI Specialist Society Account"* or you may pay by credit card

Please find enclosed a cheque to the sum of £

Please debit my credit card as detailed below £

Credit Card (Visa / Mastercard / Delta); or Maestro/Switch

Card/Switch Number

Start Date Expiry Date

Security Code (last three digits on signature strip) Issue No (Switch only)

Name on the card

Statement Address (if different from above).....

.....Postcode

Cardholder's signature Date

Please return your completed registration form to:

4th Annual Conference, Anaesthetists in Management, 21 Portland Place, London, W1B 1PY
For further information please visit www.aimgbi.org or telephone 020 7631 8891

We regret that we cannot accept telephone bookings.

CANCELLATION CHARGES

Up to 15th September 2006 a full refund will be given less a £25 administration charge. From 15th September to 15th October 2006 a 50% refund will be given. After 15th October 2006, no refund will be given.



4TH ANNUAL CONFERENCE

“MAKING SENSE OF CHANGES IN THE NHS”

16th November, 2006,
RCoA, Churchill House, Red Lion Square, London

Topics for discussion to include:

Impact of ISTC on training and consultant job plans
Making sure anaesthetists and their contribution to the NHS are recognised and valued
Patient safety and medical performance - Learning lessons from Anaesthesia and Surgery
Understanding reforms in the NHS - the big picture and its local impact
New disciplinary procedures for Doctors
Delivering and achieving the SpR Management competencies
Recruitment and Selection into Run Through Training

Confirmed speakers to include:

Dr David Whitaker, President, AAGBI
Dr Griselda Cooper, Vice President, Royal College of Anaesthetists
Sir John Lilleyman, Medical Director, NPSA
Dr Allan Cole, Medical Director, Leicester
Prof. David Whitney, Clinical Management Unit, Keele University
Mr Nigel Edwards, Policy Director, NHS Confederation

Delegate registration: Members £110.00; Non Members £120.00

Numbers for this event are limited.
Early application is advised to ensure a place.
Trainees welcome.

For further information contact:

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Further details will be available from www.aimgbi.org.